

9-8-98
Vol. 63 No. 173
Pages 47419-48080

Federal Register

**Tuesday
September 8, 1998**

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and notice of recently enacted public laws.

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Federal Register

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The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 51

[Docket No. 98-016-2]

Brucellosis; Increased Indemnity for Cattle and Bison

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Final rule.

SUMMARY: We are adopting as a final rule, with two changes, an interim rule that amended the regulations governing Federal indemnity paid under the brucellosis eradication program to increase the amount of indemnity that may be paid for certain cattle and bison destroyed because of brucellosis. The interim rule described two indemnity methods—an appraisal method and a fixed-rate method—from which owners of certain animals approved for destruction may choose. As amended by this document, the rule now allows owners to receive Federal indemnity for unweaned, neutered calves in herds approved for depopulation, and the fixed-rate indemnity method now accounts for the higher value of registered beef cattle and dairy cattle compared to nonregistered beef cattle and bison. This action will provide sufficient financial incentive for cattle and bison owners to depopulate brucellosis-affected herds. The continued existence of these herds increases the risk of disease spread and prolongs the eradication process.

EFFECTIVE DATE: September 8, 1998.

FOR FURTHER INFORMATION CONTACT: Dr. Valerie Ragan, Senior Staff Veterinarian, National Animal Health Programs Staff, VS, APHIS, 4700 River Road Unit 36, Riverdale, MD 20737-1231, (301) 734-3754.

SUPPLEMENTARY INFORMATION:

Background

The regulations in part 78 of title 9 of the Code of Federal Regulations (CFR) govern the interstate movement of cattle, bison, and swine to help prevent the interstate spread of brucellosis, a contagious disease affecting animals and humans caused by bacteria of the genus *Brucella*. In humans, brucellosis initially causes flulike symptoms, but the disease may develop into a number of chronic conditions, such as arthritis. In cattle and bison, brucellosis causes, among other things, decreased milk production and loss of young through abortion or birth of weak calves. Humans can be treated for brucellosis with antibiotics; there is no feasible means of curing brucellosis in food animals.

The regulations in part 78 are part of a cooperative Federal and State program, administered by the Animal and Plant Health Inspection Service (APHIS), U.S. Department of Agriculture (USDA), to eradicate brucellosis from the United States. Program officials are striving to eradicate the field strain of *Brucella abortus* from domestic cattle and bison herds by the end of December 1998. Among other things, the regulations in part 78 provide a system for classifying States or portions of States (areas) according to the rate of *B. abortus* infection present and the general effectiveness of the brucellosis control and eradication program in the State or area. The classifications are Class Free, Class A, Class B, Class C, and quarantined States and areas, with Class Free States being those in which there has been no finding of brucellosis in cattle or bison for the 12 months preceding classification and quarantined States and areas being those States and areas with the highest rates of brucellosis. As of July 31, 1998, there were only 8 known affected cattle herds and 1 known affected bison herd, and APHIS had declared 43 States, Puerto Rico, and the U.S. Virgin Islands free of the disease.

Brucellosis is commonly transmitted to susceptible animals by direct contact with infected animals. The disease is also transmitted to susceptible animals in contact with an environment that has been contaminated by discharges from infected animals. Infected pregnant cows may discharge billions of *Brucella* bacteria at calving or abortion. Although

it is not common, infected bulls can spread the disease to cows during breeding. Because brucellosis is transmitted by sexually intact animals, steers and spayed heifers do not pose a risk of transmitting brucellosis.

The basic approach to brucellosis eradication in cattle and bison has been to test cattle and bison for infection and send sexually intact infected and exposed animals to slaughter. Brucellosis-exposed cattle and brucellosis-exposed bison have a high probability of contracting brucellosis, and may, in fact, be contagious before they react to an official test for brucellosis. Because the continued presence of brucellosis in a herd seriously threatens the health of animals in that herd and other herds, the prompt destruction of sexually intact brucellosis-affected cattle or bison is critical to the success of the eradication program.

To encourage destruction of sexually intact cattle and bison that are infected with or that have been exposed to brucellosis, USDA pays Federal indemnity to owners of certain animals that are destroyed because of brucellosis. The regulations governing indemnification under the brucellosis eradication program are in 9 CFR part 51 (referred to below as the regulations). Without sufficient financial incentive to destroy exposed animals or depopulate affected herds, many owners prefer to quarantine exposed animals or, when the exposed animals in a herd cannot be isolated, the entire herd. Quarantining is a lengthy and expensive process for both the owner and USDA. USDA has to pay to have the quarantined herd tested periodically, until the herd is found to be free of brucellosis, and the owner may not sell or move any animals while they are under quarantine, except for slaughter, which provides less revenue than sales for breeding purposes.

In an interim rule effective March 24, 1998, and published in the **Federal Register** on March 31, 1998 (63 FR 15281-15284, Docket No. 98-016-1), we amended the regulations to provide additional financial incentive for owners to choose depopulation when USDA offers to pay indemnity for destruction of a herd. We amended § 51.3, "Payment to owners for animals destroyed," by changing the system of determining the indemnity to be paid for all cattle and bison destroyed under

the program, except for individual reactors and sexually intact exposed female calves that are not part of a whole-herd depopulation.

As a result of the interim rule, the Administrator may authorize the payment of indemnity by USDA to any owner of the following animals destroyed under the brucellosis eradication program: (1) Cattle and bison identified as reactors as a result of a complete herd test and any sexually intact exposed female calves (defined in § 51.1 as "a female bovine less than 6 months of age that is nursed by a brucellosis reactor at the time such reactor is condemned, and that has not been altered to make it incapable of reproduction"), (2) cattle and bison in a herd that has been approved by APHIS for depopulation, and (3) brucellosis-exposed cattle and brucellosis-exposed bison that were previously sold or traded from any herd that has, subsequent to the sale or trade, been found to be affected with brucellosis.

For individual cattle and bison identified as reactors on a complete herd test and for any sexually intact exposed female calves, the interim rule provided a fixed indemnity rate: \$250 for any registered cattle and nonregistered dairy cattle and \$50 for any bison, nonregistered cattle other than dairy cattle, or sexually intact exposed female calves. For cattle and bison herds that have been approved for depopulation and for brucellosis-exposed cattle and brucellosis-exposed bison that meet the conditions described above, the interim rule allowed owners to choose an appraisal method or a fixed-rate method for determining the indemnity amounts. As specified in the interim rule, under the appraisal method, the indemnity is the appraised market value of the animal minus the salvage value, and under the fixed-rate method, the indemnity will not exceed \$250 per animal. The method chosen must be used for all animals to be destroyed.

According to the interim rule, owners have the option of having an appraisal of their animals done prior to choosing the method used. Appraisals are conducted by an independent appraiser selected by the APHIS Administrator, and the cost of the appraisals is borne by APHIS. In all cases, the amount of Federal indemnity is determined in accordance with the regulations that were in effect on the date that reactors were found or the date that depopulation or removal of individual exposed animals was approved. Prior to payment of indemnity, proof of

destruction¹ must be furnished to the Veterinarian in Charge. The Administrator shall authorize the maximum per-head amount for animals approved for indemnity under the brucellosis eradication program unless: (1) Sufficient funds are not available, (2) the State or area in which the animal is located is under Federal quarantine, (3) the State does not request payment of Federal indemnity, or (4) the State requests a rate lower than the maximum.

We solicited comments concerning the interim rule for 60 days ending June 1, 1998. We received 14 comments by that date. The comments were from cattle industry associations, State departments of agriculture, and veterinary associations. All of the commenters were in favor of the intent of the interim rule. Many stated that increased indemnification is important for the rapid completion of the brucellosis eradication program because some producers have been reluctant to depopulate their affected herds. However, all but one of the commenters requested changes to the provisions of the interim rule. The suggestions made in the comments are discussed in detail below.

The comments primarily dealt with two concerns. The most prevalent suggestion was to allow cows and nursing calves in herds approved for depopulation to be appraised as a pair because these animals are generally worth more as a unit than as individuals.

The second most prevalent suggestion was to allow indemnity to be paid for all unweaned calves in herds approved for depopulation and to exempt any neutered calves from "B" branding and slaughter requirements. (Currently, the regulations allow for indemnity to be paid for sexually intact calves of both sexes but not for spayed heifers or steers, with the exception of work oxen, because neutered animals do not present a threat of spreading brucellosis. However, a common herd-management practice involves neutering nursing calves, especially the males. Owners of herds approved for depopulation are

reluctant to slaughter cows with nursing calves that have been neutered because these calves are not eligible for indemnity and feeding unweaned calves is a labor-intensive and frequently unsuccessful undertaking.) The commenters expressed concern that owners of herds approved for depopulation may either delay depopulation until the neutered calves can be weaned (generally at about 6 months of age) or opt to test the herd with removal of reactors until the herd qualifies for release from quarantine. In either case, the herd remains as a potential source of disease transmission for an extended period of time. Several commenters stated that herd owners whose management practices include neutering of calves are "seriously disadvantaged" by the provisions in the interim rule.

One commenter stated that it is important to pay adequate indemnity to the owners of cows with nursing bull calves. The commenter stated that 4 to 6 months after weaning, the nursing bull calf becomes a valuable steer worth approximately \$500. Without being offered adequate indemnity, owners of exposed cows with nursing bull calves may resist depopulation. The commenter further stated that either "an indemnity option to encourage such owners to depopulate should be provided" or the Federal fixed indemnity should be increased by \$100 and the States should be permitted to apply State indemnity funds to address this issue.

One commenter suggested several other changes to the regulations. (1) State clearly that bull calves are eligible for indemnity. These calves would include weaned and unweaned bull calves that are to be used for breeding and unweaned bull calves that are not to be used for breeding. (2) Require destruction of all sexually intact males and females for which indemnity is paid. However, bull calves under 18 months of age for which indemnity is paid could be castrated and not destroyed and exempted from reactor tagging and "B" branding requirements. (3) For the purpose of herd depopulation, define a "steer" as a castrated male that has been weaned and a "not weaned steer" as a castrated male that has not been weaned. Allow indemnity to be paid for not weaned steer calves and exempt these calves from reactor tagging, "B" branding, and slaughter.

One commenter "encourages APHIS to continue to vigorously attack the remaining vestiges of this contagious disease affecting animals and humans." The commenter urged that, as the

¹ The Veterinarian in Charge shall accept any of the following documents as proof of destruction: (a) A postmortem report; (b) a meat inspection certification of slaughter; (c) a written statement by a State representative, APHIS representative, or accredited veterinarian attesting to the destruction of the animal; (d) a written, sworn statement by the owner or caretaker of the animal attesting to the destruction of the animal; (e) a permit (VS Form 1-27) consigning the animal from a farm or livestock market directly to a recognized slaughtering establishment; or (f) in unique situations where the documents listed above are not available, other similarly reliable forms of proof of destruction.

eradication program winds down, APHIS continue adequate monitoring and surveillance at first points of market concentration and/or slaughter to prevent reinfection of the Nation's cattle herd from undetected animals.

Our final rule incorporates some of the suggestions made in the comments.

We agree with the comments about the increased value of cow-calf pairs over individual animals, and the appraisals made under the brucellosis program already take into account the increased value of such pairs. We further believe that adequate indemnity is currently offered for both weaned and unweaned bull calves and that no clarification needs to be made to the regulations regarding the eligibility of bull calves for indemnity. We also do not believe that definitions of steer and bull calves need to be added to the regulations. However, we will amend the regulations to allow for payment of indemnity for certain neutered calves as explained below.

In regard to the suggestions regarding unweaned calves in herds approved for depopulation, we recognize the problems described previously for herd owners caused by slaughtering cows that have nursing calves. We have decided to offer herd owners indemnity for unweaned, neutered cattle and bison in herds approved for depopulation. We are changing the regulations in paragraph (d) of § 51.9, "Claims not allowed," to allow for such payment. However, for reasons described below, we are not changing our regulations to incorporate the suggestion to allow indemnity to be paid for these calves but not require them to be destroyed.

As with all other animals for which Federal indemnity is provided under the brucellosis eradication program, we will require that owners of unweaned, neutered cattle and bison in herds approved for depopulation send these unweaned calves to slaughter or otherwise destroy them in accordance with the regulations in order to receive indemnity for them. Although these animals do not pose a threat of spreading brucellosis, we believe that it is important to require their destruction because we do not want to establish a situation in which it is financially beneficial for owners to have brucellosis infection in their herds. By providing indemnity for these calves and then allowing the owners to keep them, the possibility exists that the owners could profit from this action if the animals are raised and then sold at a later date. As stated previously, our goal in providing indemnification to owners under the brucellosis eradication program is to provide sufficient financial incentive to

encourage destruction of infected and exposed animals. Therefore, we are not amending the requirement in § 51.3 of the regulations that owners must provide proof of destruction of their animals in order to collect Federal indemnity for them. We are also not amending the requirements in § 51.5, which specifies methods of identification, including an option for "B" branding, for animals to be destroyed. Owners who choose to seek Federal indemnity for unweaned, neutered calves in herds approved for depopulation must identify and move these calves to slaughter in accordance with § 51.5 of the regulations and provide proof of destruction for them in accordance with § 51.3 of the regulations.

In regard to the comment concerning continued efforts by APHIS to identify and eliminate the last vestiges of brucellosis, we recognize the need to ensure adequate monitoring and surveillance to detect and eliminate any newly discovered sources of the disease and are committed to continuing efforts in this regard.

We are also making a change to the interim rule to correct an inadvertent omission. As stated previously, the interim rule specifies that, for owners of herds and individual exposed animals that qualify for either the appraisal method or the fixed-rate method of indemnity, the indemnity rate under the fixed-rate method shall not exceed \$250 per animal. For reasons explained below, the interim rule should have stated that, under the fixed-rate system, the indemnity shall not exceed \$250 per animal for bison and nonregistered cattle other than dairy cattle and \$750 per animal for registered cattle and nonregistered dairy cattle. We are amending the language in § 51.3 (a)(2)(ii)(B) accordingly.

Prior to publication of the interim rule, the indemnity regulations for herd depopulation in States other than Class Free States took into account the higher value of dairy cattle and registered beef cattle in comparison with bison and nonregistered beef cattle. The former regulations provided that, in States other than Class Free States, the indemnity for animals in herds depopulated because of brucellosis would not exceed \$250 per animal for any bison and nonregistered cattle other than dairy cattle and the lesser of 95 percent of appraised value minus salvage value or \$750 for any registered cattle or nonregistered dairy cattle. The regulations essentially provided a fixed-rate system with an appraisal component in States other than Class Free States: For regulated animals with

comparatively lower values (bison and nonregistered beef cattle), the indemnity was capped at \$250; for regulated animals with comparatively higher values (registered beef cattle and dairy cattle), the indemnity was capped at \$750.

As stated previously, under the new indemnity system established by the interim rule, owners of herds approved for depopulation must choose one of the two methods (appraisal or fixed rate) for all of the animals in the herd. While the appraisal method obviously accounts for differences in value of animals, the fixed-rate method (\$250 per animal) does not account for any differences in value. In changing the former indemnity regulations to the interim rule, we inadvertently omitted under the fixed-rate method the higher rates (up to \$750 per animal) that had been in place under the former regulations for registered animals and dairy cattle in States other than Class Free States.

Under the interim rule, owners of nonregistered beef cattle herds are expected to choose the fixed-rate method because the rate of \$250 per animal plus salvage value is fair compensation for these animals; owners of registered beef cattle herds are expected to choose the appraisal method because \$250 per animal plus salvage value is inadequate compensation for such animals. Owners of beef cattle herds with a mixture of registered and nonregistered animals would have to choose the appraisal method to obtain adequate compensation for all their animals. However, in certain situations, the fixed-rate method can be advantageous to both APHIS and the owner, i.e., APHIS can avoid the cost of conducting the appraisals, and the owner can receive the indemnity money quickly. To make the fixed-rate method under the interim rule commensurate with the former indemnity regulations, which accounted for the higher value of registered beef cattle and dairy cattle, we are splitting the fixed-rate method into the two levels described above. This change in the fixed-rate method should not cause a significant difference in program expenditures and will facilitate depopulation of affected herds with a mixture of registered and nonregistered animals.

Therefore, based on the rationale set forth in the interim rule and in this document, we are adopting the provisions of the interim rule as a final rule with the changes discussed in this document.

This final rule also affirms the information contained in the interim rule concerning Executive Orders 12372

and 12988 and the Paperwork Reduction Act. Because the emergency nature of the interim rule made compliance with section 603 and timely compliance with section 604 of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) impracticable, we are addressing the Regulatory Flexibility Act in this document as set forth below.

Effective Date

This is a substantive rule that relieves restrictions concerning the payment of indemnity for certain cattle and bison. Therefore, pursuant to the provisions of 5 U.S.C. 553, it may be made effective less than 30 days after publication in the **Federal Register**.

Executive Order 12866 and Regulatory Flexibility Act

This rule has been reviewed under Executive Order 12866. The rule has been determined to be not significant for the purposes of Executive Order 12866 and, therefore, has not been reviewed by the Office of Management and Budget.

In its effort to eradicate brucellosis, an infectious and contagious bacterial disease affecting animals and humans, the Federal Government offers indemnity payments to owners of cattle and bison destroyed because of brucellosis in accordance with the regulations in 9 CFR part 51. As completion of the brucellosis eradication program approaches, whole-herd depopulation of affected herds has become critical. Program officials recently determined that the Federal indemnity payments needed to be increased to provide sufficient incentive for owners to agree to depopulate herds. When whole-herd depopulation is necessary, producers incur costs related not only to animal loss, but also to transactions, including expenses of gathering and loading, transportation, and commission fees. Furthermore, with the loss of an entire herd, producers suffer production losses; dairy operations lose milk production, and beef operations lose calves. Registered herds may experience the irretrievable loss of valuable breeding characteristics.

In an interim rule published in the **Federal Register** on March 31, 1998, (63 FR 15281–15284, Docket No. 98–016–1), APHIS increased the Federal indemnity payments under the brucellosis eradication program to better reflect the appraised value, or fair market value, of certain animals destroyed under the program. Program officials believe that the increased payments will provide the necessary inducement for producers to depopulate affected herds and replace slaughtered animals with healthier ones. The continued existence of these herds

increases the risk of disease spread and prolongs the eradication process.

In 1997, the total number of cattle and bison in the United States was approximately 101.2 million, valued at about \$53 billion. Gross income of the U.S. cattle industry was about \$31 billion, and total U.S. earnings from exports of live cattle, beef, and veal was approximately \$2.6 billion. More than 97 percent of the 1,167,910 U.S. cattle and bison operations had gross cash values of less than \$500,000, which, according to standards for agricultural producers set by the Small Business Administration, categorizes these operations as small entities.

The number of brucellosis-affected herds varies over time. According to an informal APHIS estimate, for each herd in quarantine, program officials expect the possible existence of two potential suspect herds. As of July 31, 1998, eight cattle herds and one bison herd were under quarantine. However, only six herds (all owned by persons considered to be small entities) were potential candidates for depopulation. Five were nonregistered beef herds with a total of approximately 1,367 head of cattle, and one was a registered beef herd with about 155 head.

According to the indemnity regulations in place prior to publication of the interim rule, the producers accepting herd depopulation would have received \$250 per head as indemnity payment for bison and nonregistered beef cattle destroyed and the lesser of either 95 percent of appraised value minus salvage value or \$750 for any registered cattle or nonregistered dairy cattle. In addition to these Federal indemnity payments, these owners would have received the salvage value for each animal and possibly a State supplement to the Federal indemnity payment.

In 1997, beef and cull dairy cows sold for slaughter brought an average of \$270 salvage value per 900-lb animal. The replacement cost of a nonregistered beef cow with calf averaged \$750, and a cow with no calf, \$500. A replacement cow from a registered beef herd averaged \$1,200. These figures show that, even before taking into account the other costs, the total compensation (the sum of the salvage value and the indemnity amounts in place at that time) paid to a nonregistered herd owner still fell short of the replacement costs. Specifically, the shortfall averaged \$230 per nonregistered beef cow with calf. As a result, many producers would not opt for whole-herd depopulation if offered. The continued existence of affected herds can result in the spread of

brucellosis, hindering the eradication process and increasing long-term costs.

Under this final rule, which gives producers of herds approved for depopulation the option of receiving a fixed rate for their animals or an amount based on an appraisal, it is anticipated that many producers will choose the fixed-rate method for claiming indemnity for bison and nonregistered beef cattle and the appraisal method for registered cattle and nonregistered dairy cattle. For owners of bison and nonregistered beef cattle, the value per animal would be about \$520 (the fixed rate plus the estimated salvage value), which is very close to the market value of the animals. Owners of registered cattle and nonregistered dairy cattle would not incur a direct market loss because the new indemnity payments would amount to the appraised market value of the live animals minus the salvage value realized. Owners of herds comprising registered and nonregistered beef cattle could choose either indemnity method to receive adequate compensation for their animals as a result of a change from the interim rule to the final rule that split the flat rate into two levels—\$250 for bison and nonregistered beef cattle and \$750 for registered beef cattle and dairy cattle. Another change from the interim rule to the final rule is the inclusion in the indemnity payment program of neutered calves that are nursing cows in herds approved for depopulation. These calves were formerly excluded from eligibility for indemnity. This change will have an additional mitigating impact on the losses certain producers would incur through herd depopulation.

The cost to APHIS for paying indemnity to the six eligible herd owners if they had decided to participate in whole-herd depopulation under the former indemnity regulations would have been approximately \$322,375; the cost to APHIS under the regulations created by the interim and final rules would be approximately \$352,450—a difference of \$30,075. (We estimate that \$26,625 of that total is the result of paying indemnity for the neutered calves.) Because keeping potentially diseased animals or having a herd under quarantine creates a severe competitive disadvantage, these producers can be expected to participate in whole-herd depopulation if their losses are reasonably reduced. These figures do not take into account any currently unidentified affected herds for which APHIS may want to encourage depopulation in the future. However, the total compensation that APHIS will provide in fiscal year 1998 will be limited by available appropriated

funding and will not exceed \$3.41 million on a nationwide basis.

Compared with the value of the U.S. cattle industry and its importance to the national economy, the actual costs of increased indemnity for depopulating all animals in all brucellosis-affected herds is small. Competitiveness in the international market depends upon a reputation for producing high-quality, disease-free animals. Both the actual product and the purchasers' perception of the product's quality contribute to continued world market acceptance. While isolated brucellosis outbreaks resulting in relatively small potential losses in cattle production can reduce the confidence of importers and cause a loss of trade, the damage that would result from a widespread brucellosis infection would be extremely costly and harmful to U.S. gross national income. Therefore, efforts to eradicate brucellosis and secure the health of the cattle industry continue to serve the economic interests of the Nation. The increased indemnity payments promulgated by this rule are expected to provide a stronger incentive for whole-herd depopulation of affected cattle. This rule should result in savings to the eradication program because the rule will facilitate the program's progress. The overall effect of this rule upon supply, price, and competitiveness is expected to be minor or none.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action will not have a significant economic impact on a substantial number of small entities.

List of Subjects in 9 CFR Part 51

Animal diseases, Cattle, Hogs, Indemnity payments, Reporting and recordkeeping requirements.

Accordingly, we are amending 9 CFR part 51 as follows:

PART 51—ANIMALS DESTROYED BECAUSE OF BRUCELLOSIS

1. The authority citation for part 51 continues to read as follows:

Authority: 21 U.S.C. 111–113, 114, 114a, 114a–1, 120, 121, 125, and 134b; 7 CFR 2.22, 2.80, and 371.2(d).

2. In § 51.3, paragraph (a)(2)(ii)(B) is revised to read as follows:

§ 51.3 Payment to owners for animals destroyed.

- (a) * * *
- (2) * * *
- (ii) * * *

(B) *Fixed-rate method.* The indemnity shall not exceed \$250 per animal for bison and nonregistered cattle other

than dairy cattle and \$750 per animal for registered cattle and nonregistered dairy cattle.

* * * * *

3. In § 51.9, paragraph (d) is revised to read as follows:

§ 51.9 Claims not allowed.

* * * * *

(d) If the animals are:

- (1) Barrows or gilts maintained for feeding purposes; or
- (2) Spayed heifers or steers, unless the steers are work oxen, or unless the spayed heifers or steers are unweaned animals in a herd approved for depopulation in accordance with § 51.3 of this part.

* * * * *

Done in Washington, DC, this 28th day of August, 1998.

Joan M. Arnoldi,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 98–24016 Filed 9–4–98; 8:45 am]

BILLING CODE 3410–34-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98–NM–18–AD; Amendment 39–10742; AD 98–18–26]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A320 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain Airbus Model A320 series airplanes, that requires repetitive inspections to detect fatigue cracking of the front spar vertical stringers on the wings; and repair, if necessary. This amendment also provides for an optional terminating action for the repetitive inspections. This amendment is prompted by issuance of mandatory continuing airworthiness information by a foreign civil airworthiness authority. The actions specified by this AD are intended to detect and correct fatigue cracking of the front spar vertical stringers on the wings, which could result in reduced structural integrity of the airframe.

DATES: Effective October 13, 1998.

The incorporation by reference of certain publications listed in the regulations is approved by the Director

of the Federal Register as of October 13, 1998.

ADDRESSES: The service information referenced in this AD may be obtained from Airbus Industrie, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT:

Norman B. Martenson, Manager, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–2110; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an airworthiness directive (AD) that is applicable to certain Airbus A320 series airplanes was published in the **Federal Register** on May 5, 1998 (63 FR 24760). That action proposed to require repetitive inspections to detect fatigue cracking of the front spar vertical stringers on the wings; and repair, if necessary. That action also proposed to provide for an optional terminating action for the repetitive inspections.

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Request To Allow Flight With Known Cracks

One commenter, the manufacturer, requests that the proposed AD be revised to allow operators to continue operation of an unrepaired airplane following detection of cracks, utilizing the follow-on inspections and conditions described in Airbus Service Bulletin A320–57–1016, Revision 1, dated December 6, 1995. The commenter states that the follow-on inspection intervals are based on fatigue test results and calculations of the crack propagation rate, depending on the crack length. The commenter also states that the structure of the Airbus Model A320 series airplane is classified as damage tolerant. Additionally, the commenter notes that the inspection program specified in the service bulletin was developed in order to prevent the need for extensive repairs of the aircraft.

The FAA does not concur. It is the FAA's policy to require repair of known cracks prior to further flight, except in certain cases of unusual need, as

discussed below. This policy is based on the fact that such damaged airplanes do not conform to the FAA certificated type design, and therefore, are not airworthy until a properly approved repair is incorporated. While recognizing that repair deferrals may be necessary at times, the FAA policy is intended to minimize adverse human factors relating to the lack of reliability of long-term repetitive inspections, which may reduce the safety of the type certificated design if such repair deferrals are practiced routinely.

As noted above, the FAA's policy regarding flight with known cracks does allow deferral of repairs in certain cases, if there is an unusual need for a temporary deferral. Unusual needs include such circumstances as legitimate difficulty in acquiring parts to accomplish repairs. Under such conditions, the FAA may allow a temporary deferral of the repair, subject to a stringent inspection program acceptable to the FAA. The FAA acknowledges that the manufacturer has specified inspection intervals that are intended to allow continued operation with known cracks, and to prevent the need for extensive repairs. However, since the FAA is not aware of any unusual need for repair deferral in regard to this AD, the FAA has not evaluated these inspection intervals.

Additionally, the FAA policy applies to airplanes certificated to damage tolerance evaluation regulations as well as those not so certificated. Therefore, the commenter's statement that "the Airbus Model A320 airplane structure is classified as damage tolerant" is not relevant to the application of the FAA's policy in this regard.

The FAA considers the compliance times in this AD to be adequate to allow operators to acquire parts to have on hand in the event that a crack is detected during inspection. Therefore, the FAA has determined that, due to the safety implications and consequences associated with such cracking, any subject bottom flange or fastener hole that is found to be cracked must be repaired or modified prior to further flight. No change to the final rule is necessary.

Request To Revise Service Bulletin Dates

One commenter supports the intent of the proposed AD, but requests that it be revised to reflect the correct issuance date for Revision 1 of Airbus Service Bulletins A320-57-1016 and A320-57-1017. The commenter states that the correct issuance date for both of these service bulletins is September 3, 1991. The FAA does not concur. The original

version of these service bulletins is dated September 3, 1991, rather than Revision 1. Therefore, the FAA finds that no change to the final rule is necessary.

Conclusion

After careful review of the available data, including the comments noted above, the FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

Cost Impact

The FAA estimates that 16 airplanes of U.S. registry will be affected by this AD, that it will take approximately 2 work hours per airplane to accomplish the required inspection, and that the average labor rate is \$60 per work hour. Based on these figures, the cost impact of the inspection required by this AD on U.S. operators is estimated to be \$1,920, or \$120 per airplane, per inspection cycle.

The cost impact figure discussed above is based on assumptions that no operator has yet accomplished any of the requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted.

Should an operator elect to accomplish the optional terminating modification, rather than continue the repetitive inspections, it would require approximately 6 work hours to accomplish it, at an average labor rate of \$60 per work hour. Required parts would cost approximately \$700 per airplane. Based on these figures, the cost impact of the optional terminating modification provided by this AD on U.S. operators is estimated to be \$1,060

Regulatory Impact

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory

Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

98-18-26 Airbus Industrie: Amendment 39-10742. Docket 98-NM-18-AD.

Applicability: Model A320 series airplanes on which Airbus Modification 21290 (reference Airbus Service Bulletin A320-57-1017, Revision 01, dated March 17, 1997) has not been installed, certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been otherwise modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (c) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated, unless accomplished previously.

To detect and correct fatigue cracking of the front spar vertical stringers on the wings, which could result in reduced structural integrity of the airframe, accomplish the following:

(a) Prior to the accumulation of 24,000 total flight cycles, or within 60 days after the effective date of this AD, whichever occurs later: Perform an eddy current inspection to detect fatigue cracking of the front spar vertical stringers on the wings, in accordance with Airbus Service Bulletin A320-57-1016, Revision 1, dated December 6, 1995.

(1) If no crack is detected, repeat the eddy current inspection thereafter at intervals not to exceed 14,000 flight cycles.

(2) If any crack is detected, prior to further flight, repair in accordance with a method approved by the Manager, International Branch, ANM-116, FAA, Transport Airplane Directorate; or the Direction Generale de l'Aviation Civile (or its delegated agent). Thereafter, repeat the eddy current inspection at intervals not to exceed 14,000 flight cycles.

(b) Modification of the front spar vertical stringers on the wings, in accordance with Airbus Service Bulletin A320-57-1017, Revision 01, dated March 17, 1997, constitutes terminating action for the repetitive inspection requirements of this AD.

(c) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, International Branch, ANM-116. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, International Branch, ANM-116.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the International Branch, ANM-116.

(d) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

(e) The inspections shall be done in accordance with Airbus Service Bulletin A320-57-1016, Revision 1, dated December 6, 1995, which contains the following list of effective pages:

Page No.	Revision level shown on page	Date shown on page
1-4, 7	1	Dec. 6, 1995
5-6, 8-13	Original	Sept. 3, 1991

This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from Airbus Industrie, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Note 3: The subject of this AD is addressed in French airworthiness directive 97-311-105(B), dated October 22, 1997.

(f) This amendment becomes effective on October 13, 1998.

Issued in Renton, Washington, on August 28, 1998.

Vi L. Lipski, Acting Manager,

Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98-23738 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-13-P

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 100

[CGD08-98-054]

RIN 2115-AE46

Special Local Regulations; 1998 Busch Beer Drag Boat Classic; Kaskaskia River Mile 28.0-29.0, New Athens, Illinois

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: Special local regulations are being adopted for the Busch Beer Drag Boat Classic. This event will be held on September 12 and 13, 1998 from 7 a.m. until 8 p.m. at New Athens, Illinois. These regulations are needed to provide for the safety of life on navigable waters during the event.

EFFECTIVE DATE: These regulations are effective from 7 a.m. until 8 p.m., on September 12 and 13, 1998..

ADDRESSES: All documents referred to in this regulation are available for review at Marine Safety Office, St. Louis, 1222 Spruce Street, St. Louis, Missouri 63103-2835.

FOR FURTHER INFORMATION CONTACT: Lieutenant D. Schroder, USCG Marine Safety Office, St. Louis, Missouri at (314) 539-3091, ext. 01.

SUPPLEMENTARY INFORMATION:

Drafting Information

The drafters of this regulation are Lieutenant D. Schroder, Project Officer, USCG Marine Safety Office, St. Louis, and LTJG M. Woodruff, Project Attorney, Eighth Coast Guard District Legal Office.

Regulatory History

In accordance with 5 U.S.C. 553, a notice of proposed rule making for these regulations has not been published, and good cause exists for making them effective in less than 30 days from the date of publication in the **Federal Register**. Following normal rule making procedures would be impracticable. The details of the event were not finalized in sufficient time to publish proposed rules in advance of the event or to provide for a delayed effective date.

Background and Purpose

The marine event requiring this regulation is a two day drag boat event consisting of numerous races through each day on September 12 and 13. The Kaskaskia River at mile 28.0-29.0 will be closed during these events. The event is sponsored by the St. Louis Drag Boat Association.

Regulatory Evaluation

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(3) of that order. It has been exempted from review by the Office Management and Budget under that order. It is not significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040; February 26, 1979). The Coast Guard expects the economic impact of this rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary because of the event's short duration, and commercial vessel transit schedule stated above.

Small Entities

The Coast Guard finds that the impact, if any, on small entities is not substantial. Therefore, the Coast Guard certifies under section 605(b) of the Regulatory Flexibility Act (5 U.S.C. 601 et seq) that this temporary rule will not have a significant economic impact on a substantial number of small entities because of the event's short duration, and commercial vessel transit schedule stated above.

Collection of Information

This rule contains no information collection requirements under the Paperwork Reduction Act (44 U.S.C. 3501 et. seq).

Federalism Assessment

The Coast Guard has analyzed this action in accordance with the principles and criteria of Executive Order 12612 and has determined that this rule does not raise sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environmental Assessment

The Coast Guard considered the environmental impact of this rule and concluded that under section 2-1, paragraph (34)(h) of Commandant Instruction M16475.1C, this rule is excluded from further environmental documentation.

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water), Reporting and recordkeeping requirements, Waterways.

Temporary Regulations

In consideration of the foregoing, part 100 of Title 33, Code of Federal Regulations, is amended as follows:

PART 100—[AMENDED]

1. The authority citation for part 100 continues to read as follows:

Authority: 33 U.S.C. 1233; 49 CFR 1.46 and 33 CFR 100.35

2. A temporary § 100.35–T08–054 is added to read as follows:

§ 100.35–T08–054 Kaskaskia River at Mile 28.0–29.0

(a) *Regulated Area:* A regulated area is established between mile 28.0 and 29.0 of the Kaskaskia River.

(b) *Special Local Regulation:* All persons and/or vessels not registered with the sponsors as participants or official patrol vessels are considered spectators. “Participants” are those persons and/or vessels identified by the sponsor as taking part in the event. The “official patrol” consists of any Coast Guard, public, state or local law enforcement and/or sponsor provided vessel assigned to patrol the event. The Coast Guard “Patrol Commander” is a Coast Guard commissioned, warrant, or petty officer who has been designated by Commanding Officer, Coast Guard Marine Safety Office St. Louis.

(1) No vessel shall anchor, block, loiter in, or impede the through transit of participants or official patrol vessels in the regulated area during effective dates and times, unless cleared for such entry by or through an official patrol vessel.

(2) When hailed and/or signaled by an official vessel, a spectator shall come to an immediate stop. Vessels shall comply with all directions given; failure to do so may result in a citation.

(3) The Patrol Commander is empowered to forbid and control the movement of all vessels in the regulated area. The Patrol Commander may terminate the event at any time it is deemed necessary for the protection of life and/or property and can be reached on VHF–FM Channel 16 by using the call sign “PATCOM”.

(c) *Effective Date:* This section is effective from 7 a.m. until 8 p.m. on September 12 and 13, 1998.

Dated: August 21, 1998.

Paul J. Pluta,

Adm, USCG.

[FR Doc. 98–24054 Filed 9–4–98; 8:45 am]

BILLING CODE 4910–15–M

DEPARTMENT OF TRANSPORTATION**Coast Guard****33 CFR Part 117**

[CGD08–98–049]

Drawbridge Operating Regulation; Victoria Channel, TX

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is removing the operating regulation for the Missouri Pacific railroad automated bridge across Victoria Channel, mile 29.4, near Bloomington, Texas, which was published in 1978 allowing the bridge to operate as an automated bridge. However, the mechanism to automate the bridge was never connected and the bridge owner does not wish to automate the bridge. The bridge opens on signal. Therefore, the operating regulation is unnecessary and is being removed.

DATES: This regulation becomes effective September 8, 1998.

ADDRESSES: Documents referred to in this rule are available for inspection or copying at the office of the Eighth Coast Guard District, Bridge Administration Branch, Hale Boggs Federal Building, room 1313, 501 Magazine Street, New Orleans, Louisiana 70130–3396 between 7 a.m. and 4 p.m., Monday through Friday, except Federal holidays. The telephone number is (504) 589–2965. Commander (ob) maintains the public docket for this rulemaking.

FOR FURTHER INFORMATION CONTACT: Mr. David Frank, Bridge Administration Branch, telephone number 504–589–2965.

SUPPLEMENTARY INFORMATION:**Background**

In 1977, the contractor proposing to automate the Missouri Pacific railroad bridge across Victoria Channel, mile 29.4, at Bloomington, Texas, requested a special operating regulation for the automation of the drawbridge. The Coast Guard proceeded with the publication of the proposed regulation and on November 9, 1978, the operation regulation was published in the **Federal Register** (43 FR 53236). The regulation was amended on January 11, 1979 (44 FR 2386). However, the railroad never established the automation system and

the bridge has operated manually throughout its existence. Presently, the bridge operates as required by 33 CFR 117.5 rather than under 33 CFR 117.991. Therefore, 33 CFR 117.991 is unnecessary and should be removed.

The Coast Guard has determined that good cause exists under the Administrative Procedure Act (5 U.S.C. 553) to forego notice and comment for this rulemaking because although the drawbridge operation regulation was established, the bridge was never automated and continues to open on signal. Since the bridge was never automated and the owner does not wish to automate the bridge, there is no need for the regulation.

The Coast Guard, for the reason just stated, has also determined that good cause exists for this rule to become effective upon publication in the **Federal Register**.

Regulatory Evaluation

This final rule is not a significant regulatory action under section 39f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget under that Order has not reviewed it. It is not significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040; February 26, 1979). The Coast Guard expects the economic impact of this final rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Coast Guard considers whether this final rule will have a significant economic impact on a substantial number of small entities. “Small entities” include (1) small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and (2) governmental jurisdictions with populations of less than 50,000.

The Missouri Pacific railroad bridge across Victoria Channel, mile 29.4, at Bloomington, Texas opens for the passage of traffic on signal making the rule governing the bridge unnecessary. Therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this final rule will not have a significant economic impact on a substantial number of small entities.

Collection of Information

This final rule does not provide for a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3051 *et seq.*).

Federalism

The Coast Guard has analyzed this final rule under the principals and criteria contained in Executive Order 12612 and has determined that this rulemaking does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environment

The Coast Guard considered the environmental impact of this final rule and concluded that under Figure 2-1, CE # 32(e) of the NEPA Implementing Procedures, COMDINST M16475.1C, this final rule is categorically excluded from further environmental documentation. A "Categorical Exclusion Determination" is available in the docket for inspection or copying where indicated under **ADDRESSES**.

List of Subjects in 33 CFR Part 117

Bridges.

Regulations

For the reasons set out in the preamble, the Coast Guard is amending part 117 of Title 33, Code of Federal Regulations as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for Part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05-1(g); section 117.255 also issued under the authority of Pub. L. 102-587, 105 Stat. 5039.

§ 117.991 [Removed]

2. Section 117.991 is removed.

Dated: August 21, 1998.

Paul J. Pluta,

Rear Admiral, U.S. Coast Guard Commander, Eighth Coast Guard District.

[FR Doc. 98-24053 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-15-M

DEPARTMENT OF TRANSPORTATION**Coast Guard****33 CFR Part 117**

[CGD08-98-052]

RIN 2115-AE47

Drawbridge Operation Regulation; Lafourche Bayou, LA

AGENCY: Coast Guard, DOT.

ACTION: Temporary rule.

SUMMARY: The Coast Guard is temporarily changing the regulation for the operation of the draw of the SR1 vertical lift bridge across Lafourche Bayou, mile 13.3, in Leeville, Lafourche Parish, Louisiana. The draw will remain closed to navigation continuously from noon on Mondays through noon on Fridays from October 5, 1998, through November 6, 1998. In the event of an approaching tropical storm or hurricane, work on the bridge will be discontinued and the draw will return to normal operation. This temporary rule is issued to allow for the replacement of the electrical and mechanical components of the bridge.

DATES: This temporary rule is effective from noon on October 5, 1998 through noon on November 6, 1998.

ADDRESSES: All documents referred to in this notice will be available for inspection and copying at room 1313 in the Hale Boggs Federal Building at Commander (ob), Eighth Coast Guard District, Hale Boggs Federal Building, room 1313, 501 Magazine Street, New Orleans, Louisiana 70130-3396 between 7 a.m. and 4 p.m., Monday through Friday, except Federal holidays. The Bridge Administration Branch of the Eighth Coast Guard District maintains the public docket for this temporary rule.

FOR FURTHER INFORMATION CONTACT: Phil Johnson or David Frank, Bridge Administration Branch, Commander (ob), Eighth Coast Guard District, 501 Magazine Street, New Orleans, Louisiana, 70130-3396, telephone number 504-589-2965.

SUPPLEMENTARY INFORMATION: On June 5, 1998, the Louisiana Department of Transportation and Development (LDOTD), requested a change to the operating schedule of the SR1 vertical lift bridge across Lafourche Bayou, mile 13.3, in Leeville, Lafourche Parish, Louisiana. LDOTD requested that the bridge be closed to navigation continuously from 7 a.m. on Tuesday through 7 p.m. on Thursday each week from July 7, 1998 through July 30, 1998. The reason for the closure was to allow for the replacement of the four (4) lift Cables on the bridge. The District Commander granted the deviation request on June 11, 1998. The deviation (CGD 08-98-28) was published in the **Federal Register** on Friday, June 19, 1998 (63 FR 33575). The lift cables were replaced and work was completed by July 30, 1998.

Additionally, on June 5, 1998, LDOTD requested a second temporary deviation from the regulation governing the

operation of the SR1 vertical lift bridge across Lafourche Bayou, mile 13.3, in Leeville, Lafourche Parish, Louisiana. LDOTD requested that the bridge be closed to navigation from 7 a.m. until 9 a.m.; 9:30 a.m. until noon; 12:30 p.m. until 3 p.m.; and 3:30 p.m. until 7 p.m., Monday through Friday, except Federal holidays, from August 3, 1998, until October 2, 1998. This temporary deviation was requested to allow for general maintenance repairs. The District Commander granted the deviation request on July 11, 1998. The deviation (CGD 08-98-30) was published in the **Federal Register** on Friday, June 19, 1998 (63 FR 33577). General maintenance repairs are currently underway and the deviation is in effect.

On July 16, 1998, LDOTD requested a modification to temporary deviation (CGD 08-98-30) to allow the bridge to be closed continuously during the mid-week period for two weeks in August, two weeks in September, and two weeks in October. LDOTD stated that the contractor was unable to complete scheduled electric and mechanical repairs without disconnecting power to the bridge rendering the draw inoperable. LDOTD subsequently requested that the SR1 vertical lift bridge across Lafourche Bayou, mile 13.3, in Leeville, Lafourche Parish, Louisiana remain closed to navigation continuously from noon on Mondays through noon on Fridays from October 5, 1998, through November 6, 1998. This closure would allow the contractor to replace the electrical and mechanical components on the bridge. The contractor can not complete these repairs without disconnecting power to the bridge, rendering the draw inoperable.

In making this revised request for closure, LDOTD has moved the dates of the closure outside of the height of hurricane season. However, in the event of an approaching tropical storm or hurricane, work on the bridge will be discontinued and the draw will return to normal operation. The contractor has also worked out an agreement with the Port Authority which will allow larger vessels that are unable to transit through the bridge while in the closed-to-navigation position to off load their catch below the bridge. Since the applicant has adequately resolved the concerns of the Coast Guard, the District Commander is granting LDOTD's request for a temporary change to bridge operating procedures.

In accordance with 5 U.S.C. 553, a notice of proposed rulemaking for this rule has been published, and good cause exists for making it effective in less than

30 days from the date of publication. Following normal rule making procedures would have been impracticable. There was not sufficient time to publish proposed rules in advance of implementing the change to the bridge operating procedures or to provide for a delayed effective date.

Background and Purpose

The bridge has a vertical clearance of 40 feet above mean high water in the closed-to-navigation position. Mean high water elevation is 3 feet above Mean Sea Level (MSL). Navigation on the waterway consists primarily of fishing vessels, some tugs with tows and occasional recreational craft. Presently, the draw opens on signal for the passage of vessels. The contractor has requested a complete closure of the bridge to allow for the replacement of the electrical and mechanical components of the bridge and for the pulling of electric conduit wiring on the bridge. During portions of this repair work, scaffolding may be placed below the bridge over the navigation channel reducing the approved vertical clearance to less than 40 feet above mean high water. The reduction in the vertical clearance will be approximately 4 feet. Additionally, if a tropical storm or hurricane develops in the Gulf of Mexico, work will be discontinued and the bridge returned to normal operation for the passage of vessel traffic. Alternate routes are available to vessel operators wishing to enter the area. This work is essential for the continued safe operation of the vertical lift span.

Regulatory Evaluation

This temporary rule is not a significant regulatory action under section 3(f) of Executive Order 12866 and does not require an assessment of potential cost and benefits under section 6(a)(3) of that order. The Office of Management and Budget has not reviewed it under that order. It is not significant under the Regulatory Policies and Procedures of the Department of Transportation (DOT) (44 FR 11040, February 26, 1979). The Coast Guard expects the economic impact of this temporary rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary. This is because the majority of vessels using the waterway will not be affected by the closure. The majority of the fishing vessels are able to transit under the bridge, which has a vertical clearance of 40 feet above mean high water in the closed-to-navigation position. Additionally, larger vessels

will be able to off load their cargoes downstream of the bridge site.

Small Entities

Under the Regulatory Flexibility Act, 5 U.S.C. 601 et seq., the Coast Guard must consider whether this temporary rule will have a significant economic impact on a substantial number of small entities. "Small entities" may include (1) small businesses and not-for-profit organizations that are independently owned and operated and are not dominate in their fields and (2) governmental jurisdictions with populations of less than 50,000. The majority of commercial vessels and fishing vessels that normally transit the bridge will still be able to do so beneath the bridge in the closed-to-navigation position. Thus, the Coast Guard expects there be no significant economic impact on these vessels. The Coast Guard is not aware of any other waterway users who would suffer economic hardship from being unable to transit the waterway during these closure periods. Therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this temporary rule will not have a significant economic impact on a substantial number of small entities.

Collection of Information

This temporary rule contains no collection-of-information requirements under the Paperwork Reduction Act, 44 U.S.C. 3501 et seq..

Federalism

The Coast Guard has analyzed this proposal under the principles and criteria contained in Executive Order 12612, and it has been determined that this rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environment

The Coast Guard considered the environmental impact of this temporary rule and concluded that this action is categorically excluded from further environmental documentation under current Coast Guard CE #32(e), in accordance with Section 2.B.2 and Figure 2-1 of the National Environmental Protection Act Implementing Procedures, COMDTINST M16475.1C. A "Categorical Exclusion Determination" is available in the docket for inspection or copying where indicated under ADDRESSES.

List of Subjects in 33 CFR Part 117

Bridges.

Temporary Regulations

For the reasons set out in the preamble, the Coast Guard is

temporarily amending part 117 Title 33 Code of Federal Regulations as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; and 33 CFR 1.05-1(g); section 117.255 also issued under the authority of Pub. L. 102-587, 106 Stat. 5039.

2. Effective noon, October 5, 1998, through noon, November 6, 1998, § 117.465 is amended by adding paragraph (g) to read as follows:

§ 117.465 Lafourche Bayou.

* * * * *

(g) The draw of the SR 1 bridge, mile 13.3, at Leeville, shall open to signal, except that; from noon on October 5, 1998, through noon on November 6, 1998, the draw will remain closed to navigation continuously from noon on Mondays through noon on Fridays. In the event of an approaching tropical storm or hurricane, work on the bridge will be discontinued and the draw will return to normal operation.

Dated: August 27, 1998.

Paul J. Pluta,

Rear Admiral, U.S. Coast Guard Commander, Eighth Coast Guard District.

[FR Doc. 98-24052 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-15-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 165

[COTP CHARLESTON 98-053]

RIN 2115-AA97

Safety Zone; Around Alone 98/99 Fireworks, Custom House Reach, Charleston, SC.

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a safety zone on September 25 in the vicinity of the Custom House Reach, Charleston Harbor, South Carolina to protect vessels in the vicinity from the hazards associated with the storage, preparation, and launching of fireworks. Entry into this zone is prohibited unless authorized by the Captain of the Port.

DATES: This regulation becomes effective at 9 p.m. Eastern Standard Time (EST), and terminates at 10:15 p.m. (EST), on September 25, 1998.

FOR FURTHER INFORMATION CONTACT:

LTJG Robert M. Hengst, Project Manager, U.S. Coast Guard Marine Safety Office Charleston, at (843) 724-7685.

SUPPLEMENTARY INFORMATION:

Background and Purpose

The event requiring this regulation will occur on September 25, 1998. The Charleston Maritime Commission is sponsoring a Bon Voyage Fireworks Display on this date for the departure of the Around Alone fleet. The fireworks display will be positioned on a barge in the Custom House Reach, Charleston Harbor, South Carolina. The approximate position of this barge will be 32-46.86' North, 079-55.17' West, directly east of Waterfront Park, downtown Charleston. The safety zone will be bounded on the north by the 32-47.03' North latitude and on the south by the 32-46.65' North latitude. The border to the east is Shutes Folly and to the west is the downtown Charleston peninsula. The safety zone is needed to prevent damage to vessels or injury to persons from hazards associated with a fireworks display.

In accordance with 5 U.S.C. 553, a notice of proposed rulemaking was not published for this regulation and good cause exists for making it effective in less than 30 days after **Federal Register** publication. Publishing a NPRM and delaying its effective date would be contrary to safety interests since immediate action is needed to minimize potential danger to the public as the permit was not received in sufficient time to process as an NPRM.

Regulatory Evaluation

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(3) of the order. It has been exempted from review by the Office of Management and Budget under that order. It is not significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040, February 26, 1979). The Coast Guard expects the economic impact of this rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary. Maritime traffic will not be significantly impacted because this proposal will only be in effect for approximately one hour and fifteen minutes in a limited area.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Coast Guard must consider whether this rule, if

adopted, will have a significant economic impact on a substantial number of small entities. "Small entities" include small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their field and governmental jurisdictions with populations of less than 50,000.

Therefore, the Coast Guard certifies under section 605(b) that this rule will not have a significant effect upon a substantial number of small entities because this proposal will only be in effect for approximately one hour and fifteen minutes in a limited area.

Collection of Information

This rule contains no collection of information requirements under the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*).

Federalism

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that the rulemaking does not have sufficient Federal implications to warrant the preparation of a Federalism Assessment.

Environmental Assessment

The Coast Guard has considered the environmental impact of this action and has determined pursuant to Figure 2-1, paragraph 34(g) of Commandant Instruction M16475.1C that this action is categorically excluded from further environmental documentation.

List of Subjects in 33 CFR Part 165

Harbors, Marine Safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

Temporary Regulation

In consideration of the foregoing, the Coast Guard amends part 165 of Title 33, Code of Federal Regulations, as follows:

PART 165—[AMENDED]

1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 50 U.S.C. 191; 33 CFR 1.05-1(g), 6.04-1, 6.04-6, and 160.5; 49 CFR 1.46.

2. A new § 165.T07-053 is added to read as follows:

§ 165.T07-053 Temporary Safety Zone; Around Alone 98/99 Fireworks Custom House Reach, Charleston, SC.

(a) *Location.* The following boundaries are established as a safety zone: All waters within an area bounded on the north by the 32-47.03' North

latitude; bounded on the south by the 32-46.65' North latitude; bounded on east by Shutes Folly and bounded on the west by the downtown Charleston peninsula. All coordinates referred use datum: NAD 1983.

(b) *Regulations.* (1) The Captain of the Port, Charleston, SC will activate this safety zone by means of a locally promulgated broadcast notice to mariners. Once implemented, all vessels and persons are prohibited from entering this zone, unless otherwise authorized by the Captain of the Port, Charleston, SC.

(2) The general regulations governing safety zones contained in 33 CFR 165.20 and 165.23 apply.

(c) *Effective Date.* this section is effective from 9 p.m. EST and until 10:15 p.m. EST, on September 25, 1998.

Dated: August 20, 1998.

F.J. Sturm,

Commander of the Port, Charleston, South Carolina.

[FR Doc. 98-24055 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-15-U

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[LA-47-1-7388a; FRL-6156-3]

Approval and Promulgation of Implementation Plans; Louisiana: Reasonable Available Control Technology for Emissions of Volatile Organic Compounds from Batch Processes

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: The EPA is approving a revision to the Louisiana State Implementation Plan (SIP) rule requiring Reasonable Available Control Technology (RACT) for emissions of Volatile Organic Compounds (VOC) from Synthetic Organic Chemical Manufacturing Industry (SOCMI) Batch Processes. The EPA finds the rules for Batch Processes in the Louisiana SIP are consistent with EPA's guidance for this source category and therefore constitute RACT. This action converts the conditional approval to a full approval.

DATES: This action is effective on November 9, 1998 unless adverse or critical comments are received by October 8, 1998. If EPA receives such comments, then it will publish a timely withdrawal in the **Federal Register** informing the public that this rule will not take effect.

ADDRESSES: Written comments on this action should be addressed to Mr. Thomas H. Diggs, Chief, Air Planning Section (6PD-L), at the EPA Region 6 Office listed below.

Copies of documents relevant to this action are available for public inspection during normal business hours at the following locations. Anyone wanting to examine these documents should make an appointment with the appropriate office at least two working days in advance.

Environmental Protection Agency,
Region 6, Air Planning Section (6PD-L), 1445 Ross Avenue, Dallas, Texas 75202-2733.

Louisiana Department of Environmental Quality, Air Quality Division, 7290 Bluebonnet Boulevard, Baton Rouge, Louisiana 70810, telephone (504) 765-7247.

Documents which are incorporated by reference are available for public inspection at the Air and Radiation Docket and Information Center, Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460.

FOR FURTHER INFORMATION CONTACT: Bill Deese of the EPA Region 6 Air Planning Section (6PD-L) at (214) 665-7253 at the Region 6 address above.

SUPPLEMENTARY INFORMATION:

I. Background

A. RACT Rule Requirements

Sections 182(b)(2)(A) and 182(c) of the Clean Air Act (the Act) as amended in 1990 requires States to adopt RACT rules for stationary sources of VOCs located in ozone nonattainment areas classified as moderate or above that are covered by a Control Technique Guideline (CTG). A CTG has been developed by EPA providing guidance on the level of control that constitutes RACT for SOCMI processes.

B. Conditional Approval

On December 2, 1997 (62 FR 63658), EPA conditionally approved the Louisiana SOCMI Batch Processing RACT rule. The rule was conditionally approved because of a deficiency identified in the single unit operation exemption thresholds. The State made a commitment to EPA to correct the deficiency in the rule within one year of the publication of the conditional approval. This condition was codified in 40 CFR 52.994(b).

C. State Submittal

In a letter dated March 23, 1998, the Governor of Louisiana submitted a revision to the Batch Processing RACT rule found in Louisiana Administrative Code, Title 33, Part III, Section 2149

(LAC 33:III.2149) entitled "Limiting Volatile Organic Compound Emissions from Batch Processing." The revision eliminates the individual process single unit operation exemptions and sets the overall single unit operation exemption to 500 pounds per year or less. The revision also adds language which clarifies the successive ranking scheme exemptions for aggregate streams of unit operations. Louisiana's rules for Batch Processes are consistent with EPA's guidance for this source category and therefore have been determined to constitute RACT.

The EPA removed 40 CFR 52.994(b) by mistake in a **Federal Register** action published March 9, 1998 (63 FR 11374), when EPA removed the entire section 40 CFR 52.994. The intent of the March 9, 1998, action was to remove only section 52.994(a). Because 40 CFR 52.994(b) is already removed, it not necessary to remove it in this action.

II. Final Action

The EPA is approving a revision to the Louisiana SIP rule requiring RACT for emissions of VOC from SOCMI Batch Processes. Louisiana's rules for Batch Processes are consistent with EPA's guidance for this source category and therefore have been determined to constitute RACT. The rule revision sets the overall single unit operation exemption to 500 pounds per year and clarifies the successive ranking scheme exemptions for aggregate streams of unit operations. This action converts the conditional approval to a full approval.

The EPA is publishing this rule without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. However, in the proposed section of this **Federal Register** publication, EPA is publishing a separate document that will serve as the proposal to approve the SIP revision should relevant adverse comments be filed. This rule will be effective November 9, 1998 without further notice unless the Agency receives relevant adverse comments by October 8, 1998.

If EPA receives such comments, then EPA will publish a document withdrawing the final rule and informing the public that the rule will not take effect. All public comments received will then be addressed in a subsequent final rule based on this rule. The EPA will not institute a second comment period on this rule. Only parties interested in commenting on this rule should do so at this time. If no such comments are received, the public is advised that this rule will be effective on November 9, 1998 and no further

action will be taken on the proposed rule.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any SIP. Each request for revision to the SIP shall be considered separately in light of specific technical, economic, and environmental factors and in relation to relevant statutory and regulatory requirements.

III. Administrative Requirements

A. Executive Orders (E.O.) 12866 and 13045

The Office of Management and Budget has exempted this regulatory action from E.O. 12866, entitled "Regulatory Planning Review," review. The final rule is not subject to E.O. 13045, entitled "Protection of Children from Environmental Health Risks and Safety Risks," because it is not an "economically significant" action under E.O. 12866.

B. Regulatory Flexibility

The Regulatory Flexibility Act (RFA), 5 U.S.C. 600 *et seq.*, generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and small governmental jurisdictions. This final rule will not have a significant impact on a substantial number of small entities because SIP approvals under section 110 and subchapter I, part D of the Act do not create any new requirements but simply approve requirements that the State is already imposing. Therefore, because the Federal SIP approval does not create any new requirements, I certify that this action will not have a significant economic impact on a substantial number of small entities. Moreover, due to the nature of the Federal-State relationship under the Act, preparation of flexibility analysis would constitute Federal inquiry into the economic reasonableness of state action. The Act forbids EPA to base its actions concerning SIPs on such grounds. See *Union Electric Co., v. U.S. EPA*, 427 U.S. 246, 255-66 (1976); 42 U.S.C. 7410(a)(2).

C. Unfunded Mandates

Under section 202 of the Unfunded Mandates Reform Act of 1995, signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule

that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to private sector, of \$100 million or more. Under section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule.

The EPA has determined that the approval action promulgated does not include a Federal mandate that may result in estimated costs of \$100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves preexisting requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

D. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. The EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a "major rule" as defined by 5 U.S.C. 804(2).

E. Petitions for Judicial Review

Under section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by November 9, 1998. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. *See* section 307(b)(2).

List of Subjects in 40 CFR part 52

Environmental protection, Air pollution control, Hydrocarbons, Incorporation by reference, Ozone, Volatile organic compounds.

Dated: August 21, 1998.

Jerry Clifford,

Acting Regional Administrator, Region 6.

Part 52, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

1. The authority citation of part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart T—Louisiana

2. Section 52.970 is amended by adding paragraph (c)(77) to read as follows:

§ 52.970 Identification of plan.

* * * * *

(c) * * *

(77) Revisions to the Louisiana Administrative Code, Title 33, Part III, Chapter 21, Section 2149 (LAC 33:III.2149), "Limiting Volatile Organic Compound Emissions from Batch Processing," submitted by the Governor on March 23, 1998.

(i) Incorporation by reference. LAC 33:III Chapter 21, revised paragraph 2149.A.2.b; paragraphs 2149.C.2.a, b, and c become paragraphs 2149.C.2.d, e, and f respectively; and add new paragraphs 2149.C.2.a, b, and c, as adopted in the Louisiana Register on November 20, 1997 (LR 23:1507).

(ii) Additional material. None.

[FR Doc. 98-24043 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IL172-1a; FRL-6152-5]

Approval and Promulgation of Implementation Plan; Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: On November 14, 1995, and May 9 and June 14, 1996, the State of Illinois submitted State Implementation Plan (SIP) revision requests to meet commitments related to the conditional approval of Illinois' May 15, 1992, SIP submittal for the Lake Calumet (SE Chicago), McCook, and Granite City,

Illinois, Particulate Matter (PM) nonattainment areas. The EPA is approving the SIP revision request as it applies to the McCook area, including the attainment demonstration for the McCook PM nonattainment area. The SIP revision request corrects, for the McCook PM nonattainment area, all of the deficiencies of the May 15, 1992, submittal (as discussed in the November 18, 1994, conditional approval notice). This document also revises the codification of the conditional approval to remove issues which have been resolved. No action is being taken on the submitted plan revisions for the Lake Calumet area at this time; they will be addressed in a separate rulemaking action. Approval of the Granite City PM plan became effective on May 11, 1998 (see 63 FR 11842).

DATES: This rule is effective on November 9, 1998, unless EPA receives written adverse comments by October 8, 1998. If adverse comment is received, EPA will publish a timely withdrawal of the rule in the **Federal Register** informing the public that the rule will not take effect.

ADDRESSES: Copies of the revision request and EPA's analysis are available for inspection at the following address: U.S. Environmental Protection Agency, Region 5, Air and Radiation Division, 77 West Jackson Boulevard, Chicago, Illinois 60604. (It is recommended that you telephone David Pohlman at (312) 886-3299 before visiting the Region 5 Office.)

Written comments should be sent to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR-18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: David Pohlman at (312) 886-3299.

SUPPLEMENTARY INFORMATION:

I. Background

Under section 107(d)(4)(B) of the Clean Air Act (Act), as amended on November 15, 1990 (amended Act), certain areas ("initial areas") were designated nonattainment for PM. Under section 188 of the amended Act these initial areas were classified as "moderate." The initial areas included the Lake Calumet, McCook, and Granite City, Illinois, PM nonattainment areas. The McCook area includes Lyons Township in Cook County, Illinois. (See 40 CFR 81.314 for a complete description of these areas.) Section 189 of the amended Act requires State submittal of a PM SIP for the initial areas by November 15, 1991. Illinois submitted the required SIP revision for

the McCook, Illinois, PM nonattainment area to EPA on May 15, 1992. Upon review of Illinois' submittal, EPA identified several concerns. Illinois submitted a letter on March 2, 1994, committing to satisfy all of these concerns within one year of final conditional approval. On May 25, 1994, the EPA proposed to conditionally approve the SIP. Final conditional approval was published on November 18, 1994, and became effective on December 19, 1994. The final conditional approval allowed the State until November 20, 1995, to correct the stated deficiencies. Of the five deficiencies, only three apply to the McCook area:

1. Invalid emissions inventory and attainment demonstration, due to underestimated emissions from 3 coal-fired boilers at CPC International, and 3 coal-fired boilers at GM Electromotive Division.

2. Failure to adequately address maintenance of the PM National Ambient Air Quality Standards (NAAQS) for at least 3 years beyond the applicable attainment date.

3. The following enforceability concerns:

- a. Section 212.107, Measurement Methods for Visible Emissions could be misinterpreted as requiring use of Method 22 for sources subject to opacity limits as well as sources subject to limits on detectability of visible emissions.

- b. Inconsistencies in the measurement methods for opacity, visible emissions, and "PM" in section 212.110, 212.107, 212.108, and 212.109.

- c. Language in several rules which exempts from mass emissions limits those sources having no visible emissions.

The Illinois Environmental Protection Agency (IEPA) held a public hearing on the proposed rules on January 5, 1996. The rules became effective at the State level on May 22, 1996, and were published in the Illinois Register on June 7, 1996. Illinois made submittals to meet the commitments related to the conditional approval on November 14, 1995, May 9, 1996, and June 14, 1996. At this time, the EPA is only acting on the portions of those submittals that pertain to the McCook PM nonattainment area.

Based on Illinois' submittals, the EPA is now fully approving the SIP for the McCook area.

II. Analysis of State Submittal

The first deficiency was an incomplete emissions inventory and attainment demonstration. The emissions inventory issue involved

emissions estimations from 3 coal-fired boilers at CPC International and 3 coal-fired boilers at GM Electromotive Division. The EPA had pointed out that emissions from these sources were underestimated in the emissions inventory. Illinois recalculated these emissions, and EPA agrees that they are now correct. (Appendix 1 to Attachment 18 of Illinois' May 9, 1996 submittal)

To correct the problems with the attainment demonstration and emissions inventory, Illinois submitted a revised emissions inventory, which includes corrected emissions estimates from the GM Electromotive Division and CPC International boilers, and a revised attainment demonstration including an air quality modeling analysis.

In the submitted modeled attainment demonstration, which uses 5 years of meteorological data, a violation of the 24-hour NAAQS is indicated when six exceedances of the 24-hour standard are predicted. Each receptor's predicted 6th highest 24-hour value is, therefore, compared to the standard. The 24-hour PM standard is 150 micrograms per cubic meter ($\mu\text{g}/\text{m}^3$). The highest, sixth highest predicted 24-hour PM concentration at any receptor in the McCook nonattainment area was 145.3 $\mu\text{g}/\text{m}^3$. Thus, the modeling analysis predicts that the 24-hour NAAQS will be met.

A modeled violation of the annual PM standard is indicated when any receptor's 5 year arithmetic mean annual PM concentration exceeds the annual PM standard of 50 $\mu\text{g}/\text{m}^3$. The highest arithmetic mean annual PM concentration predicted by the modeling for the McCook area was 47.38 $\mu\text{g}/\text{m}^3$. Therefore, the modeling analysis predicts that the annual PM NAAQS will be met.

The second deficiency was Illinois' failure to adequately address maintenance of the PM NAAQS for at least 3 years beyond the applicable attainment date. Because of the length of time it may take to determine whether an area has attained the standards, EPA recommends that PM nonattainment area SIP submittals demonstrate maintenance of the PM NAAQS for at least 3 years beyond the applicable attainment date. (See a August 20, 1991, memorandum from Fred H. Renner, Jr. to Regional Air Branch Chiefs titled "Questions and Answers for Particulate Matter, Sulfur Dioxide, and Lead".) Illinois' May 15, 1992, submittal took growth into account in the modeling analysis, but did not sufficiently address maintenance of the NAAQS for PM.

The attainment date was December 31, 1994. Therefore, Illinois needs to show maintenance up to December 31,

1997. In the May 9, 1996, submittal, Illinois used ambient monitoring data to show that background concentrations of PM were no higher in 1995 than they were in 1991, and there are no significant trends in background PM concentrations from 1989 to 1995. Illinois concluded from this analysis that the effects of growth on ambient PM concentrations in the McCook PM nonattainment area would continue to be negligible through the end of the maintenance period. The EPA agrees, because the maintenance period is over, that the projection of trends in PM background concentrations is sufficient for this maintenance demonstration.

The final issue from the November 18, 1994, conditional approval notice which applies to the McCook area involves specific wording in several of Illinois' rules. In the 1992 submittal, 35 IAC Section 212.107, Measurement Methods for Visible Emissions, stated that Method 22 should be used for "detection of visible emissions." This could be misinterpreted as requiring use of Method 22 for sources subject to opacity limits as well as sources subject to limits on detectability of visible emissions. The revised rule (See the June 14, 1996, submittal) contains revised language which adequately clarifies the intended uses of Method 22.

Another wording problem was the fact that measurement methods for opacity, visible emissions, and "PM" in 35 IAC 212.107, 212.108, and 212.109, and 212.110 were not always consistent with each other. The revised rules in the June 14, 1996, submittal contain much less potential overlap than the previous rules. The rules are now consistent.

Finally, several of the rules in the 1992 submittal contained language which exempted sources with no visible emissions from mass emissions limits. Illinois has added language which states that the exemption "is not a defense to a finding of a violation of the mass emission limits." This issue has been adequately addressed, and these rules were approved by the USEPA on March 11, 1998. (63 FR 11842)

Section 179(a) of the amended Act states that if the Administrator finds that a State has failed to make a required submission, finds that a SIP or SIP revision submitted by the State does not satisfy the minimum criteria established under section 110(k) of the amended Act, or disapproves a SIP submission in whole or in part, unless the deficiency has been corrected within 18 months after the finding, one of the sanctions referred to in section 179(b) of the amended Act shall apply until the Administrator determines that the State

has come into compliance. (Pursuant to 40 CFR 52.31, the first sanction shall be a sanction requiring 2 to 1 offsets, in the absence of a case-specific selection otherwise.) If the deficiency has not been corrected within 6 months of the selection of the first sanction, the second sanction under section 179(b) shall also apply. In addition, section 110(c) of the Act requires promulgation of a Federal Implementation Plan (FIP) within 2 years after the finding or disapproval, as discussed above, unless the State corrects the deficiency and the SIP is approved before the FIP is promulgated.

On December 17, 1991, a letter was sent to the Governor of Illinois notifying him that the EPA was making a finding that the State of Illinois had failed to submit a PM SIP for the McCook PM nonattainment area. This letter triggered both the sanctions and FIP processes as explained above. Illinois submitted a PM SIP revision for the nonattainment area on May 15, 1992, and in an April 30, 1993, letter to the State the EPA informed the State that the SIP was determined to be complete. Therefore, the deficiency which started the sanctions and FIP processes was corrected, and the sanctions process ended. The FIP process, however, was not stopped by the correction of the deficiency and EPA was to promulgate a FIP within 2 years of the failure-to-submit letter (or December 17, 1993), unless a PM SIP for the nonattainment area was finally approved before then.

On November 18, 1994, the EPA conditionally approved the SIP. The final conditional approval allowed the State until November 20, 1995, to correct the five stated deficiencies. Conditional approval does not start a new sanctions process, unless the State fails to make a submittal to address the deficiencies, makes an incomplete submittal, or the submittal is ultimately disapproved. Illinois made a submittal to meet the commitments related to the conditional approval on November 14, 1995. Supplemental information was submitted on May 9, 1996, and June 14, 1996. This submittal became complete by operation of law on May 14, 1996. No sanctions process is currently running. Upon full approval of the McCook PM plan, FIP liability will also end.

III. Final Rulemaking Action

Illinois has corrected all of the deficiencies listed in the November 18, 1994, conditional approval as they relate to the McCook PM nonattainment area. Because Illinois has met all of the commitments of the conditional approval, the EPA is approving the plan for the McCook PM nonattainment area.

The EPA is publishing this rule without prior proposal because EPA views this as a noncontroversial revision and anticipates no adverse comments. However, in a separate document in this **Federal Register** publication, the EPA is proposing to approve the SIP revision should specified written adverse or critical comments be filed. This rule will become effective without further notice unless the Agency receives relevant adverse written comment within 30 days from the date of publication, as indicated above. Should the Agency receive such comments, it will publish a final rule informing the public that this rule will not take effect. Any parties interested in commenting on this action should do so at this time.

IV. Administrative Requirements

A. Executive Order 12866

The Office of Management and Budget has exempted this regulatory action from Executive Order 12866 review.

B. Executive Order 13045

This final rule is not subject to Executive Order 13045, entitled "Protection of Children from Environmental Health Risks and Safety Risks," because it is not an "economically significant" action under Executive Order 12866.

C. Future Requests

Nothing in this action should be construed as permitting, allowing or establishing a precedent for any future request for revision to any SIP. Each request for revision to the SIP shall be considered separately in light of specific technical, economic, and environmental factors and in relevant statutory and regulatory requirements.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and small governmental jurisdictions. This final rule will not have a significant impact on a substantial number of small entities because SIP approvals under section 110 and subchapter I, part D of the Clean Air Act do not create any new requirements, but simply approve requirements that the State is already imposing. Therefore, because the federal SIP approval does not impose any new requirements, I certify that this action

will not have a significant economic impact on a substantial number of small entities. Moreover, due to the nature of the Federal-State relationship under the Clean Air Act, preparation of a flexibility analysis would constitute Federal inquiry into the economic reasonableness of State action. The Clean Air Act forbids EPA to base its actions concerning SIPs on such grounds. *Union Electric Co. v. EPA.*, 427 U.S. 246, 256–66 (1976); 42 U.S.C. 7410(a)(2).

E. Unfunded Mandates.

Under section 202 of the Unfunded Mandates Reform Act of 1995, signed into law on March 22, 1995, EPA must undertake various actions in association with any proposed or final rule that includes a Federal mandate that may result in estimated costs to state, local, or tribal governments in the aggregate; or to the private sector, of \$100 million or more. This Federal action approves pre-existing requirements under state or local law, and imposes no new requirements. Accordingly, no additional costs to state, local, or tribal governments, or the private sector, result from this action.

F. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 et seq., as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress, and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the Federal Register. This rule is not a "major rule" as defined by 5 U.S.C. 804(2).

G. Petitions for Judicial Review

Under section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by November 9, 1998. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review, nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to

enforce its requirements. (See section 307(b)(2)).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Particulate matter.

Dated: August 11, 1998.

David A. Ullrich,

Acting Regional Administrator.

For the reasons stated in the preamble, part 52, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52 [AMENDED]

1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 et seq.

Subpart O—Illinois

2. Section 52.719 is amended by revising paragraph (a) to read as follows:

§ 52.719 Identification of plan—Conditional approval.

* * * * *

(a) On May 15, 1992, Illinois submitted a part D particulate matter (PM) nonattainment area plan for the Lake Calumet (Southeast Chicago) moderate nonattainment area. This plan included control measures adopted in a final opinion and order of the Illinois Pollution Control Board, on April 9, 1992, in proceeding R91-22. The United States Environmental Protection Agency conditionally approved the State's plan, contingent on fulfillment of the State's commitment to meet 3 requirements by November 20, 1995. The first requirement is for the State to adopt and submit additional enforceable control measures, if necessary, that will achieve attainment. The second requirement is for the State to submit a complete and accurate emissions inventory (including corrected emissions estimates, as well as any new control measures which may be needed) and an acceptable modeled attainment demonstration. The third requirement is for the State to impose an opacity limit for coke oven combustion stacks which is reflective of their mass emission limits.

(1) Incorporation by reference.

(i) Illinois Administrative Code Title 35: Environmental Protection, Subtitle B: Air Pollution, Chapter 1: Pollution Control Board, Subchapter c: Emission Standards and Limitations for Stationary Sources, Part 211: Definitions and General Provisions, Subpart A: General Provisions, Section 211.101. Adopted at 16 Illinois Register 7656, effective May 1, 1992. (ii) Illinois

Administrative Code Title 35: Environmental Protection, Subtitle B: Air Pollution, Chapter 1: Pollution Control Board, Subchapter c: Emission Standards and Limitations for Stationary Sources, Part 212: Visible and Particulate Matter Emissions, Subpart A: General, Sections 212.107, 212.108, 212.109, 212.110, 212.113; Subpart E: Particulate Matter Emissions from Fuel Combustion Sources, Section 212.210; Subpart K: Fugitive Particulate Matter, Sections 212.302, 212.309, 212.316; Subpart L: Particulate Matter from Process Emission Sources, Section 212.324; Subpart N: Food Manufacturing, Section 212.362; Subpart Q: Stone, Clay, Glass and Concrete Manufacturing, Section 212.425; Subpart R: Primary and Fabricated Metal Products and Machinery Manufacture, Section 212.458; Subpart S: Agriculture, Section 212.464; Section 212 Illustration D: McCook Vicinity Map, Illustration E: Lake Calumet Vicinity Map, and Illustration F: Granite City Vicinity Map. Adopted at 16 Illinois Register 7880, effective May 11, 1992.

3. Section 52.725 is amended by adding paragraph (f) to read as follows:

§ 52.725 Control strategy: Particulates.

* * * * *

(f) On November 14, 1995, May 9, 1996, and June 14, 1996, the State of Illinois submitted State Implementation Plan (SIP) revision requests to meet commitments related to the conditional approval of Illinois' May 15, 1992, SIP submittal for the Lake Calumet (SE Chicago), McCook, and Granite City, Illinois, Particulate Matter (PM) nonattainment areas. The EPA is approving the SIP revision request as it applies to the McCook PM nonattainment area. For the McCook PM nonattainment area, all of the deficiencies of the May 15, 1992, submittal have been corrected.

[FR Doc. 98-24037 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[PA039/067-4077; FRL-6149-1]

Approval and Promulgation of Air Quality Implementation Plans; Pennsylvania: Attainment Demonstration and Contingency Measures for the Liberty Borough PM-10 Nonattainment Area

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is approving State Implementation Plan (SIP) revisions submitted by the Pennsylvania Department of Environmental Protection (PADEP) consisting of an attainment demonstration and contingency measures for Allegheny County, Pennsylvania's Liberty Borough particulate matter moderate nonattainment area. EPA is approving the attainment demonstration because the Allegheny County Healthy Department's (ACHD) modeling analysis (submitted as a SIP revision by PADEP) adequately demonstrates that the regulatory portion of the attainment plan is sufficient to attain and maintain the National Ambient Air Quality Standards (NAAQS) for particulate matter that were in effect at the time of the submittal, and because its analyses have been corroborated by monitored air quality data. EPA is approving the contingency measures for the area because they satisfy the requirements of the Clean Air Act (the Act). EPA approved the regulatory portion of the attainment plan for the Liberty Borough area as a SIP revision in an earlier rulemaking action. Elsewhere in today's **Federal Register**, EPA has published its determination that the Liberty Borough area has attained the NAAQS for particulate matter. In an earlier action, EPA approved source-specific control requirements for the USX Clairton Coke Works which further strengthen the SIP for the Liberty Borough area.

EFFECTIVE DATE: This final rule is effective on October 8, 1998.

ADDRESSES: Copies of the documents relevant to this action are available for public inspection during normal business hours at the Air Protection Division, U. S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103; the Air and Radiation Docket and Information Center, U.S. Environmental Protection Agency, 401 M Street, SW, Washington, DC 20460; the Allegheny County Health Department, Department of Air Quality, 301 39th Street, Pittsburgh, Pennsylvania 15201; and Pennsylvania Department of Environmental Protection, Bureau of Air Quality, P.O. Box 8468, 400 Market Street, Harrisburg, Pennsylvania 17105.

FOR FURTHER INFORMATION CONTACT: Ruth E. Knapp (215) 814-2191, or by e-mail at knapp.ruth@epamail.epa.gov.

SUPPLEMENTARY INFORMATION: On January 6, 1994, the Pennsylvania Department of Environmental Protection (PADEP) submitted an attainment plan

to EPA on behalf of the Allegheny County Health Department (ACHD) for the Liberty Borough PM-10 nonattainment area.¹ PM-10 is particulate matter smaller than 10 microns in diameter. On July 12, 1995, PADEP submitted contingency measures to EPA on behalf of the ACHD for the Liberty Borough PM-10 nonattainment area. These two revisions to the Pennsylvania SIP were submitted to fulfill the Act's requirements for an attainment plan consisting of regulatory control measures, an attainment demonstration (including air quality modeling) that the regulations are sufficient to attain the PM-10 NAAQS, and contingency measures. These "Part D" requirements are described in more detail in the technical support document (TSD) prepared by EPA to support this rulemaking. Copies of the TSD are available, upon request, from the EPA Regional office listed in the **ADDRESSES** section of this notice.

As stated above, EPA previously took final action² to approve the regulatory portion of the attainment plan which included control measures for a variety of industrial sources. That action made those measures part of the SIP and federally enforceable. On June 12, 1998 (63 FR 32173), EPA published a notice of proposed rulemaking (NPR) proposing approval of the attainment demonstration and contingency measures portions of the attainment plan for the Liberty Borough PM-10 nonattainment area. The rationale for EPA's action was explained in the NPR and will not be restated here. No public comments were received on the NPR.

Please note that while EPA revised the NAAQS for particulate matter³ on July 18, 1997, in this notice the terms "NAAQS" and "PM-10 NAAQS" refer to the previously existing NAAQS that were in effect at the time that the attainment plan was required and submitted.

Final Action

EPA is approving the attainment demonstration and the contingency measures as a revision to the Pennsylvania SIP. Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any state implementation plan. Each request for a revision to the state implementation plan shall be considered separately in light of specific

technical, economic, and environmental factors and in relation to relevant statutory and regulatory requirements.

Administrative Requirements

A. Executive Orders 12866 and 13045

The Office of Management and Budget (OMB) has exempted this regulatory action from E.O. 12866 review. The final rule is not subject to E.O. 13045, entitled "Protection of Children from Environmental Health Risks and Safety Risks," because it is not an "economically significant" action under E.O. 12866.

B. Regulatory Flexibility Act

Under the Regulatory Flexibility Act, 5 U.S.C. 600 *et seq.*, EPA must prepare a regulatory flexibility analysis assessing the impact of any proposed or final rule on small entities. 5 U.S.C. 603 and 604. Alternatively, EPA may certify that the rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and government entities with jurisdiction over populations of less than 50,000.

SIP approvals under section 110 and subchapter I, part D of the Clean Air Act do not create any new requirements but simply approve requirements that the State is already imposing. Therefore, because the Federal SIP approval does not impose any new requirements, EPA certifies that it does not have a significant impact on any small entities affected. Moreover, due to the nature of the Federal-State relationship under the CAA, preparation of a flexibility analysis would constitute Federal inquiry into the economic reasonableness of state action. The Clean Air Act forbids EPA to base its actions concerning SIPs on such grounds. *Union Electric Co. v. U.S. EPA*, 427 U.S. 246, 255-66 (1976); 42 U.S.C. 7410(a)(2).

C. Unfunded Mandates

Under Section 202 of the Unfunded Mandates Reform Act of 1995 ("Unfunded Mandates Act"), signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to private sector, of \$100 million or more. Under Section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA

to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule. EPA has determined that the approval action being promulgated does not include a Federal mandate that may result in estimated costs of \$100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves pre-existing requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

D. Submission to Congress and the General Accounting Office

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a "major rule" as defined by 5 U.S.C. 804(2).

E. Petitions for Judicial Review

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action to approve the Liberty Borough PM-10 attainment demonstration and contingency measures must be filed in the United States Court of Appeals for the appropriate circuit by November 9, 1998. Filing a petition for reconsideration of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Particulate matter.

¹ The Liberty Borough PM-10 nonattainment area is comprised of the City of Clairton and the Boroughs of Glassport, Liberty, Lincoln, and Port Vue.

² See 61 FR 29664.

³ See 62 FR 38652.

Dated: August 13, 1998.

W. Michael McCabe,

Regional Administrator, Region III.

40 CFR Part 52 is amended as follows:

PART 52—[AMENDED]

1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401et seq.

Subpart NN—Pennsylvania

2. Section 52.2020 is amended by adding paragraphs (c)(135) to read as follows:

§ 52.2020 Identification of plan.

* * * * *

(c) * * *

(135) Revisions to the Pennsylvania State Implementation Plan consisting of contingency measures for USX Clairton in the Liberty Borough PM-10 Nonattainment Area, submitted on July 12, 1995 by the Pennsylvania Department of Environmental Protection:

(i) Incorporation by reference.

(A) Letter of July 12, 1995 from the Pennsylvania Department of Environmental Protection transmitting a SIP revision for contingency control measures for USX Clairton Works located in Liberty Borough PM-10 nonattainment area of Allegheny County.

(B) Revision to Allegheny County's Article XXI applicable to USX's Clairton Coke Works, effective July 11, 1995 specifically:

(1) Revisions to section 2105.21.e included in Appendix 34 which require improved procedures to capture pushing emissions for all USX-Clairton batteries except Battery B.

(ii) Additional Material—Remainder of the July 12, 1995 submittal.

3. Section 52.2059 is amended by adding paragraph (b) to read as follows:

§ 52.2059 Control strategy: particulate matter.

* * * * *

(b) EPA approves the PM-10 attainment demonstration for the Liberty Borough Area of Allegheny County submitted by the Pennsylvania Department of Environmental Protection on January 6, 1994.

[FR Doc. 98-24040 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[VA 011-5034a; FRL-6155-9]

Approval and Promulgation of State Air Quality Plans for Designated Facilities and Pollutants; Commonwealth of Virginia; Control of Total Reduced Sulfur Emissions from Existing Kraft Pulp Mills

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA is approving the 111(d) plan for Kraft pulp mills submitted by the Commonwealth of Virginia. The plan requires the control of total reduced sulfur (TRS) emissions from existing Kraft pulp mills. The Virginia plan establishes emission limits for existing Kraft pulp mills, and provides for the implementation and enforcement of those limits. The intended effect of this action is to approve the plan which was submitted in accordance with the Clean Air Act (the Act).

DATES: This direct final rule is effective on November 9, 1998, without further notice, unless EPA receives adverse comments by October 8, 1998. If adverse comments are received EPA will publish a timely withdrawal of the direct final rule in the **Federal Register** and inform the public that the rule will not take effect.

ADDRESSES: Comments may be mailed to Makeba A. Morris, Chief, Technical Assessment Branch, Mailcode 3AP22, Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the documents relevant to this action are available for public inspection during normal business hours at the following locations: Air Protection Division, Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103; and Commonwealth of Virginia, Department of Environmental Quality, 629 East Main Street, Richmond, VA 23219.

FOR FURTHER INFORMATION CONTACT: Artra B. Cooper at (215) 814-2096, or by e-mail at cooper.artra@epamail.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Act requires that states submit plans to EPA to implement and enforce the Emission Guidelines (EG) promulgated for Kraft pulp mills pursuant to Section 111(d). As required by section 111(d) of the Act, EPA

established a process at 40 CFR Part 60, Subpart B, which is similar to the process required by section 110 of the Act, which the states must follow for adopting and submitting 111(d) plans. Subpart B provides that, once a standard of performance for the control of a designated pollutant from a new source category is promulgated, the Administrator will then publish an emission guideline (E.G.) and guideline document applicable to the control of the same pollutant from designated (existing) facilities. The E.G. and related information were provided in a guideline document entitled "Kraft Pulping—Control of TRS Emissions from Existing Mills" (March 1979).

On May 15, 1990, the Commonwealth of Virginia submitted its Kraft pulp mill 111(d) plan for the control of TRS from existing kraft pulp mills to EPA for approval. The plan consists of regulations and consent agreements with the affected facilities within the Commonwealth. EPA has determined that the plan meets the requirements of 40 CFR Part 60, Subpart B. The Virginia regulation entitled: "Regulation for the Control and Abatement of Air Pollution, VR 120-01, Part IV, Rule 4-13, Emission Standard for Kraft Pulp Mills," is the regulatory portion of Virginia's 111(d) plan. This regulation provides for control of TRS emissions from Kraft pulp mills. The Commonwealth's regulation contains the emission limits found in the E.G. issued by EPA. The regulation includes emission limitations for applicable emission sources, provisions for compliance schedules, monitoring, record keeping and reporting requirements, all of which comport with the E.G. The regulation also requires operational standards for continuous monitoring systems, development and implementation of a quality control plan and submittal of control plans. The consent agreements included in the 111(d) plan were reached with the four affected facilities located within the Commonwealth of Virginia. They include the following sources: Westvaco Corporation—Covington, Union Camp—Franklin, Stone Container Corporation—Hopewell, and Chesapeake Corporation—West Point. These consent agreements provided interim emission limits while providing time for the affected facilities to comply with the E.G.-based limits. The consent agreements required compliance with the E.G.-based limits specified in the Commonwealth's regulation by no later than October 1994.

More detailed information on the requirements of Virginia's plan and EPA's evaluation are contained in the

Technical Support Document (TSD) accompanying this rulemaking. Copies of the TSD are available upon request from the EPA Regional Office listed in the ADDRESSES section of this document.

II. Final Action

EPA is approving the Commonwealth of Virginia's 111(d) plan for the control of total reduced sulfur emissions from Kraft pulp mills.

EPA is approving this rule without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. However, in the proposed rules section of this **Federal Register** publication, EPA is publishing a separate document that will serve as the proposal to approve the 111(d) plan should adverse or critical comments be filed. This rule will be effective November 9, 1998, without further notice unless the Agency receives adverse comments by October 8, 1998. If EPA receives such comments, then EPA will publish a document withdrawing the final rule and informing the public that the rule will not take effect. All public comments received will then be addressed in a subsequent final rule based on the proposed rule. EPA will not institute a second comment period on this rule. Parties interested in commenting on this rule should do so at this time. If no such comments are received, the public is advised that this rule will be effective on November 9, 1998, and no further action will be taken on the proposed rule.

III. Administrative Requirements

A. Executive Orders 12866 and 13045

The Office of Management and Budget (OMB) has exempted this regulatory action from E.O. 12866 review. The final rule is not subject to E.O. 13045, entitled "Protection of Children from Environmental Health Risks and Safety Risks," because it is not an "economically significant" action under E.O. 12866.

B. Regulatory Flexibility Act

Under the Regulatory Flexibility Act, 5 U.S.C. 600 *et seq.*, EPA must prepare a regulatory flexibility analysis assessing the impact of any proposed or final rule on small entities (5 U.S.C. 603 and 604). Alternatively, the EPA may certify that the rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and government entities with jurisdiction over populations of less than 50,000. State

plan approvals under section 111 of the Act do not create any new requirements, but simply approve requirements that the State is already imposing. Therefore, because the federal action to approve the state plan does not impose any new requirements, EPA certifies that it does not have a significant impact on any small entities affected. Moreover, due to the nature of the Federal-State relationship under the Act, preparation of a flexibility analysis would constitute Federal inquiry into the economic reasonableness of State action. The Act forbids EPA to base its actions concerning State plans on such grounds. See *Union Electric Co. v. U.S. EPA*, 427 U.S. 246, 255–66 (1976); 42 U.S.C. 7410(a)(2).

C. Unfunded Mandates

Under Section 202 of the Unfunded Mandates Reform Act of 1995 ("Unfunded Mandates Act"), signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to private sector, of \$100 million or more. Under Section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule. EPA has determined that the approval action promulgated does not include a Federal mandate that may result in estimated costs of \$100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves pre-existing requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

D. Submission to Congress and the General Accounting Office

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate,

the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a "major rule" as defined by 5 U.S.C. 804(2).

E. Petitions for Judicial Review

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action approving The Commonwealth of Virginia's 111(d) plan for Kraft pulp mills must be filed in the United States Court of Appeals for the appropriate circuit by November 9, 1998. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 62

Environmental protection, Air pollution control, Reporting and recordkeeping requirements, Total reduced sulfur.

Dated: August 27, 1998.

Thomas C. Voltaggio,

Acting Regional Administrator, EPA Region III.

40 CFR Part 62 is amended as follows:

PART 62—[AMENDED]

1. The authority citation for Part 62 continues to read as follows:

Authority: 42 U.S.C. 7401–7671q.

Subpart VV—Virginia

2. Under existing heading, § 62.11610 is added to read as follows:

Total Reduced Sulfur Emissions From Existing Kraft Pulp Mills

§ 62.11610 Identification of plan.

(a) Title of Plan. Commonwealth of Virginia State Implementation Plan under section 111(d) plan for the Designated Facility—Kraft Pulp Mills.

(b) The plan was officially submitted by the Executive Director of the Department of Virginia Department of Air Pollution Control, on May 15, 1990.

(c) Identification of sources. The Plan includes the following Kraft Pulp Mills:

(1) Chesapeake Corporation, West Point;

(2) Stone Container Corporation, Hopewell;

(3) Union Camp Corporation, Franklin; and

(4) Westvaco Corporation, Covington.
(d) Article 13, 9 VAC—40—1690, Section 120—04—1304 (Standard for total reduced sulfur), effective October 1, 1989. This plan was submitted on May 15, 1990 by the Commonwealth of Virginia.

[FR Doc. 98–23888 Filed 9–4–98; 8:45 am]
BILLING CODE 6560–50–P

**GENERAL SERVICES
ADMINISTRATION**

41 CFR Part 301–10

[FTR Amendment 73]

RIN 3090–AG75

**Federal Travel Regulation; Privately
Owned Vehicle Mileage
Reimbursement**

AGENCY: Office of Governmentwide
Policy, GSA.

ACTION: Final rule.

SUMMARY: This final rule increases the mileage reimbursement rates for use of a privately owned vehicle (POV) on official travel to reflect current costs of operation as determined in cost studies conducted by the General Services Administration (GSA). The governing regulation is revised to increase the mileage allowance for advantageous use of a privately owned airplane from 85 to 88 cents per mile, the cost of operating a privately owned automobile from 31 to 32.5 cents per mile, and the cost of operating a privately owned motorcycle from 25 to 26 cents per mile.

EFFECTIVE DATE: This final rule is effective September 8, 1998.

FOR FURTHER INFORMATION CONTACT: Devoanna R. Reels, General Services Administration, Travel and Transportation Management Policy Division (MTT), Washington, DC 20405, telephone 202–501–3781.

SUPPLEMENTARY INFORMATION: GSA has determined that this rule is not a significant regulatory action for the purposes of E.O. 12866 of September 30, 1993. This final rule is not required to be published in the **Federal Register** for notice and comment; therefore, the Regulatory Flexibility Act does not apply. The Paperwork Reduction Act does not apply, because the proposed revisions do not impose recordkeeping or information collection requirements, or the collection of information from offerors, contractors, or members of the public which require the approval of the Office of Management and Budget under 44 U.S.C. 501 *et seq.* This proposed rule is also exempt from Congressional

review prescribed under 5 U.S.C. 801, since it relates solely to agency management and personnel.

List of Subjects in 41 CFR Part 301–10

Government employees, Travel and transportation expenses.

For the reasons set out in the preamble, 41 CFR part 301–10 is amended as follows:

**PART 301–10—TRANSPORTATION
EXPENSES**

1. The authority citation for 41 CFR part 301–10 continues to read as follows:

Authority: 5 U.S.C. 5707; 40 U.S.C. 486(c); 49 U.S.C. 40118.

2. Section 301–10.303 is amended by revising the entries for “Privately owned airplane,” “Privately owned automobile,” and “Privately owned motorcycle” to read as follows:

**§ 301–10.303 What am I reimbursed when
use of a POV is determined by my agency
to be advantageous to the Government?**

For use of a—	Your reim- bursement is—
* * * *	*
Privately owned airplane	188.0
Privately owned automobile	132.5
Privately owned motorcycle	126.0

¹ Cents per mile.

Dated: September 1, 1998.

David J. Barram,
Administrator of General Services.

**General Services Administration; Report to
Congress on the Costs of Operating Privately
Owned Vehicles**

Subparagraph (b)(1)(A) of Section 5707 of Title 5, United States Code, requires the Administrator of General Services to periodically investigate the cost to Government employees of operating privately owned vehicles (airplanes, automobiles, and motorcycles) while on official travel, to report the results of the investigations to Congress, and to publish the report in the **Federal Register**. This report is being published to comply with the requirements of the law.

Dated: September 1, 1998.

David J. Barram,
Administrator of General Services.

Report to Congress

Subparagraph (b)(1)(A) of Section 5707 of Title 5, United States Code, requires that the Administrator of General Services, in consultation with the Secretary of Transportation, the Secretary of Defense, and representatives of Government employee organizations, conduct

periodic investigations of the cost of operating privately owned vehicles (airplanes, automobiles, and motorcycles) to Government employees while on official travel and report the results to Congress at least once a year. The law further requires that a determination of the average, actual cost per mile be based on the results of the investigation. Such figures must be reported to Congress within 5 working days after the determination has been made.

Pursuant to the requirements of subparagraph (b)(1)(A) of Section 5707 of Title 5, United States Code, the General Services Administration (GSA) conducted an investigation of the cost of operating privately owned automobiles, airplanes, motorcycles, and consulted with the Secretaries of Defense, Transportation and representatives of employee organization on the results. As required, GSA is reporting the results of the investigation and the cost per mile determinations. GSA’s cost studies show and I have determined the per-mile operating costs of privately owned vehicles to be 88 cents for airplanes, 32.5 cents for automobiles, and 26 cents for motorcycles.

I will issue a regulation to increase the current 85 to 88 cents for privately owned airplanes, 31 to 32.5 cents for privately owned automobiles, and the current 25 to 26 cents for privately owned motorcycles.

This report on the cost of operating privately-owned vehicles will be published in the **Federal Register**.

[FR Doc. 98–24019 Filed 9–4–98; 8:45 am]
BILLING CODE 6820–34–P

**FEDERAL COMMUNICATIONS
COMMISSION**

47 CFR Part 1

[MD Docket No. 98–36; FCC 98–115]

**Assessment and Collection of
Regulatory Fees for Fiscal Year 1998**

AGENCY: Federal Communications
Commission.

ACTION: Final rule; correction.

SUMMARY: This document corrects portions of the Commission’s rules that were published in the **Federal Register** of July 1, 1998 (63 FR 35847).

EFFECTIVE DATE: September 8, 1998.

FOR FURTHER INFORMATION CONTACT: Terry Johnson, Office of Managing Director, (202) 418–0445.

SUPPLEMENTARY INFORMATION: The Federal Communications Commission published a document establishing rules

for assessment and collection of regulatory fees in the **Federal Register** of July 1, 1998 (63 FR 35847). In rule FR Doc. 98-17222, published on July 1, 1998, (63 FR 35847) make the following corrections:

1. On page 35873, in the table labeled "Attachment F-FY 1998 Schedule of Regulatory Fees" and under the first column labeled "Fee Category," line 12 is corrected to read as follows:

CMRS Mobile Services (per unit) (47 CFR Parts 20, 22, 24, 27, 80 and 90).

2. On page 35873, in the table labeled "Attachment F-FY 1998 Schedule of Regulatory Fees" and under the first column labeled "Fee Category," line 13 is corrected to read as follows:

CMRS Messaging Services (per unit) (47 CFR Parts 20, 22, 24 and 90).

3. On page 35874, in the table labeled "Attachment G-Comparison Between FY 1997 and FY 1998 Proposed and Final Regulatory Fees-Continued" and under the first column labeled "Fee Category," line 5 is corrected to read as follows:

CMRS Mobile Services (per unit) (47 CFR Parts 20, 22, 24, 27, 80 and 90).

4. On page 35874, in the table labeled "Attachment G-Comparison Between FY 1997 and FY 1998 Proposed and Final Regulatory Fees-Continued" and under the first column labeled "Fee Category," line 6 is corrected to read as follows:

CMRS Messaging Services [formerly One-Way Paging] (per unit) (47 CFR Parts 20, 22, 24 and 90).

5. On page 35876, in the second column, paragraph 14., the sentence beginning in the middle of line 19 is corrected to read:

While specific rules pertaining to each covered service remain in separate parts 22, 24, 27, 80 and 90, general rules for CMRS are contained in part 20. CMRS Mobile Services will include: Specialized Mobile Radio Service (part 90);¹⁴⁴ Personal Communications Services (part 24); Public Coast Stations (part 80); Public Mobile Radio (Cellular, 800 MHz Air-Ground Radiotelephone, and Offshore Radio Services) (part 22); and Wireless Communications Services (part 27).

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 98-23965 Filed 9-4-98; 8:45 am]

BILLING CODE 6712-01-P

DEPARTMENT OF DEFENSE

48 CFR Part 246

[DFARS Case 97-D038]

Defense Federal Acquisition Regulation Supplement; Quality Assurance Among North Atlantic Treaty Organization Countries

AGENCY: Department of Defense (DoD).

ACTION: Correction to final rule.

SUMMARY: The Department of Defense is issuing a correction to the final rule published at 63 FR 43890, August 17, 1998.

EFFECTIVE DATE: August 17, 1998.

FOR FURTHER INFORMATION CONTACT: Defense Federal Acquisition Regulations Council, Attn: Ms. Michele Peterson, PDUSD (A&T) DP (DAR), IMD 3D139, 3062 Defense Pentagon, Washington, DC 20301-3062.

Correction

In the issue of Monday, August 17, 1998, on page 43890, in the third column, amendatory instruction 2 is corrected by removing the reference "225.78" and inserting in its place the reference "225.8".

Michele P. Peterson,

Executive Editor, Defense Acquisition Regulations Council.

[FR Doc. 98-23975 Filed 9-4-98; 8:45 am]

BILLING CODE 5000-04-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 971208297-8054-02; I.D. 090298A]

Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 610 of the Gulf of Alaska

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Closure.

SUMMARY: NMFS is prohibiting directed fishing for pollock in Statistical Area 610 of the Gulf of Alaska (GOA). This action is necessary to prevent exceeding the 1998 total allowable catch (TAC) of pollock in this area.

DATES: Effective 1200 hrs, Alaska local time (A.l.t.), September 2, 1998, until 2400 hrs, A.l.t., December 31, 1998.

FOR FURTHER INFORMATION CONTACT: Thomas Pearson, 907-486-6919.

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fishery in the GOA exclusive economic zone according to the Fishery Management Plan for Groundfish of the Gulf of Alaska (FMP) prepared by the North Pacific Fishery Management Council under authority of the Magnuson-Stevens Fishery Conservation and Management Act. Regulations governing fishing by U.S. vessels in accordance with the FMP appear at subpart H of 50 CFR part 600 and 50 CFR part 679.

In accordance with § 679.20(c)(3)(ii), the Final 1998 Harvest Specifications of Groundfish for the GOA (63 FR 12027, March 12, 1998) established the amount of the 1998 TAC of pollock in Statistical Area 610 of the GOA as 29,790 metric tons (mt).

In accordance with § 679.20(d)(1)(i), the Administrator, Alaska Region, NMFS (Regional Administrator), has determined that the 1998 TAC for pollock will be reached. Therefore, the Regional Administrator is establishing a directed fishing allowance of 29,590 mt, and is setting aside the remaining 200 mt as bycatch to support other anticipated groundfish fisheries. In accordance with § 679.20(d)(1)(iii), the Regional Administrator finds that this directed fishing allowance has been reached. Consequently, NMFS is prohibiting directed fishing for pollock in Statistical Area 610 of the GOA.

Maximum retainable bycatch amounts for applicable gear types may be found in the regulations at § 679.20(e) and (f).

Classification

This action responds to the best available information recently obtained from the fishery. It must be implemented immediately to prevent overharvesting the 1998 TAC of pollock for Statistical Area 610 of the GOA. A delay in the effective date is impracticable and contrary to the public interest. Further delay would only result in overharvest. NMFS finds for good cause that the implementation of this action should not be delayed for 30 days. Accordingly, under 5 U.S.C. 553(d), a delay in the effective date is hereby waived.

This action is required by 50 CFR 679.20 and is exempt from review under E.O. 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: September 2, 1998.

Bruce Morehead,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 98-24023 Filed 9-2-98; 1:49 pm]

BILLING CODE 3510-22-F

Proposed Rules

Federal Register

Vol. 63, No. 173

Tuesday, September 8, 1998

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

NUCLEAR REGULATORY COMMISSION

10 CFR Part 60

RIN 3150-AE40

Clarification of the Assessment Requirements for the Siting Criteria and Performance Objectives

AGENCY: Nuclear Regulatory Commission.

ACTION: Proposed rule: Withdrawal.

SUMMARY: The Nuclear Regulatory Commission (NRC) is withdrawing a proposed rule that would clarify uncertainties in regulations that contain generic criteria governing the disposal of high-level radioactive wastes (HLW) in geologic repositories. Because the NRC is developing site-specific disposal regulations for Yucca Mountain, Nevada, consistent with the Energy Policy Act of 1992 (EnPA), the proposed rule is being withdrawn.

FOR FURTHER INFORMATION CONTACT: Janet P. Kotra, Performance Assessment and High-Level Waste Integration Branch, Division of Waste Management, Office of Nuclear Material Safety and Safeguards, Nuclear Regulatory Commission, 11545 Rockville Pike, Rockville, Maryland 20852-2738. Telephone 301/415-6674. E-mail JPK@NRC.GOV.

SUPPLEMENTARY INFORMATION: Existing NRC regulations at 10 CFR part 60, initially issued in 1983, contain generic criteria governing the disposal of HLW in a geologic repository. On July 9, 1993 (58 FR 36902), the NRC published, for public comment, proposed amendments intended to clarify certain regulatory uncertainties in those regulations related to the investigation and evaluation of potentially adverse conditions at potential repository sites. The public comment period ended on October 7, 1993.

In anticipation of the results of a National Academy of Science (NAS) study undertaken in response to the EnPA, as well as Congressional activity

with respect to the Nuclear Waste Policy Act of 1982, as amended, the Commission decided not to issue a final rule and directed the NRC staff to withdraw the proposed rulemaking and reconsider the need for it when the legislative environment had stabilized. The purpose of this **Federal Register** notice is to announce the NRC's withdrawal of this proposed rule.

At present, the NRC staff has considered and is implementing a strategy for developing site-specific disposal regulations that would apply solely to the proposed geologic repository at Yucca Mountain, and is deferring the updating of 10 CFR part 60 generic requirements to a later date. These site-specific regulations will be promulgated consistent with EnPA, which also requires the Environmental Protection Agency to issue radiation standards for a geologic repository at Yucca Mountain, based on and consistent with the 1995 findings and recommendations of the NAS. A proposed rule will be published for public comment by the end of the calendar year.

The NRC staff's strategy for developing the site-specific disposal regulations for Yucca Mountain can be found in a Commission Paper, designated SECY-97-300, that is dated December 24, 1997. This strategy was approved by the Commission in an SRM dated March 6, 1998. The Commission Paper, the SRM, and associated documents are available for public inspection and/or copying at the NRC Public Document Room located at 2120 L Street (lower level), NW, Washington, DC 20012-7082. Telephone: 202-512-2249.

Dated at Rockville, Maryland, this 31st day of August, 1998.

For the Nuclear Regulatory Commission.

John C. Hoyle,

Secretary of the Commission.

[FR Doc. 98-24007 Filed 9-4-98; 8:45 am]

BILLING CODE 7590-01-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98-NM-217-AD]

RIN 2120-AA64

Airworthiness Directives; British Aerospace Model Viscount 744, 745, 745D, and 810 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes the superseding of an existing airworthiness directive (AD), applicable to all British Aerospace Model Viscount 700, 800, and 810 series airplanes, that currently requires repetitive inspections to detect cracks and corrosion in the inboard and outboard engine nacelle structures on the wings; replacement of any cracked fittings and mating struts; and treatment or replacement of any corroded fittings or struts. This action would require repetitive inspections to detect cracking or corrosion of the eye end fittings of the outboard engine lower support or of the bore of the taper pin holes, and repair, if necessary. This action also would limit the applicability of the existing AD. This proposal is prompted by reports of cracked and separated lower eye end fittings. The actions specified by the proposed AD are intended to detect and correct cracking of the eye end fittings of the outboard engine lower support, which could result in reduced structural integrity of the engine nacelle support structures.

DATES: Comments must be received by October 8, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM-114, Attention: Rules Docket No. 98-NM-217-AD, 1601 Lind Avenue, SW., Renton, Washington 98055-4056. Comments may be inspected at this location between 9:00 a.m. and 3:00 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from British Aerospace Regional Aircraft Limited, Chadderton Division, Engineering Support, Greengate,

Middleton, Manchester M24 1SA, England. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT:

Norman B. Martenson, Manager, International Branch, ANM-116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055-4056; telephone (425) 227-2110; fax (425) 227-1149.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 98-NM-217-AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM-114, Attention: Rules Docket No. 98-NM-217-AD, 1601 Lind Avenue, SW., Renton, Washington 98055-4056.

Discussion

On September 10, 1990, the FAA issued AD 90-20-17, amendment 39-6744 (55 FR 38539, September 19, 1990), applicable to all British Aerospace Model Viscount 700, 800, and 810 series airplanes, to require repetitive visual, x-ray, ultrasonic, and dye penetrant inspections to detect cracks and corrosion in the inboard and

outboard engine nacelle structures on the left and right wings; replacement of any cracked fittings and mating struts; and treatment or replacement of any corroded fittings or struts. That action was prompted by reports indicating that nacelle lower eye end fittings had cracked and separated due to fatigue failure or stress corrosion. The requirements of that AD are intended to detect and correct fatigue or stress corrosion cracking of the nacelle lower eye end fittings, which could result in reduced structural integrity of the engine nacelle support structures.

Actions Since Issuance of Previous Rule

Since the issuance of AD 90-20-17, the Civil Aviation Authority (CAA), which is the airworthiness authority for the United Kingdom, has determined that long-term continued operational safety would be better assured by using eddy current inspections, rather than visual, x-ray, ultrasonic, and dye penetrant inspections, to detect cracking and corrosion in engine nacelle support structures. British Aerospace has issued new service information to reflect this determination.

Explanation of Relevant Service Information

British Aerospace has issued Preliminary Technical Leaflet (PTL) No. 326, Issue 2, including Appendices 1 and 2, all dated December 1, 1994 (for Model Viscount 744, 745, and 745D series airplanes). British Aerospace also has issued PTL 197, Issue 3, including Appendices 1 and 2, all dated November 20, 1993 (for Model Viscount 810 series airplanes). Those PTL's describe procedures for repetitive eddy current inspections to detect cracking or corrosion of the eye end fittings of the outboard engine lower support and of the bore of the taper pin holes in the engine nacelle subframes, tubes, and fittings. The CAA classified these PTL's as mandatory in order to assure the continued airworthiness of these airplanes in the United Kingdom.

FAA's Conclusions

These airplane models are manufactured in the United Kingdom and are type certificated for operation in the United States under the provisions of § 21.29 of the Federal Aviation Regulations (14 CFR 21.29) and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the CAA has kept the FAA informed of the situation described above. The FAA has examined the findings of the CAA, reviewed all available information, and determined that AD action is necessary

for products of this type design that are certificated for operation in the United States.

Explanation of Requirements of Proposed Rule

Since an unsafe condition has been identified that is likely to exist or develop on other airplanes of the same type design registered in the United States, the proposed AD would supersede AD 90-20-17 to require new repetitive eddy current inspections to detect cracking or corrosion of the eye end fittings of the outboard engine lower support or of the bore of the taper pin holes, and repair, if necessary. The proposed AD also would limit the applicability of the existing AD. The actions would be required to be accomplished in accordance with the PTL's described previously, except as discussed below.

Differences Between Proposed Rule and Preliminary Technical Leaflets

Operators should note that, although the PTL's specify that the manufacturer may be contacted for disposition of repair conditions, this proposal would require the repair of those conditions to be accomplished in accordance with a method approved by either the FAA, or the CAA (or its delegated agent). In light of the type of repair that would be required to address the identified unsafe condition, and in consonance with existing bilateral airworthiness agreements, the FAA has determined that, for this proposed AD, a repair approved by either the FAA or the CAA would be acceptable for compliance with this proposed AD.

Explanation of Revisions to Applicability

The applicability of the proposed AD has been reduced to include only Model Viscount 744, 745, and 745D series airplanes on which British Aerospace Modification D3227 has not been accomplished, and Model Viscount 810 series airplanes, on which British Aerospace Modification FG 2103 has not been accomplished. This change is necessary to incorporate restrictions to the effectivity of the PTL's that are specified in the Compliance paragraph of each PTL.

Other Relevant Rulemaking

The FAA previously has issued AD 98-12-17, amendment 39-10444 (63 FR 31347, June 9, 1998), which is applicable to all British Aerospace Model Viscount 744, 745, 745D, and 810 series airplanes. That AD requires repetitive inspections to detect cracking

and corrosion of components of the engine nacelle subframe structure; corrective action, if any cracking or corrosion is found; and replacement of any component that has reached its life limit with a new or serviceable component. That AD references British Aerospace Viscount Alert Preliminary Technical Leaflet (PTL) 500, dated January 1, 1993; including Appendices 1 through 4 inclusive, dated November 1992, and Appendix 5, dated October 1992; as the appropriate sources of service information for accomplishment of the actions required by AD 98-12-17. PTL 500 superseded and canceled British Aerospace Viscount Alert PTL No. 122, Issue 4, and British Aerospace Viscount Alert PTL No. 258, Issue 4, which were referenced in AD 90-20-17 as appropriate sources of service information for accomplishment of certain actions required by that AD. For this reason, those actions would not be mandated by this new proposed AD.

Cost Impact

There are approximately 29 airplanes of U.S. registry that would be affected by this proposed AD.

The new eddy current inspections that are proposed in this AD action would take approximately 2 work hours per airplane to accomplish, at an average labor rate of \$60 per work hour. Based on these figures, the cost impact of the proposed requirements of this AD on U.S. operators is estimated to be \$3,480, or \$120 per airplane, per inspection cycle.

The cost impact figure discussed above is based on assumptions that no operator has yet accomplished any of the current or proposed requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted.

Regulatory Impact

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44

FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. Section 39.13 is amended by removing amendment 39-6744 (55 FR 38539, September 19, 1990), and by adding a new airworthiness directive (AD), to read as follows:

British Aerospace Regional Aircraft Limited (Formerly British Aerospace Commercial Aircraft Limited, Vickers-Armstrongs Aircraft Limited): Docket 98-NM-217-AD. Supersedes AD 90-20-17, amendment 39-6744.

Applicability: Model Viscount 744, 745, and 745D series airplanes, on which British Aerospace Modification D3227 has not been accomplished; and Model Viscount 810 series airplanes, on which British Aerospace Modification FG 2103 has not been accomplished; certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been otherwise modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (c) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated, unless accomplished previously.

To detect and correct cracking of the eye end fittings of the outboard engine lower support, which could result in reduced structural integrity of the engine nacelle support structures, accomplish the following:

(a) Perform an eddy current inspection to detect cracking or corrosion of the eye end fittings of the outboard engine lower support, or of the bore of the taper pin holes, in accordance with the Accomplishment Instructions of British Aerospace Preliminary Technical Leaflet (PTL) No. 326, Issue 2, including Appendices 1 and 2, all dated December 1, 1994 (for Model Viscount 744, 745, and 745D series airplanes); or PTL 197, Issue 3, including Appendices 1 and 2, all dated November 20, 1993 (for Model Viscount 810 series airplanes); at the applicable time specified in either paragraph (a)(1) or (a)(2) of this AD. Thereafter, repeat the inspection at intervals not to exceed 900 landings.

(1) For Model Viscount 744, 745, and 745D series airplanes: Inspect within 3 months after the effective date of this AD.

(2) For Model Viscount 810 series airplanes: Inspect within 900 landings after the last inspection performed in accordance with PTL 197, Issue 2, dated July 10, 1992; or within 3 months after the effective date of this AD, whichever occurs later.

(b) If any cracking is found during any inspection performed in accordance with paragraph (a) of this AD, prior to further flight, repair in accordance with a method approved by the Manager, International Branch, ANM-116, FAA, Transport Airplane Directorate; or the Civil Aviation Authority (or its delegated agent).

(c) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, International Branch, ANM-116. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, International Branch, ANM-116.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the International Branch, ANM-116.

(d) Special flight permits may be issued in accordance with §§ 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on September 1, 1998.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.
[FR Doc. 98-24064 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-13-U

DEPARTMENT OF TRANSPORTATION**Federal Aviation Administration****14 CFR Part 39**

[Docket No. 98–NM–109–AD]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Model DC–9–80 Series Airplanes, Model MD–88 Airplanes, and Model MD–90–30 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes the adoption of a new airworthiness directive (AD) that is applicable to certain McDonnell Douglas Model DC–9–80 series airplanes, Model MD–88 airplanes, and Model MD–90–30 airplanes. This proposal would require repetitive inspections to detect cracking of the main landing gear (MLG) shock strut pistons, and replacement of a cracked piston with a new or serviceable part. This proposal is prompted by reports indicating that, while an airplane was positioned on the taxiway, the right MLG shock strut piston failed due to fatigue cracking. The actions specified by the proposed AD are intended to detect and correct such fatigue cracking, which could result in failure of the piston, and consequent damage to the airplane structure or injury to the passengers and flightcrew.

DATES: Comments must be received by October 23, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM–114, Attention: Rules Docket No. 98–NM–109–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056. Comments may be inspected at this location between 9:00 a.m. and 3:00 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from The Boeing Company, Douglas Products Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Technical Publications Business Administration, Dept. C1–L51 (2–60). This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington, or at the FAA, Transport Airplane Directorate, Los Angeles Aircraft

Certification Office, 3960 Paramount Boulevard, Lakewood, California.

FOR FURTHER INFORMATION CONTACT: Brent Bandle, Aerospace Engineer, Airframe Branch, ANM–120L, FAA, Transport Airplane Directorate, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5237; fax (562) 627–5210.

SUPPLEMENTARY INFORMATION:**Comments Invited**

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: “Comments to Docket Number 98–NM–109–AD.” The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM–114, Attention: Rules Docket No. 98–NM–109–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056.

Discussion

The FAA has received a report of failure of the shock strut piston of the right main landing gear (MLG) while a McDonnell Douglas Model DC–9–80 series airplane was positioned on the taxiway. (A similar incident also occurred in 1991.) The report indicated that the affected piston on the airplane had accumulated 22,484 total flight cycles. Investigation revealed that the cause of this failure was attributed to a

large fatigue crack that had propagated across the bottom of the MLG shock strut piston. The crack initiated near the jackball, which is located on the bottom of the MLG shock strut piston and is used by operators to jack up the airplane. This condition, if not corrected, could result in failure of the MLG shock strut piston, and consequent damage to the airplane structure or injury to the passengers and flightcrew.

The subject area on certain McDonnell Douglas Model MD–88 airplanes and Model MD–90–30 airplanes is identical to that of the affected Model DC–9–80 series airplanes. Therefore, all of these airplanes may be subject to the same unsafe condition.

Explanation of Relevant Service Information

The FAA has reviewed and approved McDonnell Douglas Alert Service Bulletins MD80–32A308, dated March 5, 1998, and MD80–32A308, Revision 01, dated May 12, 1998 [for Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), and DC–9–87 (MD–87) series airplanes, and Model MD–88 airplanes]; and MD90–32A030, dated March 26, 1998, and MD90–32A030, Revision 01, dated May 11, 1998 (for Model MD–90–30 airplanes). These alert service bulletins describe procedures for repetitive fluorescent dye penetrant and fluorescent magnetic particle inspections to detect cracking of the MLG shock strut piston, and replacement of any cracked piston with a new or serviceable part.

Explanation of Requirements of Proposed Rule

Since an unsafe condition has been identified that is likely to exist or develop on other products of this same type design, the proposed AD would require accomplishment of the actions specified in the alert service bulletins described previously.

Interim Action

This is considered to be interim action. The manufacturer has advised that it currently is developing a modification that will positively address the unsafe condition addressed by this AD. Once this modification is developed, approved, and available, the FAA may consider additional rulemaking.

Cost Impact

There are approximately 1,250 airplanes of the affected design in the worldwide fleet. The FAA estimates that 828 airplanes of U.S. registry would be affected by this proposed AD, that it

would take approximately 4 work hours per airplane to accomplish the proposed inspection, and that the average labor rate is \$60 per work hour. Based on these figures, the cost impact of the inspection proposed by this AD on U.S. operators is estimated to be \$198,720, or \$240 per airplane, per inspection cycle.

The cost impact figures discussed above are based on assumptions that no operator has yet accomplished any of the proposed requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted.

Should an operator be required to accomplish the proposed replacement of an MLG shock strut piston, it would take approximately 16 work hours per airplane to accomplish, at an average labor rate of \$60 per work hour. Required parts would cost approximately \$107,070 per airplane. Based on these figures, the cost impact of the replacement proposed by this AD on U.S. operators is estimated to be \$108,030 per airplane.

Regulatory Impact

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption ADDRESSES.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation

Administration proposes to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

McDonnell Douglas: Docket 98–NM–109–AD.

Applicability: Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), and DC–9–87 (MD–87) series airplanes, and Model MD–88 airplanes, as listed in McDonnell Douglas Alert Service Bulletin MD80–32A308, Revision 01, dated May 12, 1998; and Model MD–90–30 airplanes, as listed in McDonnell Douglas Alert Service Bulletin MD90–32A030, Revision 01, dated May 11, 1998; certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (e) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated, unless accomplished previously.

To detect and correct fatigue cracking of the main landing gear (MLG) shock strut pistons, which could result in failure of the piston, and consequent damage to the airplane structure or injury to the passengers and flightcrew, accomplish the following:

(a) Perform fluorescent dye penetrant and fluorescent magnetic particle inspections to detect cracking of an MLG shock strut piston, in accordance with McDonnell Douglas Alert Service Bulletin MD80–32A308, dated March 5, 1998, or MD80–32A308, Revision 01, dated May 12, 1998 [for Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), and DC–9–87 (MD–87) series airplanes, and Model MD–88 airplanes]; or MD90–32A030, dated March 26, 1998, or MD90–32A030, Revision 01, dated May 11, 1998 (for Model MD–90–30 airplanes); as applicable. Perform the inspections at the later of the times specified in paragraphs (a)(1) and (a)(2) of this AD.

(1) Prior to the accumulation of 10,000 total landings on an MLG shock strut piston, or within 6 months after the effective date of this AD, whichever occurs later.

(2) Within 2,500 landings after a major overhaul and initial inspection of the MLG shock strut piston accomplished prior to the effective date of this AD, in accordance with McDonnell Douglas All Operator Letter 9–2153 [for Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), and DC–9–87 (MD–87) series airplanes, and Model MD–88 airplanes], or McDonnell Douglas Component Maintenance Manual, Chapter 32–17–01 (for Model MD–90–30 airplanes).

(b) Condition 1. If any cracking is detected, prior to further flight, replace any cracked MLG shock strut piston with a new or serviceable piston, in accordance with McDonnell Douglas Alert Service Bulletin MD80–32A308, dated March 5, 1998, or MD80–32A308, Revision 01, dated May 12, 1998 [for Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), and DC–9–87 (MD–87) series airplanes, and Model MD–88 airplanes]; or MD90–32A030, dated March 26, 1998, or MD90–32A030, Revision 01, dated May 11, 1998 (for Model MD–90–30 airplanes); as applicable. Repeat the fluorescent dye penetrant and fluorescent magnetic particle inspections thereafter at intervals not to exceed 2,500 landings.

(c) Condition 2. If no cracking is detected, repeat the fluorescent dye penetrant and fluorescent magnetic particle inspections thereafter at intervals not to exceed 2,500 landings, in accordance with McDonnell Douglas Alert Service Bulletin MD80–32A308, dated March 5, 1998, or MD80–32A308, Revision 01, dated May 12, 1998 [for Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), and DC–9–87 (MD–87) series airplanes, and Model MD–88 airplanes]; or MD90–32A030, dated March 26, 1998, or MD90–32A030, Revision 01, dated May 11, 1998 (for Model MD–90–30 airplanes); as applicable.

(d) As of the effective date of this AD, no person shall install on any airplane a replacement MLG shock strut piston, part number 5935347–509, –511, or –513, or an MLG assembly from an operator's spares inventory, unless those components have been inspected in accordance with the requirements specified by paragraph (a) of this AD.

(e) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Los Angeles Aircraft Certification Office (ACO), FAA, Transport Airplane Directorate. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Los Angeles ACO.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Los Angeles ACO.

(f) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on September 1, 1998.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98-24063 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-13-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 97-NM-129-AD]

RIN 2120-AA64

Airworthiness Directives; British Aerospace Model BAe 146 and Model Avro 146-RJ Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes the adoption of a new airworthiness directive (AD) that is applicable to certain British Aerospace Model BAe 146 and Model Avro 146-RJ series airplanes. This proposal would require a one-time measurement to determine the thickness of the outer links of the side stays of the main landing gear (MLG), and corrective actions, if necessary. This proposal also would provide for replacement of a thin outer link with a new or serviceable part in lieu of certain follow-on inspections. This proposal is prompted by issuance of mandatory continuing airworthiness information by a foreign civil airworthiness authority. The actions specified by the proposed AD are intended to prevent cracking of the outer links of the side stays of the MLG, which could result in increased braking distance during landing, and consequent runway overrun.

DATES: Comments must be received by October 8, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM-114, Attention: Rules Docket No. 97-NM-129-AD, 1601 Lind Avenue, SW., Renton, Washington 98055-4056. Comments may be inspected at this location between 9:00 a.m. and 3:00 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from AI(R) American Support, Inc., 13850 Mclearen Road, Herndon, Virginia 20171. This information may be

examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT: Norman B. Martenson, Manager, International Branch, ANM-116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055-4056; telephone (425) 227-2110; fax (425) 227-1149.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 97-NM-129-AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM-114, Attention: Rules Docket No. 97-NM-129-AD, 1601 Lind Avenue, SW., Renton, Washington 98055-4056.

Discussion

The Civil Aviation Authority (CAA), which is the airworthiness authority for the United Kingdom, notified the FAA that an unsafe condition may exist on certain British Aerospace Model BAe 146 and Model Avro 146-RJ series airplanes. The CAA advises that it has received a report of cracking on the shoulder of two outer links of a side stay of the main landing gear (MLG). Investigation has revealed that the

insufficient thickness of the outer links on certain Model BAe 146 and Model Avro 146-RJ series airplanes causes them to be susceptible to this type of cracking. In addition, this cracking may have been aggravated by insufficient greasing of the spherical bearing, which could result in increased stress on the side stay when the gear is in transit. Such cracking, if not corrected, could result in increased braking distance during landing, and consequent runway overrun.

Explanation of Relevant Service Information

The manufacturer has issued British Aerospace Service Bulletin SB.32-144, dated December 11, 1996, which describes procedures for a one-time measurement to determine the thickness of the outer links of the side stays of the MLG. The measurement involves placing a profile gauge over the thinnest section of the outer link profile. For outer links on which a profile gauge slips over the profile, the service bulletin also describes procedures for follow-on repetitive detailed visual inspections to detect cracking of the outer links, and replacement of any cracked outer link with a new or serviceable part.

The British Aerospace service bulletin references Messier-Dowty Service Bulletin 146-32-128, dated December 6, 1996, as an additional source of service information for accomplishment of the measurement.

Accomplishment of the actions specified in the service bulletins is intended to adequately address the identified unsafe condition. The CAA approved Messier-Dowty Service Bulletin 146-32-128, dated December 6, 1996; classified British Aerospace Service Bulletin SB.32-144, dated December 11, 1996, as mandatory; and issued British airworthiness directive 005-12-96 in order to assure the continued airworthiness of these airplanes in the United Kingdom.

FAA's Conclusions

These airplane models are manufactured in the United Kingdom and are type certificated for operation in the United States under the provisions of section 21.29 of the Federal Aviation Regulations (14 CFR 21.29) and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the CAA has kept the FAA informed of the situation described above. The FAA has examined the findings of the CAA, reviewed all available information, and determined that AD action is necessary for products of this type design that are

certificated for operation in the United States.

Explanation of Requirements of Proposed Rule

Since an unsafe condition has been identified that is likely to exist or develop on other airplanes of the same type design registered in the United States, the proposed AD would require accomplishment of the actions specified in the British Aerospace service bulletin described previously, except as discussed below.

Differences Between Proposed Rule and Service Bulletin

Operators should note that, unlike the procedures described in Messier-Dowty Service Bulletin 146-32-128 and British Aerospace Service Bulletin SB.32-144, this proposed AD would not permit further flight if cracks are detected in the outer links of the side stays of the MLG. The FAA has determined that, because of the safety implications and consequences associated with such cracking, any subject outer link that is found to be cracked must be replaced prior to further flight.

In addition, operators should note that, for airplanes on which the profile gauge slips over the top edge of the outer link profile, the service bulletins do not describe a terminating action for the follow-on repetitive inspections to detect cracking of the outer links. However, this proposed AD would allow replacement of a thin outer link with a new or serviceable part in lieu of the follow-on inspections.

Cost Impact

The FAA estimates that 37 airplanes of U.S. registry would be affected by this proposed AD. It would take approximately 1 work hour per airplane to accomplish the proposed measurement, at an average labor rate of \$60 per work hour. Required parts would be supplied by the manufacturer at no cost to operators. Based on this figure, the cost impact of the measurement proposed by this AD on U.S. operators is estimated to be \$2,220, or \$60 per airplane.

The cost impact figure discussed above is based on assumptions that no operator has yet accomplished any of the proposed requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted.

Regulatory Impact

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and

the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption ADDRESSES.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

British Aerospace Regional Aircraft

(Formerly British Aerospace Regional Aircraft Limited, Avro International Aerospace Division; British Aerospace, PLC; British Aerospace Commercial Aircraft Limited): Docket 97-NM-129-AD.

Applicability: Model BAe 146 and Model Avro 146-RJ series airplanes, equipped with side stays of the main landing gear (MLG) having part numbers (P/N) listed in Messier-Dowty Service Bulletin 146-32-128, dated December 6, 1996; certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the

requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (c) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated, unless accomplished previously.

To prevent cracking of the outer links of the side stays of the main landing gear (MLG), which could result in increased braking distance during landing, and consequent runway overrun, accomplish the following:

(a) Within 500 landings or 60 days after the effective date of this AD, whichever occurs later, perform a one-time measurement to determine the thickness of the outer links of the side stays of the MLG, in accordance with British Aerospace Service Bulletin SB.32-144, dated December 11, 1996.

Note 2: The British Aerospace service bulletin references Messier-Dowty Service Bulletin 146-32-128, dated December 6, 1996, as an additional source of service information for accomplishment of the measurement.

(1) If the profile gauge does not slip over the top edge of the outer link profile, no further action is required by this AD.

(2) If the profile gauge slips over the top edge of the outer link profile, prior to further flight, accomplish either paragraph (a)(2)(i) or (a)(2)(ii) of this AD.

(i) Replace the outer link with a new or serviceable part in accordance with the service bulletin. After replacement of the outer link, no further action is required by this AD.

Note 3: For purposes of this AD, a "serviceable" outer link is defined as an outer link that is not cracked and on which a profile gauge does not slip over the top edge of the profile, as described in the service bulletin.

(ii) Perform a detailed visual inspection to detect cracking of the outer links of the side stays of the MLG, in accordance with the service bulletin.

(A) If no cracking is detected, repeat the detailed visual inspection thereafter at intervals not to exceed 4,000 landings.

(B) If any cracking is detected during any detailed visual inspection required by this AD, prior to further flight, replace the cracked outer link with a new or serviceable part in accordance with the service bulletin. After replacement of the outer link, no further action is required by this AD.

(b) As of the effective date of this AD, no person shall install on any airplane a side stay of the MLG having a part number listed in paragraph 1.A. of Messier-Dowty Service Bulletin 146-32-128, dated December 6, 1996; unless the profile gauge does not slip over the profile of the outer links of the side stay, as described in British Aerospace Service Bulletin SB.32-144, dated December 11, 1996.

(c) An alternative method of compliance or adjustment of the compliance time that

provides an acceptable level of safety may be used if approved by the Manager, International Branch, ANM-116, FAA, Transport Airplane Directorate. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, International Branch, ANM-116.

Note 4: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the International Branch, ANM-116.

(d) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Note 5: The subject of this AD is addressed in British airworthiness directive 005-12-96.

Issued in Renton, Washington, on September 1, 1998.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.
[FR Doc. 98-24060 Filed 9-4-98; 8:45 am]
BILLING CODE 4910-13-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98-NM-223-AD]

RIN 2120-AA64

Airworthiness Directives; Boeing Model 747 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes the adoption of a new airworthiness directive (AD) that is applicable to certain Boeing Model 747 series airplanes. This proposal would require a one-time detailed visual inspection to detect improperly installed or frayed aileron cables, and a one-time detailed visual inspection to detect improper identification or location of the cable markers, and corrective actions, if necessary. This proposal is prompted by a report that an aileron cable failed, due to improper installation onto the wrong groove of an aileron cable drum. The actions specified by the proposed AD are intended to detect and correct an improperly installed aileron cable; such installation could lead to the failure of the aileron cable, and consequent reduced lateral control capability of the airplane.

DATES: Comments must be received by October 23, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM-114, Attention: Rules Docket No. 98-NM-223-AD, 1601 Lind Avenue, SW., Renton, Washington 98055-4056. Comments may be inspected at this location between 9:00 a.m. and 3:00 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from Boeing Commercial Airplane Group, P.O. Box 3707, Seattle, Washington 98124-2207. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT:

Tamara L. Anderson, Aerospace Engineer, Airframe Branch, ANM-120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington; telephone (425) 227-2771; fax (425) 227-1181.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 98-NM-223-AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM-103, Attention: Rules Docket No. 98-NM-223-AD, 1601 Lind Avenue, SW., Renton, Washington 98055-4056.

Discussion

The FAA has received a report indicating that an operator of a Boeing Model 747 series airplane experienced a failure of a wing aileron control cable (AA-11) during the taxi-out phase of operations. An adjacent aileron cable (AB-13) also was found to be severely frayed. An investigation attributed the aileron cable failure and cable fraying to the improper installation of the aileron cables onto the aileron cable drum. Specifically, the improper installation consisted of both aileron cables being installed into the wrong grooves of the aileron cable drum. This allowed the aileron cables to make contact with the forward guide pin of the aileron cable drum, which in turn led to the fraying of the cables.

The misrouting of the aileron cables on the incident airplane was probably related to the fact that certain aileron cable markers, which are merely decals that the manufacturer uses as guides for installation, were installed incorrectly. Further investigation indicated that as many as eight other airplanes also had aileron cable markers that had been installed incorrectly. In addition, at least three other airplanes have experienced excessive aileron cable wear due to misrouting of the aileron cables during installation. An improperly installed aileron cable, if not corrected, could lead to the eventual failure of an aileron cable, and consequent reduced lateral control capability of the airplane.

Explanation of Relevant Service Information

The FAA has reviewed and approved Boeing Service Bulletin 747-27-2367, dated June 25, 1998, which describes procedures for performing a one-time detailed visual inspection to detect improper installation or fraying of the aileron cables, and a one-time detailed visual inspection to detect improper identification or location of the associated aileron cable markers, and corrective actions, if necessary. The corrective actions include replacing frayed cables with new cables, and rerouting misrouted aileron cables; and replacing any incorrectly installed aileron cable markers with new markers.

Explanation of Requirements of Proposed Rule

Since an unsafe condition has been identified that is likely to exist or develop on other products of this same type design, the proposed AD would require accomplishment of the actions specified in the service bulletin described previously. The proposed AD also would require that operators report the results of adverse inspection findings to the FAA.

Cost Impact

There are approximately 1,053 Boeing Model 747 series airplanes of the affected design in the worldwide fleet. The FAA estimates that 228 airplanes of U.S. registry would be affected by this proposed AD.

It would take approximately 9 work hours per airplane to accomplish the proposed detailed visual inspections, at an average labor rate of \$60 per work hour. Based on these figures, the cost impact of the proposed AD on U.S. operators is estimated to be \$123,120, or \$540 per airplane.

The cost impact figure discussed above is based on assumptions that no operator has yet accomplished any of the proposed requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted.

Regulatory Impact

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption ADDRESSES.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39 AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

Boeing: Docket 98–NM–223–AD.

Applicability: Model 747 series airplanes, line numbers 1 through 1129 inclusive, excluding line number 1122; certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (c) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated, unless accomplished previously.

To detect and correct an improperly installed aileron cable, which could lead to the failure of the aileron cable, and consequent reduced lateral control capability of the airplane, accomplish the following:

(a) Within 18 months after the effective date of this AD, perform a one-time detailed visual inspection to detect improper installation or fraying of the aileron cables on both wings. In addition, perform a one-time detailed visual inspection of the aileron cable markers on both wings to detect improper identification or location. Perform both inspections in accordance with the Accomplishment Instructions of Boeing Service Bulletin 747–27–2367, dated June 25, 1998.

(1) If no improperly installed or frayed aileron cable is found, and if no aileron cable marker is improperly identified or located, no further action is required by this AD.

(2) If any aileron cable is found to be improperly installed (but not frayed), prior to further flight, reroute the discrepant aileron cable in accordance with the Accomplishment Instructions of the service bulletin.

(3) If any aileron cable is found to be frayed, prior to further flight, replace the discrepant aileron cable with a new aileron cable in accordance with the Accomplishment Instructions of the service bulletin.

(4) If any aileron cable marker is found to be improperly identified or located, prior to further flight, replace the discrepant aileron cable marker with a new aileron cable marker in accordance with the Accomplishment Instructions of the service bulletin.

(b) Within 10 days after accomplishing the detailed visual inspections required by paragraph (a) of this AD, submit a report of the inspection results (adverse findings only) to the Manager, Boeing Certificate Management Office, FAA, Transport Airplane Directorate, 2500 East Valley Road, Suite C2, Renton, Washington 98055; fax (425) 227–1159. Required information for each report must include the following: description of the adverse finding, airplane serial number, and total flight cycles and flight hours accumulated at the time of the inspection. Information collection requirements contained in this regulation have been approved by the Office of Management and Budget (OMB) under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*) and have been assigned OMB Control Number 2120–0056.

(c) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Seattle Aircraft Certification Office (ACO), FAA, Transport Airplane Directorate. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Seattle ACO.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Seattle ACO.

(d) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on September 1, 1998.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98–24065 Filed 9–4–98; 8:45 am]

BILLING CODE 4910–13–U

TENNESSEE VALLEY AUTHORITY

18 CFR Part 1301

Revision of Tennessee Valley Authority Freedom of Information Act Regulations and Implementation of Electronic Freedom of Information Act Amendments of 1996

AGENCY: Tennessee Valley Authority.

ACTION: Proposed rule.

SUMMARY: These proposed revisions incorporate TVA's former Freedom of Information Act (FOIA) regulations, as revised herein, and contain new provisions implementing the Electronic Freedom of Information Act (EFOIA) of 1996. Additionally, the regulations include updated cost figures to be used in calculating and charging fees.

DATES: Submit comments on or before October 8, 1998.

ADDRESSES: Address all comments concerning this proposed rule to Wilma H. McCauley, FOIA Officer, Tennessee Valley Authority, 1101 Market Street (WR 4Q), Chattanooga, Tennessee 37402.

FOR FURTHER INFORMATION: Wilma H. McCauley, FOIA Officer, Tennessee Valley Authority, 1101 Market Street (WR 4Q), Chattanooga, Tennessee 37402-2801, telephone number (423) 751-2523.

SUPPLEMENTARY INFORMATION: These proposed revisions will revise TVA's existing regulations to reflect the provisions of Public Law 104-231, the EFOIA, to provide the public access to government information and records maintained in an electronic format, lengthen the time limits for responding to FOIA requests as prescribed by the EFOIA, provide for expedited processing of certain requests, establish electronic reading rooms, provide for multi-track processing of requests, and provide for an agency reference guide on FOIA. Additionally, the proposed regulations have been revised to include updated cost figures used in calculating and charging fees. The duplication charge will remain the same at ten cents per page, while document search and review charges will increase to \$14.90 per hour for clerical time and \$34.30 per hour for professional and managerial time.

Regulatory Flexibility Act Certification

We certify that these rules will not have a significant economic impact on a substantial number of small entities because these rules affect primarily individuals, not small entities, and for the most part simply implement the language of the EFOIA amendments. There is no reason to believe that the revised rules will impose any costs on FOIA requesters beyond those nominal costs imposed under TVA's former rules. Further, the "small entities" that make FOIA requests, as compared with individual requesters and other requesters, are relatively few in number.

List of Subjects in 18 CFR Part 1301

Freedom of Information, Privacy, Sunshine Act.

For the reasons stated in the preamble, TVA proposes to amend 18 CFR Part 1301 as follows:

Part 1301—PROCEDURES

1. The authority citation for part 1301 Subpart A continues to read as follows:

Authority: 16 U.S.C. 831-831dd, 5 U.S.C. 552.

2. Subpart A of Part 1301 is revised to read as follows:

Subpart A—Freedom of Information Act Sec.

- 1301.1 General provisions.
- 1301.2 Public reading rooms.
- 1301.3 Requirements for making requests.
- 1301.4 Responsibility for responding to requests.
- 1301.5 Timing of responses to requests.
- 1301.6 Responses to requests.
- 1301.7 Exempt records.
- 1301.8 Business information.
- 1301.9 Appeals.
- 1301.10 Fees.
- 1301.11 Other rights and services.

Subpart A—Freedom of Information Act

§ 1301.1 General provisions

This subpart contains the rules that TVA follows in processing requests for records under the Freedom of Information Act (FOIA), 5 U.S.C. 552. These rules should be read together with the FOIA, which provides additional information about access to records maintained by TVA. Requests made by individuals for records about themselves under the Privacy Act of 1974, 5 U.S.C. 552a, which are processed under subpart B of this part, are processed under this subpart also. Information routinely provided to the public as part of a regular TVA activity (for example, press releases) may be provided to the public without the need for a FOIA request under this subpart. As a matter of policy, TVA makes discretionary disclosures of records or information exempt from disclosure under the FOIA whenever disclosure would not foreseeably harm an interest protected by a FOIA exemption, but this policy does not create any right enforceable in court.

§ 1301.2 Public reading rooms.

TVA maintains a public electronic reading room accessible in its Corporate Libraries at 400 Summit Hill Drive, Knoxville, TN 37902-1499 and 1101 Market Street, Chattanooga, TN 37402-2801. This electronic reading room contains the records that the FOIA requires to be made regularly available for public inspection and copying. Each TVA organization is responsible for determining which of the records it

generates are required to be made available in this way and for ensuring that those records are available in TVA's reading room. TVA's FOIA Officer will maintain a current subject-matter index of TVA's reading room records. The index will be updated regularly, at least quarterly, with respect to newly included records.

§ 1301.3 Requirements for making requests.

(a) *How made and addressed.* You may make a request for records of TVA by writing to the Tennessee Valley Authority, TVA FOIA Officer, Enterprise Document Management (EDM), 1101 Market Street (WR 4Q), Chattanooga, TN 37402-2801. You may find TVA's "Guide to Information About TVA"—which is available electronically at TVA's World Wide Web site, and is available in paper form as well—helpful in making your request. For additional information about the FOIA, you may refer directly to the statute. If you are making a request for records about yourself, see Subpart B Privacy Act for additional requirements. If you are making a request for records about another individual, either a written authorization signed by that individual permitting disclosure of those records to you or proof that that individual is deceased (for example, a copy of a death certificate or an obituary) will help the processing of your request. Your request will be considered received as of the date it is received by the FOIA Officer. For the quickest possible handling, you should mark both your request letter and the envelope "Freedom of Information Act Request."

(b) *Descriptions of records sought.* You must describe the records that you seek in enough detail to enable TVA personnel to locate them with a reasonable amount of effort. Whenever possible, your request should include specific information about each record sought, such as the date, title or name, author, recipient, and subject matter of the record. If known, you should include any file designations or descriptions for the records that you want. As a general rule, the more specific you are about the records or type of records that you want, the more likely TVA will be able to locate those records in response to your request. If TVA determines that your request does not reasonably describe records, it shall tell you either what additional information is needed or why your request is otherwise insufficient. TVA shall also give you an opportunity to discuss your request so that you may modify it to meet the requirements of this section. If your request does not

reasonably describe the records you seek, the agency's response to your request may be delayed.

(c) *Agreement to pay fees.* If you make a FOIA request, it shall be considered an agreement by you to pay all applicable fees charged under section 1301.11, up to \$25.00, unless you seek a waiver of fees. TVA's FOIA Officer will confirm this agreement in an acknowledgement letter. When making a request, you may specify a willingness to pay a greater or lesser amount.

§ 1301.4 Responsibility for responding to requests.

(a) TVA's FOIA Officer, or the FOIA Officer's designee, is responsible for responding to all FOIA requests. In determining which records are responsive to a request, TVA will include only records in its possession as of the date the request is received by the FOIA Officer. If any other date is used, the FOIA Officer shall inform the requester of that date.

(b) *Authority to grant or deny requests.* TVA's FOIA Officer, or the FOIA Officer's designee, is authorized to grant or deny any request for a TVA record.

(c) *Consultations and referrals.* When the FOIA Officer receives a request for a record in TVA's possession, the FOIA Officer shall determine whether another agency of the Federal Government is better able to determine whether the record is exempt from disclosure under the FOIA and, if so, whether it should be disclosed as a matter of administrative discretion. If the FOIA Officer determines that TVA is not best able to process the record, the FOIA Officer shall either:

(1) Respond to the request regarding that record, after consulting with the agency best able to determine whether to disclose it and with any other agency that has a substantial interest in it; or

(2) Refer the responsibility for responding to the request regarding that record to the agency that originated the record (but only if that agency is subject to the FOIA). Ordinarily, the agency that originated a record will be presumed to be best able to determine whether to disclose it.

(d) *Notice of referral.* Whenever TVA refers all or any part of the responsibility for responding to a request to another agency, it ordinarily shall notify the requester of the referral and inform the requester of the name of each agency to which the request has been referred and of the part of the request that has been referred.

(e) *Timing of responses to consultations and referrals.* All consultations and referrals will be

handled according to the date the FOIA request initially was received by the FOIA Officer, not any later date.

(f) *Agreements regarding consultations and referrals.* TVA may make agreements with other agencies to eliminate the need for consultations or referrals for particular types of records.

§ 1301.5 Timing of responses to requests.

(a) In general, TVA ordinarily shall respond to requests according to their order of receipt and placement in an appropriate processing track, as follows.

(b) *Multi-track processing procedures.* TVA has established three tracks for handling requests and the track to which a request is assigned will depend on the nature of the request and the estimated processing time, including a consideration of the number of pages involved. If TVA places a request in a track other than Track 1, it will advise requesters of the limits of its faster track(s). TVA may provide requesters in its tracks 2 and 3 with an opportunity to limit the scope of their requests in order to qualify for faster processing within the specified limits of TVA's faster track(s). When doing so, TVA may contact the requester either by telephone or by letter, whichever is most efficient in each case.

(1) Track 1. Requests that can be answered with readily available records or information. These are the fastest to process. These requests ordinarily will be responded to within 20 working days of receipt of a request by the FOIA Officer. The 20 working day time limit provided in this paragraph may be extended by TVA for unusual circumstances, as defined in § 1301.5(c), upon written notice to the person requesting the records.

(2) Track 2. Requests where we need records or information from other offices throughout TVA, where we must consult with other Governmental agencies, or when we must process a submitter notice as described in § 1301.8(d), but we do not expect that the decision on disclosure will be as time consuming as for requests in Track 3.

(3) Track 3. Requests which require a decision or input from another office or agency, extensive submitter notifications because of the presence of Business Information as defined in § 1301.8(b)(1), and a considerable amount of time will be needed for that, or the request is complicated or involves a large number of records. Usually, these cases will take the longest to process.

(c) *Unusual circumstances.* (1) Where the time limits for processing a request cannot be met because of unusual

circumstances and TVA determines to extend the time limits on that basis, TVA shall as soon as practicable notify the requester in writing of the unusual circumstances and of the date by which processing of the request can be expected to be completed. Where the extension is for more than ten working days, TVA shall provide the requester with an opportunity either to modify the request so that it may be processed within the time limits or to arrange an alternative time period with TVA for processing the request or a modified request. As used in this paragraph, 'unusual circumstances' means, but only to the extent reasonably necessary to the proper processing of the particular requests:

(i) The need to search for and collect the requested records from field facilities or other establishments that are separate from the office processing the request;

(ii) The need to search for, collect, and appropriately examine a voluminous amount of separate and distinct records which are demanded in a single request; or

(iii) The need for consultation, which shall be conducted with all practicable speed, with another agency having a substantial interest in the determination of the request or among two or more components of the agency having substantial subject matter interest therein.

(2) When TVA reasonably believes that multiple requests submitted by a requester, or by a group of requesters acting in concert, constitute a single request that would otherwise involve unusual circumstances, and the requests involve clearly related matters, they may be aggregated, as defined in § 1301.10(h). Multiple requests by a requester involving unrelated matters will not be aggregated.

(d) *Expedited processing.* (1) Requests and appeals will be taken out of order and given expedited treatment whenever TVA determines that they involve:

(i) Circumstances in which the lack of expedited treatment could reasonably be expected to pose an imminent threat to the life or physical safety of an individual;

(ii) An urgency to inform the public about an actual or alleged federal government activity, if made by a person primarily engaged in disseminating information;

(iii) The loss of substantial due process rights; or

(iv) A matter of widespread and exceptional media interest in which there exist possible questions about the

government's integrity which affect public confidence.

(2) A request for expedited processing may be made at the time of the initial request for records or at any later time. For a prompt determination, a request for expedited processing must be sent to and received by TVA's FOIA Officer.

(3) A requester who seeks expedited processing must submit a statement, certified to be true and correct to the best of that person's knowledge and belief, explaining in detail the basis for requesting expedited processing. For example, a requester within the category in paragraph (d)(1)(ii) of this section, if not a full-time member of the news media, must establish that he or she is a person whose main professional activity or occupation is information dissemination, though it need not be his or her sole occupation. A requester within the category in paragraph (d)(1)(ii) of this section also must establish a particular urgency to inform the public about the government activity involved in the request, beyond the public's right to know about government activity generally. The formality of certification may be waived as a matter of administrative discretion.

(4) Within ten calendar days of receipt of a request for expedited processing, TVA's FOIA Officer shall decide whether to grant it and shall notify the requester of the decision. If a request for expedited treatment is granted, the request shall be given priority and shall be processed as soon as practicable. If a request for expedited processing is denied, any appeal of that decision shall be acted upon expeditiously.

§ 1301.6 Responses to requests.

(a) *Acknowledgements of requests.* On receipt of a request, the FOIA Officer ordinarily shall send an acknowledgement letter to the requester which shall confirm the requester's agreement to pay fees under section 1301.10 and provide an assigned request number for further reference.

(b) *Grants of requests.* Ordinarily, TVA shall have twenty business days from when a request is received to determine whether to grant or deny the request. Once TVA makes a determination to grant a request in whole or in part, it shall notify the requester in writing. The FOIA Officer shall inform the requester in the notice of any fee charged under section 1301.10 and shall disclose records to the requester promptly on payment of any applicable fee, if the fee is equal to or more than \$100. If the fee is less than \$100, the FOIA officer shall disclose the records along with a statement of the fee. Records disclosed in part shall be

marked or annotated to show the amount of information deleted unless doing so would harm an interest protected by an applicable exemption. The location of the information deleted also shall be indicated on the record, if technically feasible.

(c) *Adverse determinations of requests.* If TVA makes an adverse determination denying a request in any respect, they shall notify the requester of that determination in writing. Adverse determinations, or denials of requests, consist of: a determination to withhold any requested record in whole or in part; a determination that a requested record does not exist or cannot be located; a determination that a record is not readily reproducible in the form or format sought by the requester; a determination that what has been requested is not a record subject to the FOIA; a determination on any disputed fee matter, including a denial of a request for a fee waiver; and a denial of a request for expedited treatment. The denial letter shall be signed by the FOIA Officer or the FOIA Officer's designee, and shall include:

(1) The name and title or position of the person responsible for the denial;

(2) A brief statement of the reason(s) for the denial, including any FOIA exemption applied by TVA in denying the request;

(3) An estimate of the volume of records or information withheld, in number of pages or in some other reasonable form of estimation. This estimate does not need to be provided if the volume is otherwise indicated through deletions on records disclosed in part, or if providing an estimate would harm an interest protected by an applicable exemption; and

(4) A statement that the denial may be appealed under section 1301.9 and a description of the requirements of section 1301.9.

§ 1301.7 Exempt records.

(a) *Records available.* TVA's records will be made available for inspection and copying upon request as provided in this section, except that records are exempt and are not made available if they are:

(1)(i) Specifically authorized under criteria established by an Executive order to be kept secret in the interest of national defense or foreign policy and

(ii) Are in fact properly classified pursuant to such Executive order;

(2) Related solely to the internal personnel rules and practices of TVA;

(3) Specifically exempted from disclosure by statute;

(4) Trade secrets and commercial or financial information obtained from any person and privileged or confidential;

(5) Inter-agency or intra-agency memorandums or letters which would not be available by law to a private party in litigation with TVA, including without limitation records relating to control and accounting for special nuclear material and to the physical security plans for the protection of TVA's nuclear facilities;

(6) Personnel and medical files and similar files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy;

(7) Records or information compiled for law enforcement purposes, but only to the extent that the production of such law enforcement records or information:

(i) Could reasonably be expected to interfere with enforcement proceedings,

(ii) Would deprive a person of a right to a fair trial or an impartial adjudication,

(iii) Could reasonably be expected to constitute an unwarranted invasion of personal privacy.

(iv) Could reasonably be expected to disclose the identity of a confidential source, including a State, local, or foreign agency or authority or any private institution which furnished information on a confidential basis, and, in the case of a record or information compiled by a criminal law enforcement authority in the course of a criminal investigation or by an agency conducting a lawful national security intelligence investigation, information furnished by a confidential source,

(v) Would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law, or

(vi) Could reasonably be expected to endanger the life or physical safety of any individual.

(8) Contained in or related to examination, operation, or condition reports prepared by, on behalf of, or for the use of any agency responsible for the regulation or supervision of financial institution; or

(9) Geological and geophysical information and data, including maps, concerning wells.

(b) The availability of certain classes of nonexempt records is deferred for such time as TVA may determine is reasonably necessary to avoid interference with the accomplishment of its statutory responsibilities. Such records include bids and information concerning the identity and number of bids received prior to bid opening; all

nonexempt records relating to bids between the time of bid opening and award; and all nonexempt records relating to negotiations in progress involving contracts or agreements for the acquisition or disposal of real or personal property by TVA prior to the conclusion of such negotiations. Any reasonably segregable portion of an available record shall be provided to any person requesting such record after deletion of the portions which are exempt under this paragraph.

§ 1301.8 Business information.

(a) *In general.* Business information obtained by TVA from a submitter will be disclosed under the FOIA only under this section.

(b) *Definitions.* For purposes of this section:

(1) *Business information* means commercial or financial information obtained by TVA from a submitter that may be protected from disclosure under Exemption 4 of the FOIA.

(2) *Submitter* means any person or entity from whom TVA obtains business information, directly or indirectly. The term includes corporations; state and local governments; and foreign governments.

(c) *Designation of business information.* A submitter of business information will use good-faith efforts to designate, by appropriate markings, either at the time of submission or at a reasonable time thereafter, any portions of its submission that it considers to be protected from disclosure under Exemption 4. These designations will expire ten years after the date of the submission unless the submitter requests, and provides justification for, a longer designation period.

(d) *Notice to submitters.* TVA shall provide a submitter with prompt written notice of a FOIA request or administrative appeal that seeks its business information wherever required under paragraph (e) of this section, except as provided in paragraph (h) of this section, in order to give the submitter an opportunity to object to disclosure of any specified portion of that information under paragraph (f) of this section. The notice shall either describe the business information requested or include copies of the requested records or record portions containing the information. When notification of a voluminous number of submitters is required, notification may be made by posting or publishing the notice in a place reasonably likely to accomplish notification of submitters.

(e) *Where notice is required.* Notice shall be given to a submitter wherever:

(1) The information has been designated in good faith by the submitter as information considered protected from disclosure under Exemption 4; or

(2) TVA has reason to believe that the information may be protected from disclosure under Exemption 4.

(f) *Opportunity to object to disclosure.* TVA will allow a submitter a reasonable time to respond to the notice described in paragraph (d) of this section. If a submitter has any objection to disclosure, it is required to submit a detailed written statement. The statement must specify all grounds for withholding any portion of the information under any exemption of the FOIA and, in the case of Exemption 4, it must show why the information is a trade secret or commercial or financial information that is privileged or confidential. In the event that a submitter fails to respond to the notice within the time specified in it, the submitter will be considered to have no objection to disclosure of the information. Information provided by the submitter that is not received by TVA until after its disclosure decision has been made shall not be considered by TVA. Information provided by a submitter under this paragraph may itself be subject to disclosure under the FOIA.

(g) *Notice of intent to disclose.* TVA shall consider a submitter's objections and specific grounds for nondisclosure in deciding whether to disclose business information. Whenever TVA decides to disclose business information over the objection of a submitter, TVA shall give the submitter written notice, which shall include:

(1) A statement of the reason(s) why each of the submitter's disclosure objections was not sustained;

(2) A description of the business information to be disclosed, and

(3) A specified disclosure date, which shall be a reasonable time subsequent to the notice.

(h) *Exceptions to notice requirements.* The notice requirements of paragraphs (d) and (g) of this section shall not apply if:

(1) TVA determines that the information should not be disclosed;

(2) The information lawfully has been published or has been officially made available to the public;

(3) Disclosure of the information is required by statute (other than the FOIA) or by applicable regulation; or

(4) The designation made by the submitter under paragraph (c) of this section appears obviously frivolous—except that, in such a case, the component shall, within a reasonable

time prior to a specified disclosure date, give the submitter written notice of any final decision to disclose the information.

(i) *Notice of FOIA lawsuit.* Whenever a requester files a lawsuit seeking to compel the disclosure of business information, TVA shall promptly notify the submitter.

(j) *Corresponding notice to requesters.* Whenever TVA provides a submitter with notice and an opportunity to object to disclosure under paragraph (d) of this section, TVA shall also notify the requester(s). Whenever TVA notifies a submitter of its intent to disclose requested information under paragraph (g) of this section, TVA shall also notify the requester(s). Whenever a submitter files a lawsuit seeking to prevent the disclosure of business information, TVA shall notify the requester(s).

§ 1301.9 Appeals.

(a) *Appeals of adverse determinations.* If you are dissatisfied with TVA's response to your request, you may appeal an adverse determination denying your request, in any respect, to TVA's FOIA Appeal Official, the Senior Manager, Administrative Services, Tennessee Valley Authority, 400 Summit Hill Drive (ET 6M), Knoxville, TN 37902–1499. You must make your appeal in writing and it must be received by the Senior Manager within 30 days of the date of the letter denying your request. Your appeal letter may include as much or as little related information as you wish, as long as it clearly identifies the TVA determination (including the assigned request number, if known) that you are appealing. An adverse determination by the TVA Appeal Official will be the final action of TVA.

(b) *Responses to appeals.* The decision on your appeal will be made in writing within 20 days (excluding Saturdays, Sundays, and legal holidays) after an appeal is received. A decision affirming an adverse determination in whole or in part shall contain a statement of the reason(s) for the affirmance, including any FOIA exemption(s) applied, and will inform you of the FOIA provisions for court review of the decision. If the adverse determination is reversed or modified on appeal, in whole or in part, you will be notified in a written decision and your request will be reprocessed in accordance with that appeal decision.

(c) *When appeal is required.* If you wish to seek review by a court of any adverse determination, you must first appeal it under this section.

§1301.10 Fees.

(a) *In general*, TVA shall charge for processing requests under the FOIA in accordance with paragraph (c) of this section, except where fees are limited under paragraph (d) of this section or where a waiver or reduction of fees is granted under paragraph (k) of this section. If the applicable fees are \$100 or more, TVA ordinarily will collect all applicable fees before sending copies of requested records to a requester. If the applicable fees are less than \$100, TVA ordinarily will bill the requester for the fees in the letter responding to the request and enclosing the requested records. Requesters must pay fees by check or money order made payable to the Tennessee Valley Authority.

(b) *Definitions*. For purposes of this section:

(1) *Commercial use request* means a request from or on behalf of a person who seeks information for a use or purpose that furthers his or her commercial, trade, or profit interests, which can include furthering those interests through litigation. TVA shall determine, whenever reasonably possible, the use to which a requester will put the requested records. When it appears that the requester will put the records to a commercial use, either because of the nature of the request itself or because TVA has reasonable cause to doubt a requester's stated use, TVA shall provide the requester a reasonable opportunity to submit further clarification.

(2) *Direct costs* means those expenses that TVA actually incurs in searching for and duplicating (and, in the case of commercial use requests, reviewing) records to respond to a FOIA request. Direct costs include, for example, the salary of the employee performing the work (the basic rate of pay for the employee, plus 16 percent of that rate to cover benefits, unless the fee is a standard TVA fee as set forth in paragraph (c) of this section) and the cost of operating duplication machinery. Not included in direct costs are overhead expenses such as the costs of space and heating or lighting of the facility in which the records are kept.

(3) *Duplication* means the making of a copy of a record, or of the information contained in it, necessary to respond to a FOIA request. Copies can take the form of paper, microform, audiovisual materials, or electronic records (for example, magnetic tape or disk), among others. TVA shall honor a requester's specified preference of form or format of disclosure if the record is readily reproducible with reasonable efforts in the requested form or format.

(4) *Educational institution* means a preschool, a public or private elementary or secondary school, an institution of undergraduate higher education, an institution of graduate higher education, or an institution of professional education, or an institution of vocational education, that operates a program of scholarly research. To be in this category, a requester must show that the request is authorized by and is made under the auspices of a qualifying institution and that the records are not sought for commercial or private use, but are sought to further scholarly research.

(5) *Noncommercial scientific institution* means an institution that is not operated on a "commercial" basis, as that term is defined in paragraph (b)(1) of this section, and that is operated solely for the purpose of conducting scientific research the results of which are not intended to promote any particular product or industry. To be in this category, a requester must show that the request is authorized by and is made under the auspices of a qualifying institution and that the records are not sought for a commercial or private use but are sought to further scientific research.

(6) *Representative of the news media, or news media requester*, means any person actively gathering news for an entity that is organized and operated to publish or broadcast news to the public. The term "news" means information that is about current events or that would be of current interest to the public. Examples of news media entities include television or radio stations broadcasting to the public at large and publishers of periodicals (but only in those instances where they can qualify as disseminators of "news") who make their products available for purchase or subscription by the general public. For "freelance" journalists to be regarded as working for a news organization, they must demonstrate a solid basis for expecting publication through that organization. A publication contract would be the clearest proof, but TVA shall also look to the past publication record of a requester in making this determination. To be in this category, a requester must not be seeking the requested records for a commercial or private use. However, a request for records supporting the news-dissemination function of the requester shall not be considered to be for a commercial use.

(7) *Review* means the examination of a record located in response to a request in order to determine whether any portion of it is exempt from disclosure. It also includes processing any record

for disclosure—for example, doing all that is necessary to redact it and prepare it for disclosure. Review costs are recoverable even if a record ultimately is not disclosed. Review time includes time spent considering any formal objection to disclosure made by a business submitter under section 1301.8, but does not include time spent resolving general legal or policy issues regarding the application of exemptions.

(8) *Search* means the process of looking for and retrieving records or information responsive to a request. It includes page-by-page or line-by-line identification of information within records and also includes reasonable efforts to locate and retrieve information from records maintained in electronic form or format. TVA shall ensure that searches are done in the most efficient and least expensive manner reasonably possible. For example, TVA shall not search line-by-line where duplicating an entire document would be quicker and less expensive.

(c) *Fees*. In responding to a FOIA request, TVA shall charge the following fees unless a waiver or reduction of fees has been granted under paragraph (k) of this section:

(1) Search time charges for other than computer searches. For time spent by clerical employees in searching files, the charge is \$14.90 per hour. For time spent by supervisory and professional employees, the charge is \$34.30 per hour.

(2) Duplication charges. For photostatic reproduction of requested material which consists of sheets no larger than 8½ by 14 inches, the charge is 10 cents per page. For copies produced by computer, such as tapes or printouts, TVA will charge the direct costs, including operator time, of producing the copy. For other forms of duplication, TVA will charge the direct cost of that duplication.

(3) Review charges. Review fees will be charged to requesters who make a commercial use request. Review fees will be charged only for the initial record review—in other words, the review done when TVA determines whether an exemption applies to a particular record or record portion at the initial request level. No charge will be made for review at the administrative appeal level for an exemption already applied. However, record or record portions withheld under an exemption that is subsequently determined not to apply may be reviewed again to determine whether any other exemption not previously considered applies; the costs of that review are chargeable where it is made necessary by a change of circumstances. Review fees will be

charged at the same rates as those charged for a search under paragraph (c)(1) of this section.

(d) *Limitations on charging fees.* (1) No search fee will be charged for requests by educational institutions, noncommercial scientific institutions, or representatives of the news media.

(2) No search fee or review fee will be charged for a quarter-hour period unless more than half of that period is required for search or review.

(3) Except for requesters seeking records for a commercial use, TVA will provide the following without charge:

(i) The first 100 pages of duplication (or the cost equivalent); and

(ii) The first two hours of search (or the cost equivalent).

(4) No fee is charged to any requester if the cost of collecting the fee would be equal to or greater than the fee itself.

(5) The provisions of paragraphs (d)(3) and (4) of this section work together. This means that for requesters other than those seeking records for a commercial use, no fee will be charged unless the cost of search in excess of two hours plus the cost of duplication in excess of 100 pages is equal to or greater than the fee itself.

(e) *Notice of anticipated fees in excess of \$25.00.* When TVA determines or estimates that the fees to be charged under this section will amount to more than \$25.00, TVA shall notify the requester of the actual or estimated amount of the fees, unless the requester has indicated a willingness to pay fees as high as those anticipated. If only a portion of the fee can be estimated readily, TVA shall advise the requester that the estimated fee may be only a portion of the total fee. In cases in which a requester has been notified that actual or estimated fees amount to more than \$25.00, the request shall not be considered received and further work shall not be done on it until the requester agrees to pay the anticipated total fee. Any such agreement should be documented in writing. A notice under this paragraph will offer the requester an opportunity to discuss the matter with TVA personnel in order to reformulate the request to meet the requester's needs at a lower cost.

(f) *Charges for other services.* Apart from the other provisions of this section, when TVA chooses as a matter of administrative discretion to provide a special service—such as certifying that records are true copies or sending them by other than ordinary mail—the direct costs of providing the service ordinarily will be charged.

(g) *Charging interest.* TVA may charge interest on any unpaid bill starting on the 31st day following the date of billing

the requester. Interest charges will be assessed at the rate provided in 31 U.S.C. 3717 and will accrue from the date of the billing until payment is received by TVA.

(h) *Aggregating requests.* When TVA reasonably believes that a requester or a group of requesters acting together is attempting to divide a request into a series of requests for the purpose of avoiding fees, TVA may aggregate those requests and charge accordingly. TVA may presume that multiple requests of this type made within a 30-day period have been made in order to avoid fees.

Where requests are separated by a longer period, TVA will aggregate them only where there exists a solid basis for determining that aggregation is warranted under all of the circumstances involved. Multiple requests involving unrelated matters will not be aggregated.

(i) *Advance payments.* (1) For requests other than those described in paragraphs (i) (2) and (3) of this section, TVA shall not require the requester to make an advance payment—in other words, a payment made before work is begun or continued on a request. Payment owed for work already completed (i.e., a prepayment before copies are sent to a requester) is not an advance payment.

(2) Where TVA determines or estimates that a total fee to be charged under this section will be more than \$250.00, it may require the requester to make an advance payment of an amount up to the amount of the entire anticipated fee before beginning to process the request, except where it receives a satisfactory assurance of full payment from a requester that has a history of prompt payment.

(3) Where a requester has previously failed to pay a properly charged FOIA fee to TVA or another agency within 30 days of the date of billing, TVA may require the requester to pay the full amount due, plus any applicable interest, and to make an advance payment of the full amount of any anticipated fee, before TVA begins to process a new request or continues to process a pending request from that requester.

(4) In cases in which TVA requires advance payment or payment due under paragraph (i) (2) or (3) of this section, the request shall not be considered received and further work will not be done on it until the required payment is received.

(j) *Other fees for TVA published materials.* The fee schedule of this section does not apply to fees charged by TVA for documents, including maps or reports and the like, which TVA sells

to the public at established prices.

Where records responsive to requests are maintained for distribution and sale by TVA at established prices, TVA will inform requesters of the steps for obtaining records from those sources so that they may do so most economically.

(k) *Waiver or reduction of fees.* (1) Records responsive to a request will be furnished without charge or at a charge reduced below that established under paragraph (c) of this section where TVA determines, based on all available information, that the requester has documented that:

(i) Disclosure of the requested information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government, and

(ii) Disclosure of the information is not primarily in the commercial interest of the requester.

(2) To determine whether the first fee waiver requirement is met, TVA will consider the following factors:

(i) The subject of the request: Whether the subject of the requested records concerns “the operations or activities of the government.” The subject of the requested records must concern identifiable operations or activities of the federal government, with a connection that is direct and clear, not remote or attenuated.

(ii) The informative value of the information to be disclosed: Whether the disclosure is “likely to contribute” to an understanding of government operations or activities. The disclosable portions of the requested records must be meaningfully informative about government operations or activities in order to be “likely to contribute” to an increased public understanding of those operations or activities. The disclosure of information that already is in the public domain, in either a duplicative or a substantially identical form, would not be as likely to contribute to such understanding where nothing new would be added to the public's understanding.

(iii) The contribution to an understanding of the subject by the public likely to result from disclosure: Whether disclosure of the requested information will contribute to “public understanding.” The disclosure must contribute to the understanding of a reasonably broad audience of persons interested in the subject, as opposed to the individual understanding of the requester. A requester's expertise in the subject area and ability and intention to effectively convey information to the public shall be considered. It shall be presumed that a representative of the

news media will satisfy this consideration.

(iv) The significance of the contribution to public understanding: Whether the disclosure is likely to contribute "significantly" to public understanding of government operations or activities. The public's understanding of the subject in question, as compared to the level of public understanding existing prior to the disclosure, must be enhanced by the disclosure to a significant extent. TVA shall not make value judgments about whether information that would contribute significantly to public understanding of the operations or activities of the government is "important" enough to be made public.

(3) To determine whether the second fee waiver requirement is met, TVA will consider the following factors:

(i) The existence and magnitude of a commercial interest: Whether the requester has a commercial interest that would be furthered by the requested disclosure. TVA shall consider any commercial interest of the requester (with reference to the definition of "commercial use" in paragraph (b) (1) of this section), or of any person on whose behalf the requester may be acting, that would be furthered by the requested disclosure. Requesters shall be given an opportunity in the administrative process to provide explanatory information regarding this consideration.

(ii) The primary interest in disclosure. Whether any identified commercial interest of the requester is sufficiently large, in comparison with the public interest in disclosure, that disclosure is "primarily in the commercial interest of the requester." A fee waiver or reduction is justified where the public interest standard is satisfied and that public interest is greater in magnitude than that of any identified commercial interest in disclosure. TVA ordinarily shall presume that where a news media requester has satisfied the public interest standard, the public interest will be the interest primarily served by disclosure to that requester. Disclosure to data brokers or others who merely compile and market government information for direct economic return shall not be presumed to primarily serve the public interest.

(4) Where only some of the requested records satisfy the requirements for a waiver of fees, a waiver shall be granted for those records.

(5) Requests for the waiver or reduction of fees should address the factors listed in paragraphs (k) (2) and (3) of this section, insofar as they apply to each request. TVA will exercise their

discretion to consider the cost-effectiveness of their investment of administrative resources in this decisionmaking process, however, in deciding to grant waivers or reductions of fees.

§ 1301.11 Other rights and services.

Nothing in this subpart shall be construed to entitle any person, as of right, to any service or to the disclosure of any record to which such person is not entitled under the FOIA.

William S. Moore,

Senior Manager, Administrative Services.

[FR Doc. 98-23690 Filed 9-4-98; 8:45 am]

BILLING CODE 8120-08-P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG-251698-96]

RIN 1545-AU77

S Corporation Subsidiaries; Hearing

AGENCY: Internal Revenue Service, Treasury.

ACTION: Postponement of public hearing.

SUMMARY: This document postpones the public hearing on proposed regulations relating to the treatment of corporate subsidiaries of S corporations.

DATES: The public hearing originally scheduled for Wednesday, September 9, 1998, is postponed.

FOR FURTHER INFORMATION CONTACT: Mike Slaughter of the Regulations Unit, Assistant Chief Counsel (Corporate), (202) 622-7190 (not a toll-free number).

SUPPLEMENTARY INFORMATION: The subject of the public hearing is proposed regulations under section 1308 of the Internal Revenue Code. A notice of public hearing appearing in the **Federal Register** on Thursday, August 13, 1998 (63 FR 43353), announced that a public hearing will be held Wednesday, September 9, 1998, beginning at 1 p.m. in room 3411, Internal Revenue Building, 1111 Constitution Avenue NW, Washington, DC.

The public hearing is postponed. A new hearing date will be scheduled at a later date.

Cynthia E. Grigsby,

Chief, Regulations Unit Assistant Chief Counsel (Corporate).

[FR Doc. 98-24022 Filed 9-4-98; 8:45 am]

BILLING CODE 4830-01-U

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 165

[CGD01-98-042]

RIN 2121-AA97

Safety Zone: Tri-State Inboard Powerboat Championships, Hackensack River, Secaucus, NJ

AGENCY: Coast Guard, DOT.

ACTION: Withdrawal of notice of proposed rulemaking.

SUMMARY: The Coast Guard is withdrawing its notice of proposed rulemaking to establish a temporary safety zone in the Hackensack River for the Tri-State Inboard Powerboat Championships. The event has been cancelled by the sponsor. Therefore, the rule is no longer needed and the Coast Guard is terminating further rulemaking under docket number 98-042.

DATES: The notice of proposed rulemaking is withdrawn effective September 8, 1998.

ADDRESSES: Documents as indicated in this preamble are available for inspection or copying at Coast Guard Activities New York, 212 Coast Guard Drive, room 205, Staten Island, New York 10305, between 8 a.m. and 3 p.m., Monday through Friday, except Federal holidays. The telephone number is (718) 354-4195.

FOR FURTHER INFORMATION CONTACT:

Lieutenant Junior Grade Alma Kenneally, Waterways Oversight Branch, Coast Guard Activities New York (718) 354-4195.

SUPPLEMENTARY INFORMATION: On May 18, 1998, the Coast Guard published a notice of proposed rulemaking entitled "Safety Zone: Tri-State Inboard Powerboat Championships, Hackensack River, Secaucus, NJ" in the **Federal Register** (63 FR 27243). This project is no longer necessary as the event has been cancelled by the sponsor, Meadowlands Inboard Racing Association. Therefore, this rulemaking is no longer necessary, and the Coast Guard is withdrawing the NPRM and terminating further rulemaking under docket number 98-042.

Dated: August 26, 1998.

R.E. Bennis,

Captain, U.S. Coast Guard, Captain of the Port, New York.

[FR Doc. 98-24056 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-15-M

POSTAL RATE COMMISSION**39 CFR 3001****[Docket No. RM98-2; Order No. 1219]****Revisions to Library Reference Rule****AGENCY:** Postal Rate Commission.**ACTION:** Proposed rule.

SUMMARY: The Commission proposes amending its rules of practice to clarify the use of library references in evidentiary proceedings. The proposed amendments specify conditions under which library references may be filed; improve labeling and identification; and establish a process for conditional acceptance that entails motion practice.

DATES: Comments should be filed on or before October 14, 1998.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202-789-6820.

SUPPLEMENTARY INFORMATION: The Commission's rules of practice authorize participants in evidentiary proceedings to label material as a library reference and file it with the Commission's docket section. *See generally* Rule 31(b), and Docket No. R97-1 Special Rule of Practice No. 5. Designation as a library reference and acceptance in the Commission's docket section confer no evidentiary status on the material; instead, these steps are part of an administrative practice designed to relieve participants of the burden of serving copies of voluminous material on others or to facilitate reference to, or identification of, the material.

The Commission's longstanding approach has been to allow the Postal Service and others to file material as a library reference without requiring them to make a threshold showing of the appropriateness of the designation, and without conducting an independent evaluation. In Docket No. R97-1, serious concerns arose that the library reference practice could be employed, either inadvertently or strategically, to insulate material from effective cross-examination (or to control the timing of such examination), and thereby interfere with participants' due process rights and the timely completion of Commission proceedings. A related concern was that the complexity of issues in Docket No. R97-1 and the extensive amount of material filed in support of the Service's request made it difficult to determine the contents of some library references; to distinguish between evidentiary and non-evidentiary material; and to determine responsibility for sponsorship. A series

of rulings and orders addressed the immediate due process concerns of Docket No. R97-1, and a related Notice of Inquiry (NOI) invited comments on suggestions for improving the rule. *See, for example*, P.O. Ruling R97-1/20 (September 17, 1997); Order No. 1201 (November 4, 1997); and NOI No. 1, Question 3 (September 17, 1997). The comments are available for review in the Commission's docket room.

Scope of Proposed Rulemaking

The Commission proposes a limited update of its rules of practice to address certain aspects of the controversy that surfaced in Docket No. R97-1. Among other things, the revisions require that approval of the designation of material as a library reference be obtained through a motion. They also specify circumstances or conditions, in addition to those already identified in Commission rules, under which material can be designated as a library reference. The revisions also improve the labeling and description of material contained in library references, and require participants to file an electronic version of the material, absent a satisfactory demonstration of why an electronic version cannot be supplied, or should not be required to be supplied. These changes effectively eliminate the need for the special rule that was used in Docket No. R97-1, but do not address all of the issues that arose with respect to library references in Docket No. R97-1 or preclude the possibility that special rules governing the use of library references may continue to be needed. The remaining discussion briefly reviews comments submitted in response to NOI No. 1 in Docket No. R97-1; describes proposed revisions, and sets out proposed changes.

Comments Submitted in Response to NOI No. 1

In its response to the NOI, Nashua Photo Inc., District Photo Inc., Mystic Color Lab and Seattle Filmworks, Inc. (NDMS) state that they do not view "the mere act of labeling a particular document as a library reference as especially problematic," even if the document is not voluminous as now anticipated by the Commission's rules. NDMS Response to NOI No. 1 on Interpretation of Commission Rules Authorizing the Use of Library References (October 3, 1997) at 2. They add:

In fact, it may be a relatively harmless procedure if the party submitting the library reference feels the information in the library reference is information few would want to read, or that inclusion with testimony would

be unduly burdensome, or divert the reader, or if the information is in the nature of a secondary source which is provided to facilitate access by other parties. Except for abuse, the designation of a document as a library reference should not, of itself, create a serious issue in a rate or classification proceeding.

Id. at 2.

However, NDMS further observe:

Designation of library references becomes abusive if the party offering the library reference offers it with one or more of the following purposes or results: (i) To circumvent the requirement for the presentation of record evidence before the Commission; (ii) to circumvent the requirement that a live witness vouch for the accuracy and reliability of the study (or other information); (iii) to circumvent the requirement that a live witness be made available for written or oral cross-examination; or (iv) to interpose delay and unnecessary discovery and motions practice and associated expense on intervenors during a statutorily-limited proceeding where every day counts.

Id. at 2-3.

Alliance of Nonprofit Mailers (ANM)

ANM observes that the Commission has not set a minimum page limit or word count as a condition for designating a document as a library reference, but says it is "unlikely that a blanket rule of this kind would be useful." ANM Comments (October 3, 1997) at 1-2. ANM also notes that a document of general interest and importance may warrant individual service even if voluminous and, conversely, that a document devoid of general interest or importance may be "too voluminous reasonably to be distributed" by individual service even if the document is short. *Id.* at 2.

In the absence of a bright line standard, ANM says that "deciding which Postal Service library references were *not* 'too voluminous reasonably to be distributed' is likely to be more contentious than helpful." *Id.* Thus, instead of establishing a minimum page count or word count for library references, ANM suggests that the Commission should consider requiring parties sponsoring library references to provide individual copies to interested parties upon request. It further states that if this approach is adopted, the Commission might consider the advisability of prohibiting parties, with the possible exception of the Postal Service and the Commission's Office of the Consumer Advocate (OCA), from submitting blanket requests for copies of all library references. *Id.* Also, ANM said the Commission should make mandatory the now-voluntary practice of submitting library references in

electronic form for posting on, and downloading from, the Commission web site. Id.

ANM also states that the "formalities of designating library references are far less critical than the need to ensure that data, studies or other information in a library reference, if relied upon by the sponsoring party, are open to meaningful cross-examination." Id. Therefore, it suggests that a party choosing to rely on a library reference in support of its case should be required to offer a witness sponsoring the library reference for cross-examination, except when the information at issue is of a kind that is normally admissible without a sponsoring witness, such as a statement against interest, or an admission by an adverse party. Id. at 3-4. ANM further contends that the Postal Service should be required to identify—when filing its formal request and written case-in-chief, but no later than the beginning of hearings—which portions of which library references will be sponsored into evidence, and by which witnesses. Id. at 4.

Newspaper Association of America (NAA)

NAA maintains that instead of revisions to existing rules, there simply should be adherence to and serious enforcement of the rules as they now exist. NAA Comments in Response to NOI No. 1 at 2 (October 3, 1998).

Parcel Shippers Association (PSA)

PSA's response does not directly address revisions, but cites its September 17, 1997 Memorandum of Law on the Issue of the Evidentiary Value of Un-sponsored Library References, which reviewed PSA's concerns about the Service's reliance on un-sponsored library references not only in Docket No. R97-1, but in Docket No. MC95-1 as well. PSA Response to NOI No. 1 at 1 (October 2, 1997). PSA notes that its memorandum makes clear that it "is concerned about the status of Library Reference H-108, currently anonymously authored and un-sponsored, but heavily relied upon by several Postal Service witnesses' filed testimony as the source of their testimony." Id.

Office of the Consumer Advocate (OCA)

In the course of extensive comments, the OCA notes that an ongoing problem with library references is that "a fair number of them have merely been deposited in the Commission's docket room without any explanation for their purpose and being." OCA Response to NOI No. 1 on Interpretation of Commission Rules Authorizing the Use

of Library References at 10 (October 3, 1997). It contends that a "roadmap" is necessary to ensure that it can evaluate the evidence contained in library references. Id. at 12. A related problem, according to the OCA, is the incompleteness of explanation about what is contained in a library reference. Id. at 20. It observes:

* * * [USPS-LR-JH-146 described six computer programs that were not discussed in the Postal Service's direct testimony. Interrogatory OCA/USPS-T-12-35 was necessary to elicit information concerning the objectives and uses of such programs, and how the program may have changed over time. The Postal Service's failure to state clearly (without having the information extracted by OCA) that the outputs of these programs are used in the testimony and workpapers of witness Alexandrovich demonstrates how the Postal Service misuses the opportunity to file what is, in reality, evidence, as matter buried within a library reference.

Id. at 20 (fn. omitted).

The OCA suggests that Rule 53 should be amended to require the Service to identify, at the time it files its request, the evidence on which it intends to rely, and the witness whose responsibility it will be to answer questions concerning all filed material. Id. at 21. Among other things, the OCA also suggests amendments to address the sponsorship of institutional responses and surveys and what it refers to as an "administrative change" which would require a party filing a library reference to supply both the statistical information and the accompanying text in diskette form. Id. at 22-27.

Postal Service

The Postal Service acknowledges that the Docket No. R97-1 experience may justify clarifying or revising the library reference practice, but indicates it "does not believe that it is a foregone conclusion that a formal rulemaking is necessary. * * *" Response of the United States Postal Service to NOI No. 1 at 4 (October 6, 1997). It suggests that "[f]urther clarification or refinement of the Commission's existing practices, as well as a better understanding of the effect on the evidentiary record, may obviate a formal rule change." Id.

Proposed Revisions

Based on recent experience in Docket No. R97-1 and other dockets, and on the comments submitted in response to NOI No. 1, the Commission has determined that certain improvements in its rules of practice are necessary and desirable. The Commission's proposal draws on suggestions and observations made in comments briefly reviewed above. Since the practice of allowing participants to

designate material as a library reference is intended to foster convenience, a central focus of the revisions is on adequate identification of material contained in a library reference and its relationship to issues in the proceeding. The proposal does not include a page limit, but anticipates that if "volume" or length is a reason for designating material as a library reference, this will be addressed in the participant's motion. An electronic version of the document or material is to be filed, absent a showing of why this cannot or should not be supplied.

The most significant change is the introduction of formal motion practice, with conditional acceptance of the material proposed for designation pending a ruling. The proposed rule provides that the motion is to affirmatively address various matters, such as an explanation of how the material relates to the participant's case or to issues in the proceeding; whether the material will be entered into the evidentiary record; and the anticipated sponsor.

The rule reflects the longstanding principle, which appears in the existing rule, that designation of a material as a library reference and acceptance in the Commission's docket room does not confer evidentiary status on the material.

List of Subjects in 39 CFR Part 3001

Administrative practice and procedure, Postal Service.

For the reasons stated in the preamble, 39 CFR 3001.31 is amended as follows:

PART 3001—RULES OF PRACTICE AND PROCEDURE

1. The authority citation for part 3001 continues to read as follows:

Authority: 39 U.S.C. 404(b), 3603, 3622-24, 3661, 3662.

2. Amend § 3001.31 by revising paragraph (b) to read as follows:

§ 3001.31 Evidence.

* * * * *

(b) *Documentary material*—(1) *General.* Documents and detailed data and information shall be presented as exhibits. Where relevant and material matter offered in evidence is embraced in a document containing other matter not material or relevant or not intended to be put in evidence, the participant offering the same shall plainly designate the matter offered excluding the immaterial or irrelevant parts. If other matter in such document is in such bulk or extent as would unnecessarily encumber the record, it may be marked

for identification, and, if properly authenticated, the relevant and material parts thereof may be read into the record, or, if the Commission or presiding officer so directs, a true copy of such matter in proper form shall be received in evidence as an exhibit. Copies of documents shall be delivered by the participant offering the same to the other participants or their attorneys appearing at the hearing, who shall be afforded an opportunity to examine the entire document and to offer in evidence in like manner other material and relevant portions thereof.

(2) *Library references.* The term "library reference" is a generic term or label that participants and others may use to identify or designate certain documents or things ("material") filed with the Commission's docket section. The practice of filing a library reference is authorized primarily as a convenience to participants and the Commission under certain circumstances. These include:

(i) when the participant satisfactorily demonstrates that the physical characteristics of the material, such as number of pages or bulk, are reasonably likely to render compliance with service requirements unduly burdensome;

(ii) when the participant satisfactorily demonstrates that interest in the material or things so labeled is likely to be so limited that service on the entire list would be unreasonably burdensome, and the participant agrees to serve the material on individual participants upon request;

(iii) when the participant satisfactorily demonstrates that designation of material as a library reference is appropriate because the material constitutes a secondary source. A "secondary source" is one that provides background for a position or matter referred to elsewhere in a participant's case or filing, but does not constitute essential support and is unlikely to be a material factor in a decision on the merits of issues in the proceeding;

(iv) when the participant satisfactorily demonstrates that the reference to, identification of, or use of the material would be facilitated if it is filed as a library reference; or

(v) when otherwise justified by circumstances, as determined by the Commission or presiding officer.

(3) *Form and timing of required demonstration.* The requisite demonstration shall be provided in the form of a motion. In general, the motion shall be accompanied by the simultaneous filing, with the Commission's docket section, of a copy of the material proposed for designation

as a library reference. If appropriate, a comprehensive description of the material may be filed with the docket section in lieu of the material itself.

The motion shall set forth with particularity the reason(s) why designation of the material as a library reference is being sought; explain how the material relates to the participant's case or to issues in the proceeding; indicate whether the material contains a survey or survey results; and provide a good-faith indication of whether the participant anticipates that the material will be entered, in whole or in part, into the evidentiary record. The motion shall also identify authors or others materially contributing to the preparation of the library reference.

If the participant filing the library reference anticipates seeking to enter all or part of the material contained therein into the evidentiary record, the motion also shall identify portions expected to be entered and the expected sponsor(s).

(4) *Conditional acceptance.* Material accompanying a motion invoking the library reference designation shall be accepted in the Commission's docket section conditionally, pending a ruling on the merits of the motion.

(5) *Labels and descriptions.* Material proposed to be filed as a library reference shall be labeled in a manner consistent with standard Commission notation and any other conditions the Presiding Officer or Commission establishes. In addition, material designated as a library reference shall include a preface or summary addressing the following matters: The proceeding and document or issue to which the material relates; the identity of the participant designating the library reference; the identity of the witness or witnesses who will be sponsoring the material or the reason why a sponsor cannot be identified; and to the extent feasible, other library references or testimony referred to within. In addition, the preface or summary shall explicitly indicate whether the library reference is an update or revision to a library reference filed in another Commission proceeding, and provide an adequate identification of the predecessor material.

(6) *Electronic version.* Material filed as a library reference shall also be made available in an electronic version, absent a showing of why an electronic version cannot be supplied or should not be required to be supplied.

(7) *Status of library references.* Designation of material as a library reference and acceptance in the Commission's docket section does not confer evidentiary status. The

evidentiary status of the material is governed by this section.

* * * * *

Dated: August 27, 1998.

Margaret P. Crenshaw,
Secretary.

[FR Doc. 98-23635 Filed 9-2-98; 8:45 am]

BILLING CODE 7710-FW-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[LA-47-1-7388b; FRL-6156-2]

Approval and Promulgation of Implementation Plans; Louisiana: Reasonable Available Control Technology for Emissions of Volatile Organic Compounds from Batch Processes

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: In this action, EPA is approving a revision to the Louisiana State Implementation Plan rule requiring Reasonable Available Control Technology for emissions of Volatile Organic Compounds from Synthetic Organic Chemical Manufacturing Industry Batch Processes. In the Rules and Regulations Section of this **Federal Register**, EPA is approving the State's SIP revision as a direct final rule without prior proposal because the Agency views this as a noncontroversial revision and anticipates no adverse comments. The rationale for the approval is set forth in the direct final rule. If no relevant adverse comments are received in response to this rule, no further activity is contemplated in relation to this proposed rule. If EPA receives relevant adverse comments, EPA will publish a timely withdrawal informing the public that the final rule will not take effect, and all relevant public comments received during the 30-day comment period set forth below will be addressed in a subsequent final rule based on this proposed rule. Any parties interested in commenting on this action should do so at this time.

DATES: Comments must be received in writing by October 8, 1998.

ADDRESSES: Written comments should be addressed to Thomas H. Diggs, Chief, Air Planning Section, at the EPA Region 6 Office listed below. Copies of the documents relevant to this proposed rule are available for public inspection during normal business hours at the following locations. Anyone wanting to examine these documents should make

an appointment with the appropriate office at least two working days in advance.

Environmental Protection Agency, Region 6, Air Planning Section (6PD-L), 1445 Ross Avenue, Dallas, Texas 75202-2733.

Louisiana Department of Environmental Quality, Air Quality Division, 7290 Bluebonnet Boulevard, Baton Rouge, Louisiana 70810.

FOR FURTHER INFORMATION CONTACT: Bill Deese of the EPA Region 6 Air Planning Section (6PD-L) at (214) 665-7253 at the Region 6 address above.

SUPPLEMENTARY INFORMATION: See the information provided in the direct final rule in the Rules and Regulations section of this **Federal Register**.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: August 21, 1998.

Jerry Clifford,

Acting Director, Regional Administrator, Region 6.

[FR Doc. 98-24044 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IL172-1b; FRL-6152-6]

Approval and Promulgation of Implementation Plan; Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: On November 14, 1995, May 9 and 1996, June 14, 1996, the State of Illinois submitted State Implementation Plan (SIP) revision requests to meet commitments related to the conditional approval of Illinois' May 15, 1992, SIP submittal for the Lake Calumet (SE Chicago), McCook, and Granite City, Illinois, Particulate Matter (PM) nonattainment areas. The EPA is approving the SIP revision request as it applies to the McCook area, including the attainment demonstration for the McCook PM nonattainment area. The SIP revision request corrects, for the McCook PM nonattainment area, all of the deficiencies of the May 15, 1992, submittal (as discussed in the November 18, 1994, conditional approval notice). The EPA is also revising the codification of the conditional approval to remove issues which have been resolved. No action is being taken on the submitted plan revisions for the Lake Calumet area at this time; they will be addressed in a separate rulemaking action. Approval of the Granite City PM plan became

effective on May 11, 1998 (see 63 FR 11842). In the final rules section of this **Federal Register**, the EPA is approving the State's requests as a direct final rule without prior proposal because EPA views this action as noncontroversial and anticipates no adverse comments. A detailed rationale for approving the State's request is set forth in the direct final rule. The direct final rule will become effective without further notice unless the Agency receives relevant adverse written comment on this rulemaking within 30 days of publication of today's document. Should the Agency receive such comment, it will publish a timely withdrawal informing the public that the direct final rule will not take effect and such public comment received will be addressed in a subsequent final rule based on this proposed rule. If no adverse written comments are received, the direct final rule will take effect on the date stated in that action and no further activity will be taken on this rule. EPA does not plan to institute a second comment period on this rule. Any parties interested in commenting on this rule should do so at this time.

DATES: Written comments must be received on or before October 8, 1998.

ADDRESSES: Written comments should be mailed to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR-18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

Copies of the State submittal and EPA's analysis of it are available for inspection at: Regulation Development Section, Air Programs Branch (AR-18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: David Pohlman, Regulation Development Section, Air Programs Branch (AR-18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312) 886-3299.

SUPPLEMENTARY INFORMATION: For additional information see the direct final rule published in the rules section of this **Federal Register**.

Dated: August 11, 1998.

David A. Ullrich,

Acting Regional Administrator, Region V.
[FR Doc. 98-24038 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[VA 011-5034b; FRL-6156-1]

Approval and Promulgation of State Air Quality Plans for Designated Facilities and Pollutants, Commonwealth of Virginia; Control of Total Reduced Sulfur Emissions from Existing Kraft Pulp Mills

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA proposes to approve the Commonwealth of Virginia's 111(d) for the control of total reduced sulfur (TRS) emissions from existing Kraft pulp mills. In the final rules section of the **Federal Register**, EPA is approving the Commonwealth's plan as a direct final rule without prior proposal because the Agency views this as a noncontroversial action and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule and in the accompanying technical support document. If no adverse comments are received in response to this rule, no further activity is contemplated in relation to this plan. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed plan. EPA will not institute a second comment period on this action. Parties interested in commenting on this document should do so at this time.

DATES: Comments must be received in writing by October 8, 1998.

ADDRESSES: Comments may be mailed to Makeba A. Morris, Chief, Technical Assessment Branch, Mailcode 3AP22, Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103.

FOR FURTHER INFORMATION CONTACT: Artra B. Cooper at (215) 814-2096, or by e-mail at cooper.artra@epamail.gov.

SUPPLEMENTARY INFORMATION: See the information provided in the direct final rule with the same title which is located in the rules section of the **Federal Register**.

Dated: August 27, 1998.

Thomas C. Voltaggio,

Acting Director, Regional Administrator EPA Region III.

[FR Doc. 98-23889 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Ch. I

[WT Docket 98–20 and WT Docket 98–100; DA 98–1687]

Streamlining of Wireless Regulations

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; request for comments.

SUMMARY: In this *Public Notice*, DA 98–1687, the Wireless Telecommunications Bureau seeks public comment on the Personal Communications Industry Association's (PCIA) July 31, 1998 letter proposing streamlining of wireless regulations.

ADDRESSES: Federal Communications Commission, 1919 M Street, NW, Room 222, Washington, DC 20554.

DATES: Comments are due September 23, 1998.

ADDRESSES: Federal Communications Commission, 1919 M Street, NW, Room 222, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Jeffrey Steinberg, Commercial Wireless Division, Wireless Telecommunications Bureau, (202) 418–0620.

SUPPLEMENTARY INFORMATION: This *Public Notice*, DA 98–1687, released on August 21, 1998, is available for inspection and copying during normal business hours in the FCC Reference Center, Room 5608, 2025 M Street NW, Washington, DC. The complete text, including attachments, may also be purchased from the Commission's copy contractor, International Transcription Service, Inc., 1231—20th Street, NW, Washington, DC 20037, (202) 857–3800.

Summary of Public Notice

1. In numerous proceedings, the Commission has emphasized its desire to take a "common sense" approach to regulation, committing to streamlining its regulations to the greatest extent possible in order to reduce unnecessary regulatory costs and burdens consistent with the public interest. The Commission has also encouraged and received industry input on these issues.

2. On July 31, 1998, Mary McDermott, Senior Vice President & Chief of Staff, Public Relations, PCIA submitted a letter to Daniel B. Phythyon, Chief, Wireless Telecommunications Bureau (PCIA Letter) concerning potential streamlining or elimination of certain wireless regulations. In the letter, PCIA identified three categories of regulations that it regards as administratively unnecessary: (1) Regulations that have

been the subject of comment in the Commission's Universal Licensing System (ULS) rulemaking; (2) other regulations that PCIA contends could be eliminated or modified by the Commission without the need for prior notice and comment; and (3) regulations that PCIA believes should be eliminated or modified but that may require prior notice and comment.

3. We note that many of the specific proposals in the PCIA letter are already the subject of ongoing Commission proceedings, including the ULS rulemaking and the Commission's Notice of Proposed Rulemaking, 63 FR 43025 (August 11, 1998) seeking comment on additional areas where it could apply streamlining or forbearance to its wireless regulations (Wireless Forbearance). In the interest of furthering these and other initiatives, the Bureau believes it serves the public interest to seek public comment on the PCIA Letter, and on the proposals made therein for streamlining and elimination of Commission regulations. We note that this will not delay any streamlining action that the Bureau or the Commission may elect to take without further notice and comment. In addition, we will incorporate comments on the PCIA Letter into the record of our ULS and Wireless Forbearance proceedings, and will incorporate them into other proceedings as appropriate.

Federal Communications Commission.

Rosalind Allen,

Deputy Chief, Wireless Telecommunications Bureau.

[FR Doc. 98–24005 Filed 9–4–98; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF DEFENSE

48 CFR Parts 232 and 252

[DFARS Case 98–D400]

Defense Federal Acquisition Regulation Supplement; Flexible Progress Payments

AGENCY: Department of Defense (DoD).

ACTION: Proposed rule with request for comments.

SUMMARY: The Director of Defense Procurement is proposing to amend the Defense Federal Acquisition Regulation Supplement (DFARS) to remove references to the flexible progress payments method of contract financing. The current DFARS coverage does not permit its use for contracts awarded as a result of solicitations issued on or after November 11, 1993.

DATES: Comments on the proposed rule should be submitted in writing to the address specified below on or before November 9, 1998, to be considered in the formulation of the final rule.

ADDRESSES: Interested parties should submit written comments on the proposed rule to: Defense Acquisition Regulations Council, Attn: Ms. Sandra G. Haberlin, PDUSD (A&T) DP (DAR), IMD 3D139, 3062 Defense Pentagon, Washington, DC 20301–3062. Telefax number (703) 602–0350. E-mail comments submitted over the Internet should be addressed to:

dfars@acq.osd.mil. Please cite DFARS Case 98–D400 in all correspondence related to this issue. E-mail correspondence should cite DFARS Case 98–D400 in the subject line.

FOR FURTHER INFORMATION CONTACT: Ms. Sandra G. Haberlin, (703) 602–0131.

SUPPLEMENTARY INFORMATION:

A. Background

The Director of Defense Procurement established a special interagency team to review existing policies and procedures related to progress payments, to make them easier to understand and to minimize the burdens imposed on contractors and contracting officers. Regulatory requirements pertaining to progress payments that were not required by statute, required to ensure adequately standardized government business practices, or required to protect the public interest were considered for revision or elimination.

An advance notice of proposed rulemaking (ANPR) was published in the **Federal Register** on May 1, 1997 (62 FR 23740). The ANPR solicited comments from industry and government personnel on how the Federal Acquisition Regulation (FAR) could be revised to result in a simplified and streamlined process of applying for and administering progress payments.

After reviewing progress payment policies and public comments received in response to the ANPR, the team identified potential changes to the FAR and the DFARS. One of the changes for consideration was to eliminate DFARS coverage for flexible progress payments. A second ANPR was published in the **Federal Register** on March 5, 1998 (63 FR 11074), that solicited comments on the potential changes identified in the notice. The ANPR also announced a public meeting, that was subsequently held on April 23, 1998.

After considering written comments received in response to the two notices, and verbal comments provided during the public meeting, the working group

submitted a report to the Defense Acquisition Regulations Council.

This proposed rule reflects the conclusion of the working group that references to flexible progress payments as a method of contract financing should be removed from the DFARS. This financing method is administratively complex and burdensome, and may be replaced with the less cumbersome financing method of performance-based payments in some situations. In addition, as indicated in Table 32-1 at DFARS 232.502-1-71, flexible progress payments currently are not permitted for use for contracts awarded as a result of solicitations issued on or after November 11, 1993.

B. Regulatory Flexibility Act

The proposed rule is not expected to have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.*, because most contracts awarded to small entities have a dollar value less than the simplified acquisition threshold, and, therefore, do not use the flexible progress payments method of financing. In addition, flexible progress payments currently are not permitted for use for contracts awarded as a result of solicitations issued on or after November 11, 1993. An initial regulatory flexibility analysis has, therefore, not been performed. Comments are invited from small businesses and other interested parties. Comments from small entities concerning the affected DFARS subparts also will be considered in accordance with 5 U.S.C. 610. Such comments should be submitted separately and should cite 5 U.S.C. 601, *et seq.* (DFARS Case 98-D400), in correspondence.

C. Paperwork Reduction Act

The Paperwork Reduction Act does not apply because the proposed rule does not impose any information collection requirements that require Office of Management and Budget approval under 44 U.S.C. 3501, *et seq.*

List of Subjects in 48 CFR Parts 232 and 252

Government procurement.

Michele P. Peterson,
Executive Editor, Defense Acquisition Regulations Council.

Therefore, 48 CFR Parts 232 and 252 are proposed to be amended as follows:

1. The authority citation for 48 CFR Parts 232 and 252 continues to read as follows:

Authority: 41 U.S.C. 421 and 48 CFR Chapter 1.

PART 232—CONTRACT FINANCING

2. Section 232.501 is revised to read as follows:

§ 232.501 General.

§ 232.501-1 [Amended]

3. Section 232.501-1 is amended by removing paragraph (a)(iii).

§ 232.501-2 [Amended]

4. Section 232.501-2 is amended in the second sentence by revising the parenthetical "(232.171)" to read "(see 232.071)".

§ 232.502-1-71 [Removed]

5. Section 232.502-1-71 is removed.

§ 232.502-4-70 [Amended]

6. Section 232.502-4-70 is amended by removing paragraph (b) and redesignating paragraph (c) as paragraph (b).

PART 252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

§ 252.232-7003 [Removed and Reserved]

7. Section 252.232-7003 is removed and reserved.

8. Section 252.232-7004 is amended by revising the introductory text to read as follows:

§ 252.232-70004 DoD progress payment rates.

As prescribed in 232.502-4-70(b), use the following clause:

* * * * *

[FR Doc. 98-23976 Filed 9-4-98; 8:45 am]

BILLING CODE 5000-04-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[I.D. 082698D]

RIN 0648-AK05

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Snapper-Grouper Fishery off the Southern Atlantic States; Amendment 9

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of availability of an amendment to a fishery management plan; request for comments.

SUMMARY: NMFS announces that the South Atlantic Fishery Management

Council (Council) has submitted Amendment 9 to the Fishery Management Plan for the Snapper-Grouper Fishery of the South Atlantic Region for review, approval, and implementation by NMFS. Written comments are requested from the public.

DATES: Written comments must be received on or before November 9, 1998.

ADDRESSES: Comments must be mailed to the Southeast Regional Office, NMFS, 9721 Executive Center Drive N., St. Petersburg, FL 33702.

Requests for copies of Amendment 9, which includes a final supplemental environmental impact statement, an initial regulatory flexibility analysis, a regulatory impact review, and a social impact/fishery impact statement, should be sent to the South Atlantic Fishery Management Council, One Southpark Circle, Suite 306, Charleston, SC 29407-4699; Phone: 843-571-4366; Fax: 843-769-4520.

FOR FURTHER INFORMATION CONTACT: Peter J. Eldridge, 727-570-5305.

SUPPLEMENTARY INFORMATION: The Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) requires each regional fishery management council to submit any fishery management plan or amendment to the Secretary of Commerce for review and approval, disapproval, or partial approval. The Magnuson-Stevens Act also requires that NMFS, upon receiving an amendment, immediately publish a document in the **Federal Register** stating that the amendment is available for public review and comment.

Amendment 9 would: increase the minimum size for red porgy, black sea bass, gag, and black grouper for all participants; increase the minimum size for vermilion snapper for a person subject to the bag limit; establish bag limits for red porgy and black sea bass; during March and April, prohibit harvest and possession in excess of the bag limit and prohibit purchase and sale of red porgy, gag grouper, and black grouper; for greater amberjack, reduce the bag limit, establish a commercial quota and trip limit, prohibit sale of greater amberjack caught under the bag limit when the commercial fishery is closed, prohibit harvest and possession in excess of the bag limit during April, change the beginning of the fishing year to May 1, and prohibit coring (removal of the head from the carcass); restrict possession of gag and black grouper within the aggregate grouper bag limit; establish an aggregate bag limit for all

snapper-grouper species currently not under a bag limit (excluding tomate and blue runner); require escape vents and escape panels with degradable hinges and fasteners in black sea bass pots; and specify that a vessel with longline gear on board may only possess certain deep-water species of snapper-grouper.

A proposed rule to implement Amendment 9 has been received from the Council. In accordance with the Magnuson-Stevens Act, NMFS is evaluating the proposed rule to determine whether it is consistent with Amendment 9, the Magnuson-Stevens Act, and other applicable law. If that determination is affirmative, NMFS will publish it in the **Federal Register** for public review and comment.

Comments received by November 9, 1998 whether specifically directed to the amendment or the proposed rule, will be considered by NMFS in its decision to approve, disapprove, or partially approve Amendment 9. Comments received after that date will not be considered by NMFS in this decision. All comments on Amendment 9 or on the proposed rule during their respective comment periods will be addressed in the final rule.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: September 1, 1998.

Bruce Morehead,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.
[FR Doc. 98-24032 Filed 9-4-98; 8:45 am]

BILLING CODE 3510-22-F

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 980826225-8225-01 ; I.D. 081498C]

RIN 0648-AL50

Fisheries of the Exclusive Economic Zone Off Alaska; Extension of the Interim Groundfish Observer Program through December 31, 2000

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS issues a proposed rule to extend the current groundfish observer coverage requirements and implementing regulations for the North Pacific Groundfish Observer Program

(Observer Program) that expire December 31, 1998. This action is necessary to assure uninterrupted observer coverage through December 31, 2000.

This action is intended to accomplish the objectives of the Fishery Management Plan for Groundfish of the Gulf of Alaska and the Fishery Management Plan for the Groundfish Fishery of the Bering Sea and Aleutian Islands Area (FMPs).

DATES: Comments on this proposed rule must be received by October 8, 1998.

ADDRESSES: Comments should be sent to Sue Salvesson, Assistant Regional Administrator for Sustainable Fisheries, Alaska Region, NMFS, P.O. Box 21668, Juneau, AK 99802, Attn: Lori J. Gravel, or delivered to the Federal Building, 709 West 9th Street, Juneau, AK. Copies of the Environmental Assessment/Regulatory Impact Review/Final Regulatory Flexibility Analysis (EA/RIR/FRFA) prepared for the 1997 Interim Groundfish Observer Program, the RIR/FRFA prepared for the 1998 Interim Groundfish Observer Program, and the RIR/Initial Regulatory Flexibility Analysis (IRFA) prepared for this proposed regulatory action also may be obtained from the same address.

FOR FURTHER INFORMATION CONTACT: Sue Salvesson, 907-586-7228.

SUPPLEMENTARY INFORMATION:

Background

NMFS manages the U.S. groundfish fisheries of the Gulf of Alaska and the Bering Sea and Aleutian Islands management area in the Exclusive Economic Zone under the FMPs. The North Pacific Fishery Management Council (Council) prepared the FMPs pursuant to the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act). Regulations implementing the FMPs appear at 50 CFR part 679. General regulations that also pertain to U.S. fisheries appear at subpart H of 50 CFR part 600.

In 1996, the Council adopted and NMFS implemented the Interim Groundfish Observer Program. The Interim Groundfish Observer Program superseded the North Pacific Fisheries Research Plan and extended the 1996 mandatory groundfish observer requirements through 1997 (61 FR 56425, November 1, 1996) and again through 1998 (62 FR 67755, December 30, 1997). The intent of the Interim Observer Program is to provide for the collection of observer data necessary to manage the Alaska groundfish fisheries while a long-term program is being developed to address concerns about

observer data integrity, observer compensation and working conditions, and equitable distribution of observer coverage costs. During 1997 and 1998, NMFS attempted to address the first two concerns through the development of a joint partnership agreement (JPA). The JPA would be an agreement with a third party organization that would be implemented by 1999 for that organization to provide observer procurement services for the Alaska groundfish industry. The Pacific States Marine Fisheries Commission (PSMFC) expressed a willingness to serve as the third party organization to provide these services under a JPA. Throughout 1997 and 1998, NMFS consulted with the Council on the progress toward development of a JPA between NMFS and PSMFC.

At its December 1997 meeting, the Council further requested NMFS to address the observer coverage cost distribution issue through either reconsideration of the North Pacific Fisheries Research Plan that was repealed in 1995 (61 FR 56425, November 1, 1996), or the development of an alternative funding mechanism. The Council intended that options to address the cost distribution issue be developed concurrently with the JPA, although the implementation schedule of the JPA and of measures to address industry cost concerns were anticipated to differ.

During late spring 1998, NMFS became aware of two issues that forestalled the ability of PSMFC to go forward with the JPA concept as endorsed by the Council and conceptualized by NMFS. First, the authorities and respective roles of NMFS and PSMFC under a JPA could subject the agreement to the Services Contract Act (SCA). While it would be possible to develop a JPA under the SCA, under the SCA's wage provisions costs of observer services under the JPA would likely increase beyond those negotiated under union settlement and envisioned by the Council for this program.

Second, the role envisioned for PSMFC under the JPA would increase PSMFC's exposure to potential lawsuits. PSMFC determined this exposure to be too high. Furthermore, NMFS could not sufficiently indemnify PSMFC against legal challenge because (1) no statutory authority for such indemnification exists, and (2) the Anti-Deficiency Act precludes open-ended indemnification. Regulations developed to implement the JPA could deflect potential lawsuits away from PSMFC to NMFS.

Nonetheless, such deflection could not sufficiently reduce the potential for lawsuits in a manner that would allow PSMFC to go forward with the JPA as endorsed by the Council.

At its June 1998 meeting, the Council was informed that development of a JPA failed due to the issues described here. Subsequently, the Council requested NMFS to develop new options for an alternative infrastructure for the Observer Program that would (1) better assure the continued collection of quality observer data, and (2) address observer coverage cost distribution issues through a fee collection or alternative funding mechanism. NMFS is scheduled to report back to the Council at its October 1998 meeting on a plan to achieve these objectives. The Council also recognized that the development of measures to address concerns about the continued integrity of observer data and industry cost distribution issues would require extensive time and coordination efforts among NMFS staff, different industry sectors, and representatives of observer interests. At its June 1998 meeting, the Council unanimously requested NMFS to extend the current Interim Observer Program through December 31, 2000.

A description of the regulatory provisions of the Interim Groundfish Observer Program was provided in the proposed rule and final rule implementing this program (61 FR 40380, August 2, 1996; 61 FR 56425, November 1, 1996, respectively) as well as the proposed and final rule that extended the interim program through 1998 (62 FR 49198, September 19, 1997; 62 FR 67755, December 30, 1997, respectively). Consistent with the final rule extending the existing observer program into 1998, § 679.50(i)(1)(i) of the proposed rule specifies that observer contractors certified prior to January 1, 1999, and providing observer services during 1998, would be exempt from the requirement to submit an application for certification. The intent of this provision is to alleviate an unnecessary paperwork burden on those observer contractors who are certified by NMFS and currently provide observer services. No other changes to the existing regulations are proposed at this time.

Classification

This proposed rule has been determined to be not significant for purposes of E.O. 12866.

This rule would extend without change existing collection-of-information requirements subject to the Paperwork Reduction Act (PRA). The collection of this information has been approved by the Office of Management

and Budget (OMB) under OMB control numbers 0648-0318 and 0648-0307.

Notwithstanding any other provision of the law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the PRA, unless that collection of information displays a currently valid OMB control number.

The extension of the existing regulations implementing the interim observer program through December 31, 2000, is consistent with the intent and purpose of the Interim Groundfish Observer Program. The proposed action is a necessary extension of the rule implementing the Interim Groundfish Observer Program and will provide the same benefits as listed in the EA/RIR/FRFA for the Interim Groundfish Observer Program, dated August 27, 1996, and the RIR/FRFA for the extension of Interim Observer Program through 1998 dated October 28, 1997. Copies of these analyses are available from NMFS (see ADDRESSES).

NMFS prepared an IRFA as part of the RIR, which describes the impact this proposed rule would have on small entities, if adopted. Based on the analysis, it was determined that this proposed rule could have a significant economic impact on a substantial number of small entities. A copy of this analysis is also available from NMFS (see ADDRESSES).

Observer costs borne by vessels and processors are based on whether an observer is aboard a vessel and on overall coverage needs. Higher costs are borne by those vessels and shoreside processors that require higher levels of coverage. Most of the catcher vessels participating in the groundfish fisheries off Alaska and required to carry observers (i.e., vessels 60 ft (18.3 mt) LOA and longer) meet the definition of a small entity under the Regulatory Flexibility Act (RFA). Since 1995, about 270 catcher vessels carry observers annually. The FRFAs prepared for the 1997 and 1998 Interim Groundfish Observer Program describe the degree to which these catcher vessels would be economically impacted by observer coverage levels or other regulatory provisions of the Observer Program. The proposed action is not expected to result in any economic impacts beyond those already analyzed in these previous FRFAs because this rule would not implement any changes in required observer coverage levels or other regulations implementing the Interim Observer Program, except for an extension of the effective date, and the underlying socioeconomic conditions of the fishery and participating small

entities has remained constant. These impacts are summarized from the IRFA prepared for this proposed action as follows:

Table 4 of the IRFA summarizes costs by groundfish harvesting and processing sector considering observer costs as a fraction of exvessel groundfish value alone, and of the sum of exvessel values for groundfish and halibut. For most sectors, ranges, averages and medians are similar for both groundfish only and groundfish plus halibut categories. Participation in halibut fisheries occurred in only four of the ten sectors examined (100 percent and 30 percent fixed-gear catch vessels (CVs), 30 percent fixed-gear catcher/processor vessels (CPs), and 30 percent trawlers CVs). The data in Table 4 are based on 1995 assumptions for estimated costs per observer day (\$180-\$198/day) and indicate that vessel and processor observer costs ranged from .02 to 24.8 percent of the operations exvessel value of catch. Fixed gear vessels generally experience the highest relative cost for observer coverage (about 3.5 percent of the groundfish exvessel value for catch vessels > 125 ft LOA and 2.5 percent for catch vessels > 60 ft and < 125 ft LOA). These relative costs are decreased slightly to 3.4 and 2.0 percent, respectively, if the vessels' exvessel value of halibut catch is also considered. Shoreside processors and trawl catcher processors generally paid the least for observer coverage relative to exvessel value (0.5 percent and 1.0 percent, respectively). Note that these relative costs would increase under the proposed action to the extent that observer union negotiations continue to result in increased costs per deployment day.

Table 4 also presents data based on an assumption for estimated costs per observer day of \$325/day. Under this higher cost scenario, vessel and processor observer costs ranged from .04 percent to 40.7 percent of the operations' exvessel value of catch. Again, fixed gear vessels generally experience the highest relative cost for observer coverage (about 6.3 percent of the groundfish exvessel value for catcher vessels > 125 ft LOA and 4.2 percent for catcher/processor vessels > 125 ft LOA). The relative costs for catcher vessels is decreased slightly to 6.1 if the vessels' exvessel value of halibut catch is also considered. Shoreside processors and trawl catcher processors generally paid the least for observer coverage relative to exvessel value (0.8 percent and 1.7 percent, respectively).

Under both cost scenarios, the highest relative costs of observer coverage were correlated with vessel operations that were at the lowest end of the revenue spectrum within each sector examined. The fact that fixed gear operations generally pay higher relative costs for observer coverage reflects that these operations generally receive less revenue from the groundfish/halibut fisheries compared to trawl operations. The single case where observer costs exceeded 20 percent reflected a single vessel operation that earned less than \$5,500 in groundfish revenues for 1995.

The RFA requires that the IRFA describe significant alternatives to the proposed rule that accomplish the stated objectives of the applicable

statutes and that minimize any significant impact on small entities. The IRFA must discuss significant alternatives to the proposed rule such as (1) establishing different reporting requirements for small entities that take into account the resources available to small entities, (2) consolidating or simplifying of reporting requirements, (3) using performance rather than design standards, and (4) allowing exemptions from coverage for small entities.

Alternatives that addressed modifying reporting requirements for small entities or the use of performance rather than design standards for small entities were not considered by the Council or in this analysis. Such alternatives are not relevant to this proposed action and would not mitigate the impacts on small entities. Allowing exemptions for small entities from this proposed action would not be appropriate because the objective to assure uninterrupted observer coverage requirements through 2000 could not be achieved if small entities were exempted.

However, this action does include measures that will minimize the significant economic impacts of observer coverage requirements on at least some small entities. Vessels less than 60 ft (18.3 m) LOA are not required to carry an observer while fishing for groundfish. Similarly, vessels between 60 ft (18.3 m) and 125 ft (38.1 m) LOA have lower levels of observer coverage than those for vessels over 125 ft (38.1 m) LOA. These measures, which have been incorporated into the requirements of the North Pacific Groundfish Observer Program since its inception in 1989, effectively mitigate the economic impacts on some small entities without adversely affecting implementation of the conservation and management

responsibilities imposed by the FMPs and the Magnuson-Stevens Act.

The EA/RIR/FRFA prepared for the 1997 Interim Groundfish Observer Program (61 FR 56425, November 1, 1996) included the North Pacific Fisheries Research Plan (Research Plan) as an alternative. However, the Research Plan currently is not a viable alternative to the proposed interim observer program because fees collected in 1995 were refunded in early 1996 and, if the Research Plan were pursued as the preferred alternative, start-up funding would have to be collected again. Regulations implementing the existing observer program will expire at the end of 1998. Implementation of a fee-based observer program is not feasible by the end of this year, which would be necessary to provide observer coverage for the 1999–2000 groundfish fisheries. The preferred alternative for an interim observer program is the only option that could be implemented by January 1, 1999, so that the groundfish fisheries could commence without interruption.

With the demise of the JPA, the Council again requested NMFS to address industry cost distribution issues through a fee collection or alternative funding mechanism. NMFS is scheduled to report back to the Council at its October 1998 meeting on a plan to achieve this objective.

List of Subjects in 50 CFR Part 679

Alaska, Fisheries, Reporting and recordkeeping requirements.

Dated: September 1, 1998.

Hilda Diaz-Soltero,

*Acting Assistant Administrator for Fisheries,
National Marine Fisheries Service.*

For the reasons set out in the preamble, 50 CFR part 679 is proposed to be amended as follows:

PART 679—FISHERIES OF THE EXCLUSIVE ECONOMIC ZONE OFF ALASKA

1. The authority citation for 50 CFR part 679 continues to read as follows:

Authority: 16 U.S.C. 773 *et seq.*, 1801 *et seq.*, and 3631 *et seq.*

2. In § 679.50, the section heading, paragraphs (i)(1)(i), and (i)(1)(iii) are revised to read as follows:

§ 679.50 Groundfish Observer Program applicable through December 31, 2000.

* * * * *

(i) * * *

(1) * * *

(i) *Application.* An applicant seeking to become an observer contractor must submit an application to the Regional Administrator describing the applicant's ability to carry out the responsibilities and duties of an observer contractor as set out in paragraph (i)(2) of this section and the arrangements and methods to be used. Observer contractors certified prior to January 1, 1999, and that have provided observer services during 1998, are exempt from this requirement to submit an application and are certified for the term specified in paragraph (i)(1)(iii) of this section.

* * * * *

(iii) *Term.* Observer contractors will be certified through December 31, 2000. NMFS can decertify or suspend observer contractors pursuant to paragraph (j) of this section.

* * * * *

[FR Doc. 98–24031 Filed 9–4–98; 8:45 am]

BILLING CODE 3510–22–F

Notices

Federal Register

Vol. 63, No. 173

Tuesday, September 8, 1998

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Foreign Agricultural Service

Special Provision for Frozen Concentrated Orange Juice Under the North American Free Trade Agreement Implementation Act

AGENCY: Foreign Agricultural Service, USDA.

ACTION: Notice of determination of termination of existence of price conditions necessary for imposition of temporary duty on frozen concentrated orange juice from Mexico.

SUMMARY: Pursuant to Section 309(a) of the North American Free Trade Agreement Implementation Act of 1993 ("NAFTA Implementation Act"), this is a notification that for 56 consecutive business days the daily price for frozen concentrated orange juice has exceeded the trigger price.

FOR FURTHER INFORMATION CONTACT: Joseph Somers, Horticultural and Tropical Products Division, Foreign Agricultural Service, U.S. Department of Agriculture, Washington, DC 20250-1000 or telephone at (202) 720-3423.

SUPPLEMENTARY INFORMATION: The NAFTA Implementation Act authorizes the imposition of a temporary duty (snapback) for Mexican frozen concentrated orange juice when certain conditions exist. Mexican articles falling under subheading 2009.11.00 of the Harmonized Tariff Schedule of the United States (HTS) are subject to the snapback duty provision.

Under Section 309(a) of the NAFTA Implementation Act, certain price conditions must exist before the United States can apply a snapback duty on imports of Mexican frozen concentrated orange juice. In addition, such imports must exceed specified amounts before the snapback duty can be applied. The price conditions exist when for each period of 5 consecutive business days the daily price for frozen concentrated

orange juice is less than the trigger price.

For the purpose of this provision, the term "daily price" means the daily closing price of the New York Cotton Exchange, or any successor as determined by the Secretary of Agriculture (the "Exchange"), for the closest month in which contracts for frozen concentrated orange juice are being traded on the Exchange. The term "business day" means a day in which contracts for frozen concentrated orange juice are being traded on the Exchange.

The term "trigger price" means the average daily closing price of the Exchange for the corresponding month during the previous 5-year period, excluding the year with the highest average price for the corresponding month and the year with the lowest average price for the corresponding month.

Price conditions no longer exist when the Secretary determines that for a period of 5 consecutive business days the daily price for frozen concentrated orange juice has exceeded the trigger price. Whenever the price conditions are determined to exist or to cease to exist the Secretary is required to immediately notify the Commissioner of Customs of such determination. Whenever the determination is that the price conditions exist and the quantity of Mexican articles of frozen concentrated orange juice entered exceeds (1) 264,978,000 liters (single strength equivalent) in any of calendar years 1994 through 2002, or (2) 340,560,000 liters (single strength equivalent) in any calendar years 2003 through 2007, the rate of duty on Mexican articles of frozen concentrated orange juice that are entered after the date on which the applicable quantity limitation is reached and before the date of publication in **Federal Register** of the determination that the price conditions have ceased to exist shall be the lower of—(1) the column 1—General rate of duty in effect for such articles on July 1, 1991; or (2) the column 1—General rate of duty in effect on that day. For the purpose of this provision, the term "entered" means entered or withdrawn from warehouse for consumption in the customs territory of the United States.

In accordance with section 309(a) of the NAFTA Implementation Act, it has been determined that for the period August 14–20, 1998, the daily price for

frozen concentrated orange juice has exceeded the trigger price.

Issued at Washington, D.C. the 27th day of August 1998.

Lon Hatamiya,

Administrator, Foreign Agricultural Service.
[FR Doc. 98-23650 Filed 9-4-98; 8:45 am]

BILLING CODE 3410-10-M

DEPARTMENT OF COMMERCE

International Trade Administration

[A-588-824]

Certain Corrosion-Resistant Carbon Steel Flat Products From Japan: Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, U.S. Department of Commerce.

ACTION: Notice of Preliminary Results of the Antidumping Duty Administrative Review of Certain Corrosion-Resistant Carbon Steel Flat Products From Japan.

SUMMARY: In response to requests from interested parties, the Department of Commerce (the Department) is conducting an administrative review of the antidumping duty order on certain corrosion-resistant carbon steel flat products from Japan. This review covers one manufacturer of the subject merchandise. The period of review ("POR") is August 1, 1996 through July 31, 1997.

We have preliminarily determined that sales subject to this review have been made below normal value ("NV"). If these preliminary results are adopted in our final results of these administrative reviews, we will instruct the U.S. Customs Service to assess antidumping duties based on the difference between the export price ("EP") and the NV.

EFFECTIVE DATE: September 8, 1998.

FOR FURTHER INFORMATION CONTACT: Doreen Chen, Stephen Jacques, or Rick Johnson, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, DC 20230; telephone: (202) 482-0413, 482-1391, or 482-3818, respectively.

SUPPLEMENTARY INFORMATION:

The Applicable Statute

Unless otherwise indicated, all citations to the Tariff Act of 1930, as amended (the Act), are to the provisions effective January 1, 1995, the effective date of the amendments made to the Act by the Uruguay Round Agreements Act (URAA). In addition, unless otherwise indicated, all citations to the Department's regulations are to 19 CFR part 351 (62 FR 27379, May 19, 1997).

Background

On July 19, 1993, the Department published in the **Federal Register** (58 FR 37154) the antidumping duty orders on certain corrosion-resistant carbon steel flat products from Japan ("Final Determination"). On August 13, 1997, Nippon Steel Corporation ("NSC") requested a review of its exports of corrosion-resistant steel. On September 25, 1997, in accordance with section 751 of the Act, we published a notice of initiation of administrative review of this order for the period August 1, 1996 through July 31, 1997 (62 FR 50292).

Under section 751(a)(3)(A) of the Act, the Department may extend the deadline for completion of an administrative review if it determines that it is not practicable to complete the review within the statutory time limit of 365 days. On February 9, 1998 the Department published a notice of extension of the time limit for the preliminary results in the review to July 2, 1998. See *Corrosion-Resistant Carbon Steel Flat Products From Japan: Extension of Time Limit for Preliminary Results of the Antidumping Duty Administrative Review*, 63 FR 26144 (February 9, 1998). On May 12, 1998, the Department published a notice of extension of the time limit for the preliminary results in the review to August 31, 1998. See *Corrosion-Resistant Carbon Steel Flat Products From Japan: Extension of Time Limit for Preliminary Results of the Antidumping Duty Administrative Review*, 63 FR 26144 (May 12, 1998). The Department is conducting this review in accordance with section 751(a) of the Act.

Scope of Reviews

This review of "certain corrosion-resistant steel flat products" covers flat-rolled carbon steel products, of rectangular shape, either clad, plated, or coated with corrosion-resistant metals such as zinc, aluminum, or zinc-, aluminum-, nickel- or iron-based alloys, whether or not corrugated or painted, varnished or coated with plastics or other nonmetallic substances in addition to the metallic coating, in coils (whether or not in successively

superimposed layers) and of a width of 0.5 inch or greater, or in straight lengths which, if of a thickness less than 4.75 millimeters, are of a width of 0.5 inch or greater and which measures at least 10 times the thickness or if of a thickness of 4.75 millimeters or more are of a width which exceeds 150 millimeters and measures at least twice the thickness, as currently classifiable in the Harmonized Tariff Schedule (HTS) under item numbers 7210.30.0030, 7210.30.0060, 7210.41.0000, 7210.49.0030, 7210.49.0090, 7210.61.0000, 7210.69.0000, 7210.70.6030, 7210.70.6060, 7210.70.6090, 7210.90.1000, 7210.90.6000, 7210.90.9000, 7212.20.0000, 7212.30.1030, 7212.30.1090, 7212.30.3000, 7212.30.5000, 7212.40.1000, 7212.40.5000, 7212.50.0000, 7212.60.0000, 7215.90.1000, 7215.90.3000, 7215.90.5000, 7217.20.1500, 7217.30.1530, 7217.30.1560, 7217.90.1000, 7217.90.5030, 7217.90.5060, and 7217.90.5090. Included are flat-rolled products of non-rectangular cross-section where such cross-section is achieved subsequent to the rolling process (i.e., products which have been worked after rolling)—for example, products which have been beveled or rounded at the edges. Excluded are flat-rolled steel products either plated or coated with tin, lead, chromium, chromium oxides, both tin and lead ("terne plate"), or both chromium and chromium oxides ("tin-free steel"), whether or not painted, varnished or coated with plastics or other nonmetallic substances in addition to the metallic coating. Also excluded are clad products in straight lengths of 0.1875 inch or more in composite thickness and of a width which exceeds 150 millimeters and measures at least twice the thickness. Also excluded are certain clad stainless flat-rolled products, which are three-layered corrosion-resistant carbon steel flat-rolled products less than 4.75 millimeters in composite thickness that consist of a carbon steel flat-rolled product clad on both sides with stainless steel in a 20%-60%-20% ratio. The HTS item numbers are provided for convenience and Customs purposes. The written description remains dispositive of the scope of this review.

Verification

As provided in section 782(i) of the Act, we verified cost and sales information provided by NSC, using standard verification procedures, including on-site inspection of the manufacturer's facilities and the

examination of relevant sales and financial records. Our verification results are outlined in the public versions of the verification reports, which are on file with the Department in the Central Records Unit, Room B-099.

Transactions Reviewed

In accordance with section 751 of the Act, the Department is required to determine the EP (or CEP) and NV of each entry of subject merchandise. On November 18, 1997, respondent requested that it be relieved from reporting certain information, e.g. price adjustments for sales by NSC's affiliated manufacturers. Respondent argued that it should not be required to report such information on sales by affiliated manufacturers because these sales were not exported to the United States and would not provide the most similar product matches to the subject merchandise under review. See November 18, 1997 letter. Therefore, respondent reported only matching characteristics, date of sale, quantity and price for these sales.

The Department directed respondent to report sales by affiliated resellers. See Department's September 19, 1997 antidumping questionnaire and supplemental questionnaire dated January 15, 1998 at p.1. In the response to the questionnaire, respondent stated that it was unable to collect sales data from all affiliated resellers. See Questionnaire Response, dated November 25, 1997 at p. B-6; Supplemental Questionnaire Response dated February 12, 1998 at p. S-1-3. Respondent only reported sales by one affiliated reseller. *Id.* The Department asked respondent to further explain its inability to report sales by affiliated resellers. See Second Supplemental Questionnaire dated April 14, 1998 at p. 1-2. Respondent elaborated concerning its inability to report sales, its methodology in reporting certain transactions and the impact of reporting resales on the dumping margin. See Second Supplemental Questionnaire Response dated May 13, 1998 at pp. 1-14. The Department preliminarily allowed this limited reporting for downstream sales since we found adequate home market matches to U.S. sales. As this issue involves proprietary information, please see the Department's *Decision Memorandum: Fourth Administrative Review of the Antidumping Duty Order on Certain Corrosion-Resistant Carbon Steel Flat Products from Japan* for a complete explanation of this issue.

Product Comparisons

In accordance with section 771(16) of the Act, we considered all products produced by the respondent covered by the description in the "Scope of the Review" section of this notice, (*supra*), and sold in the home market during the period of review (POR), to be foreign like products for purposes of determining appropriate product comparisons to U.S. sales. Where there were no sales of identical merchandise in the home market to compare to U.S. sales, we compared U.S. sales to the most similar foreign like product on the basis of the characteristics listed in Appendix V of the Department's September 19, 1997 antidumping questionnaire. In making product comparisons, we matched foreign like products based on the physical characteristics reported by the respondent and verified by the Department.

Fair Value Comparisons

To determine whether sales of subject merchandise to the United States were made at less than fair value, we compared the EP to the NV, as described in the "United States Price" and "Normal Value" sections of this notice. In accordance with section 777A(d)(2) of the Act, we calculated monthly weighted-average prices for NV and compared these to individual U.S. transaction prices.

United States Price

For calculation of the price to the United States, we used EP when the subject merchandise was sold directly or indirectly to the first unaffiliated purchaser in the United States prior to importation and when constructed export price (CEP) was not otherwise warranted, based on facts on the record.

The Department calculated EP for NSC based on packed, prepaid or delivered prices to customers in the United States. We made adjustments to the starting price, net of billing adjustments, for movement expenses (foreign and U.S. movement, brokerage and handling, and U.S. Customs duties), in accordance with section 772(c)(2) of the Act.

It is the Department's current practice normally to use the invoice date as the date of sale; we may, however, use a date other than the invoice date if we are satisfied that a different date better reflects the date on which the exporter or producer establishes the material terms of sale. See 19 CFR 351.401(i) (62 FR at 27411).

Accordingly, as allowed by the exception set forth in section 351.401(i)

of the regulations, we used the date of order confirmation as date of sale for all of NSC's sales in both the U.S. market and the home market. Because in this review the date of order better reflects the date on which the material terms of sale are established, we will not use the date of invoice as the new regulations prescribe. We did not use date of shipment as the date of sale, as reported by respondent, because, we determined that date of shipment did not represent the date on which the material terms of sale are established. See *Antidumping Duties; Countervailing Duties; Final Rule*, 62 FR at 27349.

Normal Value

The Department determines the viability of the home market as the comparison market by comparing the aggregate quantity of home market and U.S. sales. We found that respondent's quantity of sales in its home market exceeded five percent of its sales to the United States for the relevant class or kind of merchandise. Therefore, we have determined that respondent's home market sales are viable. Moreover, there is no evidence on the record supporting a particular market situation in the exporting country that would not permit a proper comparison of home market and U.S. prices. Therefore, we used home market sales for purposes of comparison with sales of the subject merchandise to the United States, pursuant to section 773(a)(1)(C) of the Act. In accordance with section 773(a)(1)(B)(i) of the Act, we based NV on the price at which the foreign like product was first sold for consumption in the home market, in the usual commercial quantities and in the ordinary course of trade, at the same level of trade as the EP sale.

In accordance with section 773(a)(4) of the Act, we used CV as the basis for NV when there were no above-cost contemporaneous sales of identical or similar merchandise in the comparison market. We calculated CV in accordance with section 773(e) of the Act. We included the cost of materials and fabrication, SG&A expenses, and profit. In accordance with section 773(e)(2)(A) of the Act, we based SG&A expenses and profit on the amounts incurred and realized by respondent in connection with the production and sale of the foreign like product in the ordinary course of trade for consumption in the foreign country. For selling expenses, we used the weighted-average home market selling expenses.

We used sales to affiliated customers only where we determined such sales were made at arm's-length prices, *i.e.*, at prices comparable to prices at which the

firm sold identical merchandise to unaffiliated customers.

For the class or kind of merchandise under review, the Department disregarded sales below the cost of production ("COP") in the last completed review as of the date of the issuance of the antidumping questionnaire (see *Certain Hot-Rolled Carbon Steel Flat Products, Certain Cold-Rolled Carbon Steel Flat Products, and Certain Corrosion-Resistant Carbon Steel Flat Products from Japan: Final Determinations of Sales at Less Than Fair Value*, 58 FR 37154 (July 9, 1993)). We therefore had reasonable grounds to believe or suspect, pursuant to section 773(b)(2)(A)(ii) of the Act, that sales of the foreign like product under consideration for the determination of NV in this review may have been made at prices below the COP. Pursuant to section 773(b)(1) of the Act, we initiated COP investigations of sales by respondent in the home market.

We compared sales of the foreign like product in the home market with the model-specific cost of production figure for the POR ("COP"). In accordance with section 773(b)(3) of the Act, we calculated the COP based on the sum of the costs of materials and fabrication employed in producing the foreign like product plus selling, general and administrative (SG&A) expenses and all costs and expenses incidental to placing the foreign like product in condition packed and ready for shipment. We revised respondent's reported G & A expense ratio to include certain non-operating income and expense items. We revised the reported transfer price of electricity obtained from affiliates to reflect the market value paid to non-affiliates. The market price was higher than the transfer price. See *Memorandum to the File: OA Analysis Memorandum for the Preliminary Results of Review*, August 31, 1998. In our COP analysis, we used home market sales and COP information provided by the respondent in its questionnaire responses.

After calculating COP, we tested whether home market sales of subject merchandise were made at prices below COP and, if so, whether the below-cost sales were made within an extended period of time in substantial quantities and at prices that did not permit recovery of all costs within a reasonable period of time. Because each individual price was compared against the POR-long average COP, any sales that were below cost were also not at prices which permitted cost recovery within a reasonable period of time. We compared model-specific COPs to the reported home market prices less any applicable

movement charges, discounts, and rebates.

Pursuant to section 773(b)(2)(C) of the Act, where less than 20 percent of a respondent's sales of a given model were at prices less than COP, we did not disregard any below-cost sales of that model because the below-cost sales were not made in substantial quantities within an extended period of time. Where 20 percent or more of a respondent's sales of a given model during the POR were at prices less than the weighted-average COPs for the POR, we disregarded the below-cost sales because they were made within an extended period of time in substantial quantities in accordance with sections 773(b)(2)(B) and (C) of the Act, and were at prices which would not permit recovery of all costs within a reasonable period of time in accordance with section 773(b)(2)(D) of the Act.

In accordance with section 773(a)(1)(B)(i) of the Act, where possible, we based NV on sales at the same level of trade ("LOT") as the U.S. price. See the Level of Trade Section below.

The Department determined in the final determination of the most recently completed segment of this proceeding in which NSC has participated (*Certain Hot-Rolled Carbon Steel Flat Products, Certain Cold-Rolled Carbon Steel Flat Products, and Certain Corrosion-Resistant Carbon Steel Flat Products From Japan: Final Determinations of Sales at Less than Fair Value*, 58 FR 37154, July 9, 1993) that it would be inappropriate to resort directly to constructed value (CV), in lieu of foreign market sales, as the basis for NV if the Department finds foreign market sales of merchandise identical or most similar to that sold in the United States to be outside the "ordinary course of trade." Therefore, we will match a given U.S. sale to foreign market sales of the next most similar model when all sales of the most comparable model are below cost. The Department will use CV as the basis for NV only when there are no above-cost sales that are otherwise suitable for comparison. Therefore, in this proceeding, when making comparisons in accordance with section 771(16) of the Act, we considered all products sold in the home market as described in the "Scope of Review" section of this notice, above, that were in the ordinary course of trade for purposes of determining appropriate product comparisons to U.S. sales. Where there were no sales of identical merchandise in the home market made in the ordinary course of trade to compare to U.S. sales, we compared U.S. sales to sales of the most similar

foreign like product made in the ordinary course of trade, based on the characteristics listed in Sections B and C of our antidumping questionnaire. This methodology is pursuant to the ruling of the Court of Appeals for the Federal Circuit in *CEMEX v. United States*, 133 F.3d 1098 (Fed Cir. 1998), and has been implemented to the extent that the data on the record permitted.

For those models for which there was a sufficient quantity of sales at prices above COP, we based NV on home market prices to unaffiliated purchasers, in accordance with 19 CFR 351.403. Home market prices were based on the packed, ex-factory or delivered prices to unaffiliated purchasers in the home market.

We calculated the starting price net of discounts, rebates, and post-sale adjustments, where applicable. We treated rebates that were granted after the date of sale as post-sale price adjustments. The Department allows post-sale price adjustments that reflect the respondent's normal business practice. See *Antifriction Bearings (Other Than Tapered Roller Bearings) and Parts Thereof from France, et al. (AFBs); Final Results of Antidumping Duty Administrative Review, Partial Termination of Administrative Review, and Revocation in Part of Antidumping Duty Orders*, 60 FR 10900, 10930 (Feb. 28, 1995); *Certain Corrosion-Resistant Carbon Steel Flat Products and Certain Cut-to-Length Carbon Steel Plate from Canada: Final Results of Antidumping Duty Administrative Review*, 61 FR 13815, 13823 (March 28, 1996). At verification, we examined documentation which adequately demonstrated that the adjustments to rebates reflect respondent's normal course of trade of conducting ongoing price negotiations with its HM customers. In addition, we preliminarily determine that respondent has reported rebates on a transaction-specific basis.

Although it is our general policy to allow rebates only when the terms of sale are predetermined, the purpose of requiring respondent to prove that the buyer was aware of the conditions to be fulfilled and the approximate amount of the rebates at the time of the sale is to protect against manipulation of the dumping margins by a respondent once it learns that certain sales will be subject to review. See AFB's at 10930; *Certain Corrosion-Resistant Carbon Steel Flat Products and Certain Cut-to-Length Carbon Steel Plate from Canada* at 13823. In the instant case, because we found that adjustments to rebates are part of respondent's normal business practice, we are satisfied that respondent is not engaged in the

manipulation of dumping margins through the use of rebates. For a further description of the Department's treatment of these expenses, see the *Analysis Memo*, dated August 31 at p. 3.

We made adjustments, where applicable, for packing and movement expenses in accordance with sections 773(a)(6)(A) and (B) of the Act. We also made adjustments for differences in cost attributable to differences in physical characteristics of the merchandise pursuant to section 773(a)(6)(C)(ii) of the Act and for differences in circumstances of sale ("COS") in accordance with 773(a)(6)(C)(iii) of the Act and 19 CFR 351.410. For comparison to EP, we made COS adjustments by deducting home market direct selling expenses (credit, royalties and warranty expenses) and adding U.S. direct selling expenses (credit and warranty expenses). When comparisons were made to EP sales on which commissions were paid, but no commissions were paid on the foreign market sales, we made adjustments for home market indirect selling expenses and inventory carrying costs to offset these U.S. commissions pursuant to 19 CFR section 351.410(b) or 351.410(e).

Level of Trade ("LOT")

In accordance with section 773(a)(1)(B) of the Act, to the extent practicable, we determine NV based on sales in the comparison market at the same level of trade ("LOT") as the EP or CEP transaction. The NV LOT is that of the starting-price sales in the comparison market or, when NV is based on constructed value ("CV"), that of the sales from which we derive selling, general and administrative ("SG&A") expenses and profit. For EP, the U.S. LOT is also the level of the starting-price sale, which is usually from exporter to importer.

To determine whether NV sales are at a different LOT than EP, we examine stages in the marketing process and selling functions along the chain of distribution between the producer and the unaffiliated customer. If the comparison-market sales are at a different LOT, and the difference affects price comparability, as manifested in a pattern of consistent price differences between the sales on which NV is based and comparison-market sales at the LOT of the export transaction, we make an LOT adjustment under section 773(a)(7)(A) of the Act. See *Notice of Final Determination of Sales at Less Than Fair Value: Certain Cut-to-Length Carbon Steel Plate from South Africa*, 62 FR 61731 (November 19, 1997).

In the present review, respondent claimed that only one LOT existed and did not request a LOT adjustment. To evaluate LOTs, we examined information regarding the distribution systems in both the U.S. and home market, including the selling functions, classes of customer, and selling expenses.

Respondent reported one LOT in the home market based on two classes of customers: trading companies and end users. We examined the reported selling functions and found that NSC provides the same selling functions to its home market customers regardless of channel of distribution. We preliminarily determine that the selling functions between the reported channels are sufficiently similar to consider them as one LOT in the comparison market.

NSC stated that it sells to one LOT in the United States: trading companies. We compared the selling functions performed at the home market LOT and the LOT in the United States and found them substantially similar. Of the thirteen selling functions reported for home market sales, twelve of the selling functions were identical to U.S. sales. For a further discussion of the Department's LOT analysis, see *Memorandum to the File: Analysis Memorandum for the Preliminary Results of Review*, August, 31 1998.

Preliminary Results of Reviews

As a result of our reviews, we preliminarily determine the weighted-average dumping margins for NSC for the period August 1, 1996 through July 31, 1997 is as follows:

Manufacturer/exporter	Time period	Margin (percent)
NSC	8/1/96-7/31/97	1.93

Parties to the proceeding may request disclosure within five days of the date of publication of this notice. Any interested party may request a hearing within 30 days of publication. Any hearing, if requested, will be held 37 days after the date of publication or the first business day thereafter. Case briefs from interested parties may be submitted not later than 30 days after the date of publication of this notice. Rebuttal briefs, limited to issues raised in those briefs, may be filed not later than 35 days after the date of publication of this notice. The Department will publish the final results of this administrative review, including its analysis of issues raised in the case and rebuttal briefs, not later than 120 days after the date of publication of this notice.

Upon issuance of the final results of review, the Department shall determine, and the U.S. Customs Service shall assess, antidumping duties on all appropriate entries. In accordance with 19 CFR 351.212(b), we calculated an importer-specific ad valorem duty assessment rate based on the ratio of the total amount of antidumping duties calculated for the examined sales to the total customs value of the sales used to calculate those duties. This rate will be assessed uniformly on all entries of that particular importer during the POR.

Furthermore, the following deposit requirements will be effective for all shipments of the subject merchandise entered, or withdrawn from warehouse, for consumption on or after the publication date, as provided by section 751(a) of the Act: (1) the cash deposit rate for NSC will be that established in the final results of review (except that no deposit will be required for a firm with a zero or de minimis margin, i.e., a margin less than 0.5 percent); (2) for merchandise exported by manufacturers or exporters not covered in this review, but covered in the LTFV investigation or previous review, the cash deposit rate will continue to be the company-specific rate published for the most recent segment; (3) if the exporter is not a firm covered in this review, a previous review, or the original LTFV investigation, but the manufacturer is, the cash deposit rate will be the rate established for the most recent period for the manufacturer of the merchandise; (4) the cash deposit rate for all other manufacturers or exporters will continue to be the "all others" rates established in the LTFV investigations, which was 40.19 percent for corrosion-resistant steel products (see *Final Determination*, 58 FR 37154 (July 9, 1993)). These requirements, when imposed, shall remain in effect until publication of the final results of the next administrative review.

This notice serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

These results of the administrative review are issued and published in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: August 31, 1998.

Joseph A. Spetrini

Acting Assistant Secretary for Import Administration.

[FR Doc. 98-24069 Filed 9-4-98; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

International Trade Administration

[A-580-825]

Oil Country Tubular Goods From Korea: Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, U.S. Department of Commerce.

ACTION: Notice of Preliminary Results of the Antidumping Duty Administrative Review of Oil Country Tubular Goods From Korea.

SUMMARY: In response to a request from SeAH Steel Corporation ("SeAH"), the Department of Commerce ("the Department") is conducting an administrative review of the antidumping duty order on oil country tubular goods from Korea. This review covers one manufacturer/exporter of the subject merchandise to the United States, SeAH, and the period August 1, 1996 through July 31, 1997, which is the second period of review ("POR").

We have preliminarily determined that SeAH made sales below normal value ("NV"). If these preliminary results are adopted in our final results of this administrative review, we will instruct the U.S. Customs Service to assess antidumping duties based on the difference between the constructed export price ("CEP") and the NV.

EFFECTIVE DATE: September 8, 1998.

FOR FURTHER INFORMATION CONTACT: Doug Campau, Steve Bezirgianian, or Steven Presing, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482-0409, -0162, or -0194, respectively.

SUPPLEMENTARY INFORMATION:

The Applicable Statute

Unless otherwise indicated, all citations to the Tariff Act of 1930, as amended (the Act), are to the provisions effective January 1, 1995, the effective date of the amendments made to the Act by the Uruguay Round Agreements Act (URAA). In addition, unless otherwise indicated, all citations to the Department's regulations are to 19 CFR part 351 (62 FR 27379, May 19, 1997).

Background

On August 11, 1995, the Department published in the **Federal Register** (60 FR 41058) the antidumping duty order on oil country tubular goods from Korea. On August 4, 1997, the Department published in the **Federal Register** (62 FR 41925) a notice indicating an opportunity to request an administrative review of this order for the period August 1, 1996, through July 31, 1997, and on August 29, 1997, SeAH requested an administrative review for its entries during that period. On September 25, 1997, in accordance with Section 751 of the Act, we published in the **Federal Register** a notice of initiation of an administrative review of this order for the period August 1, 1996 through July 31, 1997 (62 FR 50292).

Under section 751(a)(3)(A) of the Act, the Department may extend the deadline for completion of an administrative review if it determines that it is not practicable to complete the review within the statutory time limit of 365 days. On January 30, 1998, the Department published a notice of extension of the time limit for the preliminary results in the review to August 31, 1998. *See Oil Country Tubular Goods from Korea; Extension of Time Limit for Antidumping Duty Administrative Review*, 63 FR 4624.

The Department is conducting this review in accordance with section 751(a) of the Act.

Scope of Review

The merchandise covered by this order are oil country tubular goods ("OCTG"), hollow steel products of circular cross-section, including only oil well casing and tubing, of iron (other than cast iron) or steel (both carbon and alloy), whether seamless or welded, whether or not conforming to American Petroleum Institute ("API") or non-API specifications, whether finished or unfinished (including green tubes and limited service OCTG products). This scope does not cover casing or tubing pipe containing 10.5 percent or more of chromium, or drill pipe. The OCTG subject to this order are currently classified in the Harmonized Tariff Schedule of the United States ("HTSUS") under item numbers: 7304.29.10.10, 7304.29.10.20, 7304.29.10.30, 7304.29.10.40, 7304.29.10.50, 7304.29.10.60, 7304.29.10.80, 7304.29.20.10, 7304.29.20.20, 7304.29.20.30, 7304.29.20.40, 7304.29.20.50, 7304.29.20.60, 7304.29.20.80, 7304.29.30.10, 7304.29.30.20, 7304.29.30.30, 7304.29.30.40, 7304.29.30.50, 7304.29.30.60,

7304.29.30.80, 7304.29.40.10, 7304.29.40.20, 7304.29.40.30, 7304.29.40.40, 7304.29.40.50, 7304.29.40.60, 7304.29.40.80, 7304.29.50.15, 7304.29.50.30, 7304.29.50.45, 7304.29.50.60, 7304.29.50.75, 7304.29.60.15, 7304.29.60.30, 7304.29.60.45, 7304.29.60.60, 7304.29.60.75, 7305.20.20.00, 7305.20.40.00, 7305.20.60.00, 7305.20.80.00, 7306.20.10.30, 7306.20.10.90, 7306.20.20.00, 7306.20.30.00, 7306.20.40.00, 7306.20.60.10, 7306.20.60.50, 7306.20.80.10, and 7306.20.80.50. The HTSUS item numbers are provided for convenience and Customs purposes. The written description remains dispositive of the scope of this review.

Comparison Market

The Department determines the viability of a comparison market by comparing the aggregate quantity of comparison market and U.S. sales. An exporting country is not considered a viable comparison market if the aggregate quantity of sales of subject merchandise within it amounts to less than five percent of the quantity of sales of subject merchandise into the U.S. during the POR. Section 773(a)(1)(B) of the Act; 19 CFR 351.404. We found Korea was not a viable comparison market because the aggregate quantity of SeAH's sales of subject merchandise within Korea during the POR amounted to less than five percent of the quantity of sales of subject merchandise to the U.S. during the POR.

According to Section 773(a)(1)(B)(ii) of the Act, the price of sales to a third country can be used as the basis for normal value if such price is representative, if the aggregate quantity (or, where appropriate, value) of sales to that country is at least 5 percent of the quantity (or value) of total sales to the United States, and if the Department does not determine that the particular market situation in that country prevents proper comparison with the export price or constructed export price. The volume and value of sales to Myanmar were both found to exceed 5 percent of the volume and value of sales to the United States. We also found the price of SeAH's Myanmar sales to be representative. (see 1996-1997 *Administrative Review of the Antidumping Duty Order on Oil Country Tubular Goods from Korea: Analysis of Petitioners' Allegation of Sales Below the Cost of Production for SeAH Steel Corporation*, at 1-2, which is the January 7, 1998 memorandum from Steve Bezirgianian through Steven Presing to Roland MacDonald ("Cost

Allegation Analysis Memorandum"). Further, we found no reason to determine that the market situation in Myanmar would somehow prevent proper comparison between normal value and export price or constructed export price. *Id.* We therefore found Myanmar to be the appropriate comparison market per section 773(a)(1)(B)(ii) of the Act.

The only comparison market customer was a Korean trading company that resold the merchandise to Myanmar customers. SeAH has a joint venture with that trading company, but it is not involved with the production of subject merchandise. Accordingly, we do not consider SeAH and the Korean trading company to be affiliated for purposes of sales to Myanmar. Further, we have no other information on the record which indicates that this company should be considered an affiliated party pursuant to section 771(33) of the Act, we have preliminarily determined not to treat it as such.

Product Comparisons

In accordance with section 771(16) of the Act, we considered all products produced by the respondent, covered by the description in the Scope of the Review section, above, and sold in the comparison market during the POR, to be foreign like products for purposes of determining appropriate product comparisons to U.S. sales. Where there were no contemporaneous sales of identical merchandise in the comparison market to compare to U.S. sales, we compared U.S. sales to the most similar foreign like product on the basis of the characteristics listed in Appendix V of the Department's September 16, 1997 antidumping questionnaire.

Fair Value Comparisons

To determine whether sales of subject merchandise to the United States were made at less than fair value, we compared the Constructed Export Price (CEP) to the NV, as described in the "United States Price" and "Normal Value" sections of this notice. In accordance with section 777A(d)(2) of the Act, we calculated monthly weighted-average prices for NV and compared these to individual U.S. transaction prices.

Interested Party Comments

On August 17, 1998, petitioners submitted comments. On August 19, 1998, SeAH submitted comments. Because of the lateness of these submissions, we are not able to fully consider them for these preliminary results.

United States Price

SeAH produced OCTG in Korea and shipped it to the United States. Pusan Pipe America, Inc. ("PPA"), an affiliate of SeAH, was the importer of record. After importation, PPA maintained the merchandise in inventory. PPA sold OCTG to the Panther division of State Pipe and Supply Co. ("State"), a firm that is jointly owned by SeAH and PPA. State, in turn, sold OCTG to unaffiliated U.S. customers, typically after further manufacturing was performed by unaffiliated processors. State invoiced the unaffiliated customers and received payment.

In accordance with section 772(b) of the Act, we used CEP for calculation of the price to the United States because the first sales to unaffiliated customers in the United States were made after importation of the subject merchandise. The starting point for the calculation of CEP was the delivered price to unaffiliated customers in the United States. In accordance with section 772(c)(2) of the Act, we made deductions for movement expenses, including foreign inland freight, ocean freight, marine insurance, foreign and U.S. brokerage and handling, U.S. inland freight, and U.S. customs duties. In accordance with section 772(d)(1) of the Act, we also deducted credit expenses, warranty expenses, early payment discounts and other discounts, warehousing expenses, other direct selling expenses (inspection expenses), indirect selling expenses, and inventory carrying costs. For certain U.S. sales, a domestic court ruled SeAH should be paid for certain disputed receivables due. However, such payments have not yet been received by SeAH. Accordingly, these court-ordered payments have not been taken into account in determining dates of payment. Should SeAH receive those payments prior to the final, we will take them into consideration. For our calculations, we set the payment date (for these U.S. sales) equal to the date of SeAH's last submission (August 19, 1998) and recalculated credit expense accordingly.

In accordance with section 772(c)(1)(b) of the Act, we added duty drawback to the starting price. Pursuant to section 772(d)(3) of the Act, we made an adjustment for CEP profit. In accordance with section 772(d)(2) of the Act, we deducted the cost of further manufacturing where such deduction was appropriate. This deduction for further manufacturing was based on the fees charged by the unaffiliated U.S. processors; SeAH indicated that the reported further processors' charges

included processing and repacking, and that it did not include separate G&A or interest expense information related to this further processing because all of the expenses incurred by State and PPA, including the minimal G&A and interest expense associated with their dealings with further processors, were reported as selling expenses. Finally, we made an adjustment for an amount of profit allocated to these expenses, when incurred in connection with economic activity in the United States, in accordance with section 772(d)(3) of the Act.

Normal Value

A. Model Match

In accordance with recent practice, we matched a given U.S. sale to comparison market sales of the next most similar model if all contemporaneous sales of the most comparable model were below cost and discarded from our analysis. The Department uses CV as the basis for NV only when there are no above-cost sales that are otherwise suitable for comparison. Therefore, in this proceeding, in making comparisons in accordance with section 771(16) of the Act, we considered all products sold in the comparison market as described in the "Scope of Review" section of this notice, above, that were in the ordinary course of trade for purposes of determining appropriate product comparisons to U.S. sales. Where there were no sales of identical merchandise in the comparison market made in the ordinary course of trade to compare to U.S. sales, we compared U.S. sales to sales of the most similar foreign like product made in the ordinary course of trade, based on the characteristics listed in Sections B and C of our antidumping questionnaire. This methodology is in accordance with the ruling of the Court of Appeals for the Federal Circuit in *CEMEX vs. United States*, 133 F.3d 897 (Fed Cir. 1998).

B. Cost of Production and Constructed Value

1. Cost of Production: On December 2, 1997, petitioners alleged that SeAH made comparison market sales of OCTG at prices below the cost of production ("COP") during the POR. After analyzing petitioners' allegation (see the aforementioned *Cost Allegation Analysis Memo*), the Department determined that it had reasonable grounds to believe or suspect that sales had been made at prices that were less than the COP. Therefore, on January 8, 1998, pursuant to section 773(b) of the Act, the Department initiated a COP

investigation of SeAH. We compared sales of the foreign like product in the comparison market with the model-specific COP figure for the POR. In accordance with section 773(b)(3) of the Act, we calculated the COP based on the sum of the costs of materials and fabrication employed in producing the foreign like product, plus selling, general and administrative (SG&A) expenses, including all costs and expenses incidental to placing the foreign like product in condition packed and ready for shipment. In our COP analysis, we used comparison market sales and COP information provided by the respondent in its questionnaire responses.

The API Specification 5CT, to which SeAH states it makes its OCTG, requires that a carload lot (considered to be a minimum of 40,000 pounds, or 18.14 metric tons) meet a negative weight tolerance of 1.75% (i.e., the actual weight of the carload lot can be no less than 100% minus 1.75%, or 98.25%, of the theoretical weight of the carload, the latter being the weight basis for SeAH's sales). The weight tolerance for single lengths of pipe are plus 6.5% and minus 3.5% (i.e., the actual weight of any given pipe must be between 96.5% and 106.5% of the theoretical weight). SeAH has reported weight conversion factors that indicate actual weight was less than 96.5% of theoretical weight, outside of the API weight tolerance. Weight conversion factors are needed to convert SeAH's production costs, which for most OCTG products are maintained on an actual weight basis, to a theoretical weight basis so that the cost and sales data are on a comparable weight basis.

Petitioners argue that these conversion factors cannot, by definition, be greater than 1.75% because SeAH does not know at the time of production whether or not the customers will eventually purchase carload lots. Petitioners state that the Department should therefore deny SeAH's conversion factors in their entirety.

SeAH argues that the minus 1.75% tolerance only applies to OCTG which has an outside diameter of less than 1.660 inches and that it did not produce or make sales of these products to Myanmar or the United States. SeAH asserts that it, State, and their customers do not require that carload lots of the merchandise be weighed, and that it, State, and their customers do not interpret the API specifications to require that the carload lots of the merchandise be weighed. SeAH indicates that it performs a weight-tolerance test for plain-end pipe, to make sure its weight meets the plus 6.5% and minus 3.5% tolerances, and

that it performs the same test again, after the further processing (performed in Korea for Myanmar sales, and by the unaffiliated U.S. further processors for U.S. sales), to assure that the finished goods meet the same tolerances.

We find, based on the record, that the minus 1.75% weight tolerance API specified for carload lots of 5CT applies for all OCTG produced to that specification, not simply to OCTG with an outside diameter of less than 1.660 inches. The specification states that "[a]ll dimensions shown herein without tolerances are related to the basis for design and are not subject to measurement to determine acceptance or rejection of the product," and that "[e]xceptions are Grades C90, T95, and Q125, which may be furnished in other sizes, weights, and wall thicknesses as agreed between the purchaser and the manufacturer" (see API Specification 5CT at section 7.1, in SeAH's December 24, 1997 submission). The carload lot weight is a dimension (weight) with a tolerance (minus 1.75%), and none of SeAH's Myanmar or U.S. sales were of Grades C90, T95, or Q125.

Nevertheless, it does not appear that the API carload lot weight tolerance would apply to merchandise being transported by ship, which is the case for SeAH's Myanmar sales and for its U.S. sales to PPA. These are the transactions that are relevant for cost purposes; the further manufactured U.S. sales to unaffiliated U.S. customers need not meet any particular specification, or even be categorized as OCTG. SeAH stated that its production meets the minus 3.5% and plus 6.5% tolerance, and there is no clear reason why the actual weight should be less than 96.5% of the theoretical weight if all of SeAH's OCTG is produced to the specification. Consequently, for our preliminary results we have used a conversion factor based on this assumption (except for products for which costs were maintained on a theoretical weight basis, which require no weight conversion).

Hot-rolled steel coil is one of the main material inputs used to manufacture OCTG. SeAH purchased the majority of its hot-rolled steel coil inputs from Pohang Iron and Steel Co., Ltd. ("POSCO"). While SeAH and POSCO are involved in a joint venture that produced non-subject merchandise, we have no other information on the record which indicates that these two companies should be considered affiliated parties pursuant to section 771(33) of the Act. Therefore, we have preliminarily determined that SeAH and POSCO are not affiliated.

After calculating COP, we tested whether comparison market sales of the foreign like product were made at prices below COP and, if so, whether the below-cost sales were made within an extended period of time, in substantial quantities, and at prices that did not permit recovery of all costs within a reasonable period of time. Because each individual price was compared against the POR average COP, any sales that were below cost were also determined not to be at prices which permitted cost recovery within a reasonable period of time. We compared model-specific COPs to the reported comparison market prices, less any applicable movement charges, discounts, and rebates.

Pursuant to section 773(b)(2)(C) of the Act, where less than 20 percent of a respondent's sales of a given model were at prices less than COP, we did not disregard any below-cost sales of that model because the below-cost sales were not made in substantial quantities within an extended period of time. Where 20 percent or more of a respondent's sales of a given model during the POR were at prices less than the weighted-average COPs for the POR, we disregarded the below-cost sales because they were made within an extended period of time in substantial quantities in accordance with sections 773(b)(2) (B) and (C) of the Act, and were at prices which would not permit recovery of all costs within a reasonable period of time in accordance with section 773(b)(2)(D) of the Act.

2. Constructed Value: In accordance with section 773(a)(4) of the Act, we used constructed value ("CV") as the basis for NV when there were no above-cost contemporaneous sales of such or similar merchandise in the comparison market. We calculated CV in accordance with section 773(e) of the Act. We included SeAH's cost of materials and fabrication (including packing), SG&A expenses, and profit. See section 773(e)(2)(A) of the Act. We applied the same conversion factor methodology as noted in the COP section above. In accordance with section 773(e)(2)(A) of the Act, we based SG&A expenses and profit on the amounts incurred and realized by the respondent in connection with the production and sale of the foreign like product in the ordinary course of trade for consumption in the comparison market. For selling expenses, we used the weighted-average comparison market selling expenses.

C. Price-to-Price Comparison

Where appropriate, for comparison to CEP, we made adjustments to NV by deducting Korean inland freight,

brokerage, handling, and packing, in accordance with sections 773(a)(6)(A) and (B) of the Act, and by deducting direct selling expenses (credit expenses) in accordance with section 773(a)(6)(C)(iii) of the Act. We also made adjustments for differences in costs attributable to differences in physical characteristics of merchandise, pursuant to section 773(a)(6)(C)(ii) of the Act.

In accordance with section 773(a)(1)(B) of the Act, to the extent practicable, we determine NV based on sales in the comparison market at the same level of trade ("LOT") as the U.S. sales. The NV LOT is that of the starting-price sales in the comparison market or, when NV is based on CV, that of the sales from which we derive SG&A expenses and profit. For both EP and CEP, the relevant transaction for the level of trade analysis is the sale (or constructed sale) from the exporter to the importer.

To determine whether comparison market NV sales are at a different LOT than EP or CEP, we examine stages in the marketing process and selling functions along the chain of distribution between the producer and unaffiliated customer. If the comparison-market sales are at a different LOT and the difference affects price comparability, as manifested in a pattern of consistent price differences between the sales on which NV is based and comparison-market sales at the LOT of the export transaction, we make a LOT adjustment under section 773(a)(7)(A) of the Act. Finally, if the NV level is more remote from the factory than the CEP level and there is no basis for determining whether the difference in the levels between NV and CEP affects price comparability, we adjust NV under section 773(a)(7)(B) of the Act (the CEP-offset provision). See *Notice of Final Determination of Sales at Less Than Fair Value: Certain Cut-to-Length Carbon Steel Plate from South Africa*, 62 FR 61731, 61732 (November 17, 1997), and *Granular Polytetrafluoroethylene Resin From Italy: Preliminary Results of Antidumping Duty Administrative Review*, 63 FR 25826 (May 11, 1998).

SeAH asserted that its comparison market sales were at a different LOT than its U.S. sales because the comparison market sales are at a more advanced level of distribution than its sales to State, and because SeAH performed and incurred all expenses for all significant selling functions and support services for the comparison market sales, but did not perform them for its CEP sales made through PPA and State. SeAH requested a CEP offset to

reflect these differences (*see, e.g.*, pages 19–21 of SeAH's November 12, 1997, Section B questionnaire response).

In its original questionnaire response, SeAH asserted that it performs many functions with respect to third country sales that it does not perform with respect to U.S. sales, such as: gathering strategic and marketing information including industry developments, potential new or refined applications, products and sales practices of customers and competitors, and technical and engineering developments; establishing pricing policies for OCTG sales based on market conditions in the third-country market; establishing sales promotional and marketing strategies, including advertising, promotional activities, and technical service for third-country market sales; and maintaining a skilled sales force that is knowledgeable about SeAH's OCTG products and the OCTG market in the third country market. Therefore, SeAH claims that it has distinguished different levels of trade for its Myanmar sales versus its sales to the U.S. importer of record, PPA, by highlighting ways in which SeAH is deeply involved with, and knowledgeable about, the Myanmar market.

However, the record indicates that SeAH has greatly overstated the extent and importance of its activities with respect to the Myanmar market. For example, at page 14 of its April 3, 1998 supplemental questionnaire response, SeAH indicated that it does not even know the identity or location of the customers of the Korean trading company to which it made its Myanmar sales. While SeAH clarified this point at page 40 of its June 4, 1998 supplemental questionnaire response by saying that several documents in the third country sales process indicate the destination and identity of the ultimate Myanmar customers, it also noted that it had no contact with those Myanmar customers, nor did it have any knowledge of the prices that the unaffiliated Korean trading company charged those Myanmar customers. SeAH's knowledge of the OCTG market is based on "customer contacts and other contacts in the industry" (*see* page 13 of the April 3, 1998 supplemental questionnaire response), and based on SeAH's own statements, such contacts with respect to Myanmar are very limited.

The record does not indicate more than a minimal involvement by SeAH in either the marketing process or the selling functions associated with its Myanmar and U.S. sales. There does not appear to be any substantive difference

between the functions performed by SeAH with respect to the sales to the Korean trading company destined for Myanmar and the functions performed by SeAH with respect to its sales to PPA, the affiliated U.S. importer of record. In both instances, SeAH made sales to resellers that in turn sold to end-users, and the record does not indicate any more than the most minimal interaction of SeAH with those resellers (the unaffiliated Korean trading company for the Myanmar sales, and PPA for the U.S. sales) with respect to the sales process. Consequently, we have preliminarily determined that the sales in both markets are at the same LOT. Therefore, a CEP offset is not warranted.

Preliminary Results of Reviews

As a result of our review, we preliminarily determine the weighted-average dumping margin for the period August 1, 1996 through July 31, 1997 to be as follows:

Manufacturer/exporter	Time period	Margin (percent)
SeAH	9/1/96–8/31/97	0.35

Pursuant to 19 CFR 351.224(b), the Department will disclose to parties to the proceeding any calculations performed in connection with these preliminary results within five days after the publication of this notice. Pursuant to 19 CFR 351.309, interested parties may submit written comments in response to these preliminary results. Case briefs must be submitted within 30 days after the date of publication of this notice, and rebuttal briefs, limited to arguments raised in case briefs, must be submitted no later than five days after the time limit for filing case briefs. Parties who submit argument in this proceeding are requested to submit with the argument: (1) A statement of the issue, and (2) a brief summary of the argument. Case and rebuttal briefs must be served on interested parties in accordance with 19 CFR 351.303(f). Also, pursuant to 19 CFR 351.310, within 30 days of the date of publication of this notice, interested parties may request a public hearing on arguments to be raised in the case and rebuttal briefs. Unless the Secretary specifies otherwise, the hearing, if requested, will be held two days after the date for submission of rebuttal briefs, that is, thirty-seven days after the date of publication of these preliminary results.

The Department will publish the final results of this administrative review, including the results of its analysis of

issues raised in any case or rebuttal brief or at a hearing, not later than 120 days after the date of publication of this notice.

The Department shall determine, and the U.S. Customs Service shall assess, antidumping duties on all appropriate entries. In accordance with 19 CFR 351.212(b), we have calculated exporter/importer-specific assessment rates. We divided the total dumping margins for the reviewed sales by the total entered value of those reviewed sales for each importer. We will direct the U.S. Customs Service to assess the resulting percentage margin against the entered customs values for the subject merchandise on each of that importer's entries under the relevant order during the review period.

Furthermore, the following deposit requirements will be effective for all shipments of the subject merchandise entered, or withdrawn from warehouse, for consumption on or after the publication date, as provided by section 751(a) of the Act: (1) The cash deposit rate for each reviewed company will be that established in the final results of review (except that a deposit of zero will be required for firms with zero or de minimis margins, i.e., margins less than 0.5 percent); (2) for exporters not covered in this review, but covered in the LTFV investigation or previous review, the cash deposit rate will continue to be the company-specific rate published for the most recent period; (3) if the exporter is not a firm covered in this review, a previous review, or the original LTFV investigation, but the manufacturer is, the cash deposit rate will be the rate established for the most recent period for the manufacturer of the merchandise; (4) the cash deposit rate for all other manufacturers or exporters will continue to be the "all others" rate established in the LTFV investigation, which was 12.17 percent. These requirements, when imposed, shall remain in effect until publication of the final results of the next administrative review.

This notice serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

These administrative reviews and notices are published in accordance with 751(a)(1) of the Act (19 U.S.C.

1675(a)(1)) and 19 CFR 351.213 and 19 CFR 351.221(b)(4).

Dated: August 31, 1998.

Joseph A. Spetrini,

Acting Assistant Secretary for Import Administration.

[FR Doc. 98-24068 Filed 9-4-98; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

International Trade Administration

[A-821-803]

Titanium Sponge from the Russian Federation: Preliminary Results of Antidumping Duty Administrative Review and Partial Revocation

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of preliminary results of antidumping duty administrative review and partial revocation.

SUMMARY: In response to requests from AVISMA Titanium-Magnesium Works; the affiliated companies Interlink Metals, Inc., and Interlink Metals & Chemicals, S.A.; TMC Trading International Ltd.; and Titanium Metals Corporation, the Department of Commerce is conducting an administrative review of the antidumping finding on titanium sponge from the Russian Federation. This notice of preliminary results covers the period August 1, 1996 through July 31, 1997. This review covers one manufacturer/exporter, AVISMA Titanium-Magnesium Works, and two trading companies, TMC Trading International Ltd. and, collectively as one company, Interlink Metals, Inc., and Interlink Metals & Chemicals, S.A.

We have preliminarily determined that no dumping margins apply during this review period. If these preliminary results are adopted in our final results of administrative review, we will instruct the U.S. Customs Service to liquidate entries during the period of review without regard to dumping duties. Furthermore, if these preliminary results are adopted in our final results of review, this will be the Interlink entities' third consecutive review with no dumping margins. Therefore, in the final results we will revoke this finding with respect to Interlink. Interested parties are invited to comment on these preliminary results. Parties who submit arguments in this proceeding are requested to submit with the argument: (1) A statement of the issue; and (2) a brief summary of the argument.

EFFECTIVE DATE: September 8, 1998.

FOR FURTHER INFORMATION CONTACT:

Wendy Frankel or Mark Manning, Office of AD/CVD Enforcement, Office 4, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, D.C. 20230; telephone (202) 482-5849 and 482-3936, respectively.

SUPPLEMENTARY INFORMATION:

The Applicable Statute

Unless otherwise indicated, all citations to the Tariff Act of 1930, as amended (the Act), are references to the provisions effective January 1, 1995, the effective date of the amendments made to the Act by the Uruguay Round Agreements Act. In addition, unless otherwise indicated, all citations to the Department of Commerce's regulations refer to the regulations codified at 19 CFR part 351, 62 FR 27296 (May 19, 1997).

Background

The Department of Commerce (the Department) published an antidumping finding on titanium sponge from the Union of Soviet Socialist Republics (U.S.S.R.) on August 28, 1968 (33 FR 12138). In December 1991, the U.S.S.R. divided into fifteen independent states. To conform to these changes, the Department changed the original antidumping finding into fifteen findings applicable to each of the former republics of the U.S.S.R. (57 FR 36070, August 12, 1992).

On August 26, 1997, AVISMA Titanium-Magnesium Works (AVISMA) and Interlink Metals & Chemicals, S.A. and Interlink Metals, Inc. (collectively Interlink) requested that the Department conduct an administrative review of the antidumping finding on titanium sponge from the Russian Federation (Russia) for one manufacturer/exporter, AVISMA, and one trading company, Interlink, covering the period August 1, 1996 through July 31, 1997. On August 27, 1997, Titanium Metals Corporation (TIMET) requested that the Department conduct an administrative review for the trading companies, Interlink and TMC Trading International, Ltd. (TMC). On August 28, 1997, TMC requested that the Department conduct an administrative review of its U.S. sales. The Department published a notice of initiation of the review on September 25, 1997 (62 FR 50292). Due to the complexity of the legal and methodological issues presented by this review, the Department postponed the date of the preliminary results of review

by sixty days on February 10, 1998 (63 FR 6721). The Department published a second sixty day postponement of preliminary results of review on April 16, 1998 (63 FR 18885). The Department is conducting this administrative review in accordance with section 751 of the Act.

On August 13, 1998, the International Trade Commission (ITC) published in the **Federal Register** its determination that revocation of the findings covering titanium sponge imports from the Republic of Kazakhstan (Kazakhstan), Russia, and Ukraine and the antidumping duty order covering imports of titanium sponge from Japan is not likely to lead to continuation or recurrence of material injury to an industry in the United States. Due to this determination the Department has revoked the findings covering titanium sponge imports from Kazakhstan, Russia, and Ukraine and the antidumping duty order covering titanium sponge imports from Japan. This revocation is effective as of August 13, 1998. See *Notice of Revocation of Antidumping Findings and Antidumping Duty Order and Termination of Five-Year ("Sunset") Reviews: Titanium Sponge from Kazakhstan, Russia, Ukraine, and Japan*, (63 FR 46215, August 31, 1998).

Scope of the Review

The product covered by this administrative review is titanium sponge from Russia. Titanium sponge is chiefly used for aerospace vehicles, specifically, in construction of compressor blades and wheels, stator blades, rotors, and other parts in aircraft gas turbine engines. Imports of titanium sponge are currently classifiable under the harmonized tariff schedule (HTS) subheading 8108.10.50.10. The HTS subheading is provided for convenience and U.S. Customs purposes. Our written description of the scope of this proceeding is dispositive.

Separate Rates

During the period of review (POR), AVISMA made direct sales of subject merchandise to the U.S. market that were entered for consumption. Due to these direct sales, AVISMA has requested a separate, company-specific rate. The claimed ownership of AVISMA during the POR is that of a publicly owned joint stock company, where 100 percent of the shares are owned by private individuals and private companies. AVISMA asserted that the state owned zero percent of its shares.

To establish whether a firm is sufficiently independent from

government control to be entitled to a separate rate, the Department analyzes each exporting entity under a test arising out of the *Final Determination of Sales at Less Than Fair Value: Sparklers from the People's Republic of China*, 56 FR 20588 (May 6, 1991) and amplified in the *Final Determination of Sales at Less Than Fair Value: Silicon Carbide from the People's Republic of China*, 59 FR 22585 (May 2, 1994). Under the separate rates criteria, the Department assigns separate rates in nonmarket economy cases only if a respondent can demonstrate the absence of both *de jure* and *de facto* government control over its export activities. Since the Department did not verify the information submitted by AVISMA to the record of this proceeding, we must rely upon the information provided by AVISMA in its questionnaire responses in order to determine whether there is an absence of either *de jure* or *de facto* governmental control.

1. Absence of De Jure Control

An individual company may be considered for a separate rate if it meets the following *de jure* criteria: (1) an absence of restrictive stipulations associated with an individual exporter's business and export licenses; (2) any legislative enactments decentralizing control of companies; (3) any other formal measures by the government decentralizing control of companies. AVISMA has placed on the administrative record a number of documents demonstrating absence of *de jure* control. These documents include laws, regulations, and provisions enacted by the government of Russia, describing the deregulation of Russian enterprises as well as the deregulation of the Russian export trade. Specifically, these documents include the President of the Russian Federation's Decree Number 721, that states "a joint stock company from the moment of its registration is out of the control of Ministries, State and Local administrative organs and authorities." In addition, AVISMA has placed on the record Article 49 of the Russian Federation's Civil Code, which states "Commercial organizations * * * can have civil rights and civil obligation necessary for any kind of activities, not prohibited by the regulation." "Commercial organization" is defined to be an organization, whose activities are aimed at gaining profit (Russian Federation Civil Code Article 50). See AVISMA's questionnaire response dated November 26, 1997. Furthermore, AVISMA claims that there are no licenses issued by any government agency to AVISMA with regard to any

aspect of AVISMA's production or sales activity. Based on this information, we have concluded that there was a *de jure* absence of governmental control over AVISMA.

2. Absence of De Facto Control

The Department typically considers four factors in evaluating whether each respondent is subject to *de facto* government control of its export functions: (1) whether the export prices are set by or subject to the approval of a governmental authority; (2) whether the respondent has authority to negotiate and sign contracts and other agreements; (3) whether the respondent has autonomy from the government in making decisions regarding the selection of management; and (4) it retains the proceeds of its export sales and makes independent decisions regarding disposition of profits or financing of losses.

In its questionnaire responses, AVISMA asserted the following: (1) it establishes its own export price; (2) it negotiates contracts without guidance from any governmental entities or organizations; (3) it selects its own management; and (4) it retains the proceeds of its export sales, uses profits according to its business needs, and has no restrictions on the use of its retained foreign currency earnings. In support of its claim that it is free of *de facto* government control, AVISMA provided sample documents to one of its direct sales to the United States. These documents include the sales contract, currency control passport, commercial invoice, quality control shipping document, and customs declaration. In addition, AVISMA provided its audited financial statements from the two most recent fiscal years (1995 and 1996) as well as the income statements for the first and second quarters of 1997. This information supports a finding that, during the POR, there was a *de facto* absence of governmental control of export functions. Therefore, we have concluded that AVISMA is entitled to a separate rate.

The Russia-Wide Rate

In past reviews of this finding, the Department has examined several export companies not included in the instant review. One of these exporters, Cometals Inc., had shipments that were reviewed and received a positive margin. See *Titanium Sponge From the Russian Federation; Notice of Final Results of Antidumping Duty Administrative Review*, 62 FR 48601 (September 16, 1997) (*Titanium Sponge 1996*). Therefore, we conclude that not all exporters of titanium sponge from

Russia are included in the instant review. Accordingly, we are applying a single antidumping deposit rate—the Russia-wide rate—to all manufacturers/exporters of titanium sponge from the Russian Federation that have not received a company-specific rate in the current or prior administrative reviews.

Intent To Revoke

On August 26, 1997, Interlink submitted a request, in accordance with Section 351.222(b), that the Department revoke the finding covering titanium sponge from the Russian Federation with respect to its sales of this merchandise. In accordance with Section 351.222(b)(iii), Interlink submitted on December 10, 1997, a certification that it had not sold the subject merchandise at less than normal value for a three-year period, including this review period, and would not do so in the future.

We preliminarily determine that Interlink sold titanium sponge from Russia at not less than normal value during this review period. Based on Interlink's three consecutive years of zero margins and the absence of evidence to the contrary, we preliminarily determine that it is not likely that Interlink will in the future sell titanium sponge at less than normal value. Therefore, if these preliminary findings are affirmed in our final results, we intend to revoke the order on titanium sponge from Russia with respect to Interlink.

In the last two administrative reviews, we determined that Interlink did not sell titanium sponge at less than fair value. See *Titanium Sponge 1996* and *Titanium Sponge From the Russian Federation; Notice of Final Results of Antidumping Duty Administrative Review*, 61 FR 58525 (November 15, 1996). Additionally, as discussed below, we have preliminarily determined that Interlink has not sold titanium sponge at less than fair value during the period covered by this review. Consequently, we preliminarily determine that because Interlink has three consecutive years of zero or *de minimis* margins on titanium sponge, Interlink is eligible for revocation of the finding on titanium sponge from Russia under Section 351.222(b).

United States Price

AVISMA

We calculated U.S. price (USP) for AVISMA's sales to unaffiliated purchasers in the United States based on export price (EP), as defined in section 772(a) of the Act. For the date of sale, we used the sales invoice date.

We made deductions, where appropriate, for inland freight, brokerage and handling, international freight, marine insurance, and Russian export charges. AVISMA did not claim any other adjustments to USP, nor were any other adjustments allowed.

Interlink and TMC

For purposes of this review, we assigned a separate rate for Interlink and TMC (which are located in market-economy countries) because AVISMA, at the time of sale to these entities, did not have knowledge of the ultimate destination of the merchandise. We calculated USP for TMC based on EP. Interlink reported that its U.S. sales were EP sales that were made to unaffiliated U.S. customers prior to importation and customarily did not enter into the inventory of Interlink Metals & Chemicals S.A.'s U.S. affiliate. When U.S. sales are made in this manner, our practice is to examine several criteria in order to determine whether the sales are EP sales. Those criteria are: (1) Whether the merchandise was shipped directly from the manufacturer to the unaffiliated U.S. customer; (2) whether this was the customary commercial channel between the parties involved; and (3) whether the function of the U.S. selling agent was limited to that of a "processor of sales-related documentation" and a "communications link" with the unaffiliated U.S. buyer. Where all three criteria are met, indicating that the activities of the U.S. selling agent are ancillary to the sale, the Department has regarded the routine selling functions of the exporter as merely having been relocated geographically from the country of exportation to the United States where the sales agent performs them, and has determined the sales to be EP sales. Where one or more of these conditions is not met, indicating that the U.S. sales agent is substantially involved in the U.S. sales process, the Department has classified the sales in question as constructed export price (CEP) sales. See, e.g., *Certain Cold-Rolled and Corrosion-Resistant Carbon Steel Flat Products From Korea: Final Results of Antidumping Duty Administrative Reviews*, 63 FR 13,170 (March 18, 1998) and *Viscose Rayon Staple Fiber from Finland: Final Results of Antidumping Duty Administrative Review*, 63 FR 32,820 (June 16, 1998). The record shows that during the POR Interlink Metals, Inc., Interlink's U.S. operation, was responsible for the sale of titanium sponge to customers and that sales activities were generally performed in the United States. Thus, we have preliminarily determined that

Interlink Metals, Inc. acted as more than a "processor of sales-related documentation" and a "communications link" with the unaffiliated U.S. buyer. Therefore, we based USP on CEP, as defined in section 772(b) of the Act. For date of sale, we used the sales invoice date for both TMC and Interlink. We excluded those sales made to the United States which the respondents identified as having entered the United States under temporary importation bond (TIB). We are currently confirming the information provided by respondents regarding TIB entries through Customs and National Census Bureau data.

In calculating USP for TMC and Interlink, we made deductions, where appropriate, for ocean freight, warehouse expenses, insurance, brokerage and handling, inland freight, and U.S. duty and terminal handling charges. Additionally, in accordance with section 772 (d) of the Act and the Department's practice in non-market economy (NME) cases involving CEP sales, in calculating USP for Interlink we made deductions for U.S. credit and indirect selling expenses and the profit allocated to these U.S. expenses (see *Notice of Final Determination of Sales at Less Than Fair Value: Bicycles From the People's Republic of China* 61 FR 19026 (April 30, 1996)). TMC and Interlink did not claim any other adjustments to USP, nor were any other adjustments allowed.

Surrogate Country Selection

Section 773(c)(1) of the Act provides that the Department shall determine normal value on the basis of the value of the factors of production if (1) the subject merchandise is exported from a NME country, and (2) the available information does not permit the calculation of normal value under section 773(a) of the Act. In previous proceedings, the Department has considered Russia to be a NME country. See *Final Determination of Sales at Less Than Fair Value: Pure Magnesium and Alloy Magnesium from the Russian Federation (Magnesium From Russia)*, 60 FR 16440 (March 30, 1995); and *Final Determination of Sales at Less Than Fair Value: Ferrovandium and Nitrided Vanadium from the Russian Federation*, 60 FR 27957 (May 26, 1995). Section 771(18)(C) of the Act states that "any determination that a foreign country is a nonmarket economy country shall remain in effect until revoked by the administering authority." Because NME status has not been revoked in any previous proceeding for Russia, we are considering Russia to be a NME country

for purposes of this review. Therefore, because AVISMA is located in Russia, we have applied surrogate values to the factors of production to determine normal value.

We calculated normal value based on factors of production provided by AVISMA, in accordance with Section 773(c)(1) of the Act and section 351.408 of the Department's regulations. We determined that Venezuela is comparable to Russia in terms of per capita gross national product (GNP), the growth rate in per capita GNP, and the national distribution of labor. In addition, Venezuela is a significant producer of comparable merchandise. See Memorandum to the File, *Titanium Sponge from the Russian Federation; Surrogate Country Selection*, dated July 2, 1997. Therefore, in accordance with section 773(c)(4) of the Act, we selected Venezuela as a comparable surrogate on the basis of the above criteria and have used publicly available information relating to Venezuela to value the various factors of production, except as indicated below. See Memorandum from Jeff May, Acting Director, Office of Policy, to Holly A. Kuga, Senior Director, Office of AD/CVD Enforcement, October 20, 1997, and Memorandum from Jeff May, Acting Director, Office of Policy, to Holly A. Kuga, Senior Director, Office of AD/CVD Enforcement, January 27, 1998.

Normal Value

To determine normal value, in accordance with section 773(c)(3) of the Act, we valued the factors of production as follows (for further discussion, see the Analysis Memorandum for the Preliminary Results of Administrative Review, dated August 31, 1998):

- Except as noted below, we valued raw materials and by-products using the Venezuelan import data obtained by Interlink from the Commodity Trade Statistics Section, United Nations Statistics Division, (UN import statistics) for the calendar year 1996. We adjusted certain factor values to reflect the actual purity used in the production of the subject merchandise. We valued chlorine using the average of the calendar 1996 and 1997 price quotes that respondents obtained from a Venezuelan chlorine producer. We were unable to find publicly available information from Venezuela or from any of the other potential surrogate countries in order to value ilmenite, rutile concentrate and carnallite concentrate. For ilmenite, we used the 1995 Brazilian price that was reported in the 1995-1996 administrative review of this finding. We valued rutile concentrate using the 1997 Australian

price provided by Interlink. For carnallite concentrate, we used the Indian price for dolomite, a commodity similar to carnallite concentrate, that was reported in the antidumping duty investigation of magnesium from Russia (see *Notice of Final Determination of Sales at Less Than Fair Value: Pure Magnesium and Alloy Magnesium From the Russian Federation* 60 FR 16440, 16449 (March 30, 1995)) (*Magnesium From Russia*) and used to value carnallite concentrate in the 1995–1996 administrative review of this finding. Since we obtained values for ilmenite and carnallite concentrate that are in U.S. dollars, we did not adjust for the effects of inflation.

- Pursuant to Section 351.408(c)(3), we valued direct labor by using the regression-based wage rate for Russia as posted on the Import Administration Internet website.

- For electricity, we used the simple average of the 1996 and 1997 electricity rates for industrial users in Guayana, Venezuela, as reported by the Venezuelan Chamber of the Electric Industry. To value natural gas, we used the 1996 price of gas in Venezuela as reported by the International Energy Agency's (IEA's) publication *Energy Prices and Taxes, 4th Quarter 1997*. Since this price was reported in U.S. dollars per tonne of oil equivalent, we converted the IEA price into a U.S. dollar per metric ton measure. AVISMA reported its consumption of natural gas

in tons of reference fuel. Using the conversion rate in the calculation memorandum in *Magnesium From Russia*, we converted AVISMA's natural gas consumption into a metric ton measure.

- To value railcar freight in Russia, we used the Venezuelan rates obtained by the petitioner from the national Venezuelan railway authority. This rate is on a per kilometer, per ton basis. We were unable to find truck rates from Venezuela or from any of the other potential surrogate countries. Therefore, we used the Brazilian trucking rates, provided by Interlink, that were used in the 1995–1996 administrative review of this finding.

- For packing materials, we used the 1996 UN import statistics from Venezuela provided by Interlink. We valued labor used in packing with the above-referenced regression-based labor rate for Russia.

- We valued selling, general and administrative expenses and profit using the 1997 income statement for CVG Industria Venezolana De Aluminio C.A., a major aluminum producer in Venezuela.

- We were unable to find information on factory overhead for an appropriate company or industry from Venezuela or from any other potential surrogate country. Therefore, as in the 1995–1996 administrative review of this finding, we valued factory overhead using cost data reported in the public record of the

antidumping administrative review of silicon metal from Brazil. In the instant review, we relied on public cost data in the 1996–1997 antidumping administrative review of silicon metal from Brazil.

- We included in normal value, where appropriate, movement expenses incurred in bringing the subject merchandise from the Russian plant to the resellers' warehouses. We valued railcar freight in Russia using the Venezuelan rates obtained by the petitioner from the national Venezuelan railway authority. We valued railcar freight and brokerage in Finland using the prices AVISMA reported in the public version of the section C response that it submitted in the instant review. We valued the Russian customs fee, paid by AVISMA on its exports of subject merchandise, using the Venezuelan exportation fee as reported by the Department's commercial service personnel in Caracas, Venezuela.

Currency Conversion

We made currency conversions in accordance with section 773A(a) of the Act, based on rates certified by the Federal Reserve Bank and Dow Jones Business Information Services.

Preliminary Results

As a result of this review, we preliminarily determine that the following weighted-average dumping margins exist:

Manufacturer/exporter	Period	Margin (percent)
Interlink Metals & Chemicals, S.A	8/1/96–7/31/97	0.00
TMC Trading International, Ltd	8/1/96–7/31/97	0.00
AVISMA Titanium-Magnesium Works	8/1/96–7/31/97	0.00
Russia-wide rate	8/1/96–7/31/97	83.96

Parties to this proceeding may request disclosure of our preliminary results within five days of publication of this notice and any interested party may request a hearing within 30 days of publication. Any hearing, if requested, will be held 44 days after the date of publication, or the first working day thereafter. Interested parties may submit case briefs and/or written comments no later than 30 days after the date of publication. Rebuttal briefs and rebuttals to written comments, limited to issues raised in such briefs or comments, may be filed no later than 35 days after the date of publication. The Department will publish a notice of the final results of the administrative review, which will include the results of its analysis of issues raised in any such written comments or at the hearing,

within 120 days from the publication of the preliminary results.

The final results of this review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the determination. The Department shall determine, and Customs shall assess, antidumping duties on all appropriate entries. Individual differences between export price and normal value may vary from the percentages stated above. The Department will issue appraisal instructions directly to Customs.

This notice serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period.

Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

This administrative review and notice are in accordance with section 751(a)(1) of the Act (19 U.S.C. 1675(a)(1)). This notice is published in accordance with section 777(i) of the Act.

Dated: August 31, 1998.

Joseph A. Spetrini,

Acting Assistant Secretary for Import Administration.

[FR Doc. 98–24070 Filed 9–4–98; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE**International Trade Administration**

[A-834-803]

Titanium Sponge from the Republic of Kazakhstan: Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of Preliminary Results of Antidumping Duty Administrative Review.

SUMMARY: In response to requests from Ust-Kamenogorsk Titanium and Magnesium Plant, Specialty Metals Company, and Oremet Titanium Inc., the Department of Commerce is conducting an administrative review of the antidumping finding on titanium sponge from the Republic of Kazakhstan. This notice of preliminary results covers the period August 1, 1996 through July 31, 1997. This review covers one manufacturer/exporter, Ust-Kamenogorsk Titanium and Magnesium Plant, and one trading company, Specialty Metals Company.

We have preliminarily determined that no dumping margins apply during this review period. If these preliminary results are adopted in our final results of administrative review, we will instruct the U.S. Customs Service to liquidate entries during the period of review (POR) without regard to dumping duties. Interested parties are invited to comment on these preliminary results. Parties who submit arguments in this proceeding are requested to submit with the argument: (1) a statement of the issue; and (2) a brief summary of the argument.

EFFECTIVE DATE: September 8, 1998.

FOR FURTHER INFORMATION CONTACT: Wendy Frankel or Mark Manning, Office of AD/CVD Enforcement, Office 4, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, D.C. 20230; telephone (202) 482-5849 and 482-3936, respectively.

SUPPLEMENTARY INFORMATION:**The Applicable Statute**

Unless otherwise indicated, all citations to the Tariff Act of 1930, as amended (the Act), are references to the provisions effective January 1, 1995, the effective date of the amendments made to the Act by the Uruguay Round Agreements Act. In addition, unless

otherwise indicated, all citations to the Department of Commerce's regulations refer to the regulations codified at 19 CFR part 351, 62 FR 27296 (May 19, 1997).

Background

The Department of Commerce (the Department) published an antidumping finding on titanium sponge from the Union of Soviet Socialist Republics (U.S.S.R.) on August 28, 1968 (33 FR 12138). In December 1991, the U.S.S.R. divided into fifteen independent states. To conform to these changes, the Department changed the original antidumping finding into fifteen findings applicable to each of the former republics of the U.S.S.R. (57 FR 36070, August 12, 1992).

On August 29, 1997, Ust-Kamenogorsk Titanium and Magnesium Plant (UKTMP), Specialty Metals Company (SMC), and Oremet Titanium Inc. (Oremet) requested that the Department conduct an administrative review of the antidumping finding on titanium sponge from the Republic of Kazakhstan (Kazakhstan) for one manufacturer/exporter, UKTMP, and one trading company, SMC, covering the period August 1, 1996 through July 31, 1997. The Department published a notice of initiation of the review on September 25, 1997 (62 FR 50292). Due to the complexity of the legal and methodological issues presented by this review, the Department postponed the date of the preliminary results of review by sixty days on February 10, 1998 (63 FR 6721). The Department published a second sixty day postponement of the preliminary results of review on April 16, 1998 (63 FR 18885). The Department is conducting this administrative review in accordance with section 751 of the Act.

On August 13, 1998, the International Trade Commission (ITC) published in the **Federal Register** its determination that revocation of the findings covering titanium sponge imports from Kazakhstan, the Russian Federation (Russia), and Ukraine and the antidumping duty order covering imports of titanium sponge from Japan is not likely to lead to continuation or recurrence of material injury to an industry in the United States. Due to this determination the Department has revoked the findings covering titanium sponge imports from Kazakhstan, Russia, and Ukraine and the antidumping duty order covering titanium sponge imports from Japan. This revocation is effective as of August 13, 1998, the date of publication in the **Federal Register** of the ITC's determinations. See *Notice of*

Revocation of Antidumping Findings and Antidumping Duty Order and Termination of Five-Tear ("Sunset") Reviews: Titanium Sponge from Kazakhstan, Russia, Ukraine, and Japan, (63 FR 46215, August 31, 1998).

Scope of the Review

The product covered by this administrative review is titanium sponge from Kazakhstan. Titanium sponge is chiefly used for aerospace vehicles, specifically, in construction of compressor blades and wheels, stator blades, rotors, and other parts in aircraft gas turbine engines. Imports of titanium sponge are currently classifiable under the harmonized tariff schedule (HTS) subheading 8108.10.50.10. The HTS subheading is provided for convenience and U.S. Customs purposes. Our written description of the scope of this proceeding is dispositive.

United States Price (USP)**UKTMP and SMC**

SMC is located in a market-economy country. Since SMC owns 65 percent of UKTMP and manages the operations of UKTMP under a long-term management contract, we are considering both companies to constitute one entity and are calculating one rate that will apply to both SMC and UKTMP.

In calculating the USP for SMC, we used export price, as defined in section 772(a) of the Act. For date of sale, we used the sales invoice date because this is the date when the price and quantity are set. We excluded those sales made to the United States which the respondents identified as having entered the United States under temporary importation bond (TIB). At this time, because merchandise entered under a TIB is not entered for consumption, such merchandise is not subject to the antidumping finding. See *Titanium Metals Corp. v. The United States*, 901 F. Supp 362 (CIT 1995). Respondents provided information regarding TIB entries, and we are currently confirming this information through Customs and National Census Bureau data.

We calculated export price based on the price to unaffiliated purchasers in the United States. We made deductions, where appropriate, for ocean freight, insurance, brokerage and handling, and inland freight. SMC did not claim any other adjustments to USP, nor were any other adjustments allowed.

Surrogate Country Selection

Section 773(c)(1) of the Act provides that the Department shall determine normal value on the basis of the value

of the factors of production if (1) the subject merchandise is exported from a non-market economy (NME) country, and (2) the available information does not permit the calculation of normal value under section 773(a) of the Act. Section 771(18)(C) of the Act states that "any determination that a foreign country is a nonmarket economy country shall remain in effect until revoked by the administering authority." Because NME status has not been revoked for Kazakhstan in any previous proceedings, we are considering Kazakhstan to be a NME country for purposes of this review. Therefore, because UKTMP is located in Kazakhstan, we have applied surrogate values to the factors of production to determine normal value.

We calculated normal value based on factors of production provided by UKTMP, in accordance with section 773(c)(1) of the Act and section 351.408 of the Department's regulations. We determined that Indonesia is comparable to Kazakhstan in terms of per capita gross national product (GNP), the growth rate in per capita GNP, and the national distribution of labor. In addition, Indonesia is a significant producer of comparable merchandise. Therefore, in accordance with section 773(c)(4) of the Act, we selected Indonesia as a comparable surrogate on the basis of the above criteria and have used publicly available information relating to Indonesia to value the various factors of production, except as indicated below. See the Memorandum from Jeff May, Acting Director, Office of Policy, to Holly A. Kuga, Senior Director, Office of AD/CVD Enforcement, October 20, 1997, and the Memorandum from Jeff May, Acting Director, Office of Policy, to Holly A. Kuga, Senior Director, Office of AD/CVD Enforcement, June 15, 1998.

Normal Value

To determine normal value, in accordance with section 773(c)(3) of the Act, we valued the factors of production as follows (for further discussion, see the Analysis Memorandum for the Preliminary Results of Administrative Review, dated August 31, 1998):

- Except as noted below, we valued raw materials using Indonesian import data from the Commodity Trade Statistics Section, United Nations Statistics Division, (UN import statistics) for the calendar year 1996. We adjusted certain factor values to reflect the actual purity used in the production

of the subject merchandise. Since UKTMP purchased titanium slag from both market and non-market economy suppliers, consistent with the Department's practice, we valued this input with the market economy price, regardless of the supplier. The most recent Indonesian import statistics that we were able to find for chlorine and hydrochloric acid were Indonesia's 1993 import statistics, as reported in the United Nation's publication, *Commodity Trade Statistics, 1993*. Since the UN statistics are reported in U.S. dollars, we did not adjust for the effects of inflation. We were unable to find information from Indonesia or from any of the other potential surrogate countries in order to value carnallite and spent electrolyte. For carnallite, we used the Indian price for dolomite, a commodity similar to carnallite, that was reported in the antidumping duty investigation of magnesium from Russia (see *Notice of Final Determination of Sales at Less Than Fair Value: Pure Magnesium and Alloy Magnesium From the Russian Federation* 60 FR 16440, 16449 (March 30, 1995)) (*Magnesium From Russia*) and used to value carnallite concentrate in *Titanium Sponge From the Russian Federation; Notice of Final Results of Antidumping Duty Administrative Review* 62 FR 48601 (September 16, 1997) (also see *Titanium Sponge From the Russian Federation; Preliminary Results of Antidumping Duty Administrative Review* 62 FR 25920, 25922, (May 12, 1997)). In order to value spent electrolyte, we used the surrogate value for potassium chloride because spent electrolyte is 75 percent potassium chloride.

- Pursuant to section 351.408(c)(3) of the Department's regulations, we valued direct labor by using the regression-based wage rate for Kazakhstan as posted on the Import Administration Internet web site.

- For electricity, we used the "extra large industry user" rate from Indonesia's electricity tariff schedule that UKTMP would have received had it been an electricity consumer in Indonesia during the period of review (POR). This decision was based on finding that UKTMP's level of electricity usage during the POR was similar to the profile of "large industrial user" in *Magnesium From Russia* (page 16446). To confirm that UKTMP would have received this rate, we divided the average number of kilowatt hours used during each month of the POR by the

number of hours in a month, which demonstrated that UKTMP's kilowatt use was higher than the minimum necessary to receive the "extra large industrial user" rate in effect in Indonesia. Since the Indonesia rate was for 1994, and expressed in rupiahs, we adjusted this rate in order to account for the effects of inflation.

- We were unable to obtain recent publicly available information for Indonesian truck and railway rates. Therefore, we used the truck and railway rates as reported by the U.S. Embassy in Jakarta, Indonesia and transmitted to the Department in September 1991 via cable (Jakarta 12078). This information was obtained for the antidumping duty investigation of *Certain Butt-Weld Pipe Fittings from the PRC*. Since these 1991 rates were reported in rupiahs per metric ton per kilometer, we inflated them to take into account the effects of inflation.

- In regard to packing materials, we used the 1996 UN import statistics from Indonesia that were provided by the petitioner for polyethylene film and argon. We valued sheet steel by using Indonesia's 1994 import statistics, as reported in the United Nation's publication, *Commodity Trade Statistics, 1994*. Since the UN data is reported in U.S. dollars, we did not adjust for the effects of inflation. We valued labor used in packing with the above-referenced regression-based labor rate for Kazakhstan.

- For factory overhead, selling, general and administrative (SG&A) expense, and profit, we used information from the calendar 1996 income statement of a Philippine producer of various aluminum products. The Philippines, although not the primary surrogate country in this review, is one of the countries that the Department has identified as a comparable market economy country and a potential surrogate for Kazakhstan.

Currency Conversion

We made currency conversions in accordance with section 773A(a) of the Act, based on rates certified by the Federal Reserve Bank and Dow Jones Business Information Services.

Preliminary Results

As a result of this review, we preliminarily determine that the following weighted-average dumping margins exist:

Manufacturer/exporter	Period	Margin (percent)
Specialty Metals Company/Ust-Kamenogorsk Titanium and Magnesium Plant (one entity)	8/1/96-7/31/97	0.00
Kazakhstan-wide rate	8/1/96-7/31/97	83.96

Parties to this proceeding may request disclosure of our preliminary results of review within five days of publication of this notice and any interested party may request a hearing within 30 days of publication. Any hearing, if requested, will be held 44 days after the date of publication, or the first working day thereafter. Interested parties may submit case briefs and/or written comments no later than 30 days after the date of publication. Rebuttal briefs and rebuttals to written comments, limited to issues raised in such briefs or comments, may be filed no later than 35 days after the date of publication. The Department will publish a notice of the final results of the administrative review, which will include the results of its analysis of issues raised in any such written comments or at the hearing, within 120 days from the publication of the preliminary results.

The final results of this review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the determination. The Department shall determine, and Customs shall assess, antidumping duties on all appropriate entries. Individual differences between export price and normal value may vary from the percentages stated above. The Department will issue appraisal instructions directly to Customs.

This notice serves as a preliminary reminder to importers of their responsibility under section 351.402(f) of the Department's regulations to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

This administrative review and notice are in accordance with section 751(a)(1) of the Act (19 U.S.C. 1675(a)(1)). This notice is published in accordance with section 777(i) of the Act.

Dated: August 31, 1998.

Joseph A. Spetrini,

Acting Assistant Secretary for Import Administration.

[FR Doc. 98-24071 Filed 9-4-98; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

Minority Business Development Agency

[Docket No. 980901228-8228-01]

RIN: 0640-ZA04

Solicitation of Applications for the Minority Business Opportunity Committee (MBOC) Program

AGENCY: Minority Business Development Agency, Commerce.

ACTION: Notice.

SUMMARY: In accordance with Executive Order 11625 and 15 U.S.C. 1512, the Minority Business Development Agency (MBDA) is soliciting competitive applications from organizations seeking to operate Minority Business Opportunity Committees (MBOCs). All information required to submit a cooperative agreement application by eligible applicants is contained in this announcement and in the Competitive Application Package (CAP).

The MBDA provides business development services to minority entrepreneurs through different types of programs. Each program is designed to focus on the unique business problems of a specific market. MBDA's programs from a national business delivery network that addresses needs of minority entrepreneurs throughout the United States. The MBOC program is designed to provide minority business owners with enhanced access to the marketplace by identifying marketing and sales opportunities, financing resources, potential joint venture partners, and otherwise assisting minority firms to position themselves for long-term growth. State or local government entities, American Indian Tribes, colleges, universities, and/or non-profit organizations are eligible to operate MBOCs. For-profit organizations are not eligible to operate MBOCs.

DATES: Complete applications for the MBOC program must be: (1) Mailed (USPS postmark) by October 8, 1998 to the address below; or (2) received by MBDA at the address below no later than 5 p.m. Eastern Daylight Time. Applications postmarked later than the closing date or received after the closing date will not be considered. Anticipated time for processing of applications is 90 days. MBDA anticipates that awards

will be made with start dates of January 1, 1999.

ADDRESSES: Applicants must submit one signed original plus two (2) copies of the application, including all information required by the CAP. Completed application packages must be submitted to: Minority Business Opportunity Committee Program Manager, Office of Executive Secretariat, HCHB, Room 5073, Minority Business Development Agency, U.S. Department of Commerce, 1401 Constitution Avenue, NW, Washington, DC 20230.

If the application is hand-delivered by the applicant or its representative, it must be delivered to Room 1874, which is located at Entrance #10, 15th Street, NW, between Pennsylvania and Constitution Avenues. Unsigned applications will be considered non-responsive and will be returned to the applicant. Failure to submit other required information may result in points being deducted from an applicant's score.

FOR FURTHER INFORMATION CONTACT:

For further information and a Competitive Application Package contact Stephen Boykin, the MBOC Program Manager, at (202) 482-1712.

SUPPLEMENTARY INFORMATION:

Authority: Executive Order 11625 and 15 U.S.C. 1512.

Catalogue of Federal Domestic Assistance (CFDA): 11.803, Minority Business Opportunity Committees.

Program Description: The MBDA has established the MBOC Program as a vehicle for providing timely market leads, access to resources, and current business information to minority businesses seeking to market effectively their products and services within the local economy. In accomplishing this purpose, MBOCs help to bring regional coordination and synergy to the minority business development efforts taking place within an applicant-defined geographical service area.

MBOCs are comprised of local or regional governments, business and industry leaders, as well as representatives of organizations that conduct substantial purchasing within the regional economy. These organizations may include large corporations located or having regional headquarters within the region, government agencies at the Federal, State, and local levels, banking and

financial institutions, chambers of commerce, community development organizations, training organizations, trade associations, economic development groups, quasi-public entities such as transit authorities, ports, stadium authorities, and public utilities, and non-profit entities such as hospitals, colleges, and universities. Industries represented on the MBOC should include, where appropriate, transportation, construction, travel and tourism, high technology, health care, telecommunications, manufacturing, retailing, and any other sector of the local economy which generates, or has the potential to generate, sales, and business ownership opportunities for minority entrepreneurs. The participation on the MBOC of a broad cross-section of government and industry executives helps to ensure that minority businesses have access to a breadth of information concerning available market opportunities. The purpose of the MBOC Program is to promote the full inclusion of the minority business sector in the overall economy.

Applicants should first include a description in their proposals showing how they intend to establish a detailed organizational and functional framework for the management and operation of the MBOC. The applicant must demonstrate how the operational structure of the MBOC will function and be financed. For example, the applicant should indicate how a program will be developed to recruit members from Federal, state, local and private sector organizations, and how the applicant intends to operate the MBOC in terms of meetings and the establishment of subcommittees or task forces. In addition, the selection of key personnel, such as a chairperson and executive director to manage the MBOC on a day-to-day basis, is important. The applicant may also indicate how it intends to encourage member organizations to enter into goals for the utilization of minority business enterprises and to track performance in meeting those goals.

In designing its MBOC proposal, the applicant must note that there are six core areas in which activities must be conducted. MBOC encourages applicants to submit proposals that are "tailored" to their defined markets, and that display the imagination and innovation of the applicant in carrying out activities in the core areas to obtain the maximum business development impact for minority firms. While examples of activities that might be conducted under each of the core areas are mentioned, applicants are

encouraged to submit innovative proposals setting forth the activities which the applicant plans to conduct under the core areas.

(1) Access to Markets—MBOCs should promote relationship-building and the sharing of information between organizations in the applicant-defined geographical service area which conduct substantial purchasing activity, and minority businesses that provide the products or services sought by these organizations. MBOCs must make full use of the Agency's Phoenix and Opportunity databases (OMB No. 0640-002) by requiring participating businesses to enter the requisite information into the systems. The MBOCs will serve as a clearinghouse both for minority companies seeking timely market leads for available contract opportunities, and for mainstream institutions seeking to identify particular categories of minority suppliers. Activities in this core area may include facilitating contract awards to minority businesses by collecting and disseminating information to the minority business community concerning available market opportunities, and engaging in matchmaking between corporate and governmental purchasers and minority-owned suppliers.

(2) Access to Capital—MBOCs should work to create an environment within the finance and investment community that fairly values the business assets of minority-owned companies. Whether these assets are in the form of property, plants or equipment located in minority communities, a workforce which consists largely of minority employees, or the character and credit-worthiness of an individual minority business owner, the MBOC should help to ensure that the capital markets evaluate these assets objectively, and provide minority companies with access to capital on a nondiscriminatory basis. In addition to helping to ensure the availability of debt financing sources such as commercial banks and government-sponsored loan and/or loan guaranty programs, MBOC activities should include assisting in the identification of sources of equity capital for minority firms, such as venture capital funds, institutional investors (insurance companies, pension funds, etc.), and high net-worth individuals.

(3) Sustained Advocacy on Behalf of the Minority Business Sector—MBOCs should play a clear and highly visible role in articulating the benefits to the economic region which are derived from the full participation of the minority business sector. MBOC leadership, including government officials, private

executives, and other designated representatives of the MBOC should conduct media outreach, disseminate economic data, and otherwise advocate for inclusion of minority businesses in the region's economic mainstream, including exporting. Activities in this area may include the establishment of a newsletter, conducting workshops, holding receptions, making media appearances, participating in Minority Enterprise Development Week activities, and ensuring that achievements of the MBOC are communicated regularly to the corporate community, elected officials, and trade and industry groups. MBOCs should sponsor workshops and seminars on topics that promote utilization of minority-owned companies within the regional economy. Such activities may be directed at minority businesses, for example, arranging and promoting workshops on marketing to corporate and institutional clients, or may be directed at the mainstream business community, such as workshops on structuring diversity programs for procurements, or both. Workshops, conferences, and seminars should be designed by the MBOC leadership based on those topics which best address the needs and opportunities present within that MBOC's particular service area. For instance, an MBOC might participate in or develop educational activities to promote export opportunities for minority businesses. In addition to being a consistent vehicle for the promotion to the mainstream business community of the economic benefits of a healthy minority business sector, the MBOC should develop recommendations for changing procurement, banking, or other practices which may impede the growth of minority firms.

(4) Business Ownership Opportunities—Lack of succession, corporate divestitures, and other fortuitous circumstances often create opportunities for entrepreneurs to acquire companies as going concerns. Key to identifying such opportunities is establishing relationships with corporate decisionmakers, banking executives, suppliers and others having first-hand knowledge of such companies' conditions. The MBOC should serve as a vehicle for bringing members of the minority and non-minority business communities together through the following activities: networking, subcommittee assignments, and other activities designed to promote the sharing of information. In addition, the MBOC should assist minority executives and managers within the

corporate sector who have an interest in leveraging their current expertise through business acquisitions.

(5) **Youth Entrepreneurship**—In light of the continuing low formation rate of minority business, MBOCs should direct some of their activities to promoting youth entrepreneurship. MBOCs should, wherever possible, sponsor activities designed to cultivate the entrepreneurial spirit in minority youth between the ages of 14 and 18, and to make them view business ownership as something realistically attainable.

(6) **Resource Development**—The MBOC should maintain a constant inventory of the various resource providers within the project's service area that offer services that can assist minority companies. Such resource providers may include banks and other financial institutions, bonding companies, business consultants, chambers of commerce and other networking groups, trade associations active in all viable local industries, state, local and private technical assistance providers, etc.

In accordance with OMB Circular A-110 and 15 CFR part 24, selected recipients must manage and monitor functions and activities supported by the financial award. Recipients will be required to use program performance measures in quarterly reports and to provide an end-of-year assessment of the accomplishments of the project using these measures. Criteria to measure MBOC program performance must include, but are not limited to, the following:

1. The establishment of the MBOC and holding regularly scheduled meetings;
2. The number of contracting opportunities disseminated;
3. The generating of actual procurement opportunities;
4. The number of procurement matches effected through the Phoenix-Opportunity databases;
5. The identifying of sources of financing, both debt and equity, for capital development;
6. The identifying of business acquisition opportunities;
7. The collecting and analyzing of data on MBOC members and participants to allow tracking of minority business activities;
8. The sponsoring or participating in events, workshops, conferences, and seminars, either directly or in partnership with other public and/or private sector organizations to promote minority business;
9. The promoting of youth entrepreneurship through a series of events, conferences or workshops;

10. The providing to minority businesses of information on the resources available to assist them.

Applicants should be mindful of these performance measures and should use them when estimating projected project results in their proposals. Applicants are also encouraged to develop and utilize additional performance measures they find meaningful to demonstrate the success of innovative techniques and methodologies. Finally, applicants must include a detailed workplan that delineates a schedule of proposed activities and milestones for implementing the tasks indicated above within the award.

Funding Availability: MBDA anticipates that approximately \$2.5 million will be available in FY 1999 for Federal assistance under this program. Applicants are hereby given notice that funds have not yet been appropriated for this program. In no event will MBDA or the Department of Commerce be responsible for proposal preparation costs if this program fails to receive funding or is canceled because of other agency priorities.

Financial assistance awards under this program may range from \$100,000 to \$250,000 in Federal funding per year based upon the size of the market and its need for MBDA resources as evidenced by applicant proposals. An applicant may request up to \$750,000 in total Federal support over a period of three years. Applicants must submit project plans and budgets for three years. The annual awards must have Scopes of Work that are clearly severable and can be easily separated in annual increments of meaningful work which represent solid accomplishments if prospective funding is not made available to the Applicant. Projects will be funded for no more than one year at a time. Funding for subsequent years will be at the sole discretion of the Department of Commerce (DoC) and will depend on satisfactory performance by the recipient and the availability of funds to support the continuation of the project.

Matching Requirements: Cost sharing of at least 30% is required. Additional cost sharing is encouraged. Cost sharing may be in the form of cash, third party in-kind contributions, non-cash applicant contributions or combinations thereof. There share may also be contributed by local, state, and private sector organizations. Some applicants may want to apply jointly for an award to operate an MBOC.

Type of Funding Instrument: Financial assistance awards in the form of cooperative agreements will be used to fund this program. MBDA's

substantial involvements with recipients will include performing the following duties to further the MBOC's objectives:

1. **Post-Award Conferences**
MBDA will conduct post-award conferences for all new MBOC awards in order that each MBOC have a clear understanding of the program and its objectives. The Agency will:
 - Provide an MBDA Director to the MBOC.
 - Orient MBOC staff.
 - Provide and explain program reporting requirements and procedures.
 - Identify available resources that may enhance the capabilities of the MBOC.
 - Provide detailed information about MBDA's Phoenix-Opportunity databases.
2. **Networking, Promoting and Information Exchanges**
MBDA will provide the following:
 - Access to the Phoenix-Opportunity databases.
 - Promote the exchange of new business opportunity information within the MBDA-funded system.
 - Help promote special events at the local, state and national levels in celebration of Minority Enterprise Development Week.
3. **Project Management**
 - Monitor the performance of the MBOC. This will include an onsite review, when deemed necessary and appropriate by the Regional Office, to verify MBOC performance. MBDA will then provide a report of the findings and recommendations for improvement, if appropriate.
 - Approve qualifications of key MBOC staff.

Eligibility Criteria: State or local government entities, American Indian Tribes, colleges, universities, and/or non-profit organizations are eligible to operate MBOCs. Experience has demonstrated that public and quasi-public entities such as these are best positioned within the local market to coordinate the voluntary participation of corporate and government officials which is so critical to an MBOC's success. For-profit organizations are not eligible to operate MBOCs.

Award Period: The total project award period is three (3) years. Funding will be provided annually at the discretion of MBDA and the Department of Commerce, and will depend upon satisfactory performance by the recipient and availability of funds to continue the project. Project proposals accepted for funding will not compete for funding in subsequent budget periods within the approved project award period. Publication of this notice

does not obligate the Department of Commerce or MBDA to award any specific cooperative agreement or to obligate all or any part of available funds.

Indirect Costs: The total dollar amount of the indirect costs proposed in an application under this program must not exceed the indirect cost rate negotiated and approved by a cognizant Federal agency prior to the proposed effective date of the award or 100 percent of the total proposed direct costs dollar amount in the application, whichever is less.

Application Forms and Package: Standard Forms 424, Application for Federal Assistance; 424A, Budget Information—Non-Construction Programs; and 424B, Assurances—Non-Construction Programs, (Rev. 4-92); and other Department of Commerce forms shall be used in applying for financial assistance. These forms may be obtained by contacting MBDA as described in the "CONTACT" section above. Applicants and recipients are subject to all requirements of the CAP.

Project Funding Priorities: MBDA is especially interested in receiving innovative proposals that focus on the following: (1) Identifying and working to eliminate barriers which reduce the access of minority businesses to markets and capital; (2) identifying and working to meet the special needs of minority businesses as they seek to enter the export marketing community; (3) promoting the understanding and use of Electronic Commerce by minority businesses.

Evaluation Criteria: Proposals will be evaluated based on the following criteria:

(1) **Applicant Capability (25%).** Considers, among other things, knowledge of economic region, i.e., minority business demographics and an assessment of the community's need, prior experience in the minority business community, and relationships (ties) with organizations from which members of the MBOC will be recruited. Includes an assessment of the number, qualifications, experience, and proposed roles of staff who will administer the MBOC program. Qualifications of the chairperson and executive officer of the MBOC are particularly important. Position descriptions should be included as part of the application.

(2) **Techniques and Methodologies (40%).** Includes the applicant's plan on how to carry out the MBOC work requirements relating to activities in the six core areas, the establishment and operation of the MBOC itself, and the applicant's proposed strategies for overcoming traditional barriers to the

success of minority businesses. The applicant must provide a detailed discussion relating its plan to the particular resources and business capabilities of its service area.

Applicants and recipients are subject to all requirements in the CAP.

(3) **Creativity and Innovation (15%).** Can include unique or novel approaches to solving the problems of minority businesses, the manner in which activities are customized to meet the special economic needs of the MBOC's service area, and creativity in the way the applicant proposes to bring together the diverse components which are necessary for the success of the MBOC.

(4) **Proposed Budget/Cost (20%).** Includes the reasonableness, allowability, and allocability of costs. Cost sharing proposed by the applicant is also important, particularly if the applicant proposes cost sharing in excess of 30%.

An application must receive at least a 70% average score of all four criteria to be considered programmatically acceptable and responsive.

Selection Procedures: Each application will receive an independent, objective review by a panel qualified to evaluate the applications submitted. The independent review panel, consisting of at least three individuals, will review all applications based on the criteria above. The independent review panel will evaluate and rank the proposals. The Director of MBDA makes the final recommendations to the Department of Commerce Grants Officer regarding the funding of applications, taking into account the following selection criteria:

(1) The evaluations and rankings of the independent review panel;

(2) The degree to which applications address MBDA priorities as established under the project funding priorities listed above;

(3) The availability of funding;

(4) The national geographic distribution of the proposed awards. MBDA anticipates placing at least two MBOCs in each of the Agency's five Regions; and

(5) The mixture of large and small economic regions/markets/cities.

The amount of funds awarded to each recipient, the scope of programmatic activities, and clarifications and/or correction of errors will be determined and/or conducted in preaward negotiations between the applicant, the Grants Officer, and the MBDA Program Officer.

Other Requirements

(1) **Purchase of American-Made Equipment and Products:** Applicants

are hereby notified that they are encouraged, to the greatest extent practicable, to purchase American-made equipment and products with funding provided under this program.

(2) **Paperwork Reduction Act:** This notice involves collections of information subject to the Paperwork Reduction Act, which have been approved by OMB under OMB control numbers 0348-0043, 0348-0044, 0348-0040, and 0348-0046. Notwithstanding any other provision of law, no person is required to respond to nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB control number.

(3) **Federal Policies and Procedures—**Recipients and subrecipients are subject to all Federal laws and Federal and DoC policies, regulations, and procedures applicable to Federal financial assistance awards.

(4) **Past Performance—**Unsatisfactory performance under prior Federal awards may result in an application not being considered for funding.

(5) **Preaward Activities—**If applicants incur any costs prior to an award being made, they do so solely at their own risk of not being reimbursed by the Government. Notwithstanding any verbal or written assurance that may have been received, there is no obligation on the part of DoC to cover preaward costs.

(6) **No Obligation for Future Funding—**If an application is selected for funding, DoC has no obligation to provide any additional future funding in connection with that award. Renewal of an award to increase funding or extend the period of performance is at the total discretion of DoC.

(7) **Delinquent Federal Debts—**No award of Federal funds shall be made to an applicant who has an outstanding delinquent Federal debt until either:

- i. The delinquent account is paid in full,
- ii. A negotiated repayment schedule is established and at least one payment is received, or
- iii. Other arrangements satisfactory to DoC are made.

(8) **Name Check Review.** All non-profit and for-profit applicants are subject to a name check review process. Name checks are intended to reveal if any key individuals associated with the applicant have been convicted of or are presently facing criminal charges such as fraud, theft, perjury, or other matters which significantly reflect on the applicant's management honesty or financial integrity.

(9) *Primary Applicant Certifications.* All primary applicants must submit a completed Form CD-511, "Certifications Regarding Debarment, Suspension and Other Responsibility Matters; Drug-Free Workplace Requirements and Lobbying," and the following explanations are hereby provided:

i. *Nonprocurement Debarment and Suspension.* Prospective participants (as defined at 15 CFR part 26, Section 105) are subject to 15 CFR part 26, "Nonprocurement Debarment and Suspension" and the related section of the certification form prescribed above applies;

ii. *Drug-Free Workplace.* Grantees (as defined at 15 CFR part 26, Section 605) are subject to 15 CFR part 26, subpart F, "Governmentwide Requirements for Drug-Free Workplace (Grants)" and the related section of the certification form prescribed above applies;

iii. *Anti-Lobbying.* Persons (as defined at 15 CFR part 28, Section 105) are subject to the lobbying provisions of 31 U.S.C. 1352, "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," and the lobbying section of the certification form prescribed above applies to applications/bids for grants, cooperative agreements, and contracts for more than \$100,000, and loans and loan guarantees for more than \$150,000, or the single family maximum mortgage limit for affected programs, whichever is greater; and

iv. *Anti-Lobbying Disclosures.* Any applicant that has paid or will pay for lobbying using any funds must submit an SF-LLL, "Disclosure of Lobbying Activities," as required under 15 CFR part 28, appendix B.

(10) *Lower Tier Certifications.* Recipients shall require applicants/bidders for subgrants, contracts, subcontracts, or other lower tier covered transactions at any tier under the award to submit, if applicable, a complete Form CD-512, "Certifications Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions and Lobbying" and disclosure form, SF-LLL, "Disclosure of Lobbying Activities." Form CD-512 is intended for the use of recipients and should not be transmitted to DoC. SF-LLL submitted by any tier recipient or subrecipient should be submitted to DoC in accordance with the instructions contained in the award document.

(11) *False Statements.* A false statement on an application is grounds for denial or termination of funds and grounds for possible punishment by a

fine or imprisonment as provided in 18 U.S.C. 1001.

(12) *Intergovernmental Review.* Applications under this program are not subject to Executive Order 12372, "Intergovernmental Review of Federal Programs."

(13) *Executive Order 12866.* It has been determined that this notice is not significant for purposes of Executive Order 12866.

Dated: September 2, 1998.

Courtland Cox,

Director, Minority Business Development Agency.

[FR Doc. 98-24030 Filed 9-4-98; 8:45 am]

BILLING CODE 3510-21-M

DEPARTMENT OF COMMERCE

National Telecommunications and Information Administration (NTIA)

Advisory Committee on Public Interest Obligations of Digital Television Broadcasters; Notice of Location of September Meeting

ACTION: Notice of location for the September 9 meeting.

REFERENCE: This notice updates the notice of postponement published in the **Federal Register** on August 6, 1998. Citation: 63 FR 42010.

SUMMARY: The President established the Advisory Committee on Public Interest Obligations of Digital Television Broadcasters (PIAC) to advise the Vice President on the public interest obligations of digital broadcasters. The Committee will study and recommend which public interest obligations should accompany broadcasters' receipt of digital television licenses. The President designated the National Telecommunications and Information Administration as secretariat for the Committee.

AUTHORITY: Executive Order 13038, signed by President Clinton on March 11, 1997.

DATES: The meeting will be held on Wednesday, September 9 from 8:30 a.m. to 5:30 p.m.

ADDRESSES: The meeting is scheduled to take place in the Farragut Room of the Admiralty Ballroom of the Hilton Crystal City Hotel at 2399 Jefferson Davis Highway, Arlington, VA 22202. The nearest Metro stop is Crystal City on the blue and yellow lines. Parking at hourly rates is available at the hotel. For further directions, please call the Hilton at 703-418-6800.

FOR FURTHER INFORMATION CONTACT: Karen Edwards, Designated Federal

Officer and Telecommunications Policy Specialist, at the National Telecommunications and Information Administration, U.S. Department of Commerce, Room 4720, 14th Street and Constitution Avenue, N.W., Washington, DC 20230. Telephone: 202-482-8056; Fax: 202-482-8058; E-mail: piac@ntia.doc.gov.

Media Inquiries: Please contact Karen Kirchgasser of NTIA's Office of Public Affairs at 202-482-7002.

AGENDA

Opening remarks
Committee deliberations
Public comment
Closing remarks

This agenda is subject to change. For an updated, more detailed agenda, please check the Advisory Committee homepage at www.ntia.doc.gov/pubintadvcom/pubint.htm.

Public Participation

The meeting will be open to the public, with limited seating available on a first-come, first-served basis. This meeting is physically accessible to people with disabilities. Any member of the public requiring special services, such as sign language interpretation or other ancillary aids, should contact Karen Edwards immediately at 202-482-8056 or at piac@ntia.doc.gov.

Members of the public may submit written comments concerning the Committee's affairs at any time before or after the meeting. The Secretariat's guidelines for public comment are described below and are available on the Advisory Committee homepage (www.ntia.doc.gov/pubintadvcom/pubint.htm) or by calling 202-482-8056.

Guidelines for Public Comment

The Advisory Committee on Public Interest Obligations of Digital Television Broadcasters welcomes public comments.

Oral Comment: In general, opportunities for oral comment will usually be limited to no more than five (5) minutes per speaker and no more than thirty (30) minutes total at each meeting.

Written Comment: Written comments must be submitted to the Advisory Committee Secretariat at the address listed below. Comments can be submitted either by letter addressed to the Committee (please place "Public Comment" on the bottom left of the envelope and submit at least thirty-five (35) copies) or by electronic mail to piac@ntia.doc.gov (please use "Public Comment" as the subject line). Written comments received within three (3)

workings days of a meeting and comments received shortly after a meeting will be compiled and sent as briefing material to Committee members prior to the next scheduled meeting.

Obtaining Meeting Minutes

Within thirty (30) days following the meeting, copies of the minutes of the meeting may be obtained over the Internet at www.ntia.doc.gov/pubintadvcom/pubint.htm, by phone request at 202-482-8056, by email request at piac@ntia.doc.gov or by written request to Karen Edwards; Advisory Committee on Public Interest Obligations of Digital Television Broadcasters; National Telecommunications and Information Administration; U.S. Department of Commerce, Room 4720; 14th Street and Constitution Avenue N.W., Washington, DC 20230.

Larry Irving,

Assistant Secretary for Communications and Information.

[FR Doc. 98-24123 Filed 9-4-98; 8:45 am]

BILLING CODE 3510-60-P

DEPARTMENT OF DEFENSE

Office of the Secretary

Submission for OMB Review; Comment Request

ACTION: Notice.

The Department of Defense has submitted to OMB for clearance, the following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

Title, Associated Form, and OMB Number: Nomination for Appointment to the United States Military Academy, Naval Academy, and Air Force Academy; DD Form 1870; OMB Number 0701-0026.

Type of Request: Reinstatement.
Number of Respondents: 15,425.
Responses Per Respondent: 1.
Annual Responses: 15,425.
Average Burden Per Response: 30 minutes.

Annual Burden Hours: 7,713.
Needs and Uses: The information collection requirement is necessary to receive nominations from all Members of Congress, the Vice President, Delegates to Congress, and the Governor and Resident Commissioner of Puerto Rico annually to each of the three service academies, as legal nominating authorities. The DD Form 1870 is used solely by legal nominating authorities, who by federal law, are entitled to make

appointments to the United States Military Academy, Naval Academy, and Air Force Academy. The nomination form allows for legal nominating authorities to select by checking one box as to which academy is being provided with the name of a nominee. The form provides the required information in order for a nomination to be processed.

Affected Public: Individuals or households.

Frequency: On occasion.

Respondent's Obligation: Required to obtain or retain benefits.

OMB Desk Officer: Mr. Edward C. Springer.

Written comments and recommendations on the proposed information collection should be sent to Mr. Springer at the Office of Management and Budget, Desk Officer for DoD, Room 10236, New Executive Office Building, Washington, DC 20503.

DoD Clearance Officer: Mr. Robert Cushing.

Written requests for copies of the information collection proposal should be sent to Mr. Cushing, WHS/DIOR, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302.

Dated: September 2, 1998.

Patricia L. Toppings,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98-24077 Filed 9-4-98; 8:45 am]

BILLING CODE 5000-04-M

DEPARTMENT OF DEFENSE

Office of the Secretary

Submission for OMB Review; Comment Request

ACTION: Notice.

The Department of Defense has submitted to OMB for clearance, the following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

Title, Associated Form, and OMB Number: Lock Performance Monitoring System (PMS) Waterway Traffic Report; ENG Forms 3102C and 3102D; OMB Number 0710-0008.

Type of Request: Reinstatement.
Number of Respondents: 3,000.
Responses Per Respondent: 232 (average).

Annual Responses: 695,304.
Average Burden Per Response: 2.5 minutes.

Annual Burden Hours: 28,507.
Needs and Uses: The U.S. Army Corps of Engineers utilizes the data collected to monitor and analyze the use

and operation of federally owned and operated locks. Owners, agents, and masters of vessels provide general data about vessels and estimated tonnage and commodities carried. The information is used for sizing and scheduling replacement or maintenance for locks and canals. The data are used primarily by the Corps of Engineers in conducting a system-wide approach to planning and management of the waterway. The Headquarters, Division, and District Offices use the information specifically to assist in making determinations on: adequate staffing for operations and maintenance of the navigation locks and dams; to justify the hours of locks operations; to provide a basis to justify continued funding as set out in the President's Operation and Maintenance; the General Budget; to schedule routine maintenance and repairs; to serve as a basis for studies and plans for improvement; for lock operating procedures; to provide data to be used in analysis for major modifications or replacements to lock and dam structures; and, to forecast the impact that delays, downtime, and proposed changes have on the diversion of waterborne commerce to other transportation modes.

Affected Public: Business or Other For-Profit.

Frequency: On occasion.

Respondent's Obligation: Mandatory.

OMB Desk Officer: Mr. James A. Laity.

Written comments and recommendations on the proposed information collection should be sent to Mr. Laity at the Office of Management and Budget, Desk Officer for U.S. Army, COE, Room 10202, New Executive Office Building, Washington, DC 20503.
DOD Clearance Officer: Mr. Robert Cushing.

Written requests for copies of the information collection proposal should be sent to Mr. Cushing, WHS/DIOR, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302.

Dated: September 1, 1998.

Patricia L. Toppings,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98-24079 Filed 9-4-98; 8:45 am]

BILLING CODE 5000-04-M

DEPARTMENT OF DEFENSE

Office of the Secretary

Submission for OMB Review; Comment Request

ACTION: Notice.

The Department of Defense has submitted to OMB for clearance, the

following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

Title, Associated Form, and OMB Number: Terminal and Transfer Facilities Descriptions; WRSC Forms 1,2,3,4,5,6,7,8,9; OMB Number 0710-0007.

Type of Request: Reinstatement.
Number of Respondents: 1,489.
Responses Per Respondent: 1.
Annual Responses: 1,489.
Average Burden Per Response: 15 minutes.

Annual Burden Hours: 372.

Needs and Uses: The data compiled into Port Series reports are used within the Corps of Engineers for navigation and planning functions, by the Coast Guard for marine safety inspections, by the Navy for guidance in providing safe passage in time of national emergency, by the Army for mission deployment planning, and by the public for general interest studies. Data gathered and published as one of the 56 Port Series Reports, relate to terminals, transfer facilities, storage facilities, and intermodal transportation. Respondents are the terminal and transfer facility operators.

Affected Public: Business or Other For-Profit; Federal Government; State, Local, or Tribal Government.

Frequency: Annually.

Respondent's Obligation: Voluntary.

OMB Desk Officer: Mr. James A. Laity. Written comments and recommendations on the proposed information collection should be sent to Mr. Laity at the Office of Management and Budget, Desk Officer for U.S. Army, COE, Room 10202, New Executive Office Building, Washington, DC 20503.

DOD Clearance Officer: Mr. Robert Cushing.

Written requests for copies of the information collection proposal should be sent to Mr. Cushing, WHS/DIOR, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302.

Dated: September 2, 1998.

Patricia L. Toppings,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98-24080 Filed 9-4-98; 8:45 am]

BILLING CODE 5000-04-M

DEPARTMENT OF DEFENSE

Office of the Secretary

Joint Service Committee on Military Justice; Public Meeting

AGENCY: Joint Service Committee on Military Justice (JSC).

ACTION: Notice of public meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda for a public meeting of the JSC. This notice also describes the functions of the JSC.

DATES & TIMES: Thursday, October 1, 1998, at 2:00 p.m..

ADDRESSES: Room 808, 1501 Wilson Blvd., Arlington, VA 22209-22403.

Function: The JSC was established by the Judge Advocates General in 1972. The JSC currently operates under Department of Defense Directive 5500.17, May 8, 1996. The function of the JSC is to improve military justice through preparation and evaluation of proposed amendments and changes to the Uniform Code of Military Justice and the Manual for Courts-Martial.

Agenda: The JSC will receive public comment concerning the proposed amendments to the Manual for Courts-Martial regarding the offense of adultery as published on August 14, 1998. The JSC requests that individuals or organizations desiring to provide comment at the public meeting give notice of their planned attendance to the point of contact below by September 24, 1998.

This notice is provided in accordance with DoD Directive 5500.17, "Role and Responsibilities of the Joint Service Committee (JSC) on Military Justice," May 8, 1996. This notice is intended only to improve the internal management of the Federal Government. It is not intended to create any right or benefit, substantive or procedural, enforceable at law by any party against the United States, its agencies, its officers, or any person.

FOR FURTHER INFORMATION CONTACT:

Lt Col Thomas C. Jaster, U.S. Air Force, Air Force Legal Services Agency, 112 Luke Avenue, Room 343, Bolling Air Force Base, Washington, DC 20332-8000, (202) 767-1539; FAX (202) 404-8755.

Dated: September 2, 1998.

Patricia L. Toppings,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98-24078 Filed 9-4-98; 8:45 am]

BILLING CODE 5000-04-M

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

ACTION: Submission for OMB review; comment request.

SUMMARY: The Acting Deputy Chief Information Officer, Office of the Chief

Information Officer, invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before October 8, 1998.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Danny Werfel, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10235, New Executive Office Building, Washington, DC 20503. Requests for copies of the proposed information collection requests should be addressed to Patrick J. Sherrill, Department of Education, 600 Independence Avenue, S.W., Room 5624, Regional Office Building 3, Washington, D.C. 20202-4651.

FOR FURTHER INFORMATION CONTACT:

Patrick J. Sherrill (202) 708-8196. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1-800-877-8339 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Acting Deputy Chief Information Officer, Office of the Chief Information Officer, publishes this notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g., new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment at the address specified above. Copies of the requests are available from Patrick J. Sherrill at the address specified above.

Dated: September 1, 1998.

Renaldo Harper,

*Acting Deputy Chief Information Officer,
Office of the Chief Information Officer.*

Office of Elementary and Secondary Education

Type of Review: Reinstatement.

Title: High School Equivalency Program (HEP) and the College Assistance Migrant Program.

Frequency: Annually.

Affected Public: Not-for-profit institutions.

Reporting and Recordkeeping Hour Burden:

Responses: 75

Burden Hours: 1,500

Abstract: Institutions of Higher Education and non-profit organizations working with Institutions of Higher Education, are eligible applicants under the High School Equivalency Program and College Assistance Migrant Program. Data collected in the application provides program and budget information needed to evaluate the quality of the projects proposed for funding consideration. In addition, this application contains a possible means for allotting points, subject to the reviewer's professional judgment.

[FR Doc. 98-23988 Filed 9-4-98; 8:45 am]

BILLING CODE 4000-01-P

DEPARTMENT OF ENERGY

Secretary of Energy Advisory Board

Notice of Open Meeting

AGENCY: Department of Energy.

SUMMARY: Consistent with the provisions of the Federal Advisory Committee Act (Pub. L. No. 92-463, 86 Stat. 770), notice is hereby given of the following advisory committee meeting:

Name: Secretary of Energy Advisory Board—Task Force on Education.

DATE(S) AND TIME(S): Friday, September 18, 1998, 8:30 am—12:30 pm.

ADDRESSES: Marriott Key Bridge Hotel, Francis Scott Key Salon B, 1401 Lee Highway, Arlington, Virginia.

FOR FURTHER INFORMATION CONTACT:

Bruce Bornfleth, Secretary of Energy Advisory Board (AB-1), U.S. Department of Energy, 1000 Independence Avenue, SW, Washington, D.C. 20585, (202) 586-4040 or (202) 586-6279 (fax).

SUPPLEMENTARY INFORMATION: The purpose of the Task Force on Education

is to provide information and recommendations to the Secretary of Energy Advisory Board on ways to make the Department's scientific, technical and supercomputing capabilities more available to our Nation's schools, colleges and universities, and to provide recommendations on how the Department can best enhance science, technology, engineering and mathematics education in the United States. The Task Force on Education will finalize their report for submission to the Secretary of Energy Advisory Board.

Tentative Agenda

Friday, September 18, 1998

8:30—8:45 AM Welcome and Opening Remarks—Dr. Hanna Gray, Task Force Chair

8:45—10:30 AM Working Session: Final Report of the Task Force on Education

10:30—10:45 AM Break

10:45—11:30 AM Working Session: Final Report of the Task Force on Education

11:30—12:00 PM Public Comment Period

12:00—12:30 PM Closing Remarks—Dr. Hanna Gray

This agenda is subject to change. The final agenda will be available at the meeting.

Public Participation

The Chair of the Task Force is empowered to conduct the meeting in a fashion that will, in the Chairman's judgment, facilitate the orderly conduct of business. During its meeting in Arlington, Virginia the Task Force welcomes public comment. Members of the public will be heard in the order in which they sign up at the beginning of the meeting. The Task Force will make every effort to hear the views of all interested parties. Written comments may be submitted to Skila Harris, Executive Director, Secretary of Energy Advisory Board, AB-1, U.S. Department of Energy, 1000 Independence Avenue, SW, Washington, D.C. 20585. This notice is being published less than 15 days before the day of the meeting due to programmatic issues that needed to be resolved.

Minutes

Minutes and a transcript of the meeting will be available for public review and copying approximately 30 days following the meeting at the

Freedom of Information Public Reading Room, 1E-190 Forrestal Building, 1000 Independence Avenue, SW, Washington, D.C., between 9:00 AM and 4:00 PM, Monday through Friday except Federal holidays. Information on the Task Force on Education and future reports may be found at the Secretary of Energy Advisory Board's web site, located at <http://www.hr.doe.gov/seab>.

Issued at Washington, D.C., on September 1, 1998.

Althea T. Vanzego,

Acting Deputy Advisory Committee Management Officer.

[FR Doc. 98-24021 Filed 9-4-98; 8:45 am]

BILLING CODE 6450-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER98-4240-000]

Abacus Group Ltd.; Notice of Amendment to Initial Rate Filing

September 1, 1998.

Take notice that on August 24, 1998, Abacus Group, Ltd., tendered for filing an amendment to its petition for acceptance of initial rate schedule, waivers, and blanket authority, including Abacus Group, Ltd., Rate Schedule FERC No. 1, under which AGL will engage in wholesale electric power and energy transactions as a marketer.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 18 CFR 385.214). All such motions and protests should be filed on or before September 11, 1998. Protests will be considered by the Commission to determine the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23981 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY**Federal Energy Regulatory Commission**

[Docket No. CP98-741-000]

Columbia Gas Transmission Corporation; Notice of Request Under Blanket Authorization

September 1, 1998.

Take notice that on August 24, 1998, Columbia Gas Transmission Corporation (Columbia), 12801 Fair Lakes Parkway, Fairfax, Virginia 22030-0146, Charleston, West Virginia 25314-1599, filed in Docket No. CP98-741-000 a request pursuant to Sections 157.205 and 157.211 of the Commission's Regulations under the Natural Gas Act (18 CFR 157.205, 157.211) for authorization to construct and operate the facilities necessary to establish four additional points of delivery to existing customers for firm transportation service, under the Columbia's blanket certificate issued in Docket No. CP83-76-000 pursuant to Section 7 of the Natural Gas Act, all as more fully set forth in the request that is on file with the Commission and open to public inspection.

Columbia states that the customer is Mountaineer Gas Company (MGC) and the request is for 3 residential and 1 commercial delivery points. The first new delivery point will be in Randolph County, West Virginia. The estimated quantities of natural gas to be delivered is 1.5 Dth/day and 150 Dth/annually and will allow MGC to serve Wayne Hornick, a residential customer.

The second new delivery point will be in Roane County, West Virginia. The estimated quantities of natural gas to be delivered is 1.5 Dth/day and 150 Dth/annually and will allow MGC to serve Kermit Godbey, a residential customer.

The third new delivery point will be in Upshur County, West Virginia. The estimated quantities of natural gas to be delivered is 1.5 Dth/day and 150 Dth/annually and will allow MGC to serve Stephen and Rebecca Hollen, a residential customer.

The commercial new delivery point will be in Hancock County, West Virginia. The estimated quantities of natural gas to be delivered is 3.5 Dth/day and 1,100 Dth/annually and will allow MGC to serve Continental Plastic Container, a commercial customer.

Columbia states that these new delivery points to MGC will involve construction of interconnecting facilities located on Columbia's existing right-of-way to provide the service with MGC setting the meter and regulator at each location.

Columbia states that the new points of delivery will have no effect on peak day and annual deliveries, that its existing tariff does not prohibit addition of new delivery points and that deliveries will be accomplished without detriment or disadvantage to its other customers and that the total volumes delivered will not exceed total volumes authorized prior to this request.

The quantities to be provided through the new delivery points will be within Columbia's authorized level of services. Therefore, there is no impact on Columbia's existing design day and annual obligations to its customers as a result of the construction and operation of the new points of delivery for firm transportation service.

Columbia estimated that the cost to install the new taps to be approximately \$150 per tap and will be treated as an O&M expense.

Any person or the Commission's staff may, within 45 days after issuance of the instant notice by the Commission, file pursuant to Rule 214 of the Commission's Procedural Rules (18 CFR 385.214) a motion to intervene or notice of intervention and pursuant to Section 157.205 of the Regulations under the Natural Gas Act (18 CFR 157.205) a protest to the request. If no protest is filed within the time allowed therefor, the proposed activity shall be deemed to be authorized effective the day after the time allowed for filing a protest. If a protest is filed and not withdrawn within 30 days after the time allowed for filing a protest, the instant request shall be treated as an application for authorization pursuant to Section 7 of the Natural Gas Act.

Linwood A. Watson, Jr.,*Acting Secretary.*

[FR Doc. 98-23978 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY**Federal Energy Regulatory Commission**

[Docket No. RP98-347-001]

Eastern Shore Natural Gas Company; Notice of Proposed Changes in FERC Gas Tariff

September 1, 1998.

Take notice that on August 14, 1998, Eastern Shore Natural Gas Company (Eastern Shore) tendered for filing as part of its FERC Gas Tariff, Second Revised Volume No. 1, the following revised tariff sheets, with a proposed effective date of August 1, 1998:

Sub. Second Revised Sheet No. 141

Sub. Second Revised Sheet No. 143
Sub. Second Revised Sheet No. 160A
Sub. Second Revised Sheet No. 210
Second Revised Sheet No. 215

On July 9, 1998 Eastern Shore filed with the Commission revised tariff sheets to implement the Commission's April 16, 1998 final rule in Docket No. RM96-1-007; Order No. 587-G Standards for Business Practices of Interstate Natural Gas Pipelines. In the July 29th Order, the Commission directed Eastern Shore to file revised tariff sheets to incorporate the correction or omission of the following: (a) incorporate GISB standard 5.3.30 into its tariff, (b) delete GISB standard 4.3.4 from its tariff, and (c) incorporate all of the x.4.x data set standards into its tariff.

Eastern Shore states that the purpose of the instant filing is to comply with that requirement.

Eastern Shore states that copies of its filing has been mailed to all firm customers, interruptible customers, and affected state commissions.

Any person desiring to protest this filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Section 385.211 of the Commission's Rules and Regulations. All such protests must be filed as provided in Section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room.

Linwood A. Watson, Jr.,*Acting Secretary.*

[FR Doc. 98-23986 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY**Federal Energy Regulatory Commission**

[Docket No. TM99-1-131-000]

KO Transmission Company; Notice of ACA Filing

September 1, 1998.

Take notice that on August 27, 1998, KO Transmission Company (KO Transmission) tendered for filing as part of its FERC Gas Tariff, Original Volume No. 1, the following tariff sheet with a proposed effective date of October 1, 1998:

Fifth Revised Sheet No. 10

KO Transmission states that the purpose of this filing is to include Commission's Annual Charge Adjustment surcharge of \$0.0022 per dekatherm in applicable rates.

KO Transmission states that copies of this filing were served to all of its customers.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Section 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with Section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23987 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP98-747-000]

Koch Gateway Pipeline Company and Mobile Bay Pipeline Company; Notice of Application

September 1, 1998.

Take notice that on August 25, 1998, Koch Gateway Pipeline Company (Koch Gateway) and Mobile Bay Pipeline Company (Mobile Bay) (Applicants), both at 20 Greenway Plaza, P.O. Box 1478, Houston, Texas 77251-1478, filed in Docket No. CP98-747-000 a joint application pursuant to Sections 7(c) and (b) of the Natural Gas Act for a certificate of public convenience and necessity and for an order granting permission and approval to transfer facilities and services, all as more fully set forth in the application which is on file with the Commission and open to public inspection.

Koch Gateway requests a certificate of public convenience and necessity authorizing it to acquire the facilities of Mobile Bay whereby Mobile Bay's existing services will be performed by Koch Gateway. Further, Mobile Bay requests companion authority to transfer

all of its assets, operations, and services to Koch Gateway. In addition, Koch Gateway requests that it be substituted for Mobile Bay in all pending proceedings in which Mobile Bay is a party. The joint application requests that the authorizations be made effective as of the first day of operation after the jurisdictional assets are conveyed to Koch Gateway.

The Applicants state that the operations of both Koch Gateway and Mobile Bay's pipeline system will continue in an uninterrupted manner with no change in jurisdictional services or maximum rates. Mobile Bay requests companion authority to transfer, pursuant to Section 7(b), its jurisdictional facilities and operations to Koch Gateway. Further, Mobile Bay declares that it will terminate its effective FERC Gas Tariff and services will be provided under Koch Gateway's tariff that is on file with the Commission and in effect on the date of the approval of this application. In addition, Koch Gateway asserts that it will file tariff revisions to its effective tariff incorporating Mobile Bay's existing rates and services.

The Applicants state that these changes will not adversely impact the customers of either Mobile Bay or Koch Gateway or the service they receive on either pipeline. The Applicants declare there will be no change in the maximum tariff rates on either pipeline.

The Applicants state that the approval of this application is required by present and future public convenience and necessity to eliminate redundant administrative processes between Koch Gateway and Mobile Bay. The Applicants declare Mobile Bay is a wholly owned subsidiary of Koch Gateway, delivering over 98% of its volumes into Koch Gateway. The Applicants assert that this results in duplicate contract, nominations, and invoicing processes for both the Applicants and their customers.

Any person desiring to be heard or to make any protest with reference to said Application should on or before September 21, 1998, file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211 or 18 CFR 385.214) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to

participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that pursuant to the authority contained in and subject to the jurisdiction conferred upon the Commission by Sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this Application if no petition to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that a grant of the abandonment is required by public convenience and necessity. If a petition for leave to intervene is timely filed, or if the Commission, on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Applicant to appear or be represented at the hearing.

Linwood A. Waton, Jr.,

Acting Secretary.

[FR Doc. 98-23980 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP98-292-001]

Northern Natural Gas Company; Notice of Compliance Filing

September 1, 1998.

Take notice that on August 14, 1998, Northern Natural Gas Company (Northern) tendered for filing to become part of its FERC Gas Tariff, Fifth Revised Volume No. 1, the following tariff sheet, with an effective date of August 1, 1998:

Substitute First Revised Third Revised Sheet No. 204

Northern states that the instant filing is being made in compliance with the Commission's Letter Order issued July 30, 1998 in Docket No. RP98-292 (July 30 Order) addressing Order No. 587-G and the most recent version (Version 1.2) of the standards promulgated by Gas Industry Standards Boards (GISB).

Northern states that copies of the filing were served upon Northern's customers and interested State Commissions.

Any person desiring to protest this filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC

20426, in accordance with Section 385.211 of the Commission's Rules and Regulations. All such protests must be filed as provided in Section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23985 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP98-743-000]

Williams Gas Pipelines Central, Inc.; Notice of Application for Abandonment

September 1, 1998.

Take notice that on August 24, 1998 as supplemented on August 28, 1998, Williams Gas Pipelines Central, Inc. (Williams), P.O. Box 3288, Tulsa, Oklahoma 74101, filed in the above docket a request pursuant to Section 7(b) of the Natural Gas Act and Sections 157.7(a) and 157.18 of the Federal Energy Regulatory Commission's (Commission) Regulations for authorization to abandon the receipt of gas for transportation from Transtate Gas Service Company (Transtate), formerly Gulf Energy Gathering & Processing, and to reclaim measurement facilities located in Garvin County, Oklahoma, under the authorization issued in Docket No. CP82-479-000, all as more fully set forth in the request on file with the Commission and open to public inspection.

Williams states that the meter setting has been blinded for some time and that Transtate has been notified of the proposed reclaim of facilities.

Any person desiring to be heard or to make any protest with reference to said application should on or before September 22, 1998, file with the Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and procedure (18 CFR 385.211 and 385.214) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will

not serve to make the protestants parties to the proceedings. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to the jurisdiction conferred upon the Commission by Sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this application if no motion to intervene is filed within the time required herein or if the Commission on its own review of the matter, finds that a grant of the certificate for the proposal is required by the public convenience and necessity. If the Commission believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Williams to appear or be represented at the hearing.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23979 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. GT98-89-000]

Williston Basin Interstate Pipeline Company; Notice of Proposed Changes in FERC Gas Tariff

September 1, 1998.

Take notice that on August 27, 1998, Williston Basin Interstate Pipeline Company (Williston Basin), tendered for filing as part of its FERC Tariff, Second Revised Volume No. 1, the following revised tariff sheets to become effective August 27, 1998:

Seventeenth Revised Sheet No. 777

Twenty-sixth Revised Sheet No. 831

Twenty-fifth Revised Sheet No. 832

Williston Basin states that the revised tariff sheets are being filed simply to update its Master Receipt/Delivery Point List.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Sections 385.214 or 385.211 of the Commission's

Rules and Regulations. All such motions or protests must be filed in accordance with Section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23982 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. CP98-131-000 and CP98-133-000]

Vector Pipeline L.P.; Notice of Availability of the Draft Environmental Impact Statement for the Proposed Vector Pipeline Project

September 1, 1998.

The staff of the Federal Energy Regulatory Commission (FERC or Commission) has prepared a Draft Environmental Impact Statement (DEIS) on the natural gas pipeline facilities proposed by Vector Pipeline L.P. (Vector) in the above-referenced dockets.

The DEIS was prepared to satisfy the requirements of the National Environmental Policy Act. The staff concludes that approval of the proposed project with the appropriate mitigating measures as recommended, would have limited adverse environmental impact. The DEIS also analyzed system alternatives, major route alternatives, route variations, and alternative compressor station sites, and requests comments on them.

The DEIS addresses the potential environmental effects of the construction and operation of the following facilities:

- 266.9 miles of 42-inch-diameter pipeline in Illinois, Indiana, and Michigan extending from Joliet in Will County, Illinois to Oakland County, Michigan;
- 3.7 miles of 42-inch-diameter pipeline in St. Clair County, Michigan terminating at the border of the United States and Canada near St. Clair, Michigan;
- four meter stations;

- two compressor stations totaling 60,000 horsepower;
- 20 new mainline valves, two internal tool or "pig" launchers and one pig receiver; and
- permanent roads for access to compressor stations and valves.

The Vector Pipeline Project also includes the lease of 58.8 miles of an existing 36-inch-diameter pipeline from Oakland County to St. Clair County, Michigan.

The purpose of the proposed facilities would be to transport about 1 billion cubic feet per day of natural gas from the Chicago hub to the Dawn hub; deliver significant volumes of gas to markets in Michigan; and to provide increased access to the Dawn hub and markets in Canada and the eastern U.S.

Specific Comment Request

The staff has identified and evaluated in detail two compressor station

alternative sites, and evaluated eight route variations to the proposed facilities. Of these compressor station alternatives and route variations, the staff has not recommended the use of any at this time. Area residents, local or state governments, intervenors, Vector, and other interested parties are asked to provide specific comments on whether these alternatives and variations are reasonable, practicable, and environmentally preferable to the proposed facilities. Comments should also address any effect on project timing and related cost/benefits.

Comment Procedures and Public Meeting

Any person wishing to comment on the DEIS may do so. To ensure reconsideration prior to a Commission decision on the proposal, it is important that we receive your comments before

the date specified below. Please carefully follow these instructions to ensure that your comments are received in time and properly recorded:

- Send two copies of your comments to: Secretary, Federal Energy Regulatory Commission, 888 First St., NE, Room 1A Washington, DC 20426;
- Label one copy of the comments for the attention of the Environmental Review and Compliance Branch, PR-11.1;
- Reference Docket Nos. CP98-131-000 and CP98-133-000;
- Mail your comments so that they will be received in Washington, DC on or before October 19, 1998.

In addition to accepting written comments, four public meetings to receive comments on the DEIS will be held at the following times and locations:

Date/time	Location
Monday, October 5, 1998 7:00 pm	Leslie High School Auditorium, 4141 Hull Road, Leslie, MI, (517) 589-8200.
Monday, October 5, 1998 7:00 pm	Milford High School, 2380 S. Milford Road, Milford, MI, (248) 684-8091.
Tuesday, October 6, 1998 7:00 pm	Three Rivers Community Center, 103 Postage Avenue, Three Rivers, MI, (616) 279-9231.
Tuesday, October 6, 1998 7:00 pm	Radisson Hotel at Star Plaza, 800 E. 81st Avenue, Merrillville, IN, (219) 757-3537.

Interested groups and individuals are encouraged to attend and present oral comments on the environmental impacts described in the DEIS. Transcripts of the meetings will be prepared. Additional information about the meetings is available from Paul McKee in the Commission's Office of External Affairs, at (202) 208-1088.

After these comments are reviewed, any significant new issues are investigated, and modifications are made to the DEIS, a Final Environmental Impact Statement (FEIS) will be published and distributed by the staff. The FEIS will contain the staff's responses to timely comments filed on the DEIS.

Comments will be considered by the Commission but will not serve to make the commenter a party to the proceeding. Any person seeking to become a party to the proceeding must file a motion to intervene pursuant to Rule 214 of the Commission's Rules of Practice and Procedures (18 CFR 385.214).

Anyone may intervene in this proceeding based on this DEIS. You must file your request to intervene as specified above. You do not need intervenor status to have your comments considered.

The DEIS has been placed in the public files of the FERC and is available for distribution and public inspection

at: Federal Energy Regulatory Commission, Public Reference and Files Maintenance Branch, 888 First Street, NE, Room 2A, Washington, DC 20426, (202) 208-1371.

Copies of the DEIS have been mailed to Federal, State, and local agencies, public interest groups, individuals who have requested the DEIS, newspapers, and parties to this proceeding. A limited number of copies of the DEIS are available from the above address.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23977 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 10725-002]

Little Horn Energy Wyoming Inc.; Notice of Intent To Prepare an Environmental Impact Statement and Conduct Public Scoping Meetings and a Site Visit

September 1, 1998.

The Federal Energy Regulatory Commission (Commission) is reviewing the hydropower application for an original license for the 1,000-megawatt Dry Fork Energy Storage Project No.

10725. The proposed pumped storage project, to be constructed by Little Horn Energy Wyoming, Inc. (Little Horn Energy), would be located on 1,055 acres of United States lands within the Bighorn National Forest in Sheridan County, Wyoming. The project would include two reservoirs. The lower reservoir would be created by impounding the Dry Fork of the Little Bighorn River with a 265-foot-high dam. The upper reservoir would be created by constructing a perimeter dam that would be up to 100 feet high on Dry Fork Ridge.

The Commission staff has determined that licensing this project would constitute a major federal action significantly affecting the quality of the human environment. Therefore, the Commission staff intends to prepare an Environmental Impact Statement (EIS) for the project in accordance with the National Environmental Policy Act. In the EIS, the Commission staff will consider reasonable alternatives to Little Horn Energy's proposed action and analyze both site-specific and cumulative environmental impacts of the project, including economic and engineering impacts.

A draft EIS will be issued and circulated to those on the mailing list for this project, and the Commission staff will hold a public meeting to discuss the draft EIS. All comments

filed on the draft EIS will be analyzed by the staff and considered in a final EIS. The staff's conclusions and recommendations presented in the final EIS will then be presented to the Commission to assist in making a licensing decision.

Scoping

The Commission staff is asking the resource agencies, Indian tribes, non-governmental organizations, and the public to help them identify the scope of environmental issues that should be analyzed in the EIS and to provide them with information that may be useful in preparing the EIS.

To help focus comments on the environmental issues, a scoping document outlining subject areas to be addressed in the EIS will be mailed to those on the mailing list for the project.

Those with comments or information pertaining to this project should file it with the Commission at the following address within 60 days of the issuance date of the scoping document: David P. Boergers, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426.

All filings should clearly show the following on the first page: Dry Fork Energy Storage Project, FERC No. 10725.

Intervenors are reminded of the Commission's Rules of Practice and Procedure which require all intervenors filing documents with the Commission to serve a copy of that document on each person whose name appears on the official service list for the project. Further, if an intervenor files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency.

In addition to asking for written comments, the Commission staff will hold two scoping meetings to solicit any verbal input and comments that you may wish to offer on the scope of the EIS. An agency scoping meeting will begin at 9:30 a.m. on September 30, 1998, at the Holiday Inn, Sheridan, Wyoming. A public scoping meeting will begin at 5:00 PM on September 30, 1998, at the Sheridan Jr. High School Auditorium, 600 Adair Street, Sheridan, Wyoming. The first hour of the public scoping meeting will be an informal session where the public will have the opportunity to meet with the Commission staff and the applicant to discuss the proposed project. The public and agencies may attend either meeting.

There will also be a visit to the project site on September 29, 1998, to allow the parties to become more familiar with the project area. Those planning on attending the site visit should bring a four-wheel-drive vehicle, blaze orange clothing (if possible), and lunch. We plan to hike from the proposed lower reservoir site to the proposed upper reservoir site and to one alternative reservoir location.

More information about the scoping meetings and site visit is available in the scoping document. If you have any questions about this notice or need a copy of the scoping document, please contact Mr. Doug Hjorth at (781) 444-3330 ext. 283 or Mr. Nick Jayjack at (202) 219-2825.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23984 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Surrender of Exemption

September 1, 1998.

Take notice that the following hydroelectric application has been filed with the Federal Energy Regulatory Commission and is available for public inspection.

a. Type of Application: Surrender of Exemption

b. Project No: 7454-005

c. Date Filed: February 27, 1997, supplemented on June 13, 1997, and July 17, 1998

d. Applicant: El Dorado Irrigation District

e. Name of Project: Weber Dam

f. Location: North Fork Weber Creek, El Dorado County, California

g. Filed Pursuant to: Federal Power Act, 16 USC Section 791(a)-825(r)

h. Applicant Contact: Steven Hutchings, 2890 Mosquito Road, Placerville, CA 95667 (916) 622-4534

i. FERC Contact: Dave Cagnon, (202) 219-2693

j. Comment Date: October 9, 1998

k. Description of Application: El Dorado Irrigation District has applied to surrender its exemption because of difficulties in operating the hydroelectric facility in an efficient and economic manner and due to its changing priorities. The project consists of: (1) 30-inch-diameter, 100-foot-long penstock, joining a 24-inch diameter outlet pipe; (2) 90-foot-high, 308-foot-

long Weber Dam on the north fork of Weber Creek at an elevation of 2,275 feet; a powerhouse with an installed capacity of 175 kW under an operating head of 71 feet; and (3) a 7000-foot-long, 21-kV transmission line of Pacific Gas and Electric. The exemptee proposes to remove the existing hydroelectric works, rebuild the dam, and utilize the reservoir as a future domestic water supply.

l. The notice also consists of the following standard paragraphs: B, C2, and D2.

B. Comments, Protests, or Motions to Intervene—Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

C2. Filing and Service of Responsive Documents—Any filings must bear in all capital letters the title "COMMENTS," "PROTEST" or "MOTION TO INTERVENE," as applicable, and the project number of the particular application to which the filing is in response. Any of these documents must be filed by providing the original and 8 copies to: The Secretary, Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426. Any motion to intervene must also be served upon each representative of the applicant specified in the particular notice.

D2. Agency Comments—Federal, state, and local agencies are invited to file comments on the described application. A copy of the application may be obtained by agencies directly from the Applicant. If an agency does not file comments within the time specified for filing comments, it will be presumed to have no comments. One copy of an agency's comments must also be sent to the Applicant's representatives.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 98-23983 Filed 9-4-98; 8:45 am]

BILLING CODE 6717-01-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL-6149-3]

Determination of Attainment of the Air Quality for PM-10 in the Liberty Borough, Pennsylvania Area**AGENCY:** Environmental Protection Agency (EPA).**ACTION:** Finding of attainment.

SUMMARY: EPA has determined that the air quality in the Liberty Borough, Pennsylvania area has attained national ambient air quality standards (NAAQS) for particulate matter of nominal aerodynamic diameters smaller than 10 micrometers (PM-10). This finding is based on monitored air quality data for the area during the years 1995-1997. Elsewhere in the Final Rules section, EPA is approving the attainment demonstration and contingency measures submitted by the Pennsylvania Department of Environmental Protection (PADEP) on behalf of the Allegheny County Health Department (ACHD). These state implementation plan (SIP) revisions demonstrate that the attainment plan for the Liberty Borough area is sufficient to attain and maintain the NAAQS. In a previous final rulemaking, EPA also approved a SIP revision requiring additional control measures at the USX Clairton coke works.

EFFECTIVE DATE: This finding is effective on October 8, 1998.

ADDRESSES: Copies of documents relevant to this action are available for public inspection during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103; Pennsylvania Department of Environmental Protection, Bureau of Air Quality, P. O. Box 8468, 400 Market Street, Harrisburg, Pennsylvania 17105; Allegheny County Health Department, Department of Air Quality, 301 39th Street, Pittsburgh, Pennsylvania 15201.

FOR FURTHER INFORMATION CONTACT: Ruth E. Knapp (215) 814-2191, or by e-mail at knapp.ruth@epa.gov.

SUPPLEMENTARY INFORMATION: On June 12, 1998 (63 FR 32205) EPA published a notice announcing its proposed finding that the air quality in the Liberty Borough, Pennsylvania moderate nonattainment area has attained national ambient air quality standards (NAAQS) for particulate matter of nominal aerodynamic diameters smaller than 10 micrometers (PM-10). No comments were submitted on the proposed finding. The rationale for

EPA's finding was explained in the proposal and will not be restated here. While EPA revised the NAAQS for particulate matter on July 18, 1997, in this notice the terms "NAAQS" and "PM-10 NAAQS" refer only to the previously existing NAAQS.

Final Determination

EPA finds, pursuant to section 188(b)(2), that the Liberty Borough moderate nonattainment area has attained the NAAQS for PM-10.

Administrative Requirements*A. Executive Orders 12866 and 13045*

The Office of Management and Budget (OMB) has exempted this finding from E.O. 12866 review. This finding is not subject to E.O. 13045, entitled "Protection of Children from Environmental Health Risks and Safety Risks," because it is not an "economically significant" action under E.O. 12866.

B. Regulatory Flexibility Act

Under the Regulatory Flexibility Act, 5 U.S.C. 600 *et seq.*, EPA must prepare a regulatory flexibility analysis assessing the impact of any proposed or final rule on small entities. 5 U.S.C. 603 and 604. Alternatively, EPA may certify that the rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and government entities with jurisdiction over populations of less than 50,000. Determinations of attainment under the Clean Air Act do not impose any new requirements on small entities. Therefore, EPA certifies that this determination does not have a significant impact on a substantial number of small entities.

C. Unfunded Mandates

Under Section 202 of the Unfunded Mandates Reform Act of 1995 ("Unfunded Mandates Act"), signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to private sector, of \$100 million or more. Under Section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule. EPA has determined that this determination of

attainment does not include a Federal mandate that may result in estimated costs of \$100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This finding of attainment resulted from pre-existing requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this finding.

EPA's final decision to find that the Liberty Borough area attained the NAAQS for PM-10 is based on sections 179(c) and 188(b)(2) of the Clean Air Act, as amended, and EPA regulations in 40 CFR Part 50.

D. Submission to Congress and the General Accounting Office

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this finding and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This finding is not a "major rule" as defined by 5 U.S.C. 804(2).

Authority: 42 U.S.C. 7401 *et seq.*

Dated: August 28, 1998.

Thomas C. Voltaggio,

Acting Regional Administrator, Region III.

[FR Doc. 98-24039 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

[FRL-6157-4]

Proposed Settlement Agreement; Power-Bannock Counties, ID PM SIP

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of proposed settlement agreement; request for public comment.

SUMMARY: In accordance with Section 113(g) of the Clean Air Act ("Act"), notice is hereby given of a proposed settlement agreement concerning litigation instituted against the Environmental Protection Agency ("EPA") by the Portneuf Environmental Council. The lawsuit concerns EPA's alleged failure to perform a

nondiscretionary duty with respect to determining, based on air quality data, whether the Power-Bannock Counties nonattainment area in Idaho attained the PM-10 national ambient air quality standards by the December 31, 1996 statutorily-extended attainment deadline.

The Agreement generally establishes deadlines by which EPA will propose and take final action on a federal plan to control particulate matter (PM-10) for the portions of the area that are not attaining the PM-10 standards in existence prior to September 16, 1997.

For a period of thirty [30] days following the date of publication of this notice, the Agency will receive written comments relating to the settlement agreement. EPA or the Department of Justice may withhold or withdraw consent to the proposed settlement agreement if the comments disclose facts or circumstances that indicate that such consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Act.

Copies of the settlement agreement are available from Samantha Hooks, Air and Radiation Law Office (2344), Office of General Counsel, U.S. Environmental Protection Agency, 401 M Street, SW, Washington, DC 20460, (202) 260-3804. Written comments should be sent to Michael A. Prosper at the above address and must be submitted on or before October 8, 1998.

Dated: August 28, 1998.

Scott C. Fulton,

Acting General Counsel.

[FR Doc. 98-24046 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL-6157-9]

Air Quality Criteria for Carbon Monoxide

AGENCY: Environmental Protection Agency.

ACTION: Notice of public meeting: Peer-Review Workshop on Air Quality Criteria for Carbon Monoxide.

SUMMARY: The U.S. Environmental Protection Agency (EPA) is announcing a meeting organized, convened, and conducted by the Eastern Research Group, Inc., a contractor to the EPA for external scientific peer consultation, to facilitate the preparation of an external review draft of the Carbon Monoxide Air Quality Criteria Document. All interested parties may attend and assist in developing and refining the scientific

information base available for accomplishing this task.

DATES: The meeting dates are September 17 and 18, 1998.

ADDRESSES: The Durham Marriott (formerly Durham Omni), will be the meeting site. It is located on 201 Foster St. in Durham, North Carolina; the telephone number is 919-683-6664. The times for the meetings are 8:30 a.m. to 5:30 p.m. on the first day and 8:30 a.m. to 12:30 p.m. on the second day. At the time of the meetings, the Eastern Research Group will make available copies of the draft chapters that the workshop sessions will be reviewing.

FOR FURTHER INFORMATION CONTACT: Ms. Linda Cooper (telephone 919-468-7878) for registration information and logistics and Ms. Monica Seagroves (telephone 919-468-7825) for technical information. Ms. Cooper and Ms. Seagroves work for Eastern Research Group, Inc., Engineering and Science Division, 1600 Perimeter Park, P.O. Box 2010, Morrisville, NC 27560-2010.

SUPPLEMENTARY INFORMATION: The U.S. Environmental Protection Agency (EPA) is updating and revising, where appropriate, the EPA's Air Quality Criteria for Carbon Monoxide (CO). Sections 108 and 109 of the Clean Air Act require that the EPA carry out a periodic review and revision, where appropriate, of the criteria and the National Ambient Air Quality Standards (NAAQS) for the "criteria" air pollutants such as carbon monoxide.

The EPA will keep the public informed, through subsequent **Federal Register** notice announcements, of additional opportunities for public input into the preparation process, such as the public comment period following the release of the first external review draft of the Carbon Monoxide Air Quality Criteria Document and the Clean Air Scientific Advisory Committee (CASAC) review in early 1999.

Dated: September 1, 1998.

William H. Farland, Ph.D.,

Director, National Center for Environmental Assessment.

[FR Doc. 98-24086 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

[FRL-6157-7]

Proposed Administrative Settlement Agreement Pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), as Amended by the Superfund Amendments and Reauthorization Act—Hansen Container Site, Grand Junction, CO

AGENCY: Environmental Protection Agency.

ACTION: Notice and Request for Public Comment.

SUMMARY: In accordance with the requirements of section 122(h)(1) of the Comprehensive Environmental Response, Compensation, and Liability Act, as amended (CERCLA), notice is hereby given of a proposed settlement under section 122(h), concerning the Hansen Container site in Grand Junction, Colorado (Site). The proposed Administrative Settlement Agreement requires seventeen (17) Potentially Responsible Parties to Pay an aggregate total of \$1,440,720 to address their liability to the United States Environmental Protection Agency (EPA) related to response actions taken or to be taken at the Site.

DATES: Comments must be submitted on or before October 8, 1998.

ADDRESSES: The Proposed Administrative Settlement Agreement is available for public inspection at the EPA Superfund Record Center, 999 18th Street, 5th Floor, North Tower, Denver, Colorado.

Comments should be addressed to Maureen O'Reilly, Enforcement Specialist, (8ENF-T), U.S. Environmental Protection Agency, 999 18th Street, Suite 500, Denver, Colorado, 80202-2405, and should reference the Hansen Container settlement (docket number).

FOR FURTHER INFORMATION CONTACT: Maureen O'Reilly, Enforcement Specialist, at (303) 312-6402.

SUPPLEMENTARY INFORMATION: Notice of Section 122(h) Administrative Settlement Agreement: In accordance with section 122(i)(1) of CERCLA, notice is hereby given that the terms of the Administrative Settlement Agreement have been agreed to by the following parties: (in alphabetical order): Adolph Coors Company; Allied Signal, Inc.; Amoco Corporation; Canada Eldor (f/k/a Eldorado Nuclear Ltd.); Defense Logistics Agency; Chris Hansen, Jr.; Kerr-McGee Corporation; Mallinckrodt Chemical, Inc.; National Aeronautics

and Space Administration; National Lead Company of Ohio; Oil & Solvent Process Company; Thiokol Corporation; Umetco Minerals Corporation; Union Carbide Corporation; Union Pacific Railroad; U.S. Air Force, U.S. Department of Energy.

By the terms of the proposed Administrative Settlement Agreement, these parties will together pay \$1,440,720 to the Hazardous Substance Superfund. EPA applied its June 3, 1996 orphan share guidance to the facts at this site and determined that application of the orphan share policy was indeed appropriate. EPA determined that the maximum orphan share compensation at this site was \$562,500. When the orphan share amount is added to the settlement offer, the total is \$2,003,220. This amount represents 95.4% of EPA's \$2.1 million in past response costs.

In exchange for payment, EPA will provide the settling parties with a covenant not to sue for liability under section 107(a) of CERCLA, to recover past response costs incurred through January 9, 1998.

For a period of thirty (30) days from the date of this publication, the public may submit comments on EPA relating to this proposed settlement.

A copy of the proposed Administrative Settlement Agreement may be obtained from the Superfund Records Center located at the U.S. Environmental Protection Agency, Region VIII, 999 18th Street, 5th floor, Denver, Colorado 80202. Additional background information relating to the settlement is also available for review at the Superfund Records Center.

Dated: August 12, 1998.

William P. Yellowtail,

Regional Administrator, Environmental Protection Agency, Region VIII.

[FR Doc. 98-24041 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL-6155-4]

Proposed Administrative Agreement Under 42 U.S.C. Section 122(h) of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) for the Quality Plating Superfund Site

AGENCY: Environmental Protection Agency (USEPA).

ACTION: Notice. Request for Public Comments.

SUMMARY: USEPA is proposing to settle a claim under Section 107 of CERCLA

for response costs incurred during removal activities at the Quality Plating site in Chicago, Illinois. Respondent has agreed to reimburse USEPA in the amount of \$25,000. USEPA today is proposing to approve this settlement because it reimburses USEPA, in part, for costs incurred during USEPA's removal action.

DATES: Comments on this proposed settlement must be received on or before October 8, 1998.

ADDRESSES: Copies of the proposed settlement are available at the following address for review: (It is recommended that you telephone Janet Pope (312) 353-0628 before visiting the Region V Office). U.S. Environmental Protection Agency, Region V, Office of Superfund, Removal and Enforcement Response Branch, 77 W. Jackson Blvd., Chicago, Illinois 60604.

Comments on this proposed settlement should be addressed to: (Please submit an original and three copies, if possible) Janet Pope, Community Relations Coordinator, Office of Public Affairs, U.S. Environmental Protection Agency, Region V, 77 W. Jackson Boulevard (P-19J), Chicago, Illinois 60604, (312) 353-0628.

FOR FURTHER INFORMATION CONTACT:

Janet Pope, Office of Public Affairs, at (312) 353-0628.

SUPPLEMENTARY INFORMATION: The Quality Plating site, an abandoned metal plating facility that contained numerous vats, tanks, and drums of acids, caustics, cyanide and solvents, is not on the National Priorities List. USEPA investigated the Quality Plating site, located at 323 North Kilpatrick Avenue, Chicago, Illinois, and undertook response actions designed to minimize the immediate threat, test the materials involved and properly dispose of the hazardous waste.

The Settling Party is an individual who was the Chief Executive Officer and a shareholder of the plating corporation that previously operated the site. It is alleged that the Settling Party operated the site, including actively participating in the decision to close and abandon the operation. A 30-day period, beginning on the date of publication, is open pursuant to section 122(i) of CERCLA for comments on the proposed settlement.

Comments should be sent to Janet Pope of the Office of Public Affairs (P-19J), U.S. Environmental Protection

Agency, Region V, 77 W. Jackson Boulevard, Chicago, Illinois 60604.

Mony Chabria,

Assistant Regional Counsel, United States Environmental Protection Agency.

[FR Doc. 98-24042 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

[Report No. 2294]

Corrected; Petitions for Reconsideration and Clarification of Action in Rulemaking Proceeding

August 25, 1998.

Petitions for reconsideration and clarification have been filed in the Commission's rulemaking proceedings listed in this Public Notice and published pursuant to 47 CFR Section 1.429(e). The full text of these documents are available for viewing and copying in Room 239, 1919 M Street, N.W., Washington, D.C. or may be purchased from the Commission's copy contractor, ITS, Inc., (202) 857-3800. Oppositions to these petitions must be filed September 23, 1998. See Section 1.4(b)(1) of the Commission's rule (47 CFR 1.4(b)(1)). Replies to an opposition must be filed within 10 days after the time for filing oppositions has expired.

Subject: Implementation of Section 304 of the Telecommunications Act of 1996 (CS Docket No. 97-80).

Commercial Availability of Navigation Devices.

Number of Petitions File: 5.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 98-23964 Filed 9-4-98; 8:45 am]

BILLING CODE 6712-01-M

FEDERAL FINANCIAL INSTITUTIONS EXAMINATION COUNCIL

Administrative Enforcement of the Truth in Lending Act—Restitution

ACTION: Notice and request for comment.

SUMMARY: The Consumer Compliance Task Force of the Federal Financial Institutions Examination Council (FFIEC) is issuing a revised Joint Statement of Policy on the Administrative Enforcement of the Truth in Lending Act—Restitution (Policy Statement). The Policy Statement issued by the FFIEC on July 21, 1980 must be revised to reflect the statutory changes to certain provisions of the Truth in Lending Act (TILA)

made by the Congress in 1995 and 1996. The staffs of the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board (FRB), the Federal Deposit Insurance Corporation (FDIC), the Office of Thrift Supervision (OTS) and the National Credit Union Administration (NCUA) have prepared this revised Policy Statement to reflect the changes made to the TILA.

DATES: Public comment is invited on a continuing basis.

ADDRESSES: Questions and comments may be sent to Keith J. Todd, Acting Executive Secretary, Federal Financial Institutions Examination Council, 2100 Pennsylvania Avenue NW, Suite 200, Washington, DC 20037, or by facsimile transmission to (202) 634-6556.

FOR FURTHER INFORMATION CONTACT:

OCC: Gene Ullrich, National Bank Examiner, Community and Consumer Policy, (202) 874-4866, Office of the Comptroller of the Currency, 250 E Street SW, Washington, DC 20219.

FRB: Anthony Iwuji, Review Examiner, Division of Consumer and Community Affairs, (202) 452-3946, Board of Governors of the Federal Reserve System, 20th Street and Constitution Avenue NW, Washington, DC 20551.

FDIC: James K. Baebel, Senior Review Examiner, Division of Compliance and Consumer Affairs, (202) 942-3086, Federal Deposit Insurance Corporation, 550 17th Street NW, PA-1730-7048, Washington, DC 20429.

OTS: Gary Jackson, Program Analyst, Compliance Policy, (202) 906-5653, Office of Thrift Supervision, 1700 G Street NW, Washington, D.C. 20552.

NCUA: Jodee Wuerker, Program Officer, Office of Examination and Insurance, (703) 518-6375, National Credit Union Administration, 1775 Duke Street, Alexandria, VA 22314-3428.

SUPPLEMENTARY INFORMATION:

Background

The Truth in Lending Act Amendments of 1995 and the Economic Growth and Regulatory Paperwork Reduction Act of 1996 amended the TILA to incorporate new tolerances for disclosures of the finance charge and other disclosures affected by the finance charge on certain types of loans. These amendments specify that in closed-end consumer credit transactions secured by real property or a dwelling, the disclosed finance charge and other disclosures affected by the disclosed finance charge shall be treated as accurate if the amount disclosed as the finance charge is overstated, or is understated by no more than \$100 for

transactions consummated on or after September 30, 1995, or \$200 for loans made before that date. The Federal Reserve Board proposed and adopted amendments to Regulation Z in 1996 to implement the statutory changes (12 CFR 226.18(d)(1), 226.18(d)(2), 226.22(a)(4) and 226.22(a)(5)).

The Policy Statement originally issued in 1980 was directly affected by the amendments to the TILA and the changes to Regulation Z in several respects. First, the changes to the tolerances affect the definition for understated annual percentage rates (APR) contained in the Policy Statement. Second, the amendments enhanced the agencies' abilities to make modifications to the amount or timing of restitution in the event that payment of restitution would adversely affect the capital position of the financial institution. In the main, the revisions to the Policy Statement make only those changes necessary to accommodate statutory requirements. Some other editorial changes were made, however, to reflect that some provisions of the original Policy Statement were no longer needed due to the passage of time.

Summary of Changes

The revised Policy Statement drops the definition of "Irregular Mortgage Transaction." The term is used in the Truth in Lending Simplification and Reform Act in the definition of an understated APR for loans secured by dwellings consummated prior to March 31, 1982. There is no longer any need for maintaining a separate definition of this term in the Policy Statement. A footnote has been included in the revised Policy Statement to indicate that, should loans consummated prior to March 31, 1982 having understated APRs be found, the original Policy Statement should be consulted for guidance.

The definition of the term "Understated APR" in the Policy Statement has been modified to reflect revised tolerances for certain real estate secured transactions. The Truth in Lending Amendments of 1995 and the Economic Growth and Regulatory Paperwork Reduction Act of 1996 mandated these revisions. The Policy Statement has also been revised to consolidate six separate sub-parts to the definition of an "Understated APR" into two sub-parts; (1) Loans having an amortization schedule of 10 years or less, and (2) loans with an amortization schedule of more than 10 years.

- Loans having an amortization schedule of 10 years or less will be provided a tolerance of 25 basis points

(one-quarter of one percent). Loans that are secured by real estate or a dwelling will be provided the tolerances permitted by 12 CFR 226.22(a)(4) and (5).

- Loans having an amortization schedule of more than 10 years will be provided a tolerance of 12.5 basis points (one-eighth of one percent) in the case of a regular transaction and 25 basis points (one-quarter of one percent) in the case of an irregular transaction. Loans that are secured by real estate or a dwelling will be provided the tolerances permitted by 12 CFR 226.22(a)(4) and (5).

References to 15 U.S.C. 1606(c) contained in the body of the definition of an understated APR in the original Policy Statement have now been moved to footnote 3 in the revised Policy Statement. The change was purely editorial in nature. A new footnote 4 has been added to more specifically identify the sections of Regulation Z (12 CFR 226.14(a) and 226.22(a)) that define the requirements for annual percentage rate disclosures.

The "Corrective Action Period" section of the original Policy Statement contains time frames for determining which loans are subject to adjustment when violations are discovered. Previously, the agencies have collectively taken the position that the phrase "immediately preceding examination" in subsection 2.b. means the most recent examination that precedes the current examination in which compliance with Regulation Z and the Act was reviewed. However, the United States Court of Appeals for the 8th Circuit (First National Bank of Council Bluffs v. Office of the Comptroller of the Currency, 956 F.2d 1456 (8th Cir. 1992)), and the United States Court of Appeals for the Eleventh Circuit, (Consolidated Bank, N.A. v. United States Department of the Treasury, 118 F.3d 1461 (11th Cir. 1997)) determined that the phrase "immediately preceding examination" should be read as referring to an examination of any type conducted immediately prior to the current examination, including examinations in which no review of compliance with Regulation Z or the Act is conducted. Consequently, the agencies, as a matter of policy, will now apply the decisions reached by the Eighth and Eleventh Circuit Courts in carrying out their enforcement responsibilities with respect to the meaning of "immediately preceding examination." No changes to the Policy Statement are necessary to effect this policy position made by the agencies. Additional guidance will be provided to the examination staff for

each agency to advise on the proper period for corrective action when violations requiring adjustments are discovered.

In the section of the Policy Statement entitled "Violations Involving the Improper Disclosure of Credit Life, Accident, Health, or Loss of Income Insurance," the original Policy Statement had a separate provision detailing how certain violations involving credit life insurance disclosures would be treated until March 31, 1982. Since this time period has now expired that portion of the section has been deleted.

The Economic Growth and Regulatory Paperwork Reduction Act of 1996 provided additional flexibility for the regulatory agencies to require partial or delayed payments for reimbursements by an institution if the payment would cause the institution to become undercapitalized as that term is defined in section 38 of the Federal Deposit Insurance Act. Those provisions are now reflected in the section of the Policy Statement entitled "Safety and Soundness." That section states that if the results of a full and immediate adjustment required under the Policy Statement would have a significant adverse impact on the capital position of the creditor, the agencies can permit partial adjustments to be made or permit partial payments over an extended period of time.

The text of the revised Policy Statement follows:

Administrative Enforcement of the Truth in Lending Act—Restitution

Joint Statement of Policy

The Depository Institutions Deregulation and Monetary Control Act of 1980 (Pub. L. 96-221) was enacted on March 31, 1980. Title VI of that Act, the Truth in Lending Simplification and Reform Act, amends the Truth in Lending Act, 15 U.S.C. 1601, *et seq.* Section 608 of Title VI, effective March 31, 1980, authorizes the federal Truth in Lending enforcement agencies to order creditors to make monetary and other adjustments to the accounts of consumers where an annual percentage rate (APR) or finance charge was inaccurately disclosed. It generally requires the agencies to order restitution when such disclosure errors resulted from a clear and consistent pattern or practice of violations, gross negligence, or a willful violation which was intended to mislead the person to whom the credit was extended. However, the Act does not preclude the agencies from ordering restitution for isolated disclosure errors.

This policy guide summarizes and explains the restitution provisions of the

Truth in Lending Act (Act), as amended. The material also explains corrective actions the financial regulatory agencies believe will be appropriate and generally intend to take in those situations in which the Act gives the agencies the authority to take equitable remedial action.

The agencies anticipate that most financial institutions will voluntarily comply with the restitution provisions of the Act as part of the normal regulatory process. If a creditor does not voluntarily act to correct violations, the agencies will use their cease and desist authority to require correction pursuant to: 15 U.S.C. 1607 and 12 U.S.C. 1818(b) in the cases of the Board of Governors of the Federal Reserve System, the Federal Deposit Insurance Corporation, the Office of the Comptroller of the Currency, and the Office of Thrift Supervision; and 15 U.S.C. 1607 and 12 U.S.C. 1786(e)(1) in the case of the National Credit Union Administration.

Restitution Provisions

Definitions

Except as provided below, all definitions are those found in the Act and Regulation Z, 12 CFR part 226.

1. "Current examination" means the most recent examination begun on or after March 31, 1980, in which compliance with Regulation Z was reviewed.

2. "Lump sum method" means a method of reimbursement in which a cash payment equal to the total adjustment will be made to a consumer.

3. "Lump sum/payment reduction method" means a method of reimbursement in which the total adjustment to a consumer will be made in two stages:

a. A cash payment that fully adjusts the consumer's account up to the time of the cash payment; and,

b. A reduction of the remaining payment amounts on the loan.

4. "Understated APR" means a disclosed APR that is understated by more than the reimbursement tolerance provided in the Act,¹ as follows:

- For loans² with an amortization schedule of 10 years or less, a disclosed APR which, when increased by the greater of the APR tolerance specified in the Act³ and Regulation Z⁴ or one-quarter of one percent, is less than the actual APR calculated under the Act.⁵

¹ 15 U.S.C. 1607(e)

² For loans consummated after March 31, 1982. For loans consummated prior to that date refer to the Policy Guide dated July 21, 1980 (45 FR 48712) for additional guidance.

³ 15 U.S.C. 1606(c)

⁴ 12 CFR 226.14(a) and 226.22(a)

⁵ If, however, the loan is closed-end credit secured by real estate or a dwelling and the APR

- For loans with an amortization schedule of more than 10 years, a disclosed APR which, when increased by the APR tolerance specified in the Act and Regulation Z (*i.e.*, one-quarter of one percent for irregular loans, one-eighth of one percent for all other closed-end loans) is less than the actual APR.⁶

5. "Understated finance charge" means a disclosed finance charge which, when increased by the greater of the finance charge dollar tolerance specified in the Act and Regulation Z or a dollar tolerance that is generated by the corresponding APR reimbursement tolerance,⁷ is less than the finance charge calculated under the Act.

De Minimis Rule

If the amount of adjustment on an account is less than \$1.00, no restitution will be ordered. However, the agencies may require a creditor to make any adjustments of less than \$1.00 by paying into the United States Treasury, if more than one year has elapsed since the date of the violation.

is understated by more than one-quarter of one percent, the APR will be considered accurate and not subject to reimbursement if: (1) The finance charge is understated but considered accurate in accordance with the Act and Regulation (*i.e.*, the finance charge is not understated by more than \$100 on loans made on or after 9/30/95, or \$200 for loans made before that date); and (2) the APR is not understated by more than the dollar equivalent of the finance charge error and the understated APR resulted from the understated finance charge that is considered accurate.

⁶ If, however, the loan is closed-end credit secured by real estate or a dwelling and the APR is understated by more than one-eighth of one percent if the transaction is not considered to be an irregular transaction as defined by the Regulation (12 CFR 226.22(a)(3)) or one quarter of one percent if the transaction is irregular according to the definition, the APR will be considered accurate and no subject to reimbursement if: (1) The finance charge is understated but considered accurate according to the Actual Regulation (*i.e.*, the finance charge is understated but considered accurate according to the Act and Regulation *i.e.*, the finance charge is not understated by more than \$100 on loans made on or after 9/30/95, or \$200 for loans made before that date); and (2) the APR is not understated by more than the dollar equivalent of the finance charge error and the understated APR resulted from the understated finance charge that is considered accurate.

⁷ The finance charge tolerance for each loan will be generated by the corresponding APR tolerance applicable to that loan. For example, consider a single-payment loan with a one-year maturity that is subject to a one-quarter of one percent APR tolerance. If the amount financed is \$5,000 and the finance charge is \$912.50, the actual APR will be 18.25%. The finance charge generated by an APR of 18% (applying the one-quarter of one percent APR tolerance to 18.25%) for that loan would be \$900. The difference between \$912.50 and \$900 produces a numerical finance charge tolerance of \$12.50. If the disclosed finance charge is not understated by more than \$12.50, reimbursement would not be ordered.

Corrective Action Period

1. Open-end credit transactions will be subject to an adjustment if the violation occurred within the two-year period preceding the date of the current examination.

2. Closed-end credit transactions will be subject to an adjustment if the violation resulted from a clear and consistent pattern or practice or gross negligence where:

a. There is an understated APR on a loan which originated between January 1, 1977 and March 31, 1980.

b. There is an understated APR or understated finance charge, and the practice giving rise to the violation is identified during the current examination. Loans containing the violation which were consummated since the date of the immediately preceding examination are subject to an adjustment.

c. There is an understated APR or understated finance charge, the practice giving rise to the violation was identified during a prior examination and the practice is not corrected by the date of the current examination. Loans containing the violation which were consummated since the creditor was first notified in writing of the violation are subject to an adjustment. (Prior examinations include any examinations conducted since July 1, 1969).

3. Each closed-end credit transaction, consummated since July 1, 1969, and containing a willful violation intended to mislead the consumer is subject to an adjustment.

4. For terminated loans subject to 2, above, an adjustment will not be ordered if the violation occurred in a transaction consummated more than two years prior to the date of the current examination.

Calculating the Adjustment

Consumers will not be required to pay any amount in excess of the finance charge or dollar equivalent of the APR actually disclosed on transactions involving:

1. Understated APR violations on transactions consummated between January 1, 1977 and March 31, 1980, or

2. Willful violations which were intended to mislead the consumer.

On all other transactions, applicable tolerances provided in the definitions of understated APR and understated finance charge may be applied in calculating the amount of adjustment to the consumer's account.

Methods of Adjustment

The consumer's account will be adjusted using the lump sum method or the lump sum/payment reduction method, at the discretion of the creditor.

Violations Involving the Non-Disclosure of the APR or Finance Charge

1. In cases where an APR was required to be disclosed but was not, the disclosed APR shall be considered to be the contract rate, if disclosed on the note or the Truth in Lending disclosure statement.

2. In cases where an APR was required to be disclosed but was not, and no contract rate was disclosed, consumers will not be required to pay an amount greater than the actual APR reduced by one-quarter of one percentage point, in the case of first lien mortgage transactions, and by one percentage point in all other transactions.

3. In cases where a finance charge was not disclosed, no adjustment will be ordered.

Violations Involving the Improper Disclosure of Credit Life, Accident, Health, or Loss of Income Insurance

1. If the creditor has not disclosed to the consumer in writing that credit life, accident, health, or loss of income insurance is optional, the insurance shall be treated as having been required and improperly excluded from the finance charge. An adjustment will be ordered if it results in an understated APR or finance charge. The insurance will remain in effect for the remainder of its term.

2. If the creditor has disclosed to the consumer in writing that credit life, accident, health, or loss of income insurance is optional, but there is either no signed insurance option or no disclosure of the cost of the insurance, the insurance shall be treated as having been required and improperly excluded from the finance charge. An adjustment will be ordered if it results in an understated APR or finance charge. The insurance will remain in effect for the remainder of its term.

Special Disclosures

Adjustments will not be required for violations involving the disclosures required by sections 106(c) and (d) of the Act, (15 U.S.C. 1605(c) and (d)).

Obvious Errors

If an APR was disclosed correctly, but the finance charge required to be disclosed was understated, or if the finance charge was disclosed correctly,

but the APR required to be disclosed was understated, no adjustment will be required if the error involved a disclosed value which was 10 percent or less of the amount that should have been disclosed.

Agency Discretion

Adjustments will not be required if the agency determines that the disclosure error resulted from any unique circumstances involving a clearly technical and non-substantive disclosure violation which did not adversely affect information provided to the consumer and which did not mislead or otherwise deceive the consumer.

Safety and Soundness

In some cases, an agency may order, in place of an immediate, full adjustment, either a partial adjustment, or a full adjustment in partial payments over an extended time period that the agency considers reasonable. The agency may do so if it determines that (1) the full, immediate adjustment would have a significantly adverse impact upon the safety and soundness of the creditor, and (2) a partial adjustment, or making partial payments over an extended period of time, is necessary to avoid causing the creditor to become undercapitalized.⁸

Exemption from Restitution Orders

A creditor will not be subject to an order to make an adjustment if within 60 days after discovering a disclosure error, whether pursuant to a final written examination report or through the creditor's own procedures, the creditor notifies the person concerned of the error and adjusts the account to ensure that such person will not be required to pay a finance charge in excess of that actually disclosed or the dollar equivalent of the APR disclosed, whichever is lower. This 60-day period for correction of disclosure errors is unrelated to the provisions of the civil liability section of the Act.

Dated: September 2, 1998.

Keith J. Todd,

Acting Executive Secretary, Federal Financial Institutions Examination Council.

[FR Doc. 98-24057 Filed 9-4-98; 8:45 am]

BILLING CODES FRB: 6210-01-P 20%, OTS: 6720-01-P 20%, FDIC: 6714-01-P 20%, OCC: 4810-33-P 20%, NCUA: 7535-01-P 20%

⁸ The term "undercapitalized" will have the meaning as defined in section 38 of the Federal Deposit Insurance Act (12 U.S.C. 1831o).

FEDERAL MARITIME COMMISSION**Notice of Agreement(s) Filed**

The Commission hereby gives notice of the filing of the following agreement(s) under the Shipping Act of 1984.

Interested parties can review or obtain copies of agreements at the Washington, DC offices of the Commission, 800 North Capitol Street, N.W., Room 962. Interested parties may submit comments on an agreement to the Secretary, Federal Maritime Commission, Washington, DC 20573, within 10 days of the date this notice appears in the **Federal Register**.

Agreement No.: 224-200563-008.

Title: Oakland/Trans Pacific

Container Service Terminal Agreement.

Parties: Port of Oakland ("Port"), Trans Pacific Container Service Corporation ("Trans Pacific").

Synopsis: The proposed amendment recognizes Hyundai Merchant Marine Co. Ltd. ("Hyundai") as a secondary user of certain facilities in the Port's Seventh Street Marine Terminal area previously set aside for preferential use by Trans Pacific. Hyundai will utilize the facilities for an initial period of five years.

Agreement No.: 224-201057.

Title: Tampa Port Authority/

Harborside Refrigerated Services, Inc.

Parties: Tampa Port Authority,

Harborside Refrigerated Services, Inc.

Synopsis: The proposed Agreement authorizes the Port Authority to charge an incentive wharfage rate of \$1.50 per gross ton on export poultry, based on a minimum volume of 20,000 gross short tons. The term of the Agreement is for one year.

By order of the Federal Maritime Commission.

Dated: September 1, 1998.

Joseph C. Polking,

Secretary.

[FR Doc. 98-23961 Filed 9-4-98; 8:45 am]

BILLING CODE 6730-01-M

FEDERAL MARITIME COMMISSION**Ocean Freight Forwarder License Applicants**

Notice is hereby given that the following applicants have filed with the Federal Maritime Commission applications for licenses as ocean freight forwarders pursuant to section 19 of the Shipping Act of 1984 (46 U.S.C. app. 1718 and 46 CFR 510).

Persons knowing of any reason why any of the following applicants should not receive a license are requested to

contact the Office of Freight Forwarders, Federal Maritime Commission, Washington, DC 20573.

Transoptima Freight & Logistics, Inc. d/b/a Transoptima, 4135-145th Ave., NE., Bellevue, WA 98007, Officers: Georgi Dodov, Director, Anetta Dodova, Director

Magnum Freight Corporation, 2950 NW 75th Avenue, Miami, FL 33122,

Officer: Alvaro Fabre, President

Trans Forwarding, Inc., 7941 NW 21st Street, Miami, FL 33122, Officer:

Roberto Wittkop, President

LP International Inc., 3400 W. 35th

Street, Chicago, IL 60632, Officers:

James E. Hurley, President, Ralph H. Steinbarth, Director

AFS Freight Management (USA) Inc. d/

b/a, AFS Projects & Logistics USA,

2698 Junipero Avenue, Suite 201A,

Signal Hills, CA 90806, Officers:

Stephen Charles Rieson, President,

Vince Argenzio, Sr. Vice President

GAI International, 2631 So. Shaver,

Pasadena, TX 77502, Gerald Gumina,

Sole Proprietor

Dated: September 1, 1998.

Joseph C. Polking,

Secretary.

[FR Doc. 98-23962 Filed 9-4-98; 8:45 am]

BILLING CODE 6730-01-M

FEDERAL RESERVE SYSTEM**Formations of, Acquisitions by, and Mergers of Bank Holding Companies**

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act.

Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than September 28, 1998.

A. Federal Reserve Bank of Cleveland (Paul Kaboth, Banking Supervisor) 1455 East Sixth Street, Cleveland, Ohio 44101-2566:

1. *Charter One Financial, Inc.*, Cleveland, and Charter-Michigan Bancorp, Inc., both of Cleveland, Ohio; to become bank holding companies by acquiring 100 percent of the voting of ALBANK Financial Corporation, Albany, New York, and thereby indirectly acquire ALBANK Commercial, Albany, New York, and 9.9 percent of Gateway American Bank of Florida, Fort Lauderdale, Florida.

In connection with this application, Applicants have also applied to acquire all the nonbank subsidiaries of ALBANK, including Charter One Bank, FSB, Cleveland, Ohio, and ALBANK, FSB, Albany, New York, and thereby engage in operating savings associations, pursuant to § 225.28(b)(4)(ii) of Regulation Y; The First Financial Services and Development Corporation, Cleveland, Ohio, Servco, Inc., Cleveland, Ohio, and CDC-ASBANY Corp., Albany, New York, and thereby engage in community development activities, pursuant to § 225.28(b)(12) of Regulation Y; Charter One Investments, Inc., Cleveland, Ohio, Charter One Investments of Michigan, Inc., Detroit, Michigan, Charter One Investments of New York, Inc., Rochester, New York, Cuyahoga Financial Services Agency, Inc., Cleveland, Ohio, and ALVEST Financial Services, Inc., Albany, New York, and thereby engage in securities activities, pursuant to § 225.28(b)(7) of Regulation Y; Equity One Credit Corp., Cleveland, Ohio, Charter One Mortgage Corp., Richmond, Virginia, Charter One Auto Finance Corp., Rochester, New York, Equity One Credit Corp. (aka First Family Financial Services, Inc.), Cleveland, Ohio, and Servco, Inc., Cleveland, Ohio, and thereby engage in lending activities, pursuant to § 225.28(b)(1) of Regulation Y; ICX Corporation, Cleveland, Ohio, and Charter One Auto Finance Corp., Rochester, New York, and thereby engage in leasing activities, pursuant to § 225.28(b)(3) of Regulation Y; Real Estate Appraisal Services, Inc., Cleveland, Ohio, and thereby engage in real estate appraisal services, pursuant to § 225.28(b)(2)(i) of Regulation Y; Bay

Life Insurance Agency, Inc., Phoenix, Arizona, and thereby indirectly acquire 1001 Insurance Agency, Inc. (inactive), Detroit, Michigan, and thereby engage in insurance activities, pursuant to § 225.28(b)(11)(i) of Regulation Y; and GCCC, Inc., Cleveland, Ohio, and thereby engage in data processing activities, pursuant to § 225.28(b)(14) of Regulation Y.

B. Federal Reserve Bank of Atlanta (Lois Berthaume, Vice President) 104 Marietta Street, N.W., Atlanta, Georgia 30303-2713:

1. *SunTrust Banks, Inc.*, Atlanta, Georgia; to acquire 100 percent of the voting shares of Crestar Financial, Corporation, Richmond, Virginia, and thereby indirectly acquire Crestar Bank, Richmond, Virginia. In addition, Applicant seeks approval to acquire 19.9 percent of the voting shares of Crestar pursuant to an option agreement that may be exercised in the event that the full acquisition does not take place.

In connection with this application, Applicant also has applied to acquire the nonbanking subsidiaries of Crestar, including Crestar Securities Corporation, Richmond, Virginia: extending credit and servicing loans, pursuant to § 225.28(b)(1) of Regulation Y, providing leasing services, pursuant to § 225.28(b)(3) of Regulation Y, and thereby engage in providing financial and investment advisory services, pursuant to § 225.28(b)(6) of Regulation Y, providing agency transactional services for customer investments, pursuant to § 225.28(b)(7) of Regulation Y, underwriting and dealing in certain government obligations and money market instruments, pursuant to § 225.28(b)(8) of Regulation Y, engaging in sales of fixed rate and variable annuities and life insurance on an agency basis, pursuant to §§ 225.28(b)(11)(iv) and 225.28(b)(11)(vii) of Regulation Y, and underwriting and dealing in, to a limited extent, certain municipal revenue bonds, 1-4 family mortgage-related securities, consumer receivable-related securities, and commercial paper, pursuant to *Crestar Financial Corporation*, 83 Federal Reserve Bulletin 512 (1997), and other Board Orders.

In addition, Notificant proposes to engage through Crestar Insurance Agency, Richmond, Virginia, in the activity of acting as an insurance agency that provides life and property/casualty insurance coverage as agent for both individuals and businesses, pursuant to §§ 225.28(b)(11)(iv) and 225.28(b)(11)(vii) of Regulation Y; to engage through Crestar Community Development Corporation, Richmond, Virginia, in community development

activities, pursuant to § 225.18(b)(12); to operate an electronic funds transfer network and engage in data processing and management consulting activities by acquiring 5.7 percent of Honor Technologies, Inc., Maitland, Florida, pursuant to §§ 225.28(b)(9) and 225.28(b)(14) of Regulation Y, respectively. **Comments on this application must be received by September 30, 1998.**

Board of Governors of the Federal Reserve System, August 31, 1998.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 98-23792 Filed 9-4-98; 8:45 am]

BILLING CODE 6210-01-F

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act. Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than October 1, 1998.

A. Federal Reserve Bank of New York (Betsy Buttrill White, Senior Vice President) 33 Liberty Street, New York, New York 10045-0001:

1. *Commerzbank AG*, Frankfurt AM Main, Federal Republic of Germany; to become a bank holding company by

acquiring 32.39 percent of the voting shares of Korea Exchange Bank, Seoul, Korea, and thereby indirectly acquire California Korea Bank, Los Angeles, California.

B. Federal Reserve Bank of St. Louis (Randall C. Sumner, Vice President) 411 Locust Street, St. Louis, Missouri 63102-2034:

2. *Area Bancshares Corporation*, Ownesboro, Kentucky to acquire 100 percent of the voting shares of Broadway Bank and Trust, Paducah, Kentucky, a *de novo* state bank.

Board of Governors of the Federal Reserve System, September 1, 1998.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 98-23968 Filed 9-4-98; 8:45 am]

BILLING CODE 6210-01-F

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act. Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than October 2, 1998.

A. Federal Reserve Bank of New York (Betsy Buttrill White, Senior Vice President) 33 Liberty Street, New York, New York 10045-0001:

1. *Greene County Bancorp, MHC, and Greene County Bancorp, Inc.*, both of Catskill, New York; to become bank holding companies by acquiring 51 percent of the voting shares of Greene County Savings Bank, Catskill, New York.

2. *Cortland First Financial Corporation*, Cortland, New York; to acquire 100 percent of the voting shares of Oneida Valley Bancshares, Inc., Oneida, New York, and thereby indirectly acquire Oneida Valley National Bank, Oneida, New York.

3. *Oneida Financial MHC, and Oneida Financial Corp.*, both of Oneida, New York; to become bank holding companies by acquiring 53.50 percent of the voting shares of The Oneida Savings Bank, Oneida, New York.

B. Federal Reserve Bank of Chicago (Philip Jackson, Applications Officer) 230 South LaSalle Street, Chicago, Illinois 60690-1413:

1. *Legacy Bancorp, Inc.*, Milwaukee, Wisconsin; to become a bank holding company by acquiring 100 percent of the voting shares of Legacy Bank, Milwaukee, Wisconsin (in organization).

C. Federal Reserve Bank of Kansas City (D. Michael Manies, Assistant Vice President) 925 Grand Avenue, Kansas City, Missouri 64198-0001:

1. *BancFirst Corporation*, Oklahoma City, Oklahoma; to acquire 100 percent of the voting shares of Kingfisher Bancorp, Inc., Kingfisher, Oklahoma, and thereby indirectly acquire Kingfisher Bank and Trust Co., Kingfisher, Oklahoma.

Board of Governors of the Federal Reserve System, September 2, 1998.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 98-24076 Filed 9-4-98; 8:45 am]

BILLING CODE 6210-01-F

related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than September 22, 1998.

A. Federal Reserve Bank of Atlanta (Lois Berthaume, Vice President) 104 Marietta Street, N.W., Atlanta, Georgia 30303-2713:

1. *SouthTrust Corporation*, Birmingham, Alabama; to engage *de novo* through its subsidiary, SouthTrust Securities, Inc., Birmingham, Alabama, in underwriting and dealing, to a limited extent, in certain private ownership industrial development revenue bonds; *See Crestar Financial Corporation*, 83 Fed. Res. Bull. 512 (1997); *Bank South Corporation*, 81 Fed. Res. Bull. 1116 (1995)), and certain unrated municipal revenue bonds; *See Letter Interpreting Section 20 Orders*, 81 Fed. Res. Bull. 198 (1995); *Mellon Bank Corporation*, 81 Fed. Res. Bull. (1995); *SunTrust Banks, Inc.*, 81 Fed. Res. Bull. 1137 (1995)).

Board of Governors of the Federal Reserve System, September 1, 1998.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 98-23969 Filed 9-4-98; 8:45 am]

BILLING CODE 6210-01-F

disease prevention objectives for the next decade. Individuals and organizations are encouraged to comment on the draft objectives in one or more of the following three ways: (1) in writing, by submission through the mails, courier service, or the Internet; (2) in person, at one of five regional meetings scheduled at locations around the country; (3) in person, at the annual fall meeting of the national Healthy People Consortium.

DATES: The period for public comment opens at 9:00 a.m. EDT on September 15, 1998, and closes at 5:00 p.m. EST on December 15, 1998. Five regional meetings on Healthy People 2010 are scheduled on: October 5-6 in Philadelphia, PA; October 21-22 in New Orleans, LA; November 5-6 in Chicago, IL; December 2-3 in Seattle, WA; and December 9-10 in Sacramento, CA. Public comments on the Healthy People 2010 objectives will be accepted and recorded on the second day of each meeting. The Healthy People Consortium meeting is on November 12-13, 1998 in Washington, D.C. at the Capital Hilton hotel. A public hearing will be held during the afternoon of November 13, 1998. Pre-registration for these meetings is required. Registration forms and additional information about the meetings can be obtained by calling 1-800-367-4725. Seating is limited. In the event that interpretive services for the hearing-impaired are required, please indicate these special needs on the registration form.

AVAILABILITY OF DRAFT DOCUMENT: The draft document Healthy People 2010 Objectives: Draft for Public Comment will be for sale by the U.S. Government Printing Office as stock #017-001-00537. All orders must be prepaid. To order, call (202) 512-1800; FAX (202) 512-2250; or send orders to—Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. The full document and additional background information are also available on the Healthy People 2010 World Wide Web site, <http://web.health.gov/healthypeople>.

ADDRESSES: The mailing address for written comments is: Attention: Healthy People 2010 Objectives, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, Room 738-G Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Comments may also be submitted electronically through the Healthy People 2010 World Wide Web site, <http://web.health.gov/healthypeople>.

FEDERAL RESERVE SYSTEM

Notice of Proposals to Engage in Permissible Nonbanking Activities or to Acquire Companies that are Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y, (12 CFR Part 225) to engage *de novo*, or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Healthy People 2010 Objectives: Draft for Public Comment

AGENCY: DHHS/OS/Office of Public Health and Science, Office of Disease Prevention and Health Promotion (ODPHP).

ACTION: Call for comments on the draft national health objectives in Healthy People 2010.

SUMMARY: During the fall of 1998, the Department of Health and Human Services is soliciting comments on Healthy People 2010 Objectives: Draft for Public Comment, which identifies the national health promotion and

FOR FURTHER INFORMATION CONTACT:
Office of Disease Prevention and Health Promotion, Room 738–G Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, (202) 205–8583.

SUPPLEMENTARY INFORMATION:

Background

In 1979, the Department of Health and Human Services began an initiative using objectives for health promotion and disease prevention to improve the health of people living in the United States. The first set of national health targets was published in 1979 in *Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention*. This report proposed five goals to be achieved by 1990, including the reduction of mortality among four different age groups and the increase of independence among older adults. The goals were supported by objectives that were released in 1980 with 1990 targets. *Healthy People 2000*, the second and current national prevention initiative, reflects the progress and experience of 10 years, as well as an expanded science base and surveillance system. An extensive network of voluntary and professional organizations, businesses, and individuals collaborated in the design of the document’s framework. *Healthy People 2000* has three broad goals—increasing the span of health life, reducing health disparities, and achieving access to clinical preventive services—and is organized into 22 priority areas.

Structure of Health People 2010

The *Healthy People 2010* process builds on *Healthy People 2000*. Two overarching goals are proposed: (1) Increase quality and years of health life, and (2) eliminate health disparities. The first goal continues the year 2000 goal and emphasizes increasing the quality and wellness of life years, not just life expectancy. The second goal expands the year 2000 goal of reducing health disparities by calling for the elimination of these disparities. Select populations are targeted in many objectives to identify disparities in health status, health risk, or service delivery. The proposed focus areas are analogous to, and for the most part use the same names as, the *Healthy People 2000* priority areas. The term “focus area”

was chosen to avoid any implication of prioritization. New focus areas have been added in response to changes in health care and public health during the last decade and to anticipated changes in coming years. These new focus areas include: (1) Access to quality health services; (2) arthritis, osteoporosis, and chronic back conditions; (3) disability and secondary conditions; (4) health communication; (5) public health infrastructure; and (6) respiratory diseases. The focus areas are organized under the headings “Promote Healthy Behaviors,” “Promote Healthy and Safe Communities,” “Prevent and Reduce Diseases and Disorders,” and “Improve Systems of Personal and Public Health.”

Objectives for Healthy People 2010

The 2010 document has two types of objectives, measurable and developmental. Measurable objectives provide direction for action. They have baselines that use reliable data derived from currently established, nationally recognized data systems. Baseline data provide the point from which the target for 2010 can be set. Whenever possible, objectives will be measured with national systems that either build on, or are comparable with, state and local data systems. An example of a measurable objective in the Maternal, Infant, and Child Health focus area is “Reduce the infant mortality rate to no more than 5 per 1,000 live births.” The most recent data indicate that the infant mortality rate was 7.6 per 1,000 live births in 1995, as recorded by National Vital Statistics System, the data source from the Centers for Disease Control and Prevention, National Center for Health Statistics.

Developmental objectives describe a desired outcome or improvement in health status. However, current surveillance systems do not provide data to measure these objectives. The purpose of developmental objectives is to identify areas that are important to achieving improved health for Americans and to stimulate the development of data systems to measure them. An example of a developmental objective is “Increase the proportion of infants aged 18 months and younger who receive recommended primary care services at appropriated intervals.” Baseline data to measure such an objective are not currently available.

Purpose of Public Comment

The year 2010 goals and objectives need to address priorities for improving the health of the Nation and must be meaningful and useful for many stakeholders, including the general public. Comments on the 2010 objectives received by ODPHP by the three ways identified above will be assigned for review to agencies of HHS. A listing of these lead agencies is contained in the 2010 draft document. Public comments will be used to refine the draft 2010 document into its final form, which is scheduled for release in January 2000.

Dated: August 25, 1998.
David Satcher,
Assistant Secretary for Health and Surgeon General.
[FR Doc. 98–23970 Filed 9–4–98; 8:45 am]
BILLING CODE 4160–17–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request Proposed Project

Title: Form OCSE–396A, Child Support Enforcement Program Financial Report and Form OCSE–34A, Child Support Enforcement Program Quarterly Report of Collections.

OMB No.: New.
Description: These forms are used by States to report the expenditures and the collections of child support payments made under Title IV–D of the Social Security Act during each fiscal quarter. These forms also report the semiannual budget estimates for the program and the portion of the collected payments to be distributed to the custodial parent or to the Federal or State governments. The information is used to calculate quarterly grant awards, annual incentive payments to the States, annual “hold harmless” payments and is published in an Annual Report to Congress. Respondents are limited to the designated child support enforcement agency in each State.

Respondents: States.

ANNUAL BURDEN ESTIMATES				
Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
396A	54	4	8	1,728

ANNUAL BURDEN ESTIMATES—Continued

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
34A	54	4	8	1,728

Estimated Total Annual Burden Hours: 3,456.

In compliance with the requirements of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Information Services, 370 L'Enfant Promenade, S.W., Washington, D.C. 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c)

the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: September 1, 1998.

Bob Sargis,

Reports Clearance Officer.

[FR Doc. 98-23973 Filed 9-4-98; 8:45 am]

BILLING CODE 4184-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Administration for Children and Families****Proposed Information Collection Activity; Comment Request; Proposed Project**

Title: Emergency TANF Data Report (ACF-198).

OMB No.: 0970-0164.

Description: This information is being collected to meet the statutory requirements of section 411 of the Social Security Act. It consists of disaggregated and aggregated demographic and program information that will be used to determine participation rates, performance awards, and other statutorily required indicators for the Temporary Assistance for Needy Families (TANF) program. OMB previously approved this data collection through September 30, 1998. We are now requesting an extension through March 31, 2000, in order to maintain continuity of data collection.

Respondents: State, Local or Tribal Government.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
ACF-198	54	4	451	97,416

Estimated Total Annual Burden Hours: 97,416.

In compliance with the requirements of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Information Services, 370 L'Enfant Promenade, SW, Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary

for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: September 2, 1998.

Bob Sargis,

Acting Reports Clearance Officer.

[FR Doc. 98-24017 Filed 9-4-98; 8:45 am]

BILLING CODE 4184-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Food and Drug Administration**

[Docket No. 98F-0730]

Keller and Heckman LLP; Filing of Food Additive Petition

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that Keller and Heckman LLP, has filed a petition proposing that the food additive regulations be amended to change the density specifications for ethylene-maleic anhydride copolymers intended for use in contact with food.

FOR FURTHER INFORMATION CONTACT: Vir D. Anand, Center for Food Safety and Applied Nutrition (HFS-215), Food and Drug Administration, 200 C St. SW., Washington, DC 20204, 202-418-3081.

SUPPLEMENTARY INFORMATION: Under the Federal Food, Drug, and Cosmetic Act (sec. 409(b)(5) (21 U.S.C. 348(b)(5))), notice is given that a food additive petition (FAP 8B4623) has been filed by Keller and Heckman LLP, 1001 G St. NW., suite 500 West, Washington, DC 20001. The petition proposes to amend the food additive regulations in § 177.1520 *Olefin polymers* (21 CFR 177.1520) to change the density specifications from "0.92 to 0.94" to "0.92 or greater" for ethylene-maleic anhydride copolymers intended for use in contact with food.

The agency has determined under 21 CFR 25.32(i) that this action is of the type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

Dated: August 21, 1998.

George H. Pauli,

Acting Director, Office of Premarket Approval, Center for Food Safety and Applied Nutrition.

[FR Doc. 98-23960 Filed 9-4-98; 8:45 am]

BILLING CODE 4160-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Anti-Infective Drugs Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Anti-Infective Drugs Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on October 15 and 16, 1998, 8 a.m. to 5 p.m.

Location: Holiday Inn—Silver Spring, Kennedy Grand Ballroom, 8777 Georgia Ave., Silver Spring, MD.

Contact Person: Ermona B. McGoodwin, Center for Drug Evaluation and Research (HFD-21), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-827-7001, or FDA Advisory Committee Information Line, 1-800-741-8138 (301-443-0572 in the Washington, DC area), code 12530. Please call the Information Line for up-to-date information on this meeting.

Agenda: The committee will discuss the development of drug products for resistant bacteria, including selective spectrum agents.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by October 9, 1998. Oral presentations from the public will be scheduled between approximately 1 p.m. and 1:30 p.m. Time allotted for each presentation may be limited. Those desiring to make formal presentations should notify the contact person before October 9, 1998, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: September 1, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98-24003 Filed 9-4-98; 8:45 am]

BILLING CODE 4160-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Dental Plaque Subcommittee of the Nonprescription Drugs Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Dental Plaque Subcommittee of the Nonprescription Drugs Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on October 22 and 23, 1998, 8:30 a.m. to 5 p.m.

Location: Town Center Hotel, The Maryland Ballroom, 8727 Colesville Rd., Silver Spring, MD.

Contact Person: Robert L. Sherman or Stephanie A. Mason, Center for Drug Evaluation and Research (HFD-560), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD, 301-827-5191, or FDA Advisory Committee Information Line, 1-800-741-8138 (301-443-0572 in the Washington, DC area), code 12541. Please call the Information Line for up-to-date information on this meeting.

Agenda: The subcommittee will discuss: (1) The safety and efficacy of the combination of triclosan and zinc citrate and vote on the combination of zinc chloride, sodium citrate, hydrogen peroxide and sodium lauryl sulfate; (2) professional labeling for over-the-counter (OTC) antiplaque-antigingivitis drug products; and (3) the elements of their recommendations concerning OTC antiplaque-antigingivitis drug products, which will continue on October 23, 1998.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by October 15, 1998. Oral presentations from the public will be scheduled on October 22 between approximately 11 a.m. and 12 m. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before October 15, 1998, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: September 1, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98-24002 Filed 9-4-98; 8:45 am]

BILLING CODE 4160-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Food and Drug Administration****[Docket No. 98D-0340]****Draft Guidance for Industry: Use of Antibiotic Resistance Marker Genes in Transgenic Plants; Report and Guidance for Industry; Availability****AGENCY:** Food and Drug Administration, HHS.**ACTION:** Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a draft guidance entitled "Use of Antibiotic Resistance Marker Genes in Transgenic Plants: Guidance for Industry" (the draft guidance) and report entitled "Report on Consultations Regarding Use of Antibiotic Resistance Marker Genes In Transgenic Plants." The report summarizes FDA's recent consultations with outside experts on the use of antibiotic resistance marker genes in transgenic plants. The draft guidance is intended to provide information to crop developers that will assist them on the use of antibiotic resistance marker genes in the development of transgenic plants. In accordance with FDA's good guidance practices (GGP's) for Level 1 guidance, the agency is making the draft guidance available for public comment. The agency is also making the report available for public comment.

DATES: Written comments by December 7, 1998.

ADDRESSES: Submit written comments on the draft guidance and report to the Dockets Management Branch (HFA-305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit written requests for single copies of the draft guidance and report to the Division of Product Policy (HFS-206), Center for Food Safety and Applied Nutrition, Food and Drug Administration, 200 C St. SW., Washington, DC 20204. Send two self-addressed adhesive labels to assist that office in processing your requests. Requests and comments should be identified with the docket number found in brackets in the heading of this document. The draft guidance, report, and received comments are available for public examination in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

FOR FURTHER INFORMATION CONTACT:

Regarding human food issues: Nega Beru, Center for Food Safety and Applied Nutrition (HFS-206), Food and Drug Administration, 200 C St.

SW., Washington, DC 20204, 202-418-3097.

Regarding animal feed issues: William D. Price, Center for Veterinary Medicine (HFV-200), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 301-827-6652.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of May 29, 1992 (57 FR 22984), FDA published a notice on a policy statement (the 1992 policy) regarding foods derived from new plant varieties, including those derived using genetic engineering techniques. In the 1992 policy statement, FDA specifically discussed antibiotic resistance selectable marker genes and noted that both the antibiotic resistance gene and the enzyme encoded by the gene, unless removed, are expected to be present in foods derived from plants developed using the markers. The agency acknowledged that, when present in food, enzymes that are encoded by selectable marker genes and that inactivate certain clinically useful antibiotics theoretically might reduce the therapeutic efficacy of antibiotics administered orally. Accordingly, FDA believes that it is important to evaluate such concerns with respect to commercial use of antibiotic resistance marker genes in food, especially those marker genes that will be widely used. In addition, the agency also believes that it is important to consider the possibility that resistance to antibiotics in microorganisms has the potential to spread through horizontal transfer of antibiotic resistance marker genes from plants (59 FR 26700, May 23, 1994). This second consideration was reflected in FDA's evaluation of the safety of the use of the kanamycin resistance (*kan^r*) gene product, aminoglycoside 3'-phosphotransferase II (APH(3')II, also known as neomycin phosphotransferase II or nptII) when the agency amended the food additive regulations to permit the use of APH(3')II in the development of transgenic tomato, cotton, and oilseed rape.

FDA received several comments from the public regarding the use of antibiotic resistance marker genes in transgenic plants in response to the 1992 policy, and in response to the agency's solicitation for comment regarding the request of Calgene, Inc., for an advisory opinion on the use of the *kan^r* gene as a selectable marker in the development of transgenic tomatoes (56 FR 20004, May 1, 1991). FDA responded to these comments when it issued the final rule permitting the use of APH(3')II in the development of transgenic tomatoes,

oilseed rape, and cotton (59 FR 26700 at 26706).

Since FDA's decision approving the use of the APH(3')II in the development of transgenic tomatoes, cotton, and oilseed rape, the agency has continued to receive inquiries from crop developers as well as from the public regarding the safety and regulatory status of antibiotic resistance marker genes. Therefore, FDA sought to develop sound scientific principles regarding the safety of the use of antibiotic resistance marker genes in the development of transgenic plants intended for food use so as to provide sound scientific guidance to crop developers regarding the safe use of antibiotic resistance marker genes. Toward this end, FDA undertook several consultations with outside experts having expertise in relevant fields including gene transfer and antibiotic resistance. The purpose of the consultations was to determine whether circumstances exist under which FDA should recommend that a given antibiotic resistance gene not be used in crops intended for food use, and if so, to delineate the nature of those circumstances.

A team of scientists from FDA's Center for Food Safety and Applied Nutrition, Center for Veterinary Medicine, and Center for Drug Evaluation and Research held separate consultations with each expert. Following completion of all of the consultations, FDA prepared a report summarizing the discussions in each consultation. The report is entitled "Report on Consultations Regarding Use of Antibiotic Resistance Marker Genes In Transgenic Plants." The agency is by this notice making this report available for comment.

In order to facilitate the consultations, the agency developed several questions to form the basis of the discussions with the outside experts. These questions, enumerated in the report, were not intended to be exhaustive but rather to initiate the discussions with the experts. The agency is aware that there may be relevant issues not covered by these questions, e.g., the likelihood of a mutation in a given antibiotic resistance gene giving rise to resistance to another antibiotic. In commenting on the draft guidance and report, the agency encourages comments on issues that may have not been covered.

With this notice, FDA is announcing the availability of the draft guidance. The draft guidance represents the agency's current thinking on the use of antibiotic resistance marker genes in transgenic plants. It does not create or confer any rights for or on any person and does not operate to bind FDA or the

public. An alternative approach may be used if such an approach satisfies the requirements of the applicable statute, regulations, or both. The draft guidance is being distributed for comment purposes in accordance with FDA's GGP's (62 FR 8961, February 27, 1997); the draft guidance has been designated as Level 1 guidance.

Interested persons may, on or before December 7, 1998, submit written comments regarding the draft guidance and report to the Dockets Management Branch (address above). Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments and requests for copies are to be identified with the docket number found in brackets in the heading of this document. A copy of the draft guidance, report, and received comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday. After consideration of any comments received in response to this notice, FDA will revise the draft guidance as appropriate and will announce its availability in the **Federal Register**.

An electronic version of the draft guidance and report are available on the Internet using the World Wide Web (WWW) at <http://vm.cfsan.fda.gov> under the heading "Biotechnology."

Dated: August 28, 1998.

William B. Schultz,

Deputy Commissioner for Policy.

[FR Doc. 98-24072 Filed 9-4-98; 8:45 am]

BILLING CODE 4160-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA-1045-N]

RIN 0938-AJ16

Medicare Program: Request for Public Comments on Implementation of Risk Adjusted Payment for the Medicare+Choice Program and Announcement of Public Meeting

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Solicitation of comments; announcement of meeting.

SUMMARY: This notice solicits further public comments on issues related to the implementation of risk adjusted payment for Medicare+Choice organizations. Section 1853(a)(3) of the Social Security Act (the Act) requires the Secretary to implement a risk adjustment methodology that accounts for variation in per capita costs based on

health status and demographic factors for payments no later than January 1, 2000. The methodology is to apply uniformly to all Medicare+Choice plans. This notice outlines our proposed approach to implementing risk adjusted payment.

In order to carry out risk adjustment, section 1853(a)(3) of the Act also requires Medicare+Choice organizations, as well as other organizations with risk sharing contracts, to submit encounter data. Inpatient hospital data are required for discharges on or after July 1, 1997. Other data, as the Secretary deems necessary, may be required beginning July 1998.

The Medicare+Choice interim final rule published on June 26, 1998 (63 FR 34968) describes the general process for the collection of encounter data. We also included a schedule for the collection of additional encounter data. Physician, outpatient hospital, skilled nursing facility, and home health data will be collected no earlier than October 1, 1999, and all other data we deem necessary no earlier than October 1, 2000. Given any start date, comprehensive risk adjustment will be made about three years after the year of initial collection of outpatient hospital and physician encounter data. Comments on the process for encounter data collection are requested in that interim final rule. We intend to consider comments received in response to this solicitation as we develop the final methodology for implementation of risk adjustment.

This notice also informs the public of a meeting on September 17, 1998, to discuss risk adjustment and the collection of encounter data. The meeting will be held at the Health Care Financing Administration headquarters, located at 7500 Security Boulevard, Baltimore, MD, beginning at 8:30 a.m. Additional materials on the risk adjustment model will be available on or after October 15, 1998, and may be requested in writing from Chapin Wilson, Health Care Financing Administration, Department of Health and Human Services, 200 Independence Avenue, S.W., Room 435-H, Washington, DC 20201.

DATES: We request that comments be submitted on or before October 6, 1998.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1045-N, P.O. Box 26688, Baltimore, MD 21207.

If you prefer you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA-1045-N. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone (202) 686-7890).

FOR FURTHER INFORMATION CONTACT: Cynthia Tudor, (410) 786-6499.

SUPPLEMENTARY INFORMATION:

I. Background

Since 1985, Medicare payments to risk contracting Health Maintenance Organizations (HMOs) for aged and disabled beneficiaries living in a given county have been based on actuarial estimates of the per capita cost Medicare incurs paying claims on a fee-for-service (FFS) basis in that county. (Medicare's costs in paying claims for beneficiaries with end-stage renal disease are not considered in these county estimates, but are treated separately on a statewide basis.) These county estimates have been adjusted for the demographic composition of that county (age, gender, Medicaid eligibility status, and institutional status) in order to produce a figure representing the costs that would be incurred by Medicare on behalf of an average Medicare beneficiary in the county. These county per capita payment rates, adjusted for the average beneficiary, have been published annually as the county rate book. Prior to January 1998, actual payments for a given HMO enrollee were based on this county rate book amount, adjusted by demographic factors associated with each enrollee. Again, the demographic factors have been age, gender, Medicaid eligibility, and institutional status. This methodology is known as the "Adjusted Average Per Capita Cost" (AAPCC) methodology, and HMOs with Medicare contracts under section 1876 of the Social Security Act (the Act) were paid on this basis between 1985 and 1997.

In enacting the new Part C of Title XVIII to create the Medicare+Choice program, the Congress provided, a new section 1853 of the Act, for a new methodology for paying organizations that enter into Medicare+Choice contracts. Under this new methodology, the equivalent of the above-described county rate book (that is, the county-wide amount that is adjusted by an individual enrollee's demographic status to determine the final payment amount) is based on the greatest of three amounts. The first amount is a new blended payment rate methodology that would combine the area specific amounts with national data and would be subject to other adjustments. The second amount is a new minimum specified rate amount (for example, \$367 per month per enrollee in 1998). The third amount is based on a 2 percent increase over the prior year's rates, with the rate book for 1997 serving as the baseline. As in the case of the AAPCC methodology described above, the county rates under section 1853 of the Act, are adjusted for the demographic status of each enrollee.

Under section 1876(k)(3) of the Act, the new Medicare+Choice payment methodology under section 1853 of the Act applies to existing HMO contracts under section 1876 for 1998, and to Medicare+Choice plans beginning in 1999.

Section 1853(a)(3) of the Act requires the Secretary to develop and implement a new risk adjustment methodology to be used to adjust the county-wide rates under section 1853 of the Act to reflect the expected relative health status of each enrollee. This new methodology, which must be implemented by January 1, 2000, would replace the current method of adjusting county-wide rates based on the four demographic factors of age, gender, Medicaid eligibility, and institutional status. The goal is to pay Medicare+Choice organizations based on better estimates of health care costs of the population they enroll (relative to the FFS population).

While the Medicare+Choice legislation mandates the implementation of risk adjustment in general, the legislation provides the Secretary with broad discretion to develop a risk adjustment methodology that would "account for variations in per capita costs based on health status and other demographic factors." Because Medicare+Choice legislation does not allow for the collection of any data other than inpatient hospital data (in the near term), we are constrained initially to using a model that requires only inpatient data. We are currently receiving these data. In previous public

meetings on encounter data requirements, organizations have been briefed on the Principal Inpatient Diagnostic Cost Group (PIP-DCG), created by HHS-sponsored researchers at Health Economics Research, Inc., and Boston and Brandeis. This is the only risk adjuster model that has been developed to run solely on inpatient data. The model was recently updated using 1995 and 1996 Medicare data.

The remainder of this notice outlines our proposed approach for implementation of risk adjusted payments on January 1, 2000, discussing both the risk adjustment methodology and the proposed risk adjustment payment model. In the development of all risk adjustment payment models, there are two tasks that must be performed: (1) The estimation of the risk adjustment model, and (2) application of the risk adjustment model to a payment system. The estimation of the PIP-DCG model is described first.

A. The Principal In-Patient Diagnostic Cost Group (PIP-DCG) Model

In constructing a risk adjustment model, it is important to determine which set of conditions should be used to adjust payments. Under the current payment system, all enrollees are placed in a base group paid according to demographic characteristics. In this risk adjustment system, all conditions that appear as inpatient principal diagnoses are candidates for adjusting payments. The base payment category decreases as more conditions are placed into separate disease groups. Because an inpatient hospital-based system depends on a person's site of service, only a subset of conditions should be recognized for changing payments. That is, the system should recognize admissions for which inpatient care is most frequently appropriate. For example, admissions for diseases most commonly treated on an outpatient basis should remain in the base group and should not be used for adjustment.

The PIP-DCG model was estimated using diagnostic information for Medicare FFS enrollees from inpatient hospital stays during calendar year 1995. The sample used in the estimation analyses consisted of individuals included in the 5-percent sample of Medicare beneficiaries who were alive and enrolled in Medicare during all of 1995, and on January 1, 1996. Beneficiaries with certain characteristics (for example, HMO enrollees and end-stage renal disease enrollees, new Medicare eligibles in 1996) were excluded from the analyses. In general, these exclusions were made to increase confidence that a complete set of

Medicare claims for each beneficiary in the sample data set was included in the model development. The final estimation data set included 1.4 million Medicare beneficiaries.

While the PIP-DCG model uses only inpatient diagnoses in creating the risk adjustment classification system, the model predicts total expected costs for the following year across multiple sites of services. Consequently, all Medicare expenditures, other than those for hospice care, were included in the calculation. Medicare expenditures for hospice care were not included because Medicare+Choice organizations are not responsible for hospice care. The model was estimated assuming no time lag between the base year (diagnostic information) and the predicted expenditures; that is, calendar year 1995 beneficiary diagnoses were used to predict calendar year 1996 expenditures.

1. From Diagnosis Groups (DxGroups) to PIP-DCGs

The risk adjustment model estimation process begins with a classification system, forming the inherent logic of the model. For the PIP-DCG model, diagnoses are classified into DxGroups based on the principal inpatient diagnosis. The DxGroups comprise an exhaustive classification of all valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic codes. For example, DxGroup 1, Central Nervous System Infections, includes ICD-9-CM diagnostic codes for such conditions as encephalitis and meningitis. The primary criteria in forming the DxGroups were clinical coherence and an adequate sample size to estimate average expenditures. Beneficiaries with multiple different inpatient diagnoses could have multiple hospital stays, and would initially be placed in multiple DxGroups.

Next, DxGroups were aggregated into payment groups, or PIP-DCGs, using a sorting algorithm that ranked DxGroups based on 1996 actual expenditures. For example, DxGroup 7 (Metastatic Cancer with a mean future expenditure of \$26,331) was placed in PIP-DCG 26. Highest expenditure DxGroups were grouped into the "highest" PIP-DCG. Once beneficiaries with the highest costs were placed into a DxGroup, those beneficiaries and all their associated expenditures were removed from the data for other DxGroups and then the DxGroups were re-ranked. The DxGroups with the next most costly diagnoses were grouped into the next highest numbered PIP-DCG, and those beneficiaries were removed from the

remaining DxGroups. The process was repeated until each beneficiary and his or her expenditures were assigned to a single PIP-DCG group. Beneficiaries with multiple inpatient diagnoses were placed in their highest expenditure PIP-DCG group.

In this way, each PIP-DCG group was defined according to average total expenditures for beneficiaries with inpatient diagnoses, categorized and sorted using the DxGroups rather than diagnosis by diagnosis. Based upon this sorting algorithm, more than 20 initial PIP-DCGs were defined. Lower average expenditure PIP-DCG groups had lower cost ranges (or intervals), while the highest average expenditure PIP-DCG groups had wider ranges.¹

2. Modifications to the PIP-DCG Model

After the initial sorting of DxGroups into PIP-DCG groups was complete, a clinical panel reviewed the placement of the DxGroups and their resulting predicted expenditures, to determine the appropriateness of their application in a payment model. Through this process, 75 DxGroups (covering about 1/3 of the admissions) were identified as: (1) Representing only a minor or transitory disease or disorder, not clinically likely to result in significant future medical costs, (2) rarely the main cause of an inpatient stay, or (3) vague or ambiguous. These groups, as recommended by the clinical panel, were identified as those most likely to result in inconsistent or inappropriate reimbursements and were placed (with their associated expenditures) in the base payment category (for which the payment is a function of demographic factors). Examples of these groups include the DxGroup for fluid/electrolyte disorders and malnutrition. Though the treatment for individuals with this diagnoses are often quite costly in the following year, the diagnosis is clinically vague and, therefore, represented a likely target for coding "creep." The clinical panel concluded that many of the sickest individuals with this diagnosis were likely to have another hospitalization

that would trigger appropriate increased reimbursements. Then, the remaining DxGroups were resorted and placed into revised DCGs for the payment model. A total of 10 PIP-DCGs (above the base payment category) are included in the current model.

As a second strategy to ensure consistent and appropriate payment levels, beneficiary diagnoses reported as a result of a short hospital stay (1 day or less) were left in the base payment category. Since the majority of 1-day stays are for diagnoses already assigned to the base group, the effect on payment is small. Also, short stays are often indicative of less serious, and, hence, less costly cases. It is important to note that these modifications do not mean that these expenditures have been excluded from the model. Rather, the payments associated with these diseases are captured in increased payments for the base payment category, where the majority of enrollees are paid based on demographic factors.

Under the proposed PIP-DCG model, beneficiaries who are hospitalized for chemotherapy (V58.1 and V66.2) were treated as exceptions. These codes are indicators of a treatment method, rather than a particular disease. Recognizing, however, that Medicare's current inpatient coding rules require that the diagnoses for beneficiaries who are hospitalized for chemotherapy must be coded using these V-codes as the principal diagnoses, the most appropriate PIP-DCG group for these beneficiaries would be assigned based on the type of cancer, using a secondary diagnosis. A model will be estimated that uses secondary diagnoses to determine risk scores for hospitalized beneficiaries that were assigned chemotherapy V-codes (as defined above). This modification could be made for payment in calendar year 2000. The model described in this notice has left these admissions in the base group.

3. Addition of Demographic and Other Factors

The next phase in the estimation of the model was the creation of demographic variables (age, sex, and disability status) for the PIP-DCG groups. In this phase of the calibration, 24 age and sex groupings were created. Separate groupings were created for males and females, by 5-year age increments, except where numbers were too small to get good estimates (that is, age group 0 through 34 and greater than 94 for males and females).

Separate parameters were also included to estimate the unique cost effects of whether an aged beneficiary

was formerly eligible because of a disability, and whether an aged or disabled beneficiary is eligible for Medicaid. The estimated adjustments for the demographic categories are the same irrespective of which PIP-DCG an enrollee falls into. The Medicaid adjustment, however, depends on a person's status as aged or disabled.

New enrollees to Medicare, for whom there are no claims history, will be assigned a score based on a separate HCFA analysis of actual new enrollee expenditures. At this time, a separate parameter is not anticipated for the institutionalized because institutional status is not needed as an indicator of high Medicare utilization. Under the demographically adjusted system, institutional status was an indicator of a beneficiary with relatively poor health status. It, therefore, increased payments over the age and sex based amounts. The risk adjuster model has health status measures built in, and on the average, compensates for poor health status. In fact, preliminary estimates indicate that after accounting for inpatient hospital admissions, the institutional adjustment would be negative. Adjustments for the working-aged will be made in a manner similar to the current system. As a last step during the estimation, expenditures were adjusted to create an estimate of annual payments as if each beneficiary had been alive and enrolled for the entire year. This is equivalent to an expenditure per month measure. Estimation of the incremental costs associated with each of the variables (for example, demographics, DCGs) was made by the linear regression technique, which takes account of all the variables that apply to an individual.

4. The Current PIP-DCG Model

The current PIP-DCG model contains a total of 37 parameters (10 PIP-DCGs and 27 demographic or Medicaid factors). The model will continue to be refined over the next few months. While there are a number of ways to assess the "accuracy" of the model, payment for different groups of beneficiaries is improved with risk adjustment compared to the application of a demographic only model. Preliminary coefficients for the PIP-DCG model are presented in Table 1. The current placements of DxGroups into PIP-DCG groups are shown in Table 2. The next section of this notice details how we are proposing to use the PIP-DCG model in the Medicare+Choice payment system as of January 1, 2000.

¹ The PIP-DCG groupings were further refined using a number of criteria. First, each original PIP-DCG group remained in the final payment model only if it contained at least 1,000 beneficiaries from the original sample; this minimum sample size was defined to assure stability of estimated payments in the final model. If sample sizes were smaller than 1,000, the potential PIP-DCG was expanded to include DxGroups with average expenditures in the next lower range until the sample size criteria was satisfied. If at any time during the sorting algorithm a DxGroup had fewer than 50 beneficiaries assigned to it, it was assigned to the base payment category. This base payment category also included all beneficiaries (and expenditures) for whom there was no inpatient diagnosis during 1995.

B. Proposed Payment System Application of the PIP-DCG Model

In its basic form, the PIP-DCG model is an algorithm that uses base year inpatient diagnoses, along with demographic factors and Medicaid eligibility, to predict total health spending in the following year. In applying the PIP-DCG model to risk adjusted payments for the Medicare+Choice program, however, the model will be used to determine relative risk scores. These relative risk scores will be used, in place of the current demographic factors, to adjust county rate book payments for the relative health status of the individual enrollee.

1. Estimating Beneficiary Relative Risk Factors

The PIP-DCG model was developed to be "additive", meaning that incremental dollars are added together based on each beneficiary's characteristics. Referring to Table 3, the following examples illustrate how the PIP-DCG model will be used for estimating relative risk factors.

A beneficiary is placed in a PIP-DCG group, based on inpatient diagnoses reported. In this example, "Beneficiary A" was hospitalized twice during the base year. The diagnoses reported were Asthma (PIP-DCG 8) and Lung Cancer (PIP-DCG 18). The highest PIP-DCG category then for this beneficiary is PIP-DCG 18, which carries with it an estimated future year expenditure of \$12,883. The beneficiary is also placed in the appropriate demographic groups. In this case, Beneficiary A is male, aged 82. This age group carries an estimated expenditure of \$5,617. In addition, Beneficiary A had originally been Medicare eligible because of a disability (which carries an incremental expenditure of \$2,381), but is not eligible for Medicaid (no expenditure increment). Adding together these increments based on the PIP-DCG model, the predicted expenditures for this beneficiary are \$20,881.

As another example, consider "Beneficiary B." Beneficiary B had no inpatient admissions during the base year. Therefore, no specific PIP-DCG increment is added; expenditures for non-hospitalized beneficiaries are included in the demographic factors. Beneficiary B is placed in the appropriate age and sex grouping; in this case, female aged 72, which carries a predicted expenditure of \$3,118. Beneficiary B is also placed in the Aged with Medicaid eligibility group, which adds \$2,124 to her annual predicted expenditures. Since she has never been disabled, no additional expenditures are

added. Therefore, total annual predicted expenditures for Beneficiary B are \$5,242.

Because Medicare+Choice program payments are based on the county-wide rates determined under section 1853(c) of the Act, the predicted annual expenditures described above will be converted to relative risk scores. This is accomplished by dividing the predicted expenditures for each beneficiary by the national average predicted expenditure (\$5,300). Individuals whose risk scores are equal to 1.00 are "average." In the examples described above, Beneficiary A's relative risk score is 3.9 (indicating a high expected cost individual), while Beneficiary B's relative risk score is 0.99 (indicating a slightly lower than average risk individual).

After Medicare+Choice organizations submit inpatient hospital encounter data, we will use the demographic information and diagnostic information from all Medicare+Choice organizations a beneficiary may have joined and from FFS to determine the appropriate risk factor for each beneficiary. When a Medicare+Choice organization forwards enrollment information to us, we, in turn, will send the Medicare+Choice organization the appropriate risk factor, as well as the resultant payment. Because the risk factor is computed for each individual beneficiary, the factor follows that beneficiary. In addition, since all beneficiaries will have risk factors, information will be immediately available for payment purposes as beneficiaries move among Medicare+Choice organizations.

Risk adjustment factors for new Medicare beneficiaries (for whom health status information) is not available will be based on demographic information only. Examples of persons using the demographic model are new 65-year-olds and new Medicare disabled individuals. Similar to the current system, a "demographic only" model is being developed that will be used to determine the risk adjustment factors for these beneficiaries.

2. Risk Adjusted Payment Model

To determine risk adjusted monthly payment amounts for each Medicare+Choice enrollee, individual risk factors (described above) will be multiplied by the appropriate payment rate for the county determined under section 1853(c) of the Act. Beginning with the implementation of risk adjustment, the separate aged and disabled rate books (incorporating combined Medicare Parts A and B) will be combined. Risk adjusted payments will be made using a single, combined Medicare+Choice county rate book. This

change will be made because there is a single risk adjustment methodology for the entire Medicare population (excluding persons with end-stage renal disease).

In addition to combining the current aged and disabled county rate books into a single combined county rate book, an adjustment to these rate book amounts will be required before applying the risk adjustment factors discussed above. This adjustment, or re-scaling factor, is necessary in order to account for the fact that the existing county rate book already accounts for demographic factors that are addressed, in a more precise way, in the risk adjustment factors we will be using. If the PIP-DCG model risk adjustment factors were applied to unadjusted county rate book amounts, this would create unintended distortions that would produce adjustments inconsistent with Congress' mandate in section 1853(c) of the Act. The application of the re-scaling factor we are proposing would in effect translate the rate book amounts into the same language used under the risk adjustment methodology, so that we are not comparing "apples to oranges." As a result of re-scaling, payment for a person with the average risk score in a county would be the same as payment for a person with the average demographic score in that county. (However, a person with the average demographic score does not necessarily have the average risk score.) To the extent that an organization enrolls sicker people, the organization will receive higher payments.

C. Summary of HCFA's Proposed Approach for 2000

The proposed approach we will use to meet the year 2000 mandate for risk adjusted payments will—

- (1) Be based on inpatient data;
- (2) Utilize a prospective PIP-DCG risk adjuster to estimate relative beneficiary risk scores;
- (3) Apply a re-scaling factor to address inconsistencies between demographic factors in the rate book and new risk adjusters;
- (4) Apply individual enrollee risk scores in determining fully capitated payments;
- (5) Include the auditing of medical records to validate encounter data;
- (6) Implement processes to collect encounter data on additional services; and
- (7) Continue to refine the risk adjustment system based on ongoing research.

D. Other Issues

In addition to comments on the proposed risk adjustment approach, we are interested in receiving responses to the following questions: (1) Under one possible implementation approach we have considered, a Medicare+Choice organization would be paid initially based on estimates of the number of enrollees the organization has in a given risk factor category. These estimates would be based on the most recently available data (probably July 1998 through June 1999). Once more current data (from January 1999 through December 1999) became available in July 2000, a retroactive adjustment would be made pursuant to section 1853(a)(2) of the Act "to take into account any difference between the actual number of individuals enrolled" in a given risk category, and the "number of such individuals estimated to be so enrolled when the advance payment was determined." These adjustments would be made retroactive to January 2000. This would be consistent with our longstanding practice of making retroactive adjustments to reflect the actual number of enrollees in a current demographic category (such as institutional status, end-stage renal disease status, dual eligible status, or working aged status) when this number differs from the number of enrollees estimated to be in any such category at the time payments were initially made.

An alternative approach is to use data from an earlier period (for example, July 1, 1998 through June 30, 1999) to determine the risk factor for enrollees and payments to Medicare+Choice organizations for calendar year 2000. Using data from an earlier time period introduces some error into the estimates, but we do not believe it introduces any systematic bias. Note that implementation of this alternative model solves the problem of basing the payments to a plan on the estimated

number of enrollees in a given risk factor category, which would require a retroactive adjustment as described above. Assuming a relatively large and stable population for a plan, aggregate payments under this approach are not likely to differ from aggregate payments using a method requiring this type of retroactive payment adjustment. However, on an individual basis, using data from an earlier time period lengthens the time between a hospital stay for an enrollee and compensation to the organization for the future predicted cost of that illness.

Given these issues, what problems are Medicare+Choice organizations likely to encounter with retroactive payment adjustments? Conversely, if data from an earlier time period were used, what problems are organizations likely to encounter?

(2) The Secretary is required to announce the annual Medicare+Choice capitation rate for each Medicare+Choice payment area and the risk and other factors to be used in adjusting such rates by March 1 of the year preceding the payment year. In addition, at least 45 days prior to the annual announcement of capitation rates, the Secretary shall provide notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement.

The implementation of risk adjustment will alter the methodology for calculating rates for each Medicare+Choice payment area. Given the proposed changes, what types of information should be included in the 45-day notice and the annual announcement to assist Medicare+Choice organizations in planning for risk adjusted payments?

(3) What types of problems are Medicare+Choice organizations likely to encounter as capitation payments are changed from a demographic only basis to a health status adjusted basis? How

should we address these problems, especially for small plans, rural plans, and start up plans? While we are currently processing the inpatient hospital data for managed care enrollees, we note that we will be unable to model the financial impact of the risk adjustment methodology until we have completed the processing of these data and have assigned risk scores to plans enrollees.

II. September 17, 1998, Public Meeting

In addition to seeking written comments from the public, we will hold a public meeting on September 17, 1998, at HCFA, 7500 Security Boulevard, Baltimore, MD. The purpose of this meeting will be to discuss issues and concerns from potential Medicare+Choice organizations, organizations contracting under section 1876 of the Act, providers, beneficiaries, and other interested parties on the implementation of risk adjusted payment. The collection and auditing of encounter data, which was described in the Medicare+Choice interim final rule published on June 26, 1998, in the **Federal Register**, will also be addressed in this meeting. The agenda for the meeting is likely to cover the following topics:

- Background on the Principal Inpatient Diagnostic Cost Group (PIP-DCG) risk adjustment model.
- Changes to the payment rates.
- Application of the risk adjustment model for payment in CY 2000.
- Description of the overall risk adjustment implementation process.
- Auditing of encounter data.
- Collection of additional encounter data.

Comments on the proposed agenda are welcome. Further information on the meeting can be obtained from Chapin Wilson, (202) 690-7874.

In accordance with E.O. 12866, this notice was reviewed by the Office of Management and Budget.

TABLE 1.—CURRENT PIP-DCG MODEL

Number of Observations	1,401,274
R-Squared	0.058718
Dependent Variable Mean	\$5,300
Root Mean Square Error	14,256
Model Parameters	37
Base Payment Categories	
Male: Aged 0-34	1,255
Male: 35-44	1,940
Male: 45-54	2,654
Male: 55-59	3,350
Male: 60-64	3,970
Male: 65-69	2,792

TABLE 1.—CURRENT PIP—DCG MODEL—Continued

Base Payment Categories	Payment Increment
Male: 70–74	3,702
Male: 75–79	4,738
Male: 80–84	5,617
Male: 85–89	6,562
Male: 90–94	7,209
Male: 95+	7,189
Female: 0–34	1,345
Female: 35–44	2,167
Female: 45–54	2,763
Female: 55–59	3,647
Female: 60–64	4,673
Female: 65–69	2,439
Female: 70–74	3,118
Female: 75–79	3,994
Female: 80–84	4,768
Female: 85–89	5,592
Female: 90–94	5,855
Female: 95+	5,466
Other Demographic Factors	
Previously Disabled	2,381
Medicaid, Medicare Aged	2,124
Medicaid, Medicare Disabled	1,744
PIP—DCGs	
PIP—DCG 6	2,265
PIP—DCG 8	4,406
PIP—DCG 10	5,829
PIP—DCG 12	7,950
PIP—DCG 14	9,946
PIP—DCG 18	12,883
PIP—DCG 20	16,346
PIP—DCG 23	18,950
PIP—DCG 26	21,881
PIP—DCG 29	29,317

Notes: PIP—DCG 4 is combined with the demographic factors, and includes those with no hospitalizations, modified or certain low-cost admissions. Diagnoses from hospital stays of less than two days are not used in assigning PIP—DCGs.

TABLE 2.—DIAGNOSES (DXGROUPS) INCLUDED IN EACH PIP—DCG—CURRENT PAYMENT MODEL

PIP—DCG 6:		
DxGroup	18	Cancer of Prostate/Testis/Male Genital Organs.
	14	Breast Cancer.
PIP—DCG 8:		
DxGroup	82	Acute Myocardial Infarction.
	146	Pelvic Fracture.
	145	Fractures of Skull/Face.
	77	Valvular and Rheumatic Heart Disease.
	86	Atrial Arrhythmia.
	84	Angina Pectoris.
	80	Coronary Atherosclerosis.
	92	Precebral Arterial Occlusion.
	16	Cancer of Uterus/Cervix/Female Genital Organs.
	79	Hypertension, Complicated.
	36	Peptic Ulcer.
	110	Asthma.
	96	Aortic and Other Arterial Aneurysm.
	153	Brain Injury.
	1	Central Nervous System Infections.
	39	Abdominal Hernia, Complicated.
	64	Alcohol/Drug Dependence.
PIP—DCG 10:		
DxGroup	109	Bacterial Pneumonia.
	42	Gastrointestinal Obstruction/Perforation.
	143	Vertebral Fracture Without Spinal Cord Injury.
	21	Other Cancers.
	4	Tuberculosis.
	97	Thromboembolic Vascular Disease.
	59	Schizophrenic Disorders.

TABLE 2.—DIAGNOSES (DXGROUPS) INCLUDED IN EACH PIP—DCG—CURRENT PAYMENT MODEL—Continued

PIP—DCG 12: DxGroup	11	Colon Cancer.
	116	Kidney Infection.
	83	Unstable Angina.
	94	Transient Cerebral Ischemia.
	81	Post-Myocardia Infarction.
	150	Internal Injuries/Traumatic Amputations/Third Degree Burns.
	32	Pancreatitis/Other Pancreatic Disorders.
	147	Hip Fracture.
	158	Artificial Opening of Gastrointestinal Tract Status.
PIP—DCG 14: DxGroup	91	Cerebral Hemorrhage.
	93	Stroke.
	56	Dementia.
	98	Peripheral Vascular Disease.
	41	Inflammatory Bowel Disease.
	22	Benign Brain/Nervous System Neoplasm.
	48	Rheumatoid Arthritis and Connective Tissue Disease.
	49	Bone/Joint Infections/Necrosis.
	19	Cancer of Bladder, Kidney, Urinary Organs.
	45	Gastrointestinal Hemorrhage.
	87	Paroxysmal Ventricular Tachycardia.
PIP—DCG 18: DxGroup	133	Cellulitis and Bullous Skin Disorders.
	57	Drug/Alcohol Psychoses.
	66	Personality Disorders.
	29	Adrenal Gland, Metabolic Disorders.
	70	Degenerative Neurologic Disorders.
	2	Septicemia/Shock.
	144	Spinal Cord Injury.
	58	Delirium/Hallucinations.
	61	Paranoia and Other Psychoses.
	63	Anxiety Disorders.
	73	Epilepsy and Other Seizure Disorders.
PIP—DCG 20: DxGroup	10	Stomach, Small Bowel, Other Digestive Cancer.
	12	Rectal Cancer.
	26	Diabetes with Acute Complications/Hypoglycemic Coma.
	113	Pleural Effusion/Pneumothorax/Empyema.
	60	Major Depression.
	34	Cirrhosis, Other Liver Disorders.
	72	Paralytic and Other Neurologic Disorders.
	108	Gram-Negative/Staphylococcus Pneumonia.
	111	Pulmonary Fibrosis and Bronchiectasis.
	89	Congestive Heart Failure.
	105	Chronic Obstructive Pulmonary Disease.
PIP—DCG 23: DxGroup	95	Atherosclerosis of Major Vessel.
	13	Lung Cancer.
	8	Mouth/Pharynx/Larynx/Other Respiratory Cancer.
	112	Aspiration Pneumonia.
	76	Coma and Encephalopathy.
	75	Polyneuropathy.
	17	Cancer of Placenta/Ovary/Uterine Adnexa.
	55	Blood/Immune Disorders.
	134	Decubitus and Chronic Skin Ulcers.
	33	End-stage Liver Disorders.
	9	Liver/Pancreas/Esophagus Cancer.
PIP—DCG 26: DxGroup	88	Cardio-Respiratory Failure and Shock.
	27	Diabetes with Chronic Complications.
	115	Renal Failure/Nephritis.
	7	Metastatic Cancer.
	3	HIV/AIDS.
	15	Blood, Lymphatic Cancers/Neoplasms.
	20	Brain/Nervous System Cancers.
PIP—DCG 29: DxGroup		

TABLE 3.—ESTIMATING PROSPECTIVE BENEFICIARY EXPENDITURES MEAN PREDICTED EXPENDITURES = \$5300

Demographic factors base PIP-DCG	+	PIP-DCG	+	Other factors
Aged Population				
Male 65–69	\$2792	PIP-DCG 6	\$2265	Previously Disabled \$2381
Male 70–74	3702	PIP-DCG 8	4406	Medicaid, Medicare Aged 2124
Male 75–79	4738	PIP-DCG 10	5829	
Male 80–84	5617	PIP-DCG 12	7950	
Male 85–89	6562	PIP-DCG 14	9946	
Male 90–94	7209	PIP-DCG 18	12,883	
Male 95+	7189	PIP-DCG 20	16,346	
Female 65–69	2439	PIP-DCG 23	18,950	
Female 70–74	3118	PIP-DCG 26	21,881	
Female 75–79	3944	PIP-DCG 29	29,317	
Female 80–84	4768			
Female 85–89	5592			
Female 90–94	5855			
Female 95+	5466			
Disabled Population				
Male 0–34	1255	PIP-DCG 6	2265	Medicaid, Medicare Disabled 1744
Male 34–44	1940	PIP-DCG 8	4406	
Male 45–54	2654	PIP-DCG 10	5829	
Male 55–59	3350	PIP-DCG 12	7950	
Male 60–64	3970	PIP-DCG 14	9946	
Female 0–34	1345	PIP-DCG 18	12,883	
Female 34–44	2167	PIP-DCG 20	16,346	
Female 45–54	2763	PIP-DCG 23	18,950	
Female 55–59	3647	PIP-DCG 26	21,881	
Female 60–64	4673	PIP-DCG 29	29,317	

(Sec. 4002 of the Balanced Budget Act of 1997 (Public Law 105–33))

Dated: August 26, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: September 1, 1998.

Donna E. Shalala,

Secretary.

[FR Doc. 98–24085 Filed 9–2–98; 4:10 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration [HCFA–1046–N]

RIN 0938–AJ14

Medicare Program; September 23 and 24, 1998, Meeting of the Competitive Pricing Advisory Committee

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces a meeting of the Competitive Pricing Advisory Committee. This meeting is open to the public.

DATES: The meeting is scheduled for September 23, 1998, from 9:00 a.m. until 5:30 p.m. and September 24, 1998, from 9:00 a.m. until 5:30 p.m.

ADDRESSES: The meeting will be held at the Sheraton Crystal City, 1800 Jefferson Davis Highway, Arlington, Virginia 22202.

FOR FURTHER INFORMATION CONTACT: Lu Zawistowich, Sc.D., Executive Director, Competitive Pricing Advisory Committee, Health Care Financing Administration, 7500 Security Boulevard C4–14–17, Baltimore, Maryland 21244–1850, (410) 786–6451.

SUPPLEMENTARY INFORMATION: Section 4011 of the Balanced Budget Act of 1997, (BBA) (Public Law 105–33) requires the Secretary of the Department of Health and Human Services (the Secretary) to establish a demonstration project under which payments to Medicare+Choice organizations in designated areas are determined in accordance with a competitive pricing methodology. Section 4012 of the BBA requires the Secretary to appoint a Competitive Pricing Advisory Committee (the CPAC). The CPAC will meet periodically to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

The CPAC consists of 15 individuals who are independent actuaries; experts in competitive pricing and the administration of the Federal Employees Health Benefit Program; and representatives of health plans, insurers, employers, unions, and beneficiaries. In accordance with section 4012(a)(5) of the BBA, the CPAC shall terminate on December 31, 2004.

The CPAC held its first meeting on May 7, 1998, and its second meeting on June 24 and 25, 1998. The CPAC members are: James Cubbin, Executive Director, General Motors Health Care Initiative; Robert Berenson, M.D., Director, Center for Health Plans and Providers, HCFA; John Bertko, CEO and Senior Actuary, PM-Squared Inc.; Dave Durenberger, Senior Health Policy Fellow, University of St. Thomas and Founder of Public Policy Partners; Gary Goldstein, M.D., CEO, The Oschner Clinic; Samuel Havens, Healthcare Consultant and Chairman of Health Scope/United; Margaret Jordan, Healthcare Consultant and CEO, The Margaret Jordan Group; Chip Kahn, CEO, The Health Insurance Association of America; Cleve Killingsworth, President, Health Alliance Plan; Nancy Kichak, Director, Office of Actuaries, Office of Personnel Management; Len Nichols, Principal Research Associate, The Urban Institute; Robert Reischauer,

Senior Fellow, The Brookings Institute; John Rother, Director, Legislation and Public Policy, American Association of Retired Persons; Andrew Stern, President, Service Employees International Union, AFL-CIO; and Jay Wolfson, Director, The Florida Information Center, University of South Florida. The Chairperson is James Cubbin and the Co-Chairperson is Robert Berenson, M.D.

The agenda will include observations and points of view on the previous competitive pricing demonstration initiative in Denver from the health plan, provider, employer, beneficiary, and HCFA perspectives. The CPAC will discuss all of the major competitive pricing demonstration design issues and select options that it determines are appropriate for the demonstrations authorized under section 4011 of the BBA.

Individuals or organizations that wish to make 5-minute oral presentations on the agenda issues should contact the Executive Director by 12 noon, September 16, 1998, to be scheduled. The number of oral presentations may be limited by the time available. A written copy of the oral remarks should be submitted to the Executive Director no later than 12 noon, September 18, 1998. Anyone who is not scheduled to speak may submit written comments to the Executive Director by 12 noon, September 18, 1998. The meeting is open to the public, but attendance is limited to the space available.

(Section 4012 of the Balanced Budget Act of 1997, Public Law 105-33 (42 U.S.C. 1395w-23 note) and section 10(a) of Public Law 92-463 (5 U.S.C. App.2, section 10(a))

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 22, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

[FR Doc. 98-24018 Filed 9-4-98; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Current List of Laboratories Which Meet Minimum Standards To Engage in Urine Drug Testing for Federal Agencies, and Laboratories That Have Withdrawn From the Program

AGENCY: Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Notice.

SUMMARY: The Department of Health and Human Services notifies Federal agencies of the laboratories currently certified to meet standards of Subpart C of Mandatory Guidelines for Federal Workplace Drug Testing Programs (59 FR 29916, 29925). A similar notice listing all currently certified laboratories will be published during the first week of each month, and updated to include laboratories which subsequently apply for and complete the certification process. If any listed laboratory's certification is totally suspended or revoked, the laboratory will be omitted from updated lists until such time as it is restored to full certification under the Guidelines.

If any laboratory has withdrawn from the National Laboratory Certification Program during the past month, it will be identified as such at the end of the current list of certified laboratories, and will be omitted from the monthly listing thereafter.

This Notice is now available on the internet at the following website: <http://www.health.org>

FOR FURTHER INFORMATION CONTACT: Mrs. Giselle Hersh or Dr. Walter Vogl, Division of Workplace Programs, 5600 Fishers Lane, Rockwall 2 Building, Room 815, Rockville, Maryland 20857; Tel.: (301) 443-6014.

Special Note: Our office moved to a different building on May 18, 1998. Please use the above address for all regular mail and correspondence. For all overnight mail service use the following address: Division of Workplace Programs, 5515 Security Lane, Room 815, Rockville, Maryland 20852.

SUPPLEMENTARY INFORMATION: Mandatory Guidelines for Federal Workplace Drug Testing were developed in accordance with Executive Order 12564 and section 503 of Pub. L. 100-71. Subpart C of the Guidelines, "Certification of Laboratories Engaged in Urine Drug Testing for Federal Agencies," sets strict standards which laboratories must meet in order to conduct urine drug testing for Federal agencies. To become certified an applicant laboratory must undergo three rounds of performance testing plus an on-site inspection. To maintain that certification a laboratory must participate in a quarterly performance testing program plus periodic, on-site inspections.

Laboratories which claim to be in the applicant stage of certification are not to be considered as meeting the minimum requirements expressed in the HHS Guidelines. A laboratory must have its letter of certification from SAMHSA, HHS (formerly: HHS/NIDA) which

attests that it has met minimum standards.

In accordance with Subpart C of the Guidelines, the following laboratories meet the minimum standards set forth in the Guidelines:

ACL Laboratories, 8901 W. Lincoln Ave., West Allis, WI 53227, 414-328-7840 (formerly: Bayshore Clinical Laboratory)
Aegis Analytical Laboratories, Inc., 345 Hill Ave., Nashville, TN 37210, 615-255-2400
Alabama Reference Laboratories, Inc., 543 South Hull St., Montgomery, AL 36103, 800-541-4931/334-263-5745
Alliance Laboratory Services, 3200 Burnet Ave., Cincinnati, OH 45229, 513-569-2051 (formerly: Jewish Hospital of Cincinnati, Inc.)
American Medical Laboratories, Inc., 14225 Newbrook Dr., Chantilly, VA 20151, 703-802-6900
Associated Pathologists Laboratories, Inc., 4230 South Burnham Ave., Suite 250, Las Vegas, NV 89119-5412, 702-733-7866/800-433-2750
Associated Regional and University Pathologists, Inc. (ARUP), 500 Chipeta Way, Salt Lake City, UT 84108, 801-583-2787/800-242-2787
Baptist Medical Center—Toxicology Laboratory, 9601 I-630, Exit 7, Little Rock, AR 72205-7299, 501-202-2783 (formerly: Forensic Toxicology Laboratory Baptist Medical Center)
Cedars Medical Center, Department of Pathology, 1400 Northwest 12th Ave., Miami, FL 33136, 305-325-5784
Clinical Reference Lab, 8433 Quivira Rd., Lenexa, KS 66215-2802, 800-445-6917
Cox Health Systems, Department of Toxicology, 1423 North Jefferson Ave., Springfield, MO 65802, 800-876-3652/417-269-3093 (formerly: Cox Medical Centers)
Dept. of the Navy, Navy Drug Screening Laboratory, Great Lakes, IL, P.O. Box 88-6819, Great Lakes, IL 60088-6819, 847-688-2045/847-688-4171
Diagnostic Services Inc., dba DSI, 12700 Westlinks Drive, Fort Myers, FL 33913, 941-561-8200/800-735-5416
Doctors Laboratory, Inc., P.O. Box 2658, 2906 Julia Dr., Valdosta, GA 31604, 912-244-4468
DrugProof, Division of Dynacare/Laboratory of Pathology, LLC, 1229 Madison St., Suite 500, Nordstrom Medical Tower, Seattle, WA 98104, 800-898-0180/206-386-2672 (formerly: Laboratory of Pathology of Seattle, Inc., DrugProof, Division of Laboratory of Pathology of Seattle, Inc.)
DrugScan, Inc., P.O. Box 2969, 1119 Mearns Rd., Warminster, PA 18974, 215-674-9310

- Dynacare Kasper Medical Laboratories*, 14940-123 Ave., Edmonton, Alberta, Canada T5V 1B4, 800-661-9876/403-451-3702
- ElSohly Laboratories, Inc., 5 Industrial Park Dr., Oxford, MS 38655, 601-236-2609
- Gamma-Dynacare Medical Laboratories*, A Division of the Gamma-Dynacare Laboratory Partnership, 245 Pall Mall St., London, ON, Canada N6A 1P4, 519-679-1630
- General Medical Laboratories, 36 South Brooks St., Madison, WI 53715, 608-267-6267
- Hartford Hospital Toxicology Laboratory, 80 Seymour St., Hartford, CT 06102-5037, 860-545-6023
- Info-Meth, 112 Crescent Ave., Peoria, IL 61636, 800-752-1835 / 309-671-5199, (Formerly: Methodist Medical Center Toxicology Laboratory)
- LabCorp Occupational Testing Services, Inc., 1904 Alexander Drive, Research Triangle Park, NC 27709, 919-672-6900 / 800-833-3984, (Formerly: CompuChem Laboratories, Inc.; CompuChem Laboratories, Inc., A Subsidiary of Roche, Biomedical Laboratory; Roche CompuChem Laboratories, Inc., A Member of the Roche Group)
- LabCorp Occupational Testing Services, Inc., 4022 Willow Lake Blvd., Memphis, TN 38118, 901-795-1515 / 800-223-6339, (Formerly: MedExpress/National Laboratory Center)
- LabOne, Inc., 8915 Lenexa Dr., Overland Park, Kansas 66214, 913-888-3927 / 800-728-4064, (formerly: Center for Laboratory Services, a Division of LabOne, Inc.)
- Laboratory Corporation of America, 888 Willow St., Reno, NV 89502, 702-334-3400, (formerly: Sierra Nevada Laboratories, Inc.)
- Laboratory Corporation of America Holdings, 69 First Ave., Raritan, NJ 08869, 800-437-4986 / 908-526-2400, (Formerly: Roche Biomedical Laboratories, Inc.)
- Laboratory Specialists, Inc., 1111 Newton St., Gretna, LA 70053, 504-361-8989 / 800-433-3823
- Marshfield Laboratories, Forensic Toxicology Laboratory, 1000 North Oak Ave., Marshfield, WI 54449, 715-389-3734 / 800-331-3734
- MAXXAM Analytics Inc. *, 5540 McAdam Rd., Mississauga, ON, Canada L4Z 1P1, 905-890-2555, (formerly: NOVAMANN (Ontario) Inc.)
- Medical College Hospitals Toxicology Laboratory, Department of Pathology, 3000 Arlington Ave., Toledo, OH 43614, 419-381-5213
- MedTox Laboratories, Inc., 402 W. County Rd. D, St. Paul, MN 55112, 800-832-3244 / 612-636-7466
- Methodist Hospital Toxicology Services of Clarian Health Partners, Inc., Department of Pathology and Laboratory Medicine, 1701 N. Senate Blvd. Indianapolis, IN 46202, 317-929-3587
- MetroLab-Legacy Laboratory Services, 1225 NE 2nd Ave., Portland, OR 97232, 503-413-4512, 800-950-5295
- Minneapolis Veterans Affairs Medical Center, Forensic Toxicology Laboratory, 1 Veterans Drive, Minneapolis, Minnesota 55417, 612-725-2088
- National Toxicology Laboratories, Inc., 1100 California Ave., Bakersfield, CA 93304, 805-322-4250
- Northwest Toxicology, Inc., 1141 E. 3900 South, Salt Lake City, UT 84124, 800-322-3361 / 801-268-2431
- Oregon Medical Laboratories, P.O. Box 972, 722 East 11th Ave., Eugene, OR 97440-0972, 541-341-8092
- Pacific Toxicology Laboratories, 1519 Pontius Ave., Los Angeles, CA 90025, 310-312-0056, (formerly: Centinela Hospital Airport Toxicology Laboratory)
- Pathology Associates Medical Laboratories, 11604 E. Indiana, Spokane, WA 99206, 509-926-2400 / 800-541-7891
- PharmChem Laboratories, Inc., 1505-A O'Brien Dr., Menlo Park, CA 94025, 650-328-6200 / 800-446-5177
- PharmChem Laboratories, Inc., Texas Division, 7610 Pebble Dr., Fort Worth, TX 76118, 817-595-0294, (formerly: Harris Medical Laboratory)
- Physicians Reference Laboratory, 7800 West 110th St., Overland Park, KS 66210, 913-339-0372 / 800-821-3627
- Poisonlab, Inc., 7272 Clairemont Mesa Blvd., San Diego, CA 92111, 619-279-2600 / 800-882-7272
- Premier Analytical Laboratories, 15201 East I-10 Freeway, Suite 125, Channelview, TX 77530, 713-457-3784 / 800-888-4063, (formerly: Drug Labs of Texas)
- Presbyterian Laboratory Services, 5040 Airport Center Parkway, Charlotte, NC 28208, 800-473-6640 / 704-943-3437
- Quest Diagnostics Incorporated, 4444 Giddings Road, Auburn Hills, MI 48326, 810-373-9120 / 800-444-0106, (formerly: HealthCare/Preferred Laboratories, HealthCare/MetPath, CORNING Clinical Laboratories)
- Quest Diagnostics Incorporated, National Center for Forensic Science, 1901 Sulphur Spring Rd., Baltimore, MD 21227, 410-536-1485, (formerly: Maryland Medical Laboratory, Inc., National Center for Forensic Science, CORNING National Center for Forensic Science)
- Quest Diagnostics Incorporated, 4770 Regent Blvd., Irving, TX 75063, 800-526-0947 / 972-916-3376, (formerly: Damon Clinical Laboratories, Damon/MetPath, CORNING Clinical Laboratories)
- Quest Diagnostics Incorporated, 875 Greentree Rd., 4 Parkway Ctr., Pittsburgh, PA 15220-3610, 800-574-2474 / 412-920-7733, (formerly: Med-Chek Laboratories, Inc., Med-Chek/Damon, MetPath Laboratories, CORNING Clinical Laboratories)
- Quest Diagnostics Incorporated, 2320 Schuetz Rd., St. Louis, MO 63146, 800-288-7293 / 314-991-1311, (formerly: Metropolitan Reference Laboratories, Inc., CORNING Clinical Laboratories, South Central Division)
- Quest Diagnostics Incorporated, 7470 Mission Valley Rd., San Diego, CA 92108-4406, 800-446-4728 / 619-686-3200, (formerly: Nichols Institute, Nichols Institute Substance Abuse Testing (NISAT), CORNING Nichols Institute, CORNING Clinical Laboratories)
- Quest Diagnostics Incorporated, One Malcolm Ave., Teterboro, NJ 07608, 201-393-5590, (formerly: MetPath, Inc., CORNING MetPath Clinical Laboratories, CORNING Clinical Laboratory)
- Quest Diagnostics Incorporated, 1355 Mittel Blvd., Wood Dale, IL 60191, 630-595-3888, (formerly: MetPath, Inc., CORNING MetPath Clinical Laboratories, CORNING Clinical Laboratories Inc.)
- Scientific Testing Laboratories, Inc., 463 Southlake Blvd., Richmond, VA 23236, 804-378-9130
- Scott & White Drug Testing Laboratory, 600 S. 31st St., Temple, TX 76504, 800-749-3788/254-771-8379
- S.E.D. Medical Laboratories, 500 Walter NE, Suite 500, Albuquerque, NM 87102, 505-727-8800/800-999-LABS
- SmithKline Beecham Clinical Laboratories, 3175 Presidential Dr., Atlanta, GA 30340, 770-452-1590, (formerly: SmithKline Bio-Science Laboratories)
- SmithKline Beecham Clinical Laboratories, 8000 Sovereign Row, Dallas, TX 75247, 214-637-7236, (formerly: SmithKline Bio-Science Laboratories)
- SmithKline Beecham Clinical Laboratories, 801 East Dixie Ave., Leesburg, FL 34748, 352-787-9006, (formerly: Doctors & Physicians Laboratory)
- SmithKline Beecham Clinical Laboratories, 400 Egypt Rd., Norristown, PA 19403, 800-877-7484/610-631-4600, (formerly: SmithKline Bio-Science Laboratories)

SmithKline Beecham Clinical Laboratories, 506 E. State Pkwy., Schaumburg, IL 60173, 847-447-4379/800-447-4379, (formerly: International Toxicology Laboratories)

SmithKline Beecham Clinical Laboratories, 7600 Tyrone Ave., Van Nuys, CA 91405, 818-989-2520/800-877-2520

South Bend Medical Foundation, Inc., 530 N. Lafayette Blvd., South Bend, IN 46601, 219-234-4176

Southwest Laboratories, 2727 W. Baseline Rd., Tempe, AZ 85283, 602-438-8507

Sparrow Health System, Toxicology Testing Center, St. Lawrence Campus, 1210 W. Saginaw, Lansing, MI 48915, 517-377-0520, (formerly: St. Lawrence Hospital & Healthcare System)

St. Anthony Hospital Toxicology Laboratory, 1000 N. Lee St., Oklahoma City, OK 73101, 405-272-7052

Toxicology & Drug Monitoring Laboratory, University of Missouri Hospital & Clinics, 2703 Clark Lane, Suite B, Lower Level, Columbia, MO 65202, 573-882-1273

Toxicology Testing Service, Inc., 5426 N.W. 79th Ave., Miami, FL 33166, 305-593-2260

UNILAB, 18408 Oxnard St., Tarzana, CA 91356, 800-492-0800/818-996-7300, (formerly: MetWest-BPL Toxicology Laboratory)

Universal Toxicology Laboratories, LLC, 10210 W. Highway 80, Midland, Texas 79706, 915-561-8851/888-953-8851

UTMB Pathology-Toxicology Laboratory, University of Texas Medical Branch, Clinical Chemistry Division, 301 University Boulevard, Room 5.158, Old John Sealy, Galveston, Texas 77555-0551, 409-772-3197

The following lab is voluntarily withdrawing from the National Laboratory Certification Program on September 15, 1998:

Medlab Clinical Testing, Inc., 212 Cherry Lane, New Castle, DE 19720, 302-655-5227

* The Standards Council of Canada (SCC) voted to end its Laboratory Accreditation Program for Substance Abuse (LAPSA) effective May 12, 1998. Laboratories certified through that program were accredited to conduct forensic urine drug testing as required by U.S. Department of Transportation (DOT) regulations. As of that date, the certification of those accredited Canadian laboratories will continue under DOT authority. The responsibility for conducting quarterly performance testing plus periodic on-site inspections of those LAPSA-accredited laboratories was

transferred to the U.S. DHHS, with the DHHS' National Laboratory Certification Program (NLCP) contractor continuing to have an active role in the performance testing and laboratory inspection processes. Other Canadian laboratories wishing to be considered for the NLCP may apply directly to the NLCP contractor just as U.S. laboratories do. Upon finding a Canadian laboratory to be qualified, the DHHS will recommend that DOT certify the laboratory (**Federal Register**, 16 July 1996) as meeting the minimum standards of the "Mandatory Guidelines for Workplace Drug Testing" (59 **Federal Register**, 9 June 1994, Pages 29908-29931). After receiving the DOT certification, the laboratory will be included in the monthly list of DHHS certified laboratories and participate in the NLCP certification maintenance program.

Richard Kopanda,

Executive Officer, Substance Abuse and Mental Health Services Administration.
[FR Doc. 98-24087 Filed 9-4-98; 8:45 am]

BILLING CODE 4160-20-U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration (SAMHSA)

Correction of Meeting Notice

Public notice was given in the **Federal Register** on August 19, 1998 (Volume 63, Number 160, pages 44467-44468) that the Center for Substance Abuse Prevention (CSAP) National Advisory Council would be meeting on September 14-15, 1998. The agenda of the meeting has subsequently changed. The dates, location, and contact for additional information remain as originally announced.

The open portion of the meeting will begin earlier on September 14 than originally announced and the meeting agenda will include the SAMHSA Administrator's Report.

Closed: September 14, 1998, 10:00 a.m.-2 p.m.

Open: September 14, 1998, 2:15 p.m.-3:30 p.m.; September 15, 1998, 8:30 a.m.-4:00 p.m.

Dated: August 31, 1998.

Jeri Lipov,

Committee Management Officer, Substance Abuse and Mental Health Services Administration.

[FR Doc. 98-23958 Filed 9-4-98; 8:45 am]

BILLING CODE 4162-20-P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WO-350-1540-01]

Information Collection Submitted to the Office of Management and Budget for Review Under the Paperwork Reduction Act

The proposal for the collection of information listed below has been submitted to the Office of Management and Budget for approval under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35). Copies of the proposed collection of information and related forms and explanatory material may be obtained by contacting the Bureau's Clearance Officer at the phone number listed below. On June 24, 1998, BLM published a notice in the **Federal Register** (63 FR 34472) requesting comments on this proposed collection. The comment period closed on August 24, 1998. BLM received no comments from the public in response to that notice. Copies of the proposed collection of information and related documents and explanatory material may be obtained by contacting the BLM clearance officer at the telephone number listed below.

OMB is required to respond to this request within 60 days but may respond within 30 days. For maximum consideration, your comments and suggestions on the requirement should be made within 30 days directly to the Office of Management and Budget, Interior Desk Officer (1004-0060), Office of Information and Regulatory Affairs, Washington, D.C. 20503. Please provide a copy of your comments to the Bureau Clearance Officer (WO-630), 1849 C St., N.W., Mail Stop 401 LS, Washington, D.C. 20240.

Nature of Comments: We specifically request your comments on the following:

1. Whether the collection of information is necessary for the proper functioning of BLM, including whether or not the information will have practical utility;
2. The accuracy of BLM's estimate of the burden of collecting the information, including the validity of the methodology and assumptions used;
3. The quality, utility and clarity of the information to be collected; and
4. How to minimize the burden of collecting the information on those who are to respond, including the use of appropriate automated electronic, mechanical or other forms of information technology.

Title: Application for Transportation and Utility Systems and Facilities on

Federal Lands, Pub. L. 96-487 (Also applicable for 43 CFR 2800 and 2880).
OMB Approval Number: 1004-0060.

Abstract: Respondents supply information as to their identity and address and the nature, location and potential impacts of the proposed facility. The information enables the using agency to identify and communicate with the applicant and to locate and evaluate the effect of the proposed facility on the environment and other land uses.

Frequency: Once.

Description of Respondents:

Applicants needing a right-of-way on Federal Lands.

Estimated Completion Time: 2 hours.

Annual Responses: 4900.

Annual Burden Hours: 9600.

Bureau Clearance Officer: Carole Smith, (202) 452-0367.

Dated: August 25, 1998.

Carole J. Smith,

Bureau of Land Management Clearance Officer.

[FR Doc. 98-24029 Filed 9-4-98; 8:45 am]

BILLING CODE 4310-84-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[AK-962-1410-00-P]

Notice for Publication AA-11774; Alaska Native Claims Selection

In accordance with Departmental regulation 43 CFR 2650.7(d), notice is hereby given that a decision to issue conveyance under the provisions of Sec. 14(h)(1) of the Alaska Native Claims Settlement Act of December 18, 1971, 43 U.S.C. 1601, 1613(h)(1), will be issued to Koniag, Inc., Regional Native Corporation for approximately 1.1 acres. The lands involved are in the vicinity of Chowiet Island, Alaska.

Seward Meridian, Alaska

T. 48 S., R. 48 W.,
Sec. 13.

A notice of the decision will be published once a week, for four (4) consecutive weeks, in the *Anchorage Daily News*. Copies of the decision may be obtained by contacting the Alaska State Office of the Bureau of Land Management, 222 West Seventh Avenue, #13, Anchorage, Alaska 99513-7599 ((907) 271-5960).

Any party claiming a property interest which is adversely affected by the decision, an agency of the Federal government or regional corporation, shall have until October 8, 1998 to file an appeal. However, parties receiving service by certified mail shall have 30

days from the date of receipt to file an appeal. Appeals must be filed in the Bureau of Land Management at the address identified above, where the requirements for filing an appeal may be obtained. Parties who do not file an appeal in accordance with the requirements of 43 CFR part 4, subpart E, shall be deemed to have waived their rights.

Patricia A. Baker,

Land Law Examiner, ANCSA Team, Branch of 962 Adjudication.

[FR Doc. 98-23996 Filed 9-4-98; 8:45 am]

BILLING CODE 4310--\$-P

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

[AK-962-1410-00-P]

Notice for Publication AA-11774; Alaska Native Claims Selection

In accordance with Departmental regulation 43 CFR 2650.7(d), notice is hereby given that a decision to issue conveyance under the provisions of Sec. 14(h)(1) of the Alaska Native Claims Settlement Act of December 18, 1971, 43 U.S.C. 1601, 1613(h)(1), will be issued to Koniag, Inc., Regional Native Corporation for approximately 3.8 acres. The lands involved are in the vicinity of Ugaiushak Island, Alaska.

Seward Meridian, Alaska

T. 39 S., R. 48 W.,
Sec. 24.

A notice of the decision will be published once a week, for four (4) consecutive weeks, in the *Anchorage Daily News*. Copies of the decision may be obtained by contacting the Alaska State Office of the Bureau of Land Management, 222 West Seventh Avenue, #13, Anchorage, Alaska 99513-7599 ((907) 271-5960).

Any party claiming a property interest which is adversely affected by the decision, an agency of the Federal government or regional corporation, shall have until October 8, 1998 to file an appeal. However, parties receiving service by certified mail shall have 30 days from the date of receipt to file an appeal. Appeals must be filed in the Bureau of Land Management at the address identified above, where the requirements for filing an appeal may be obtained. Parties who do not file an appeal in accordance with the requirements of 43 CFR Part 4, Subpart

E, shall be deemed to have waived their rights.

Patricia A. Baker,

Land Law Examiner, ANCSA Team, Branch of 962 Adjudication.

[FR Doc. 98-23999 Filed 9-4-98; 8:45 am]

BILLING CODE 4310--\$-P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NV-931-1430-01; N-38765, N-39765]

Termination of Desert Land Entry Classifications; Nevada

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: This action terminates the desert land classifications dated January 7, 1984, and July 28, 1989, for N-38765 and N-39765, respectively. The lands will be opened to the operation of the public land laws, including location and entry under the mining laws.

EFFECTIVE DATE: October 8, 1998.

FOR FURTHER INFORMATION CONTACT:

Dennis J. Samuelson, BLM Nevada State Office, P.O. Box 12000, Reno, Nevada 89520, 702-861-6532.

SUPPLEMENTARY INFORMATION: The desert land classifications for N-38765 and N-39765, were made on January 7, 1984, and July 28, 1989, respectively, pursuant to Section 7 of the Taylor Grazing Act (43 U.S.C., et seq.). When entry to the lands was allowed, the lands became segregated from surface entry and mining. The entrymen failed to file final proof as required and the entries were canceled by decisions dated July 10, 1998.

Pursuant to Section 7 of the Taylor Grazing Act (43 U.S.C., et seq.), the desert land classifications for N-38765 and N-39765 are hereby terminated for the following described lands:

Mount Diablo Meridian, Nevada

T. 10 N., R. 43 E.,
Sec. 32.

The area described contains 640 acres in Nye County.

1. At 9 a.m. on October 8, 1998, the lands described above will be opened to the operation of the public land laws generally, subject to valid existing rights, the provision of existing withdrawals, other segregations of record, and the requirements of applicable law. All valid applications received at or prior to 9 a.m. on October 8, 1998, shall be considered as simultaneously filed at that time. Those received thereafter shall be considered in the order of filing.

2. At 9 a.m. on October 8, 1998, the lands described above will be opened to location and entry under the United States mining laws, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law. Appropriation of any of the lands described in this order under the general mining laws prior to the date and time of restoration is unauthorized. Any such attempted appropriation, including attempted adverse possession under 30 U.S.C. 38 (1988), shall vest no rights against the United States. Acts required to establish a location and to initiate a right of possession are governed by State law where not in conflict with Federal law. The Bureau of Land Management will not intervene in disputes between rival locators over possessory rights since Congress has provided for such determinations in local courts.

Dated: September 1, 1998.

William K. Stowers,

Lands Team Lead.

[FR Doc. 98-23998 Filed 9-4-98; 8:45 am]

BILLING CODE 4310-HC-P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[G-070-5101-00-YGKH; NMNM 80897]

Notice of Right-of-Way Application; New Mexico

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of realty action.

SUMMARY: An amended application, serialized as NMNM 80897, was received for a 1,140.79 feet right-of-way for construction of two 24 inch diameter pipes.

Notice is hereby given that, pursuant to Section 28 of the Mineral Leasing Act of 1920 (30 U.S.C. 185), as amended by the Act of November 16, 1973 (37 Stat. 576), Devon Energy Corporation has applied for an amended right-of-way serialized as NMNM 80897 to construct 1,140.79 feet of two 24 inch diameter natural gas pipeline across public land in Rio Arriba County, New Mexico. This will lower pressures in Devon's existing Sims Mesa Central Delivery Point which would allow them to transport the volumes of Fruitland Coal-Bed Methane (natural gas) their wells are capable of producing. The proposed line crosses the following public lands in Rio Arriba County.

New Mexico Principal Meridian

T. 30 N., R. 7 W.,

Sec. 22, NENE.

Containing 1.31 acres.

The purpose of this notice is to inform the public that the Bureau of Land Management will be deciding whether the right-of-way should be approved, and if so, under what terms and conditions.

Interested persons desiring to express their views should promptly send their name and address to the Assistant Field Office Manager for Resources, Bureau of Land Management, 1235 La Plata Highway, Suite A, Farmington, New Mexico 87401.

Dated: September 2, 1998.

John A. Phillips,

Associate District Manager.

[FR Doc. 98-24111 Filed 9-4-98; 8:45 am]

BILLING CODE 4310-FB-M

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Cancellation of Prospectus for Operation of Accommodations, Facilities, and Services Within Glen Canyon National Recreation Area

SUMMARY: This notice advises all persons and entities interested in the Prospectus for Operation of Accommodations, Facilities and Services, National Park Service, Glen Canyon National Recreation Area, which was issued on July 1, 1998, that the National Park Service is canceling this prospectus pursuant to 36 CFR 51.4(c). This notice is effective immediately. The National Park Service has concluded that several programmatic issues have arisen which require consideration and resolution before proceeding further. A new prospectus will be issued by the National Park Service as soon as is practicable. Persons requesting the prospectus issued on July 1, 1998 will be notified of its issuance at the appropriate time. Solicitation notices will be posted in accordance with 36 CFR 51.4(a).

SUPPLEMENTARY INFORMATION:

Additional information can be obtained by contacting the National Park Service, Intermountain Region-Denver Support Office, Office of Concessions Management, 12795 W. Alameda Parkway, P.O. Box 25287, Denver, Colorado 80225-0287, Attn: Kathy Fleming (303) 969-2665.

Dated: August 25, 1998.

John H. King,

Acting Director, Intermountain Region.

[FR Doc. 98-23989 Filed 9-4-98; 8:45 am]

BILLING CODE 4310-70-P

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Issue a Concession Permit at Rocky Mountain National Park

SUMMARY: Pursuant to the Act of October 9, 1965 (P.L. 89-249; 79 Stat. 969; 16 U.S.C. 20 *et seq.*), notice is hereby given that the National Park Service intends to issue a concession permit at Rocky Mountain National Park with a term of three years. The services to be provided under this permit are; instruction and guide services in technical rock climbing, mountaineering, and ski mountaineering. This short term authorization is necessary to allow the continuation of public services during the completion of planning documents for Rocky Mountain National Park. The current concessioner has performed its obligation to the satisfaction of the Secretary of Interior and retains its right of preference under this administration action.

EFFECTIVE DATE: Any party interested in making an offer for this new permit must do so within 15 days of the date of publication of this announcement. A copy of the prospectus for this concession authorization may be obtained from the Chief of Concessions Management, Intermountain Support Office, National Park Service, 12795 West Alameda Parkway, P.O. Box 25287, Denver, Colorado, 80225-0287, or call: (303) 969-2661.

INFORMATION: Information regarding this notice can be obtained from: Chief, Concessions Management, Intermountain Support Office, Attention: Judy Jennings, National Park Service, 12795 West Alameda Parkway, P.O. Box 25287, Denver, Colorado, 80225-0287, or call: (303) 969-2661.

The National Park Service is currently in the planning process to determine the future direction of concession services in Rocky Mountain National Park. This necessary planning process will directly affect future concession activities. Included in this planning process is the development of a commercial services plan. It is anticipated that the park commercial services plan will be completed in 1999. Until planning is completed, it is not in the best interest of the park to enter into a longer term concession permit. It is the intention of the National Park Service to complete the planning process then conduct a public solicitation and selection of a concessioner for a longer permit period.

Dated: September 25, 1998.

John King,

Deputy Regional Director, Southwest Intermountain Region.

[FR Doc. 98-23990 Filed 9-4-98; 8:45 am]

BILLING CODE 4310-70-P

DEPARTMENT OF INTERIOR

National Park Service

Appalachian National Scenic Trail— Notice of Realty Action

AGENCY: National Park Service.

ACTION: Notice of Realty Action.

SUMMARY: This notice announces a proposed exchange of fee simple title in federally-owned lands for fee simple title in private lands both located in Grafton County, New Hampshire. The exchange will protect .17 of a mile of trail footpath and eliminate a vehicular access across the Appalachian National Scenic Trail.

I. The following described interest acquired by the National Park Service, has been determined to be suitable for disposal by exchange. The selected Federal land is within the boundaries for the Appalachian National Scenic Trail. The land has been surveyed for cultural resources and endangered and threatened species. These reports are available upon request.

A fee interest in the following property is to be exchanged: Tract 195-29 is a 2.25 acre portion of the land acquired by the United States of America by deed recorded at Deed Book 1500, Page 894, in the Grafton County Registry of Deeds, State of New Hampshire. The United States will also resolve a potential claim to adjacent Dartmouth College lands which was disclosed by a recent survey. The potential claim involves 3.53 acres and will be settled as part of the exchange process. Conveyance by the United States will be done by a Quitclaim Deed.

II. In exchange for the interests described in Paragraph I above, the Trustees of Dartmouth College will convey to the United States of America fee simple title and a vehicular access across federal lands within the boundaries of the Appalachian National Scenic Trail.

The interest in land to be acquired by the United States of America is described as follows: Tract 195-27, being fee simple title to 1.51 acres acquired by the trustees of Dartmouth College by deed recorded in Deed Book 1040, Page 395, in the Grafton County Registry of Deeds, State of New Hampshire. Also to be acquired is Tract 199-23, being fee simple title to 13.89 acres acquired by the Trustees of

Dartmouth College by deeds recorded in Deed Book 1237, Page 366 and Deed Book 1049, Page 308 in the Grafton County Registry of Deeds, State of New Hampshire. This will include a vehicular right-of-way owned by Dartmouth College across other lands of the United States within the boundaries of the Appalachian National Scenic Trail as described in Deed Book 1797, Page 867 in Grafton County Register of Deeds, State of New Hampshire. The conveyance to the United States will be done by General Warranty Deed.

The value of the interests to be exchanged shall be determined by current fair market value appraisals and if they are not appropriately equal, the values shall be equalized by a cash payment.

SUPPLEMENTARY INFORMATION: The authority for this exchange is Section 5(b) of the Land and Water Conservation Fund Act Amendments in Pub. L. 90-401, approved July 15, 1968, and Section 7(f) of the National Trails System Act, Pub. L. 90-543, as amended.

Detailed information concerning this exchange including precise legal descriptions, Land Protection Plan and cultural reports, are available at the address below.

For a period of 45 days from the date of this notice, interested parties may submit written comments to the address below. Adverse comments will be evaluated and this action may be modified or vacated accordingly. In the absence of any action to modify or vacate, this realty action will become the final determination of the Department of Interior.

FOR FURTHER INFORMATION CONTACT: Chief, Acquisition Division, National Park Service, AT/LAFO, PO Box 908, Martinsburg, WV 25402, (304) 263-4943.

Dated: June 10, 1998.

Pamela Underhill,

Park Manager, Appalachian National Scenic Trail.

[FR Doc. 98-23991 Filed 9-4-98; 8:45 am]

BILLING CODE 4310-70-M

OVERSEAS PRIVATE INVESTMENT CORPORATION

September 22, 1998 Board of Directors Meeting; Sunshine Act

TIME AND DATE: Tuesday, September 22, 1998, 1:00 PM (OPEN Portion), 1:30 PM (CLOSED Portion).

PLACE: Offices of the Corporation, Twelfth Floor Board Room, 1100 New York Avenue NW., Washington, DC.

STATUS: Meeting OPEN to the Public from 1:00 PM to 1:30 PM, Closed portion will commence at 1:30 PM (approx.)

MATTERS TO BE CONSIDERED:

1. President's Report
2. Approved of June 9, 1998 Minutes (Open Portion)
3. Meeting schedule through June, 1999

FURTHER MATTERS TO BE CONSIDERED: (Closed to the Public 1:30 PM)

1. Proposed FY 2000 Budget Proposal and Allocation of Retained Earnings
2. Finance and Insurance Project in Venezuela
3. Insurance Project in Brazil
4. Insurance Project in Colombia
5. Finance and Insurance Project in Central America and the Caribbean
6. Finance Project in Philippines
7. Insurance Project in Angola
8. Finance and Insurance Project in Bangladesh
9. Investment Fund in Armenia, Azerbaijan, and Georgia
10. Approval of June 9, 1998 Minutes (closed Portion)
11. Pending Major Projects
12. Report on Indonesia

CONTACT PERSON FOR INFORMATION:

Information on the meeting may be obtained from Connie M. Downs at (202) 336-8438.

Dated: September 3, 1998.

Connie M. Downs,

OPIC Corporate Secretary.

[FR Doc. 98-24192 Filed 9-3-98; 3:46 pm]

BILLING CODE 3210-01-M

DEPARTMENT OF JUSTICE

Office of Community Oriented Policing Services; Agency Information Collection Activities: Proposed collection; comment request

ACTION: Notice of Information Collection Under Review; Troops to COPS II Program Solicitation.

The proposed information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted until the sixtieth day from the date published in the **Federal Register**. Request written comments and suggestions from the public and affected agencies concerning the proposed collection of information. Your comments should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

If you have additional comments, suggestions, or need a copy of the proposed information collection instrument with instructions, or additional information, please contact Kristen Mahoney, 202-616-2896, U.S. Department of Justice, Office of Community Oriented Policing Services, 1100 Vermont Avenue, NW, Washington, DC 20530.

Additionally, comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time should be directed to Kristen Mahoney, 202-616-2896, U.S. Department of Justice, Office of Community Oriented Policing Services, 1100 Vermont Avenue, NW, Washington, DC 20530.

Overview of this information collection:

(1) Type of Information Collection: *New collection.*

(2) Title of the Form/Collection: Troops to COPS II Program Solicitation.

(3) Agency form number, if any, and the applicable component of the Department of Justice sponsoring the collection: Form: None. Office of Community Oriented Policing Services, U.S. Department of Justice.

(4) Affected public who will be asked or required to respond, as well as a brief abstract: Primary: State and Local governments, private non-profit organizations, individuals, education institutions, hospitals, and private commercial organizations (if legislation allows). Other: None.

The information collected is used to determine applicant eligibility for the Troops to COPS II Grant Program. The program provides funding to law enforcement agencies for costs associated with hiring eligible military veterans as law enforcement officers. The goal of Troops to COPS II is to facilitate the transition of those who have served in the armed forces to service in community policing across America. Agencies selected to receive a

Universal Hiring Program grant on or after September 1, 1997 are eligible to apply for this program. Troops to COPS II is a one year grant which provides reimbursement up to \$25,000 per veteran for hiring expenses such as academy and field training, supplemental community policing training, uniforms and basic issue equipment. There is no local match requirement for these funds. (The local match for the UHP grant, however, remains a grant requirement.)

(5) An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond: 500 respondents at 1.5 hours per response. The information will be collected once from each respondent.

(6) An estimate of the total public burden (in hours) associated with the collection: 750 annual burden hours.

If additional information is required contact: Mr. Robert B. Briggs, Clearance Officer, United States Department of Justice, Information Management and Security Staff, Justice Management Division, Suite 850, Washington Center, 1001 G Street, NW., Washington, DC 20530.

Dated: September 1, 1998.

Robert B. Briggs,

Department Clearance Officer, United States Department of Justice.

[FR Doc. 98-24015 Filed 9-4-98; 8:45 am]

BILLING CODE 4410-21-M

DEPARTMENT OF LABOR

Employment and Training Administration

Office of Policy and Research; Job Training Partnership Act, Title IV, Demonstration Program: Opportunity Areas For Out-Of-School Youth Pilot Demonstration

AGENCY: Employment and Training Administration, Labor.

ACTION: Notice of Availability of Funds and Solicitation for Grant Applications (SGA).

SUMMARY: All information required to submit a grant application is contained in this announcement. The U.S. Department of Labor (DOL), Employment and Training Administration (ETA), announces a pilot demonstration as authorized under Title IV Part D of The Job Training Partnership Act, to increase the long-term employment of youth living in high-poverty areas. This notice provides information on the process that eligible entities must use to apply for these demonstration funds and how grantees

will be selected. It is anticipated that up to \$12.5 million will be available for funding demonstration projects covered by this solicitation, with each award being approximately \$2.25 million.

DATES: The closing date for receipt of proposals is December 7, 1998 at 4:00 p.m. (Eastern Time).

ADDRESSES: Applications must be mailed to: U.S. Department of Labor; Employment and Training Administration; Division of Acquisition and Assistance; Attention: B. Yvonne Harrell, Reference: SGA/DAA 98-016; 200 Constitution Avenue, N.W., Room S-4203; Washington, DC 20210.

FOR FURTHER INFORMATION CONTACT: All questions should be faxed to Ms. B. Yvonne Harrell at (202) 219-8739 (this is not a toll-free number). Please include a contact person, telephone number, fax number and refer to SGA-DAA-98-016.

Part I. Background

The Department of Labor currently has six (6) Youth Opportunity pilot projects. Three were funded in 1996, Chicago, Houston, and Los Angeles, and three in 1997, the Bronx, Boston, and rural Kentucky. Through this solicitation, the Department of Labor expects to award grants to establish five additional Youth Opportunity pilot sites. In these pilot projects, Opportunity Areas are created in targeted communities to expand employment, education, and training opportunities for out-of-school youth ages 16-24, with priority given to high school dropouts. The demonstrations provide employment, education and training opportunities, mentoring, support, leadership, developmental and other services as needed for all youth in the target area.

The Department expects to award five (5) grants of approximately \$2.25 million each for a period of 18 months under this competition. Based on the availability of funds and successful completion of this initial funding period, some level of second and third year funding may be provided to the demonstration sites. Award decisions will be published on the Internet at ETA's Home Page at <http://www.doleta.gov>.

Eligible Applicants.

This grant competition is limited to the Service Delivery Areas (SDAs) covering urban and rural sites designated by Housing Urban Development (HUD) and the Department of Agriculture as Empowerment Zones (EZs), supplemental empowerment zones, Enterprise Communities (ECs), or

enhanced enterprise communities. In EZ/ECs that include more than one SDA (e.g., Philadelphia/Camden and Kansas City, Missouri/Kansas), the SDAs can submit either separate applications or a joint application, which must clearly identify each SDA's responsibilities. To be eligible to apply, SDAs will need to identify a contiguous set of census tracts with a population of at least 10,000 in the 1990 Census. SDAs will need to list as partners the local public school system, the local EZ/EC governing board, the juvenile justice system, representatives of major employer networks connected to the school-to-work effort, the state School-to-Work Partnership, and if applicable, the local School-to-Work Partnership. In sites where the target area includes public housing facilities, the demonstrations should establish linkages with all employment and training and other programs being operated by the local Housing Authority.

Current DOL grantees serving Out-of-School Youth, cannot submit an application to service the same community.

Applicants should outline how they will involve residents, youth and other community-based organizations (CBOs) and faith-based organizations of the community in the planning, and other involvement of the effort. Partners do not have to be solely subcontractors. Some partners will have resources of their own which can be made available to youth in the targeted community.

Program Components

Grant funds shall be used to create an Opportunity Area for youth living in the target area. Youth employment and development activities funded under the grant shall be used for a structured set of initiatives focused sharply on getting out-of-school youth ages 16–24 into long-term employment at wage levels that will prevent future dependency. The various programs funded under the grant should constitute a coherent strategy for serving large numbers of neighborhood youth and raising the employment rate of out-of-school youth in the area up to 80 percent. This overall strategy needs to be responsive to the particular problems of out-of-school youth in high-poverty areas, especially the pervasive joblessness of males. Given the solid economy the country is now experiencing, the overall strategy should have a strong private sector emphasis with a core program of perhaps 15 case managers and job developers working to place youth and retain youth in private sector jobs.

Allowable activities will include but not be limited to job placement officers and case managers working to link youth with private sector employers; on-the-job training; programs directed towards rehabilitating inner-city housing and that teach leadership skills and prepare youth for construction careers; preparation of apprenticeship positions in commercial construction; referrals of youth to Job Corps Centers for open-entry/open-exit to academic, vocational and life skills training primarily in a structured environment; alternative and charter schools; local conservation corps programs for youth who need to gain disciplined work experience before being ready for private sector placement; and adult mentors working with youth over an extended period of time.

Offerers are encouraged to consider effective practices in their communities in workforce development, youth development and quality project management. Examples of activities within these categories include: job shadowing, long term post-placement monitoring, developing mentor/coach relationships, diverse funding and collaboration, and on-going assessment of progress through project data. The experiences gained through the "Promising and Effective Practices Network" (PEPNet), funded in part by the Department of Labor, may be useful. Information on PEPNet is available on Internet web site www.ttrc.doleta.gov/PEPNet.

A small amount, not more than \$150,000 per year, of grant funds can be used for dropout prevention, college bound type programs, and sports and recreation programs open to all youth in the target area.

DOL expects that various CBOs in each site will operate many of the services provided under this grant. However, the services should be well coordinated between CBO operations and the core program components and offered to participants in a uniform manner.

Training offered by this demonstration shall incorporate elements of the School-to-Work initiatives. This should include classroom based and work-based learning, connective or supportive activities which helps participants complete the training and enter and maintain employment. Classroom curricula should be directly linked to the jobs in the labor market with direct input from employers. Job shadowing and on-the-job training opportunities should be committed to employers and indicated in the proposal. The grantee should also investigate and experiment

with other venues of learning in the community for participants. Training and education can be offered through alternative and charter school settings using the School-to-Work model for providing both classroom and work based learning opportunities.

Applicants are encouraged to investigate, within each site, how the average daily attendance dollars from State and local school systems can be used to provide training to participants of this demonstration and provide for opportunities in alternative and charter schools. In a few States the average daily attendance dollars follow youth who drop school and enter job training programs.

Sites providing services to youth in need of bonding to become employed can utilize the services of the Federal Bonding program. More information on the Federal Bonding program will be provided at the time of grant awards.

Services must not be fragmented, but should operate as an integrated system that supports and furthers the notion of sustaining the effort beyond the grant period through the creation of a new or changed infrastructure. The primary outreach, intake and counseling activities in this initiative should be based in the targeted neighborhood in a center where participants can come for assistance in improving their employment prospects. *Project Directors and primary staff, e.g., case manager and job developers*, should be located in the center. All connecting activities should be easily accessible to program participants and should be provided in settings where it is conducive to accomplishing the goals and objectives of the demonstration.

Other partnerships/linkages should be established with the local One-Stop Center and the America's Career Infonet system. The Infonet system is a searchable database of employment trends, wages, training requirements, economic information, area cost of living, etc. The Infonet system is available through the One-Stop Center, the local employment service office, and the Internet. (Sites are encouraged to have access to the Internet.) The grantee may use a small amount, not more than \$20,000 per year, of the grant funds to purchase technical assistance to coordinate with other local service providers, e.g., welfare-to-work program, school-to-work, vocational education programs, one-stop, etc., to focus on and receive employers involvement, commitment for work-based learning, work experience, on-the-job training, and job opportunities. The technical assistance *shall* be provided by a firm or individual who is familiar

with the local labor market and has demonstrated experience in this area.

The grantee may also use a small amount, not more than \$5,000 per year, of the grant funds to purchase local technical assistance to establish and train members of a formal Community Advisory Board, which membership should include residents, youth, business leaders, community leaders, ministers, teachers, etc., to have direct involvement with the project meeting its goals and objectives, initiating and carrying out community activities that will enhance the quality of life in the local community, increase community members participation in this initiative, and have direct impact on parental involvement with the program. GED should be used only as a tool for those who seek higher education or it is needed before entering a job training component. But it should not be seen as an end in itself.

Coordination

Applicants must use partnerships both (1) to enhance the out-of-school programs funded under the grant and (2) to provide complementary programs so as to make the target neighborhood an Opportunity Area for all youth. It is expected that applicant and other partners will invest State, local, and other federal resources to secure the success of the project. Complementary projects should include: (1) School-to-work efforts in the target area high school; (2) commitments for specific numbers of career-track jobs by employers located in the wider metropolitan area; (3) school district efforts to reduce the dropout and truancy rates in area middle schools and high schools; (4) investments from other State and federal programs, such as JTPA; (5) a public/private collaboration to start a program that helps youth attend college in the target area; (6) a comprehensive sports and recreation program for youth of all ages in the target neighborhood; and (7) a comprehensive youth community service program in the target area. The application should provide dollar values for the contributions from each partner, and these figures will be included in the final grant budget. Applicants also must agree to continue initiatives started under this grant beyond the three-year grant period. Applicants are encouraged to use State and local educational funds to support education and training services for youth who have dropped out of school.

Period of Performance

The period of performance shall be 18 months from the date of execution by

the Government. Delivery of services to targeted groups shall commence within 90 days of execution of a grant.

Part II. Application Process and Guidelines

A grant application shall be limited to 12 double-spaced, single-side, 8.5-inch × 11-inch pages with 1-inch margins. Text type shall be 11 point or larger. Applications that do not meet these requirements will not be considered. SDAs wishing to apply to be a demonstration site should begin as quickly as possible forming the partnerships with State and local school-to-work efforts, local public schools, empowerment zones, juvenile justice system, community based organizations, and the private sector necessary to carry out this project. An original and three (3) copies of the application shall be submitted. The applications shall consist of two (2) separate and distinct parts: Part A, the Financial Proposal, and Part B, the Technical Proposal.

Part A—Financial Proposal

The Financial Proposal, shall contain the Standard Form 424, "Application for Federal Assistance" (Appendix A) and the "Budget Information Sheet" (Appendix B) for an 18-month initial grant period. Both of these forms are attached. The budget shall include on a separate page a detailed breakout of each proposed budget line item. For each budget line item that includes funds or in-kind contributions from a source other than the grant funds, identify the source, the amount, and in-kind contributions, including any restrictions that may apply to these funds. The Federal Domestic Assistance Catalog number is 17.249.

Part B. Technical Proposal

The technical proposal should be 12 pages or less and reflect the local partnerships that are being developed. An Executive Summary may be included, but shall not exceed two pages. The technical proposal should include letters of support from the local chief elected official.

These letters will not be counted against the page limit. No cost data or reference to price shall be included in the technical proposal. The technical proposal shall include answers to the following questions:

1. What is the need in the target community? What is its population and poverty rate in the 1990 Census? What are the dropout rates of target area high schools, as measured by the number of ninth graders enrolled in September of

1993 and the number of students graduating in June of 1997?

2. What new initiatives and on-going effective practices for out-of-school youth will be funded with the grant?

3. How will new initiatives and effective practices fit into your overall EZ/EC plan?

4. What school-to-work initiatives consistent with the School-to-Work Opportunities Act of 1994 currently exist in the target area high school? What additional school-to-work initiatives will be implemented if this grant is received?

5. What dropout prevention efforts currently exist in target area middle schools and high school? What new initiatives are committed as if this grant is received?

6. What do local major corporations promise as their role if the area becomes an opportunity area? The application should be clear in specifying existing private sector activities and new activities supported with leveraged resources. The specific number of jobs pledged for target area youth should be included in the application.

7. What strategy do you have for linking with Job Corps?

8. What State and local public sector, and non-profit sector (including faith-based organizations) commitments are being promised? Again, the application should be clear in specifying existing public sector activities in the target area and new activities being supported with leveraged resources.

9. What strategy do you have for maintaining these enhanced services to out-of-school youth after the demonstration has ended? Will school funds be provided?

10. What strategies do you have for engaging the juvenile justice system in preventing juvenile crime in the target area and in meeting the needs of target area youth who are in the criminal justice system?

11. What strategy do you have to hire and maintain high quality staff, particularly in the areas of job development, case management and project director and to provide salary levels that are comparable with other programs with same type of job responsibility.

Information required under (a), and (b), below shall be provided separately for each targeted neighborhood where out-of-school youth will be served.

(a) Target Neighborhood

Applications should identify a target area within the EZ/EC with a population of between 10,000 and 15,000 persons and a poverty rate in the 1990 Census that is among the highest in the EZ/EC.

In urban sites, the target area should be comprised of contiguous census tracts. In rural counties larger than 15,000, the target area should be comprised of contiguous census tracts or block numbering areas. In both urban and rural sites, the target area should include a high school and at least one middle school.

(b) Sample Site Plan

One example of the type of plan that could be included in the proposal is below. This example is intended to be illustrative rather than prescriptive. It is expected that each community will develop a plan that is tailored to its area. In this example, the target community within the EZ/EC has a population of 10,000, with 1,600 16–24 year-olds and with 20 percent of its population living in public housing.

Roughly half of the 16–24 year-olds are out-of-school (800) and 40 percent of the out-of-school youth are employed (320). To reach an 80 percent employment level for this group will require 640 being employed, or 320 more jobs. To achieve this level of employment and to stem the dropout rate, the following example shows how the DOL grant might be used in conjunction with the leveraging of other resources. (This is an example):

	DOL grant	Other resources
Job developers/case managers (Staff of 15)	\$850,000	.....
CET training (50 youth @ \$6,000)	150,000	150,000
On-the-job training (40 youth @ \$5,000)	200,000	.....
YouthBuild (40 youth @ \$20,000)	300,000	500,000
Local conservation corps (40 youth @ \$20,000)	400,000	400,000
Alternative school (80 youth @ \$8,000)	200,000	440,000
Middle school restructuring .....	.....	235,000
Futures program in high school	50,000	200,000
College Bound program	50,000	100,000
Sports and recreation program	50,000	100,000
Juvenile alternative sentencing program .....	.....	100,000
	2,250,000	*2,250,000

*This SGA recommends the leveraging of resources on a one-to-one basis through in-kind or cash dollars. The leveraged resources could be used to serve 22–24 year-olds, and thus come from JTPA Title II–A. Other leveraged resources could come from other Federal agencies, local corporations and foundations. Funds for a new alternative school in the target community would come from State or local education funds. In addition to these funds for job training programs, the local area would also provide funds for new initiatives to strengthen the target area's middle schools and high school. These initiatives would include enhanced school-to-work efforts in the high school; a program to prepare entering ninth graders for starting high school and to provide outreach workers to keep youth in school; a program to help youth enter college, and a comprehensive sports and recreation program for youth. These initiatives would be paid for through a combination of other Federal funds, public school funds, local corporations, and local foundations. A significant number of private sector jobs would also be pledged for participants.

Hand-Delivered Applications

Applications should be mailed no later than five (5) days prior to the closing date for the receipt of applications. However, if applications are hand-delivered, they must be received at the designated place by 4 p.m., Eastern Time on the closing date for receipt of applications. All overnight mail will be considered to be hand-delivered and must be received at the designated place by the specified time and closing date. Telegraphed and/or faxed proposals will not be honored. Applications that fail to adhere to the above instructions will not be honored.

Late Applications

Any application received at the office designated in the solicitation after the exact time specified for receipt will not be considered unless it:

(a) Was sent by U.S. Postal Service registered or certified mail not later than the fifth calendar day before the closing date specified for receipt of applications (e.g., an offer submitted in response to a solicitation requiring receipt of application by the 30th of January must have been mailed by the 25th); or

(b) Was sent by U.S. Postal Service Express Mail Next Day Service—Post

Office to Addressee, not later than 5 p.m. at the place of mailing two working days prior to the date specified for receipt of application. The term “working days” excludes weekends and U.S. Federal holidays.

The only acceptable evidence to establish the date of mailing of a late application sent by U.S. Postal Service registered or certified mail is the U.S. postmark on the envelope or wrapper and on the original receipt from the U.S. Postal Service. Both postmarks must show a legible date or the proposal shall be processed as if it had been mailed late. “Postmark” means a printed, stamped, or otherwise placed impression (exclusive of a postage meter machine impression) that is readily identifiable without further action as having been supplied and affixed by an employee of the U.S. Postal Service on the date of mailing. Therefore, applicants should request the postal clerk to place a legible hand cancellation “bull’s eye” postmark on both the receipt and the envelope or wrapper.

The only acceptable evidence to establish the date of mailing of a late application sent by “Express Mail Next Day Service—Post Office to Addressee”

is the date entered by the post office receiving clerk on the “Express Mail Next Day Service—Post Office to Addressee” label and the postmarks on both the envelope and wrapper and the original receipt from the U.S. Postal Service. “Postmark” has the same meaning as defined above. Therefore, an applicant should request the postal clerk to place a legible hand cancellation “bull’s eye” postmark on both the receipt and the envelope or wrapper.

Withdrawal of Applications

Applications may be withdrawn by written notice or telegram (including mailgram) received at any time before award. Applications may be withdrawn in person by the applicant or by an authorized representative thereof, if the representative’s identity is made known and the representative signs a receipt for the proposal.

Part III—Evaluation Component

The demonstration sites will be required to collect and maintain participant records so that this can be a learning experience for the government. We look to learn and share effective techniques and strategies for meeting

the needs of out-of-school youth. The required participant records will be similar to the Standardized Program Information Report (SPIR) required for JTPA Title II programs. Leveraged resources from schools can be provided in a variety of ways such as by changing education funding formulas to reach out of school youth, starting or expanding alternative schools, and providing space in school buildings for training programs. No funds under this grant should be set aside for local evaluations, as the project will be formally evaluated through DOL. The DOL evaluation will be aimed primarily at learning from this demonstration if a comprehensive approach to addressing the employment and other needs of out of school youth increases their employment rate, thereby, decreasing negative behavior. The Department will use the lessons learned in subsequent programs for out of school youth.

Part IV—Evaluation Criteria

Prospective offerers are advised that the selection of grantee(s) for award is to be made after careful evaluation of proposals by a panel of specialists. Each panelist will evaluate the proposals for acceptability with emphasis on the various factors enumerated below. The panel results are advisory in nature and not binding on the Grant Officer.

1. Need in target neighborhood, as measured by its poverty rate in the 1990 Census (10 points).

2. Plan and capacity for conducting project (45 points).

3. Level of investments of schools and other public sector partners (15 points)

4. Level of investments of private sector partners, including commitments for private-sector jobs (10 points)

5. Current school-to-work program and plans for next year's school-to-work program in target area high school (10 points)

6. Dropout prevention plans (10 points)

Applicants are advised that discussions may be necessary in order to clarify any inconsistencies in their applications. Site visits will be made prior to final decisions of awards, to confirm information submitted in application. The final decision on awards will be based on what is most advantageous to the Federal Government, taking into account factors such as geographic diversity, mix of EZs and ECs, and demographic characteristics. The Government may elect to award grant(s) without discussion with the offerers.

Signed on this 1st day of September 1998.

Janice E. Perry,

Grant Officer, Department of Labor/ETA.

Attachments: Standard Form 424 Budget Information Sheet

BILLING CODE 4510-30-P

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approval No. 0348-0043

1. TYPE OF SUBMISSION: Application ☐ Construction ☐ Non-Construction		2. DATE SUBMITTED	Applicant Identifier
Preapplication ☐ Construction ☐ Non-Construction		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
5. APPLICANT INFORMATION			
Legal Name:		Organizational Unit:	
Address (give city, county, State and zip code):		Name and telephone number of the person to be contacted on matters involving this application (give area code):	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 		7. TYPE OF APPLICANT: (enter appropriate letter in box) 	
8. TYPE OF APPLICATION: ☐ New ☐ Continuation ☐ Revision If Revision, enter appropriate letter(s) in box(es): A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration Other (specify): _____		A. State H. Independent School Dist. B. County I. State Controlled Institution of Higher Learning C. Municipa J. Private University D. Township K. Indian Tribe E. Interstate L. Individual F. Intermunicipal M. Profit Organization G. Special District N. Other (Specify): _____	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE:		9. NAME OF FEDERAL AGENCY:	
12. AREAS AFFECTED BY PROJECT (cities, counties, States, etc.):		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:	
13. PROPOSED PROJECT:		14. CONGRESSIONAL DISTRICTS OF:	
Start Date	Ending Date	a. Applicant	b. Project
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$	a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE _____	
b. Applicant	\$	b. NO. ☐ PROGRAM IS NOT COVERED BY E.O. 12372 ☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
c. State	\$	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
d. Local	\$	☐ Yes If "Yes," attach an explanation. ☐ No	
e. Other	\$		
f. Program Income	\$		
g. TOTAL	\$		
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.			
a. Typed Name of Authorized Representative		b. Title	c. Telephone number
d. Signature of Authorized Representative		e. Date Signed	

Previous Editions Not Usable

Standard Form 424 (REV 4-88)
Prescribed by OMB Circular A-102

Authorized for Local Reproduction

INSTRUCTIONS FOR THE SF 424

This is a standard form used by applicants as a required facesheet for preapplications and applications submitted for Federal assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and comment procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:	Entry:	Item:	Entry:
1.	Self-explanatory.	12.	List only the largest political entities affected (e.g., State, counties, cities).
2.	Date application submitted to Federal agency (or State if applicable) & applicant's control number (if applicable).	13.	Self-explanatory.
3.	State use only (if applicable)	14.	List the applicant's Congressional District and any District(s) affected by the program or project.
4.	If this application is to continue or revise an existing award, enter present Federal identifier number. If for a new project, leave blank.	15.	Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate <u>only</u> the amount of the change. For decreases, enclose the amounts in parentheses. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as item 15.
5.	Legal name of applicant, name of primary organizational unit which will undertake this assistance activity, complete address of the applicant, and name and telephone number of the person to contact on matters related to this application.	16.	Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernmental review process.
6.	Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.	17.	This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances, loans and taxes.
7.	Enter the appropriate letter in the space provided.	18.	To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)
8.	Check appropriate box and enter appropriate letter(s) in the space(s) provided. - "New" means a new assistance award. - "Continuation" means an extension for an additional funding/budget period for a project with a projected completion date. - "Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation.		
9.	Name of Federal agency from which assistance is being requested with this application.		
10.	Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is required.		
11.	Enter a brief descriptive title of the project. If more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g., construction or real property projects), attach a map showing project location. For preapplications, use a separate sheet to provide a summary description of the project.		

PART II - BUDGET INFORMATION**SECTION A - Budget Summary by Categories**

	(A)	(B)	(C)
1. Personnel			
2. Fringe Benefits (Rate %)			
3. Travel			
4. Equipment			
5. Supplies			
6. Contractual			
7. Other			
8. Total, Direct Cost (Lines 1 through 7)			
9. Indirect Cost (Rate %)			
10. Training Cost/Stipends			
11. TOTAL Funds Requested (Lines 8 through 10)			

SECTION B - Cost Sharing/ Match Summary (if appropriate)

	(A)	(B)	(C)
1. Cash Contribution			
2. In-Kind Contribution			
3. TOTAL Cost Sharing / Match (Rate %)			

NOTE: Use Column A to record funds requested for the initial period of performance (i.e. 12 months, 18 months, etc.); Column B to record changes to Column A (i.e. requests for additional funds or line item changes; and Column C to record the totals (A plus B).

INSTRUCTIONS FOR PART II - BUDGET INFORMATION**SECTION A - Budget Summary by Categories**

1. **Personnel:** Show salaries to be paid for project personnel.
2. **Fringe Benefits:** Indicate the rate and amount of fringe benefits.
3. **Travel:** Indicate the amount requested for staff travel. Include funds to cover at least one trip to Washington, DC for project director or designee.
4. **Equipment:** Indicate the cost of non-expendable personal property that has a useful life of more than one year with a per unit cost of \$5,000 or more.
5. **Supplies:** Include the cost of consumable supplies and materials to be used during the project period.
6. **Contractual:** Show the amount to be used for (1) procurement contracts (except those which belong on other lines such as supplies and equipment); and (2) sub-contracts/grants.
7. **Other:** Indicate all direct costs not clearly covered by lines 1 through 6 above, including consultants.
8. **Total, Direct Costs:** Add lines 1 through 7.
9. **Indirect Costs:** Indicate the rate and amount of indirect costs. Please include a copy of your negotiated Indirect Cost Agreement.
10. **Training /Stipend Cost:** (If allowable)
11. **Total Federal funds Requested:** Show total of lines 8 through 10.

SECTION B - Cost Sharing/Matching Summary

Indicate the actual rate and amount of cost sharing/matching when there is a cost sharing/matching requirement. Also include percentage of total project cost and indicate source of cost sharing/matching funds, i.e. other Federal source or other Non-Federal source.

NOTE:

PLEASE INCLUDE A DETAILED COST ANALYSIS OF EACH LINE ITEM.

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (98-116)]

Information Collection: Submission for OMB Review, Comment Request**AGENCY:** National Aeronautics and Space Administration (NASA).**ACTION:** Notice of Agency Report Forms Under OMB Review.**SUMMARY:** The National Aeronautics and Space Administration has submitted to the Office of Management and Budget (OMB) the following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).**DATES:** Comments on this proposal should be received on or before October 8, 1998.**ADDRESSES:** All comments should be addressed to Ms. Sue McDonald, Mail Code GS4, Lyndon B. Johnson Space Center, Houston, TX 77058.**FOR FURTHER INFORMATION CONTACT:** Ms. Carmela Simonson, Office of the Chief Information Officer, (202) 358-1223.

Reports: JSC Form 1625.

Title: Radioactive Material Transfer Receipt.

OMB Number: 2700-0007.

Type of review: Extension.

Need and Uses: Federal law requires that Johnson Space Center keep records of each radioactive material transfer.

Affected Public: Business or other for-profit, Federal Government, State, Local or Tribal Government.

Number of Respondents: 50.

Responses Per Respondent: 2.

Annual Responses: 100.

Hours Per Request: 1/2 hr.

Annual Burden Hours: 58.

Frequency of Report: On occasion.

Donald J. Andreotta,

Deputy Chief Information Officer (Operations), Office of the Administrator.

[FR Doc. 98-24075 Filed 9-4-98; 8:45 am]

BILLING CODE 7510-01-P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[98-115]

NASA Advisory Council (NAC), Space Science Advisory Committee (SScAC), Sun-Earth Connection Advisory Subcommittee; Meeting**AGENCY:** National Aeronautics and Space Administration.**ACTION:** Notice of Meeting.**SUMMARY:** In accordance with the Federal Advisory Committee Act, Pub.

L. 92-463, as amended, the National Aeronautics and Space Administration announces a meeting of the NASA Advisory Council, Space Science Advisory Committee, Sun-Earth Connection Advisory Subcommittee.

DATES: Monday, September 21, 1998, 8:30 a.m. to 5:00 p.m.; Tuesday, September 22, 1998, 8:30 a.m. to 5:00 p.m.; and Wednesday, September 23, 1998, from 8:30 a.m. to 1:00 p.m.**ADDRESSES:** National Aeronautics and Space Administration, MIC 6, Room, 6H46 300 E Street, SW, Washington, DC 20546.**FOR FURTHER INFORMATION CONTACT:** Dr. George Withbroe, Code S, National Aeronautics and Space Administration, Washington, DC 20546, (202) 358-2150.**SUPPLEMENTARY INFORMATION:** The meeting will be open to the public up to the capacity of the room. The agenda for the meeting is as follows:

- Sun-Earth Connection Program Overview: Budget, Current Program, Future Activities
- Research and Analysis Program
- Solar Terrestrial Probes Program
- Solar Probe
- Discussion and writing groups

It is imperative that the meeting be held on these dates to accommodate the scheduling priorities of the key participants. Visitors will be requested to sign a visitor's register.

Dated: September 1, 1998.

Matthew M. Crouch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. 98-24074 Filed 9-4-98; 8:45 am]

BILLING CODE 7510-01-P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50-400]

Carolina Power & Light Company; Notice of Consideration of Issuance of Amendment to Facility Operating License, Proposed No Significant Hazards Consideration Determination, and Opportunity For a Hearing

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of an amendment to Facility Operating License No. NPF-63 issued to Carolina Power & Light Company (the licensee) for operation of the Shearon Harris Nuclear Power Plant located in Wake and Chatham Counties, North Carolina.

The proposed amendment would revise the Harris Nuclear Plant (HNP) Technical Specifications (TS)

concerning the applicability of Limiting Conditions for Operation (LCO) and Surveillance Requirements (SR). Specifically, HNP proposes to revise TS 3.0.4 and associated specifications; TS 4.0.4; and Bases for TS 3.0.3, TS 3.0.4, and TS 4.0.4 to be consistent with Generic Letter 87-09 dated June 4, 1987.

This proposed TS change is needed due to the verbatim requirements of TS 3.0.4 and inoperable TS equipment that would prevent plant shutdown. A verbatim reading of the current HNP TS 3.0.4 would not allow entry into a lesser operational mode if required TS components were inoperable.

Before issuance of the proposed license amendment, the Commission will have made findings required by the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations.

The Commission has made a proposed determination that the amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety. As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. The proposed amendment does not involve a significant increase in the probability or consequences of an accident previously evaluated.

The proposed revision to TS 3.0.4 allows entry into an operational condition in accordance with action requirements when conformance to the action requirements permits continued operation of the facility for an unlimited period of time. This operational flexibility is consistent with that allowed by the existing individual LCOs and their associated action requirements which provide an acceptable level of safety for continued operation.

The proposed revision to TS 4.0.4 clarifies that Specification 4.0.4 does not prevent passage through or to operational conditions as required to comply with action requirements. This is consistent with the existing Specification 3.0.4. In addition, the potential for plant upset and challenge to safety systems is heightened if surveillances are performed during a shutdown to comply with Action Requirements.

The revisions to the Bases Section 3.0 and 4.0 and the elimination of specific exceptions

to Specification 3.0.4 are administrative in nature and, therefore, do not involve a significant increase in the probability or consequences of an accident previously evaluated.

Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated. There is no physical alteration to any plant system, nor is there a change in the method in which any safety related system performs its function.

2. The proposed amendment does not create the possibility of a new or different kind of accident from any accident previously evaluated.

The proposed amendment does not create the possibility of a new or different kind of accident from any accident previously evaluated because there is no physical alteration to any plant system, nor is there a change in the method in which any safety related system performs its function.

The revisions to the Bases Sections 3.0 and 4.0 and the elimination of specific exemptions to Specification 3.0.4 are administrative in nature and, therefore, do not create the possibility of a new or different kind of accident from any accident previously evaluated.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. The proposed amendment does not involve a significant reduction in the margin of safety.

The revision to Specification 3.0.4 allows operational flexibility which is consistent with that allowed by the existing individual LCOs and their associated action requirements which provide an acceptable level of safety for continued operation. The proposed revision to Specification 4.0.4 is a clarification to the specification and as such is administrative in nature. The revision makes it clear that Specification 4.0.4 does not prevent passage through or to operational conditions as required to comply with action requirements. This is consistent with the existing Specification 3.0.4. These revisions result in improved Technical Specifications, and therefore, increase the margin of safety.

The revisions to the Bases Sections 3.0 and 4.0 and the elimination of specific exemptions to Specification 3.0.4 are administrative in nature and, therefore, do not involve a significant reduction in a margin of safety.

Therefore, the proposed change does not involve a significant reduction in the margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of

publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of the 30-day notice period. However, should circumstances change during the notice period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility, the Commission may issue the license amendment before the expiration of the 30-day notice period, provided that its final determination is that the amendment involves no significant hazards consideration. The final determination will consider all public and State comments received. Should the Commission take this action, it will publish in the **Federal Register** a notice of issuance and provide for opportunity for a hearing after issuance. The Commission expects that the need to take this action will occur very infrequently.

Written comments may be submitted by mail to the Chief, Rules and Directives Branch, Division of Administrative Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and should cite the publication date and page number of this **Federal Register** notice. Written comments may also be delivered to Room 6D59, Two White Flint North, 11545 Rockville Pike, Rockville, Maryland, from 7:30 a.m. to 4:15 p.m. Federal workdays. Copies of written comments received may be examined at the NRC Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC.

The filing of requests for hearing and petitions for leave to intervene is discussed below.

By October 8, 1998, the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the proceeding must file a written request for a hearing and a petition for leave to intervene. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR Part 2. Interested persons should consult a current copy of 10 CFR 2.714 which is available at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the Cameron Village Regional Library, 1930 Clark Avenue, Raleigh, North Carolina 27605.

If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition; and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following factors: (1) The nature of the petitioner's right under the Act to be made party to the proceeding; (2) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspect(s) of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to 15 days prior to the first prehearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than 15 days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include a list of the contentions which are sought to be litigated in the matter. Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner shall provide a brief explanation of the bases of the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to rely in proving the contention at the hearing. The petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the petitioner intends to rely to establish those facts or expert opinion. Petitioner must provide sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The

contention must be one which, if proven, would entitle the petitioner to relief. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to present evidence and cross-examine witnesses.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment request involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, Attention: Rulemakings and Adjudications Staff, or may be delivered to the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, by the above date. A copy of the petition should also be sent to the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to William D. Johnson, Vice President and Senior Counsel, Carolina Power & Light Company, Post Office Box 1551, Raleigh, North Carolina 27602, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the presiding Atomic Safety and Licensing Board that the petition and/or request should be granted based upon a balancing of the factors specified in 10 CFR 2.714(a)(1)(I)-(v) and 2.714(d).

For further details with respect to this action, see the application for amendment dated August 27, 1998, which is available for public inspection at the Commission's Public Document

Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the Cameron Village Regional Library, 1930 Clark Avenue, Raleigh, North Carolina 27605.

Dated at Rockville, Maryland, this 21st day of September, 1998.

For the Nuclear Regulatory Commission.

Scott C. Flanders,

Project Manager, Project Directorate II-1, Division of Reactor Projects—I/II, Office of Nuclear Reactor Regulation.

[FR Doc. 98-24010 Filed 9-4-98; 8:45 am]

BILLING CODE 7590-01-P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50-295/304-LA-2 ASLBP No. 98-750-06-LA]

Commonwealth Edison Company; Establishment of Atomic Safety and Licensing Board

Pursuant to delegation by the Commission dated December 29, 1972, published in the **Federal Register**, 37 FR 28710 (1972), and Sections 2.105, 2.700, 2.702, 2.714, 2.714a, 2.717, 2.721 of the Commission's Regulations, all as amended, an Atomic Safety and Licensing Board is being established to preside over the following proceeding.

COMMONWEALTH EDISON COMPANY

Zion Nuclear Power Station

This Board is being established pursuant to a petition for leave to intervene submitted by the Committee for Safety at Plant Zion, Randy Robarge and Edwin D. Dienethal. The petition was filed in response to a notice of issuance of a license amendment to the Commonwealth Edison Company for the Zion Nuclear Power Station and the Nuclear Regulatory Commission's Staff's finding of no significant hazards considerations in connection with that license amendment. The notice was published in the **Federal Register** at 63 FR 43216, 43217 (August 12, 1998).

The Board is comprised of the following administrative judges: Thomas S. Moore, Chairman, Atomic Safety and Licensing Board Panel, U.S. Nuclear Regulatory Commission, Washington, DC 20555 Dr. Jerry R. Kline, Atomic Safety and Licensing Board Panel, U.S. Nuclear Regulatory Commission, Washington, DC 20555 Frederick J. Shon, Atomic Safety and Licensing Board Panel, U.S. Nuclear Regulatory Commission, Washington, DC 20555

All correspondence, documents and other materials shall be filed with the Judges in accordance with 10 CFR 2.701.

Issued at Rockville, Maryland, this 1st day of September 1998.

B. Paul Cotter, Jr.,

Chief Administrative Judge, Atomic Safety and Licensing Board Panel.

[FR Doc. 98-24008 Filed 9-4-98; 8:45 am]

BILLING CODE 7590-01-P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50-346]

Toledo Edison Company, Centerior Service Company and The Cleveland Electric Illuminating Company; Davis-Besse Nuclear Power Station, Unit 1; Environmental Assessment and Finding of No Significant Impact

The U.S. Nuclear Regulatory Commission (the Commission) is considering the issuance of an order approving, under 10 CFR 50.80, the transfer of Facility Operating License No. NPF-3, issued to the Toledo Edison Company, Centerior Service Company, and The Cleveland Electric Illuminating Company (the licensees) for the Davis-Besse Nuclear Power Station, Unit 1, located in Ottawa County, Ohio, with respect to operating authority under the license, and considering issuance of a conforming amendment under 10 CFR 50.90.

Environmental Assessment

Identification of the Proposed Action

The proposed action would approve the transfer of operating authority under the license to a new company, FirstEnergy Nuclear Operating Company (FENOC), to allow it to use and operate Davis-Besse and to possess and use related licensed nuclear materials in accordance with the same conditions and authorizations included in the current operating license. The proposed action would also approve issuance of a license amendment reflecting the transfer of operating authority. FENOC would be formed by FirstEnergy Corporation to become the licensed operator for Davis-Besse and would have exclusive control over the operation and maintenance of the facility.

Under the proposed arrangement, ownership of Davis-Besse will remain unchanged with each owner retaining its current ownership interest. FENOC will not own any portion of Davis-Besse. Likewise, the owners' entitlement to capacity and energy from Davis-Besse

will not be affected by the proposed change in operating responsibility for Davis-Besse. The owners will continue to provide all funds for the operation, maintenance, and decommissioning by FENOC of Davis-Besse. The responsibility of the owners will include funding for any emergency situations that might arise at Davis-Besse.

The proposed action is in accordance with the licensees' application dated June 29, 1998, as supplemented by letter dated July 14, 1998, for approval of the transfer of the license and issuance of a conforming amendment.

Need for the Proposed Action

The proposed action is needed to enable the licensees to transfer operating authority to FENOC as discussed above. The licensees have submitted that this will enable them to enhance the already high level of public safety, operational efficiency, and cost-effective operations at Davis-Besse.

Environmental Impacts of the Proposed Action

The Commission has completed its evaluation of the proposed action and concludes that there will be no physical or operational changes to Davis-Besse. The technical qualifications of FENOC to carry out its responsibilities under the operating license for Davis-Besse will be equivalent to the present technical qualifications of the current operators. FENOC will assume responsibility for, and control over, operation and maintenance of the facility. The present plant organization, the oversight organizations, and the engineering and support organizations will be transferred essentially intact to FENOC. The technical qualifications of the FENOC organization, therefore, will be at least equivalent to those of the existing organization.

The Commission has evaluated the environmental impact of the proposed action and has determined that the probability or consequences of accidents would not be increased and that post-accident radiological releases would not be greater than previously determined. Further, the Commission has determined that the proposed action would not affect routine radiological plant effluents and would not increase occupational radiological exposure. Accordingly, the Commission concludes that there are no significant radiological environmental impacts associated with the proposed action.

With regard to potential nonradiological impacts, the proposed action would not affect nonradiological plant effluents and would have no other

environmental impact. Therefore, the Commission concludes that there are no significant nonradiological environmental impacts associated with the proposed action.

Alternative to the Proposed Action

Since the Commission concluded that there is no measurable environmental impact associated with the proposed action, any alternative with equal or greater environmental impacts need not be evaluated. As an alternative to the proposed action, the staff considered denial of the requested action. Denial of the application would result in no change in current environmental impacts. The environmental impacts of the proposed action and the alternative action are identical.

Alternative Use of Resources

This action does not involve the use of any resources not previously considered in the "Final Environmental Statement Related to the Operation of Davis-Besse Nuclear Power Station, Unit 1," dated October 1975.

Agencies and Persons Contacted

In accordance with its stated policy, on July 21, 1998, the staff consulted with the State official of the Ohio Emergency Management Agency regarding the environmental impact of the proposed action. The State official had no comments.

Finding of No Significant Impact

Based upon the environmental assessment, the Commission concludes that the proposed action will not have a significant effect on the quality of the human environment. Accordingly, the Commission has determined not to prepare an environmental impact statement for the proposed action.

For further details with respect to the proposed action, see the licensees' application dated June 29, 1998, as supplemented by letter dated July 14, 1998, which are available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the University of Toledo, William Carlson Library, Government Documents Collection, 2801 West Bancroft Avenue, Toledo, OH 43606.

Dated at Rockville, Maryland, this 1st day of September 1998.

For the Nuclear Regulatory Commission.

Ronald R. Bellamy,

Director, Project Directorate III-3, Division of Reactor Projects—III/IV, Office of Nuclear Reactor Regulation.

[FR Doc. 98-24009 Filed 9-4-98; 8:45 am]

BILLING CODE 7590-01-P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. STN 50-456, STN 50-457, STN 50-454, STN 50-455, 50-237, 50-249, 50-373, 50-374, 50-254, 50-265, 50-295, and 50-304]

Commonwealth Edison Company (Braidwood Station, Units 1 and 2), (Byron Station, Units 1 and 2), (Dresden Nuclear Power Station, Units 2 and 3), (LaSalle County Station, Units 1 and 2), (Quad Cities Nuclear Power Station, Units 1 and 2), and (Zion Nuclear Power Station, Units 1 and 2); Issuance of Director's Decision Under 10 C.F.R. § 2.206

Notice is hereby given that the Director, Office of Nuclear Reactor Regulation, has taken action with regard to a Petition submitted by the National Whistleblower Legal Defense and Education Fund (Petitioner), dated March 25, 1998, regarding Commonwealth Edison Company (ComEd).

The Petitioner requested that the NRC take corrective action and impose civil penalties against ComEd. The Petitioner asserted that: (1) ComEd's assertion in a pleading in a case before the U.S. Department of Labor that the filing of a "Problem Identification Form" does not constitute a protected activity fosters an atmosphere of intimidation and chills the reporting of concerns in violation of 10 CFR § 50.7; and (2) ComEd intentionally imposed "restrictive confidentiality" aimed at prohibiting employees from providing information to the NRC in violation of 10 C.F.R. § 50.7.

The Director of the Office of Nuclear Reactor Regulation has denied the Petition. The reasons for the denial are explained in the Director's Decision under 10 C.F.R. § 2.206 (DD-98-08), the complete text of which follows this notice and which is available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, N.W., Washington, D.C. 20555-0001; and at the local public document rooms; the Byron Public Library District, 109 N. Franklin, P.O. Box 434, Byron, Illinois 61010; the Wilmington Public Library, 201 S. Kankakee Street, Wilmington, Illinois 60481; Morris Area Public Library District, 604 Liberty Street, Morris, Illinois 60450; Jacobs Memorial Library, 815 North Orlando Smith Avenue, Illinois Valley Community College, Oglesby, Illinois 61348-9692; Dixon Public Library, 221 Hennepin Avenue, Dixon, Illinois 61021; and Waukegan Public Library, 128 N. County Street, Waukegan, Illinois 60085.

A copy of this Decision will be filed with the Secretary of the Commission for the Commission's review in accordance with 10 C.F.R. § 2.206(c) of the Commission's regulations. As provided by this regulation, this Decision will constitute the final action of the Commission 25 days after the date of issuance unless the Commission, on its own motion, institutes a review of the decision within that time.

Dated at Rockville, Maryland, this 31st day of August 1998.

For the Nuclear Regulatory Commission.

Frank J. Miraglia,

Acting Director, Office of Nuclear Reactor Regulation.

Director's Decision Under 10 CFR § 2.206

I. Introduction

On March 25, 1998, the National Whistle Blower Legal Defense and Education Fund and Mr. Randy Robarge filed a Petition with the U.S. Nuclear Regulatory Commission (NRC) pursuant to Section 2.206 of Title 10 of the *Code of Federal Regulations* (10 CFR § 2.206). (Although Mr. Randy Robarge was also initially named as a Petitioner, the NRC was notified by counsel for Mr. Robarge by written submittal dated June 26, 1998, that Mr. Robarge was withdrawing his Petition). The Petition requested that the NRC take certain immediate "corrective" action and impose civil penalties against Commonwealth Edison Company (ComEd) based upon ComEd's: (1) "Interference" with the willingness of employees to file Problem Identification Forms (PIFs); and (2) "intentional prohibition" of employees from directly communicating information to the NRC. The Petitioner raised two issues. Specifically, the Petitioner asserted, first, that ComEd's assertion in a pleading in a case before the U.S. Department of Labor (DOL),¹ 98-ERA-2, that the filing of a PIF does not constitute protected activity fosters an atmosphere of intimidation and chills the reporting of safety concerns in violation of 10 CFR § 50.7. As a consequence, the Petitioner requested the NRC to: (1) Immediately issue a Show Cause Order requiring ComEd to explain why the filing of a PIF does not constitute protected activity under Section 211 of the Energy Reorganization Act of 1974, as amended, 42 U.S.C. § 5851 (1988 and Supp. V 1993) (ERA); (2) issue a

Severity Level I violation and appropriate civil penalty for taking action that ComEd knew or should have known would prevent employees from filing PIFs; and (3) require the licensee to post a public apology for claiming that the filing of a PIF does not constitute a protected activity.

In addition, the Petitioner asserted that ComEd intentionally imposed restrictive confidentiality provisions in a discovery agreement in a pending DOL proceeding aimed at prohibiting employees from providing information to the NRC in violation of 10 CFR § 50.7. As a consequence, the Petitioner requested that the NRC: (1) Issue a Show Cause Order to ComEd requiring it to explain under oath why the imposition of restrictive confidentiality clauses prohibiting employees from directly communicating information to the NRC should not be prohibited; (2) impose a Severity Level I violation and appropriate civil penalty against ComEd for the intentional violation of 10 CFR § 50.7(f); (3) require ComEd to transmit to all individuals under similar restrictive confidentiality terms notice that they are now free to communicate information to the NRC; and (4) require the licensee to release to the NRC copies of all restrictive confidentiality agreements entered into by ComEd and any subcontractors employed by ComEd since March 21, 1990 (the date the **Federal Register** notice of 10 CFR § 50.7(f) was published).

By letter dated April 29, 1998, I informed the Petitioner that the Petition had been referred to me pursuant to 10 CFR § 2.206 of the Commission's regulations. I further informed the Petitioner that the issues raised in the Petition did not constitute an immediate safety concern at ComEd's nuclear facilities and that the information provided did not warrant the immediate action that was requested, but that action would be taken upon the Petition within a reasonable time.

On May 20, 1998, the NRC forwarded a copy of the Petition to the licensee with a request to respond to the issues raised in the Petition. The licensee responded to the NRC's request by letter dated June 19, 1998.

II. Background

Mr. Randy Robarge, a former health physics supervisor at the Zion Nuclear Power Station, filed a complaint with the U.S. Department of Labor (DOL) under Section 211 of the ERA (98-ERA-2) claiming that he was discriminated against and subjected to a retaliatory discharge for filing PIFs. On November 26, 1997, during discovery in connection with the pending litigation

before the DOL Administrative Law Judge, Mr. Robarge filed through his counsel a "Request for Production of Documents, Admissions, and Interrogatory Questions" (Complainant's Request). On February 5, 1998, ComEd filed through its counsel its "Respondent's Response and Objections" (Respondent's Response). In addition, during discovery, counsel for Mr. Robarge and ComEd entered into a joint agreement to provide for the confidentiality of certain documents. The agreement was embodied in an Order signed by counsel for both parties on March 23, 1998, entitled, "Stipulation and Order Governing Confidentiality of Document and Information" (Confidentiality Order).²

III. Discussion

The Petitioner makes two assertions in support of the request that the NRC take the action requested. These assertions arise from statements made by ComEd in the discovery documents described above.

First, the Petitioner claims that ComEd's response in its Respondent's Response to a request made by Mr. Robarge in his Complainant's Request (Request Number 3) amounts to an assertion that the filing of PIFs is not a protected activity and, as such, will "chill" the reporting of safety concerns in violation of 10 CFR § 50.7. Request Number 3 requested that ComEd admit or deny the following statement: "The complainant engaged in protected activity under Section 211 when he filed 'PIFs' with the Respondent." In its Respondent's Response, ComEd stated the following: "Respondent objects to the Request as being overly broad, vague and ambiguous in referring generally to 'PIFs' and for calling for a legal conclusion and, therefore, this Request is denied."

The Petitioner asserts that this "cavalier attitude and recalcitrance to admit that the filing of PIFs is protected activity" by the licensee will "chill" the willingness of employees to file PIFs and, as such, warrants that the NRC

² On June 8, 1998, the parties submitted to the DOL Administrative Law Judge a joint motion seeking approval of a settlement agreement and to protect its confidentiality and to dismiss the claim. Attached to the motion was the settlement and release agreement signed by counsel for both parties, as well as Mr. Robarge. On June 10, 1998, the Administrative Law Judge issued a Recommended Decision and Order recommending that the joint motion to approve settlement agreement and for order of dismissal be granted, and noted that the Recommended Decision and Order would become the final order of the Secretary of Labor absent a petition for review being received by the Administrative Review Board within ten business days. We have been informed that the DOL has no record of an appeal being filed.

¹ The case involved an assertion by Mr. Robarge that he had been discriminated against by ComEd for raising Nuclear Safety concerns in violation of Section 211 of the Energy Reorganization Act of 1974, as amended, 42 U.S.C. § 5851 (1988 and Supp. V. 1993).

issue a Show Cause Order to the licensee, issue a Severity Level I violation and civil penalty, and require the licensee to post a public apology. In support of this assertion, the Petitioner submitted as an attachment to the Petition an affidavit by a ComEd employee that stated that ComEd's denial that the filing of a PIF constitutes protected activity "chills" the willingness of employees to file PIFs.

In construing ComEd's response to Request Number 3 in such a manner, the Petitioner appears to have misconstrued the statement by taking it out of context and misstating the licensee's position. In making this statement, the licensee does not appear to be taking the position that the filing of all PIFs was not a protected activity. Rather, the licensee was objecting specifically to a request for admission as being an inappropriate discovery request as a litigative technique. Nothing in its response suggests that ComEd did not recognize that the actual filing of a PIF could constitute protected activity. In fact, in its response to the Petition, dated June 19, 1998, ComEd specifically stated that it recognizes that the preparation of internal nuclear safety-related documents, such as PIFs, could give rise to protected activity.³ Thus, there is no merit to this assertion, nor does it warrant the action requested by the Petitioner.

The Petitioner's second assertion is that ComEd intentionally imposed a restrictive provision upon Mr. Robarge aimed at prohibiting employees from providing information to the NRC in violation of 10 CFR § 50.7. To "correct" this practice, the Petitioner requests that the NRC issue a Show Cause Order to ComEd, impose a Severity Level I violation and civil penalty against ComEd, require ComEd to transmit to all individuals under similar confidentiality terms notice that they are now free to communicate information to the NRC, and require ComEd to release to the NRC copies of all restrictive confidentiality agreements entered into by ComEd and its subcontractors since March 21, 1990.

The provision that the Petitioner asserts was intended to prohibit Mr. Robarge from providing information to the NRC in violation of NRC requirements is Section 3(g) of the Confidentiality Order. Section 3(g) of

the Confidentiality Order states that confidential information may be disclosed to governmental law enforcement agencies and other governmental bodies pursuant to valid subpoena, provided that: (1) The subpoenaed party give counsel for the designating party written notice of the subpoena and, if so directed by the designating party, object to such subpoena on a timely basis so as to preserve the designating party's rights; and (2) the subpoenaed party proceed in good faith to seek to obtain confidential treatment of the subpoenaed documents from the relevant governmental body. The Confidentiality Order also contains a provision (Provision 6) that would allow either party to challenge the applicability of this stipulation to any document designated as confidential.

The Petitioner alleges that Mr. Robarge objected through his counsel to the wording of Section 3 (g) and requested that the provision include an additional paragraph stating the following:

Nothing in this agreement shall constitute a prohibition on either party to communicate directly with the U.S. Nuclear Regulatory Commission any information or documentation that is designated as "confidential" by either party except that the party seeking to provide that material to the NRC shall clearly designate the documents as "confidential" and request that the documents be treated as confidential to the fullest extent reasonable under the circumstance.

The Petitioner asserts that ComEd's counsel responded in a letter dated March 19, 1998, that "the language in your addendum is not something that ComEd will stipulate to end a confidentiality order (or an addendum to such an order). On the merits, this section goes directly against the purpose for having a confidentiality order in the first place." The Petitioner also states that ComEd's counsel acknowledged to counsel for Mr. Robarge that "the restrictive confidentiality language is routinely incorporated in agreements entered into by ComEd." The Petitioner asserts that these statements demonstrate that the prohibition in communication with the NRC was intentional rather than inadvertent, and that identical restrictive language is routinely incorporated into ComEd agreements.

The language of which the Petitioner complains is reflected in the Confidentiality Order executed by counsel for *both* parties as well as the Administrative Law Judge (ALJ) presiding in the DOL proceeding regarding Mr. Robarge's Section 211 complaint. Indeed, it appears that the Confidentiality Order was executed by

counsel for both parties on March 23, 1998, and entered by the DOL ALJ on March 24, 1998; both dates are after the exchange of correspondence alluded to by counsel for Mr. Robarge with respect to his complaints about the possible restrictive nature of the provision. To the extent that Mr. Robarge had such concerns, they should have been raised in the first instance, before the DOL ALJ. That agency has, in the past, expressed no hesitation in assuring that agreements reached by parties to proceedings before it under Section 211 do not contain provisions which unlawfully interfere with an individual's right to engage in protected activity, *Polizzi v. Gibbs & Hill, Inc.*, 87-ERA-38 (Secretary of Labor, July 18, 1989). There is no indication that Mr. Robarge requested that the ALJ consider this matter in the first instance, or sought reconsideration by DOL. In the absence of consideration of this matter by the ALJ, NRC does not intend to take action.

IV. Conclusion

For the reasons discussed in the preceding section, no basis exists for taking the actions requested by the Petitioner. Accordingly, the Petition is denied.

A copy of the Decision will be filed with the Secretary of the Commission for the Commission's review. The Decision will become the final action of the Commission, 25 days after issuance unless the Commission, on its own motion, institutes review of the decision within that time.

Dated at Rockville, Maryland, this 31st day of August 1998.

For the Nuclear Regulatory Commission.

/s/ Frank J. Miraglia,

Samuel J. Collins,

Director, Office of Nuclear Reactor Regulation.

[FR Doc. 98-24012 Filed 9-4-98; 8:45 am]

BILLING CODE 7590-01-P

NUCLEAR REGULATORY COMMISSION

[Docket Number: 030-14526; License Number: 37-00062-07]

**Department of Veterans Administration
Medical Center, Philadelphia, PA;
Issuance of Director's Decision Under
10 CFR § 2.206**

Notice is hereby given that the Director, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission (Commission or NRC), has taken action with regard to a

³ With regard to the attached affidavit (Exhibit 5 to the Petition), the affiant indicates that he viewed the licensee's response to request number 3 in its Respondent's Response to represent ComEd's "official legal position." It thus appears that the affiant misunderstood the purpose of the response and its limited significance as a litigation technique and the fact that this statement did not constitute an "official legal position" about whether the filing of PIFs could constitute protected activity.

Petition dated January 28, 1998, submitted by Ann Lovell (Petitioner), regarding the Department of Veterans Administration Medical Center, Philadelphia, Pennsylvania (PVAMC). The Petitioner has requested that NRC take immediate action to suspend or revoke the NRC license issued to PVAMC. As grounds for her request, the Petitioner asserts that executive management is operating in a manner that has the potential to present a significant danger to medical center patients, staff, and the general public. Specifically, the Petitioner asserts that: (1) there has been a consistent pattern of NRC violations occurring within the medical center for which PVAMC has failed to take corrective action; (2) PVAMC has a history of supplying false information to NRC; (3) individuals, including the Petitioner, became contaminated with radioactive material in the nuclear medicine department as a result of what the Petitioner believes was an intentional incident; and (4) PVAMC employees are fearful of bringing safety concerns to the licensee for fear of retaliation, and to NRC because of NRC's "history of inaction" regarding the medical center. Additionally, the Petitioner claims that NRC withdrew a civil penalty after a change in NRC Region I management, which may have been withdrawn as it was not "cost-effective" to pursue the issue.

The Director of the Office of Nuclear Material Safety and Safeguards has denied the Petition. The reasons for this denial are explained in the "Director's Decision Under 10 CFR § 2.206," (DD-98-07) the complete text of which follows this notice. The Director's Decision is available for public inspection at NRC's Public Document Room, the Gelman Building, 2120 L Street, N.W., Washington, D.C.

A copy of this Decision will be filed with the Secretary of the Commission, for the Commission's review, in accordance with 10 CFR § 2.206(c) of the Commission's regulations. As provided by this regulation, the Decision will constitute the final action of the Commission 25 days after the date of issuance of the Decision, unless the Commission, on its own motion, institutes a review of the Decision within that time.

Dated at Rockville, Maryland, this 28 day of August, 1998.

For the Nuclear Regulatory Commission.

Carl J. Paperiello,

Director, Office of Nuclear Material Safety and Safeguards.

Director's Decision Under 10 CFR § 2.206

I. Introduction

By a Petition addressed to the Director, Division of Nuclear Materials Safety, U.S. Nuclear Regulatory Commission (NRC), Region I, dated January 28, 1998, Ann Lovell (Petitioner), requested that NRC take immediate action to suspend or revoke the NRC license issued to the Department of Veterans Administration Medical Center, Philadelphia, Pennsylvania (PVAMC or licensee). As grounds for her request, the Petitioner asserts that executive management is operating in a manner that has the potential to present a significant danger to PVAMC patients, staff, and the general public. Specifically, the Petitioner asserts that: (1) there has been a consistent pattern of NRC violations occurring within the medical center for which PVAMC has failed to take corrective action; (2) PVAMC has a history of supplying false information to NRC; (3) individuals, including the Petitioner, became contaminated with radioactive material in the nuclear medicine department as a result of what the Petitioner believes was an intentional incident; and (4) PVAMC employees are fearful of bringing safety concerns to the licensee, for fear of retaliation, and to NRC, because of NRC's "history of inaction" regarding the PVAMC. Additionally, the Petitioner claims that NRC withdrew a civil penalty after a change in NRC Region I management, which may have been withdrawn because it was not "cost-effective" to pursue the issue against the Department of Veterans Affairs.

On February 27, 1998, the receipt of the Petition was acknowledged and the Petitioner was informed that the Petition had been referred to the Office of Nuclear Material Safety and Safeguards pursuant to 10 CFR § 2.206 of the Commission's regulations. The Petitioner was also informed that her request that NRC immediately suspend or revoke the PVAMC's license was denied, and that other action on her request would be completed within a reasonable time, as provided by 10 CFR § 2.206.

II. Background

The circumstances surrounding the issues raised in the Petition can be summarized as follows. From 1994 until Spring 1998, the Petitioner was

employed by PVAMC as the Radiation Safety Officer (RSO). In November 1995, the Petitioner raised concerns to NRC regarding the safety of the licensee's operations in connection with a potential furlough of Federal government employees. As a result, NRC conducted a special inspection of the licensee's facility on November 17, 1995 (Inspection Report No. 030-14526/95-002). During the inspection, the inspector discovered that the licensee had replaced the RSO before NRC approval and had held a Radiation Safety Committee (RSC) meeting without a quorum, in that the RSO and half of the RSC membership were not present. Based on these violations, a Notice of Violation (NOV) was issued to PVAMC on January 4, 1996.

The licensee responded to the NOV by letter dated February 23, 1996. In its response, the licensee stated that it replaced the RSO with a nuclear physician, to ensure continuous coverage of the radiation safety program during a Federal government furlough, and that the full complement of the RSC could not be assembled to formalize the decision, because of the furlough of personnel, including the RSO.

On February 5, 1996, the Petitioner filed a discrimination complaint with the United States Department of Labor (DOL), asserting that she had been discriminated against for contacting NRC. In a decision issued on March 6, 1996, the Acting District Director of the DOL Wage and Hour Division determined that discrimination was a factor in the actions that comprised the complaint, in violation of Section 211 of the Energy Reorganization Act of 1974, as amended, 42 U.S.C. § 5851 (1988 and Supp. V. 1993). The licensee did not appeal the findings of the Acting District Director, so that the decision of the Acting District Director became the final DOL decision.

NRC held an Enforcement Conference with PVAMC on August 26, 1996, regarding this matter. On September 18, 1996, NRC issued a NOV and Proposed Imposition of Civil Penalty to PVAMC based on the DOL Acting District Director's decision and information provided by PVAMC during the conference, for a violation of the Commission's Employee Protection regulations, 10 CFR § 30.7 (EA 96-182). Specifically, the licensee was cited for discriminating against the Petitioner in that her supervisor had chastised her for contacting NRC. The violation was categorized, in accordance with the Commission's Enforcement Policy, NUREG-1600, "General Statement of Policy and Procedures for NRC Enforcement Actions" (hereafter,

Enforcement Policy), as a Severity Level II violation, and a civil penalty of \$8000 was proposed.

On November 15, 1996, PVAMC submitted a "Response to Notice of Violation and Proposed Imposition of Civil Penalty" and "Answer to a Notice of Violation." In these documents, it admitted the violation, but requested reconsideration of the determination that the violation constituted a Severity Level II violation warranting a civil penalty of \$8000. In support of its request, PVAMC stated that the supervisor had chastised the Petitioner not just for contacting NRC, but for failing to notify him of certain information of which she was aware; that the chastisement was an isolated occurrence; that other employees were not "chilled" from raising safety concerns as a result of this event; and that a Severity Level II violation was for the most severe violations involving actual or high potential impact on the public, which had not been the case here. Following a review of the licensee's response and the findings of an investigation conducted by NRC's Office of Investigations (OI) that there had been no continued discrimination against the Petitioner, NRC informed the licensee, by letter dated September 25, 1997, that it had concluded that the violation would be more appropriately classified as a Severity Level III violation and that enforcement discretion should be exercised to not issue a civil penalty, in accordance with Section VII.B.6. of the Enforcement Policy.¹ NRC conducted an inspection of the licensee's facility from July 9 through October 20, 1997, (Inspection Report 030-14526/97-001). On approximately July 24, 1997, a contamination incident occurred in the licensee's Nuclear Medicine Department, in which the hands of the RSO and the Chief Nuclear Medicine Technologist (CNMT) became contaminated. The inspector determined that a radiation survey instrument may have become contaminated during surveys of the Nuclear Medicine Department, and that the two individuals' hands became contaminated as a result of handling the instrument. The inspection results indicated that the incident may have

been caused by a weakness in the licensee's contamination control techniques, including not using contamination control precautions during the use of radioactive material, and, in some cases, failing to wear gloves. In addition, NRC determined that significant weaknesses existed in the licensee's program in such areas as the functioning and effectiveness of the RSC, training, teamwork, communications, leadership, and conflict resolution. NRC issued a Confirmatory Action Letter (CAL) to PVAMC on December 19, 1997, (with corrected copy issued December 31, 1997), confirming the licensee's commitments to conduct a comprehensive review and assessment of its radiation safety program; to provide training to staff, including among other things, instruction regarding employees' rights to raise safety concerns to management and NRC; and to develop a formal program audit system to continuously identify and correct program deficiencies.

III. Discussion

As stated above, the Petitioner has raised numerous issues in support of her assertion that executive management of PVAMC is operating in a manner that has the potential to present a significant danger to medical center patients, staff, and the general public. These issues, and NRC's evaluation of these issues, are set forth below.

A. Petitioner's Assertion of Consistent Pattern of Violations for Which PVAMC Failed to Take Corrective Action

Among other things, the Petitioner maintains that there has been a consistent pattern of NRC violations occurring within the medical center for which PVAMC has failed to take corrective action. In support of this assertion, the Petitioner has submitted an attachment to her Petition, entitled "Chronology of PVAMC/NRC Interaction Since Whistle Blower Incident of November 17, 1995," that she purports "attests" to such a consistent pattern of violations within the facility.

NRC inspections conducted at PVAMC's facilities from 1995 through 1997 identified several violations. However, none of these violations was of high safety significance, and, with the exception of the enforcement action discussed above, involving discrimination against the Petitioner for raising safety concerns (EA 96-182), all the violations were categorized as Severity Level IV violations in accordance with the Commission's

Enforcement Policy.² The Severity Level IV violations are described in Inspection Reports 030-14526/96-002 and 030-14526/97-001, issued on September 11, 1997, and December 10, 1997, respectively. The licensee responded to the violations identified in Inspection Report 030-14526/96-002 by letter dated November 4, 1997, and to the violations identified in Inspection Report 030-14526-001, by letter dated January 9, 1998. In its responses, the licensee described its corrective actions for the violations.

In addition, as noted above, during these inspections, certain programmatic weaknesses were identified by NRC, including conflicts between management, the RSO, the RSC, and the licensee's staff. NRC determined that weaknesses existed in such areas as the functioning and effectiveness of the RSC, training, teamwork, communications, leadership, and conflict resolution. NRC also was concerned that PVAMC employees may have been reluctant to raise safety concerns because of these communication problems. As a result of these findings, NRC management toured the facilities on December 15, 1997, and met with representatives of the licensee on December 18, 1997, to discuss these program weaknesses. Subsequently, on December 19, 1997 (with corrected copy issued December 31, 1997), a CAL was issued to PVAMC, documenting the licensee's commitment to: (1) have the RSO and the RSC Chairman conduct a comprehensive review and assessment of the radiation safety program; (2) provide training, conducted by the RSO and the RSC Chairman, to all nuclear medicine staff, researchers using radioactive material, RSC members, and the facility management, on all applicable NRC regulatory requirements, on management expectations, and on the policy on bringing forth identified program deficiencies; and (3) establish a formal program audit system to identify, report, and correct program deficiencies. The licensee completed these actions by May 30, 1998. Additionally, the CAL provided that the licensee was to notify NRC, after completing all items in the CAL, so as to arrange for a meeting between NRC and PVAMC senior management, to discuss the program status and achievements. This meeting was held as part of the exit meeting on June 3, 1998, at the conclusion of the

¹ Section VII.B.6 of the Enforcement Policy (63 FR 26630, May 13, 1998) provides that NRC may refrain from issuing a civil penalty if the outcome of the normal process described in the Enforcement Policy does not result in a sanction consistent with an appropriate regulatory message. The Enforcement Policy further provides that NRC may reduce, or refrain from issuing, a civil penalty, for a Severity Level II, III, or IV violation based on the merits of the case.

² As described in the Enforcement Policy, Severity Level IV violations are less serious violations, but of more than minor safety concerns, in that, if left uncorrected, they could lead to a more serious concern.

inspection conducted by NRC at the licensee's facilities from June 1–3, 1998 (Inspection Report 030–14526/98–001, issued July 23, 1998).³

By letters dated February 20, April 6 (with revisions to audit report dated April 10), April 13, and May 28, 1998, PVAMC responded to the CAL, and submitted the results of its audit. In its responses, it stated that it had made numerous improvements to its program. Among these were the implementation of an "Open-Door Policy" of encouraging staff to identify and report program deficiencies. A notice from executive management, the RSC, and the RSO was sent to employees and posted in numerous, visible locations. The notice encouraged all staff to report apparent radiation safety problems, violations, and potential misadministrations. It explained that management, the RSC, and the RSO encouraged all staff to report problems without fear of reprisal, indicating that it was management's responsibility to assure a safe working environment. The notice stated that the goal was to create a secure, friendly environment that fosters self-identification of problems. A list of whom to contact, including the RSO, executive management, and the members of the RSC, and their phone numbers, was included in the notice. PVAMC staff has received training in this policy. PVAMC hired an Interim RSO while the previous RSO (the Petitioner) was out on medical leave,⁴ and also informed NRC of the new Interim Director of the PVAMC. The Interim RSO was mandated to evaluate the radiation safety program and to recommend any needed changes. PVAMC provided NRC with a copy of its assessment and audit of the radiation safety program, in which it evaluated its program, identified certain program deficiencies, and specified its corrective actions. PVAMC also indicated that training would be provided, by March 15, 1998, to staff who use radioactive material. The training would include, as a minimum, instruction regarding all applicable NRC regulatory requirements, management expectations, and the policy on bringing forth identified program deficiencies. PVAMC also submitted its formal radiation safety audit program.

NRC has verified that the licensee has taken the actions required by the CAL. NRC has reviewed PVAMC's audit report and found that the licensee's audit demonstrated that PVAMC had

taken corrective actions and implemented its commitments in the CAL to improve its oversight of the radiation safety program and to improve its problems related to communication, teamwork, and conflict resolution. PVAMC has conducted a comprehensive review and assessment of the radiation safety program. NRC has determined that PVAMC's audit was thorough in its assessment of the problems with communication, teamwork, and conflict resolution, as well as its evaluation of program deficiencies. In the audit report, PVAMC recognized the problems, and indicated that it had made progress in those areas. PVAMC noted that it had been concentrating on re-focusing attention on issues rather than past interpersonal conflicts, and is working on re-establishing trust and team work. PVAMC also stated that staff was beginning to feel more comfortable with admitting mistakes and initiating corrective actions. To clarify responsibilities, and to prevent the RSO from auditing its own activity, the Interim RSO recommended that the authorized users and their staff perform their own routine monitoring duties, with radiation safety staff auditing these duties. Staff has received training on all applicable NRC regulatory requirements, on management expectations, and on the policy on bringing forth identified program deficiencies. Additionally, PVAMC has established a formal system for conducting radiation safety program audits.

NRC conducted an inspection from June 1–3, 1998, at the licensee's facility (Inspection Report 030–14526/98–001, issued July 23, 1998). The inspection focused on the licensee's responses, dated November 4, 1997, and January 8, 1998, to the violations identified in Inspection Reports 030–14526/96–002 and 030–14526/97–001, respectively; licensee actions to assess and improve the radiation safety program; and implementation of management commitments addressed in the CAL. Within the scope of this inspection, no violations were identified. The inspectors verified that PVAMC's submitted corrective actions, as described previously, had been implemented for the violations identified in Inspection Reports 030–14526/96–002 and 030–14526/97–001.

The NRC inspectors, through a review of records, discussions with the licensee's staff, and observation of onsite activities, noted that major staff changes have occurred in areas that affect radiation safety and communication of management's

message to staff concerning the significance of bringing forth any safety concerns. A new chairman of the RSC was appointed in September 1997, and a new RSO was appointed in December 1997. The Chief Operating Officer currently has direct oversight of the radiation safety program, and the RSO is reporting to this individual. When the new Chief of Staff (COS) is appointed, the RSO will report directly to the COS. The inspectors noted that these staff changes, and their initiatives, significantly improved personnel's understanding of the importance of radiation safety and the importance of a work environment in which staff is encouraged to bring forth issues relating to radiation safety without fear of retaliation. The licensee's Interim Director (appointed March 1998), the new RSC chairman, and the new RSO, in cooperation with the facility staff, have initiated and implemented specific actions that enhanced and improved management oversight of the radiation safety program. These actions included establishing a formal audit program and providing training to staff on all applicable NRC regulatory requirements and the importance of reporting any program deficiencies. Additionally, management has worked to build teamwork and improve communication, and has made a commitment to increase program oversight. In summary, although the Petitioner is correct that certain violations and programmatic weaknesses have been identified in the past at PVAMC, as discussed above, the violations were not of major safety significance, and the licensee has undertaken extensive corrective actions for such deficiencies. In addition, NRC will continue to inspect the licensee's radiation safety program on an accelerated inspection schedule, in accordance with NRC's Inspection Manual Chapter 2800, so as to closely monitor the licensee's progress in improving its radiation safety program and communication among its RSO, RSC, management, and staff. In sum, the NRC has not substantiated the Petitioner's assertion that there has been a consistent pattern of violations occurring at the licensee's facilities for which the licensee has failed to take corrective action, and has found no basis for taking the action requested by the Petitioner.

B. Petitioner's Assertions of Altered Records and Licensee's "History" of Providing Inaccurate Information

The Petitioner also asserts that the inspector to whom she had provided information concerning problems at PVAMC had "copies of records which

³ This inspection is discussed later in Section D of this Decision.

⁴ The Petitioner has subsequently resigned from PVAMC.

appeared to have been deliberately altered by medical center personnel." In addition, she asserts that PVAMC has a "history of supplying information inconsistent with reality to the NRC." Finally, in her attachment to the Petition, the Petitioner refers to a letter from PVAMC to NRC, dated February 23, 1996, which she asserts contained inaccurate information.

The Petitioner has not specified the records that were allegedly altered by PVAMC personnel, and NRC has not identified any alterations of records required to be provided or maintained by NRC requirements. Therefore, this portion of the Petitioner's assertion has not been substantiated.

The Petitioner also asserts that her attached "chronological summary" of correspondence between PVAMC and NRC will "attest" to the fact that there had been a "consistent pattern of NRC violations occurring within the medical center" and that the licensee has a "history of supplying information inconsistent with reality to the NRC, and taking minimal, if any effort to correct cited violations." The attachment to the Petition references, among other documents: (a) an NOV issued to the licensee dated January 4, 1996; (b) a letter from PVAMC responding to the NOV, dated February 23, 1996, in which PVAMC allegedly supplied NRC with inaccurate information; (c) a letter from NRC to the licensee dated April 19, 1996, which noted "inconsistencies" in the licensee's letter, dated February 23, 1996; (d) a letter from the licensee dated May 6, 1996, in which the licensee acknowledged that there were inconsistencies in its letter dated February 23, 1996; and (e) a letter from NRC, dated June 27, 1996, accepting the licensee's statements in its letter, dated May 6, 1996, and approving the licensee's corrective actions to the violations cited in the NOV dated January 4, 1996.

The licensee's letter, dated February 23, 1996, responded to the NOV issued on January 4, 1996, citing it, among other things, for violating 10 CFR 35.13(c) by replacing the RSO without receiving a license amendment, and for violating 10 CFR 35.21(a) and 35.22(a)(3) by conducting a meeting of the RSC without half of the RSC membership or the RSO being present. In its response to the violations, by letter dated February 23, 1996, the licensee stated that an amendment request had been filed during the government-wide furlough, as the RSO was furloughed but, in order to ensure uninterrupted coverage of the radiation safety program, a nuclear physician was

assigned as RSO until the shutdown terminated. The licensee also stated that the full RSC could not be assembled because its members, including the RSO, had been furloughed.

This information initially appeared to the NRC staff to be inconsistent with its understanding of the events surrounding the furlough. Among other things, the NRC determined that, contrary to the licensee's statement, the RSO had never been furloughed. By letter dated April 19, 1996, the licensee was requested to provide clarification of the facts surrounding its understanding of these events. By letter dated May 6, 1996, the licensee submitted its response to this letter. In its response, it apologized for any inconsistency. The licensee stated that the RSO had been scheduled to be furloughed and the redesignation request filed with the NRC was to ensure radiation safety compliance in preparation for the contingency of the furlough. The licensee admitted, however, that the RSO was never officially furloughed and had not been contacted to attend the meeting.

NRC evaluated the information submitted by the licensee and determined that the information it had submitted in its letter dated February 23, 1996, was inaccurate. Nonetheless, the NRC concluded that the inaccuracy was not a deliberate attempt by the licensee to deceive the NRC, and that the licensee admitted to, and clarified, its error. The Petitioner's "chronological summary" that she submits as an attachment to her Petition does not provide any additional examples of the licensee's failure to submit accurate information. Therefore, this single incident of supplying inaccurate information does not support the Petitioner's assertion that PVAMC has a "history of supplying information inconsistent with reality to the NRC and taking minimal, if any, effort to correct cited violations." In addition, as described above, the licensee has taken considerable corrective action with regard to other identified violations and problems. Therefore, this matter does not provide a sufficient basis for taking the action the Petitioner has requested.

C. Petitioner's Assertion Regarding Contamination Incident

The Petitioner also asserts that individuals at PVAMC have become contaminated in what the Petitioner believes was an intentional incident. As noted above, NRC conducted an inspection of PVAMC during the period of July 9 through October 20, 1997, during which the inspectors examined the circumstances surrounding a

contamination incident that occurred in the Nuclear Medicine Department around July 24, 1997 (Inspection Report 030-14526/97-001, dated December 5, 1997). The incident involved the contamination of the hands of the RSO and the CNMT and contamination of a survey instrument.

The cause of the contamination was not definitively identified; however, NRC staff believes that the instrument may have been contaminated during routine surveys of the Nuclear Medicine Department. The licensee later determined that the survey instrument was contaminated with indium-111, a radionuclide that is not regulated by NRC. However, during the course of NRC's investigation of the contamination incident, NRC found violations of procedures related to the use of byproduct material. The inspector noted that the incident may have been caused by a weakness in the licensee's contamination control techniques, including not using contamination control precautions during the use of radioactive material, and, in some cases, failing to wear gloves. The inspector determined that the RSO and CNMT hand contamination was most likely caused by handling the contaminated instrument. The PVAMC was cited for four violations, three of which were related to NRC program deficiencies found as a result of NRC's review of the contamination incident, in an NOV dated December 10, 1997 (Inspection Report 030-14526/97-001): (1) failure to provide training to personnel who work in or frequent an area where radioactive materials are used or stored; (2) performing inadequate surveys in an area where radiopharmaceuticals were prepared for use and administered, in that an instrument with a faulty cable that rendered the instrument inoperable was used; and (3) failure to use an extremity monitor by a nuclear medicine technologist.⁵

Notwithstanding the above, the results of urinalyses performed on the licensee personnel involved in the incident indicated that there had been no intake of radioactive material by any of these individuals, including the Petitioner. In addition, the results of thyroid counts taken of these individuals indicated that the Petitioner did not exhibit any counts above

⁵The licensee committed, in its response to the NOV by letter dated January 9, 1998, to providing training to staff, to ensure that appropriate techniques will be used by its personnel so as to minimize contamination and avoid such incidents in the future. It also committed to provide training in the requirement to use personnel monitors and proper survey techniques.

background in any of the radioactive iodine channels.⁶

The Petitioner also asserted in her Petition that she was fearful for her personal safety as well as that of her then unborn child, that certain NRC staff shared these concerns, and that she believed that the contamination was intentional. In support of her claim, she stated that "two senior NRC physicists telephoned, and cautioned me to remove all consumable items from my office and not to eat or drink anything over which I did not have positive control." Although the NRC inspector did caution the Petitioner as she stated, this was advice given following the contamination incident as a reasonable precautionary health physics recommendation, based on the circumstances of the individual situation and the Petitioner's expressed concern for her personal safety.

Additionally, the Petitioner stated that "I received a visit in my office by two NRC inspectors, one of whom came to caution me that he believed my physical safety was in jeopardy due to the allegations I had made regarding violations involving human uses of radioactive materials." The Petitioner has not provided specific information as to who the inspector was who made this statement, and NRC has been unable to identify any individual as having made this statement. Nonetheless, NRC is aware that the Petitioner had raised a concern about her personal safety during 1997 following her raising allegations to NRC. However, NRC also was aware that the PVAMC security force was contacted by the parties involved. Therefore, the Petitioner has not raised any new information of which the NRC was not aware. As discussed above, NRC investigated the contamination incident, and did not find any evidence that the contamination incident was intentional and that the Petitioner was in any physical danger as a result of this incident.

Furthermore, as explained above, the licensee has since made numerous changes to its program and organizational structure, and has developed a program to encourage employees to raise nuclear safety concerns without fear of retaliation. In addition, as is also explained above, NRC will continue to closely monitor

the licensee's program on an accelerated inspection schedule to assure that PVAMC's corrective actions for past problems continue to be effective. Therefore, notwithstanding the seriousness of the situation that occurred during 1997, the Petitioner has not provided any information that would provide a basis for the NRC to take additional action such as she requested at this time.

D. Petitioner's Assertion of Employees' Fear of Raising Safety Concerns

The Petitioner also asserts that PVAMC employees are fearful of bringing safety concerns to the licensee for fear of retaliation, and to NRC due to NRC's "history of inaction" regarding the medical center.⁷ With regard to the Petitioner's assertion that PVAMC employees are fearful of bringing forth safety concerns, as described above, during NRC inspections conducted at the licensee's facility from 1995 through 1997, certain programmatic weaknesses were identified, including communication problems among PVAMC staff, management, the prior RSO, and the previous RSC chairman. Furthermore, NRC became aware that, as a result of these problems, some PVAMC employees may have been reluctant to inform management or NRC about safety concerns. However, as described above, NRC Region I and Headquarters management met with the licensee on December 18, 1997, to discuss these program deficiencies, and subsequently issued a CAL, in which the licensee made several commitments to improve its oversight of the radiation safety program and to provide training to all nuclear medicine staff, researchers using radioactive material, RSC members and the facility management, on all applicable NRC regulatory requirements, on management expectations, and on the policy on encouraging employees to bring identified program deficiencies to management's attention. The licensee committed to complete these items by May 30, 1998. As discussed above, NRC inspected the facility June 1-3, 1998, and confirmed that the licensee completed these items. Additionally, the licensee is on an accelerated inspection schedule so that NRC can closely monitor PVAMC's progress in improving communication among the facility staff and program performance.

The licensee has conducted a comprehensive review and assessment

of its radiation safety program and provided a copy of the report to NRC by letters dated April 6 (with revised copy of report dated April 10) and April 13, 1998. NRC has determined that the assessment was of an adequate depth and breadth and covered not only technical radiation safety program issues but was expanded to include interpersonal communications, cooperation, and conflict resolution among the facility staff, as well. An audit was also performed by the Department of Veteran's Affairs' National Health Physics office manager.

NRC has found, through a review of the audit report and during its inspection performed June 1-3, 1998, that PVAMC has provided comprehensive training to all nuclear medicine staff, researchers using radioactive materials, RSC members, and facility management. The training focused on, among other things, the right and duty of employees to raise any nuclear safety concerns to management, or directly to NRC.

The inspectors also reviewed the implementation of PVAMC's actions documented in its responses to the CAL. The inspectors, through a review of records, discussions with the licensee's staff, and observation of onsite activities, noted that major staff changes have occurred in areas that affect communication of management's message to staff concerning the improved communications at all levels and the significance of bringing forth any safety concerns. The inspectors noted that these staff changes, as well as the implementations of their directives, significantly improved personnel's understanding of the importance of radiation safety and the importance of a work environment in which staff is encouraged to bring forth issues relating to radiation safety without fear of retaliation. The licensee's new senior management, the new RSC chairman, and the new RSO, in cooperation with the facility staff, have initiated and implemented specific actions, including providing training to staff on the importance of reporting any program deficiencies and safety concerns. Additionally, management has worked to build teamwork and improve communication, and has made a commitment to increase program oversight. During the June 1998 inspection, the inspectors found that the licensee's corrective actions to date have been effective. The new RSO and management team are making a concerted effort to create a favorable work environment which fosters an open flow of communication. The inspectors interviewed staff and found

⁶The CNMT did have an uptake of 1.5×10^{-3} Bq (40 nanocuries) of iodine-123, which is indicative of a minor intake of iodine-123 (a radionuclide not regulated by NRC, but regulated by the State of Pennsylvania). The licensee indicated that training will be given to this individual to ensure that appropriate techniques are used to minimize contamination in the future.

⁷The Petitioner's assertion of NRC's history of inaction regarding the PVAMC was referred to the Office of the Inspector General on February 12, 1998.

that individuals appear to be "more comfortable" raising safety concerns without fear of retaliation.

In sum, although, as a result of a general weakness in communications at the licensee's facility, there may have been, in the past, a reluctance among employees to raise safety concerns, NRC has found that the licensee has taken numerous effective corrective actions to ensure that employees are encouraged to raise nuclear safety concerns. Additionally, as stated earlier, PVAMC is on an accelerated inspection schedule, and this issue will be reviewed during future inspections. Therefore, the Petitioner's assertions regarding this issue do not provide a basis that would warrant the action she has requested.

The Petitioner also asserts that NRC withdrew a civil penalty after a change in NRC Region I management, possibly because it was not "cost-effective" to pursue the issue. She states that NRC's withdrawal of a civil penalty involving a violation of protected activities sent a "chilling" effect to individuals both within and external to the PVAMC who may have thought of raising a safety concern.

NRC staff assumes that the Petitioner is referring to the NOV dated September 18, 1996 (EA 96-182). As discussed earlier, NRC issued a NOV and Proposed Imposition of Civil Penalty of \$8000 to PVAMC as a result of concluding that PVAMC had discriminated against the Petitioner for raising safety concerns in November 1995, related to then-impending Federal government furloughs. NRC had identified this violation based on the determination of the DOL Acting District Director of the Wage and Hour Division that the Petitioner had been chastised by her immediate supervisor, the Chief of Engineering, for raising safety concerns. However, as explained previously, after its review of all of the available information, including the results of the OI investigation and PVAMC's responses to the NOV, NRC concluded, in a letter dated September 27, 1997, that the violation would be more appropriately classified as a Severity Level III violation and that enforcement discretion would be exercised to withdraw the civil penalty, pursuant to Section VII.B.6 of the Enforcement Policy. In this case, the determination to withdraw the civil penalty was made based on the fact that the chastisement of the Petitioner did not substantially affect the conditions of her employment; an apology was issued; she remained the RSO; DOL had concluded that it found that PVAMC had met the terms and conditions of

remedies it had outlined concerning the violation; and investigations conducted by DOL and OI failed to substantiate that there had been any continued discrimination against the Petitioner. Nonetheless, while NRC believes that there is no merit to the Petitioner's assertion that the decision to withdraw the civil penalty resulted from the fact that it was not "cost-effective" to pursue the issue against PVAMC, the Petition was forwarded to the Office of the Inspector General for its review on February 12, 1998.

IV. Conclusion

NRC has determined that, for the reasons discussed above, the Petitioner has not provided a sufficient basis for taking any action to suspend or revoke PVAMC's license, as requested in the Petition. Accordingly, the Petition is denied.

As provided by 10 CFR § 2.206(c), a copy of this Decision will be filed with the Secretary of the Commission, for the Commission's review. The Decision will become the final action of the Commission 25 days after issuance unless the Commission, on its own motion, institutes review of the Decision within that time.

Dated at Rockville, Maryland, this 28th day of August, 1998.

For the Nuclear Regulatory Commission.

Carl J. Paperiello,

Director, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 98-24011 Filed 9-4-98; 8:45 am]

BILLING CODE 7590-01-P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 23420; 812-11286]

DG Investor Series, et al.; Notice of Application

August 31, 1998.

AGENCY: Securities and Exchange Commission ("SEC").

ACTION: Notice of application for exemption under section 6(c) of the Investment Company Act of 1940 (the "Act") from section 15(a) of the Act.

SUMMARY OF APPLICATION: The requested order would amend a prior order (the "Prior Order")¹ permitting the implementation, without prior shareholder approval, of new advisory ("New Management Agreement") and sub-advisory agreements ("New Sub-

Advisory Agreements") (collectively, the "New Agreements").

APPLICANTS: Parksouth Corporation ("Adviser"), Womack Asset Management ("Womack"), Bennett Lawrence Management, LLC ("Bennett"), Lazard Asset Management, a division of Lazard Freres & Co. LLC ("Lazard"), and DG Investor Series (the "Trust").

FILING DATE: The application was filed on August 31, 1998. Applicants have agreed to file an amendment during the notice period, the substance of which is described in this notice period, the substance of which is described in this notice. *Hearing or Notification of Hearing:* An order granting the application will be issued unless the SEC orders a hearing. Interested persons may request a hearing by writing to the SEC's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the SEC by 5:00 p.m. on September 21, 1998, and should be accompanied by proof of service on applicants in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the SEC's Secretary.

ADDRESSES: Secretary, SEC, 450 Fifth Street, NW, Washington, DC 20549. Trust, Adviser, Womack, Bennett, and Lazard, c/o Timothy S. Johnson, Esq., Federated Investors, 5800 Corporate Drive, Pittsburgh, Pennsylvania 15237-7010.

FOR FURTHER INFORMATION CONTACT: John K. Forst, Attorney Advisor, at (202) 942-0569, or Mary Kay Frech, Branch Chief, at (202) 942-0564 (Office of Investment Company Regulation, Division of Investment Management).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained for a fee at the SEC's Public Reference Branch, 450 Fifth Street, NW, Washington, DC 20549 (tel. 202-942-8090).

Applicants' Representations

1. The Trust is a Massachusetts business trust registered under the Act as an open-end management investment company. The Trust currently offers nine series: DG Equity Fund, DG Opportunity Fund ("Opportunity Fund"), DG Mid Cap Fund ("Mid Cap Fund"), DG International Equity Fund ("International Equity Fund"), DG Limited Term Government Income Fund, DG Government Income Fund,

¹ DG Investor Series, et al., Investment Company Act Release Nos. 23107 (April 9, 1998) (notice) and 23163 (April 30, 1998) (order).

DG Municipal Income Fund, DG Prime Money Market Fund, and DG Treasury Money Market Fund (each a "Portfolio"). The assets of the Trust are managed by the Adviser pursuant to an investment management contract between the Adviser and the Trust on behalf of each Portfolio (the "Existing Management Agreement"). Womack provides investment advisory services to the Opportunity Fund pursuant to a separate agreement with the Adviser. Bennett provides investment advisory services to the Mid Cap Fund pursuant to a separate agreement with the Adviser. Lazard provides investment advisory services to the International Equity Fund pursuant to a separate agreement with the Adviser (collectively the existing Womack, Bennett and Lazard sub-advisory agreements are the "Existing Sub-Advisory Agreements"). The Adviser, Womack, Bennett, and Lazard are investment advisers registered under the Investment Advisers Act of 1940.

2. On May 1, 1998, Deposit Guaranty Corporation ("DGC"), corporate parent of the Advisor merged with First American Corporation ("First American"), a bank holding company (the "Transaction"). As a result of the Transaction, the Adviser became a wholly-owned subsidiary of First American.

3. The Transaction resulted in an assignment and thus the automatic termination of the Existing Management Agreement and Existing Sub-Advisory Agreements (together, the Existing Management Agreement and Existing Sub-Advisory Agreements are the "Existing Agreements"). On April 30, 1998, the SEC issued the Prior Order permitting (i) the implementation, during the Interim Period (as defined below), prior to obtaining shareholder approval, of the applicable New Agreements, and (ii) the Adviser and Subadvisers to receive from each Portfolio all fees earned under the New Agreements during the Interim Period, as applicable, if, and to the extent, the New Management Agreement and applicable New Sub-Advisory Agreement are approved by the shareholders of each Portfolio. The Prior Order covered the Interim Period beginning on the date the Transaction was consummated and continued through the date on which the applicable New Agreements are approved or disapproved by the shareholders of each relevant Portfolio, but in no event later than September 30, 1998. Applicants seek to amend the Prior Order to extend the Interim Period until the date on which the applicable New Agreements are approved or

disapproved by the shareholders of each relevant Portfolio, but in no event later than December 31, 1998.

4. Applicants state that the officers of the Trust and of the Adviser have been diligently exploring different scenarios under which the shareholders of the Trust can benefit from economies of scale and/or reduced fees and expenses. Applicants have recently concluded that these benefits could best be achieved by merging or otherwise combining the Portfolios with other registered investment companies advised by other subsidiaries of First American (the "Fund Mergers"). Applicants anticipate the Fund Mergers will be considered by the Trust's board of directors at a special meeting on or about the week of September 7, 1998.

5. Applicants seek to avoid the potential shareholder confusion caused by soliciting approval of the New Agreements and then shortly thereafter soliciting approval for the Fund Mergers. Applicants propose to delay approval of the New Agreements and seek approval of the New Agreements and Fund Mergers simultaneously during 1998. Applicants state that the Adviser and Sub-Advisers will bear the costs of preparing and filing this application and the costs relating to the solicitation of shareholder approval of the New Agreements and the Fund Mergers.

6. Applicants state that they will comply with all of the terms and conditions of the Prior Order.

Applicants' Legal Analysis

1. Section 15(a) of the Act provides, in pertinent part, that it is unlawful for any person to serve as an investment adviser to a registered investment company, except pursuant to a written contract that has been approved by the vote of a majority of the outstanding voting securities of the investment company. Section 15(a) further requires the written contract to provide for its automatic termination in the event of its "assignment." Section 2(a)(4) of the Act defines "assignment" to include any direct or indirect transfer of a contract by the assignor, or of a controlling block of the assignor's outstanding voting securities by a security holder of the assignor. Applicants state that the Transaction resulted in an assignment of the Existing Management Agreement and the Existing Sub-Advisory Agreements and that the Existing Agreements terminated according to the Act and their terms.

2. Section 6(c) provides that the SEC may exempt any person, security, or transaction from any provision of the Act, if and to the extent that such

exemption is necessary or appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the Act. Applicants believe that the requested relief meets this standard.

3. Applicants believe that allowing the Adviser and Subadvisers to continue to provide investment advisory services to the Portfolios during the Interim Period as extended by the requested order, thereby avoiding any interruption in services to the Portfolios, is in the best interests of the Portfolios and their shareholders. Applicants state that officers of First American and of the Trust have recently formulated definitive plans for a combination of the Portfolios with another registered investment company advised by a subsidiary of First American. Applicants note that if First American had decided to allow the proxy solicitation to occur with respect to the New Agreements and subsequently determined to solicit shareholders regarding a Fund Merger, the inconvenience and possible confusion and disruption to shareholders of the Portfolios could have been quite significant. Applicants state that they will comply with all terms and conditions of the Prior Order except that the shareholders meeting under condition 3 of the Prior Order must take place prior to December 31, 1998.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 98-23972 Filed 9-4-98; 8:45 am]

BILLING CODE 8010-01-M

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94-409, that the Securities and Exchange Commission will hold the following meeting during the week of September 7, 1998.

A closed meeting will be held on Thursday, September 10, 1995, at 10:00 a.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the closed meeting. Certain staff members who have an interest in the matters may also be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or

more of the exemptions set forth in 5 U.S.C. 552b(c)(4), (8), (9)(A) and (10) and 17 CFR 200.402(a)(4), (8), (9)(i) and (10), permit consideration of the scheduled matters at the closed meeting.

Commissioner Hunt, as duty officer, voted to consider the items listed for the closed meeting in a closed session.

The subject matter of the closed meeting scheduled for Thursday, September 10, 1998, at 10:00 a.m., will be:

Institution and settlement of injunctive actions

Institution and settlement of administrative proceedings of an enforcement nature.

Opinion.

At times, changes in Commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact:

The Office of the Secretary at (202) 942-7070.

Jonathan G. Katz,
Secretary.

Dated: September 2, 1998.

[FR Doc. 98-24117 Filed 9-3-98; 11:10 am]

BILLING CODE 8010-01-M

OFFICE OF SPECIAL COUNSEL

Agency Information Collection Activities: Proposed Collections; Comment Request

AGENCY: U.S. Office of Special Counsel.

ACTION: Notice.

SUMMARY: The U.S. Office of Special Counsel (OSC) announces an opportunity for public comment on proposed collections of certain information by the agency. Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501-3520), federal agencies are required to publish notice in the **Federal Register** about each proposed collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on three forms to be used in implementing an annual OSC survey requirement enacted by Pub. L. 103-424.

DATES: Submit written comments on each collection of information by November 9, 1998.

ADDRESSES: Submit written comments on each collection of information to Erin M. McDonnell, Associate Special Counsel for Planning and Advice, U.S. Office of Special Counsel, 1730 M Street, NW, Suite 300, Washington, DC 20036-4505.

FOR FURTHER INFORMATION CONTACT:

Requests for further information, including copies of the proposed collections of information, may be addressed to: Erin M. McDonnell, Associate Special Counsel for Planning and Advice, U.S. Office of Special Counsel, 1730 M Street, NW, Suite 300, Washington, DC 20036-4505, fax: (202) 653-5151.

SUPPLEMENTARY INFORMATION: Under the PRA, federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information that they conduct or sponsor. The term "collection of information" is defined at 44 U.S.C. 3502(3) and 5 CFR 1320.3(c), and includes written surveys. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to provide a 60-day notice in the **Federal Register** about each proposed collection of information, before submitting the collection(s) to OMB for approval. To comply with this requirement, OSC is publishing notice of the proposed collections of information discussed further below.

The OSC is an independent agency responsible for (1) investigation of allegations of prohibited personnel practices defined by law at 5 U.S.C. 2302(b), and certain other illegal employment practices under titles 5 and 38 of the U.S. Code, affecting current or former federal employees or applicants for employment, and covered state and local government employees; (2) the interpretation and enforcement of Hatch Act provisions on political activity in Chapters 15 and 73 of title 5 of the U.S. Code; and (3) the provision of a secure channel through which federal employees may make disclosures of information evidencing violations of law, rule or regulation, gross waste of funds, gross mismanagement, abuse of authority, or a substantial and specific danger to public health or safety.

Section 13 of Pub. L. 103-424, enacted in 1994, required OSC, after consultation with the Office of Policy and Evaluation at the U.S. Merit Systems Protection Board (MSPB), to conduct annual surveys of individuals seeking OSC assistance, and to report on survey results in OSC's annual reports to Congress. Sec. 13 provides that annual surveys shall determine: (1) Whether individuals seeking assistance were fully apprised of their rights; (2) whether individuals were successful at the OSC or the MSPB; and (3) if individuals, whether successful or not, were satisfied with the treatment received from the OSC.

After consultation with the MSPB, OSC obtained OMB clearance under the PRA to use three survey forms, one for each category of individuals seeking the agency's assistance—i.e., persons whose allegations of prohibited personnel practices and other violations of law within OSC's jurisdiction were investigated and closed, with or without corrective or disciplinary action; individuals who received written OSC advisory opinions about allowable and unallowable political activity under the Hatch Act; and individuals whose disclosures of possible wrongdoing by federal agencies were acted on by the OSC Disclosure Unit. The OSC sent surveys to individuals in these three categories, and reported on the results in its annual reports to Congress.

Since expiration of the OMB clearance in 1997, the OSC has modified the survey forms to focus more clearly on customer service issues, to elicit information that would place responses to the questions enumerated in the statute in a more meaningful context, and provide a clearer context for responses received to other questions. The three survey formats, as revised, are proposed for use in surveying persons whose matters were closed, or who received written Hatch Act advisory opinions, between fiscal years (FY) 1998-2000. As before, survey responses will be voluntary, will not solicit information required by law or regulation, and will be able to be submitted without personal identification if the respondent so chooses.

With respect to the following proposed collections of information, OSC invites comments on: (1) Whether they are necessary for the proper performance of OSC's functions, including whether the information will have practical utility; (2) the accuracy of OSC's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of collection of information on respondents, including through the use of automated information collection techniques, when appropriate, and other forms of information technology:

- a. OSC Form 48a (Prohibited Personnel Practice/Related Matters).
- b. OSC Form 48b (Hatch Act Advisory Opinions).
- c. OSC Form 48c (Whistleblower Disclosure Matters).

The OSC estimates that the burden of these collections of information will be as follows:

11. *OSC Form 48a (Prohibited Personnel Practice/Related Matters)*

1998: 2385 complainants in closed matters × 20 mins. = 811 hrs.

1999: 2648 complainants in closed matters × 20 mins. = 901 hrs.

2000: 2940 complainants in closed matters × 20 mins. = 1000 hrs.

2. *OSC Form 48b (Hatch Act Advisory Opinions)*

1998: 116 recipients of written advisory opinions × 12 mins. = 24 hrs.

1999: 129 recipients of written advisory opinions × 12 mins. = 26 hrs.

2000: 142 recipients of written advisory opinions × 12 mins. = 29 hrs.

13. *OSC Form 48c (Whistleblower Disclosure Matters)*

1998: 161 submitters in closed disclosure matters × 15 mins. = 41 hrs.

1999: 178 submitters in closed disclosure matters × 15 mins. = 45 hrs.

2000: 196 submitters in closed disclosure matters × 15 mins. = 49 hrs.

These estimates are derived from projected increases in the number of matters closed and opinions issued between FY 1998–2000, based on FY 1997 totals. Burden means the value of time, effort, and financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a federal agency. The term includes reviewing instructions; searching data sources; collecting data; completing and reviewing information collections; and transmitting or otherwise disclosing information.

Dated: August 24, 1998.

Elaine D. Kaplan,
Special Counsel.

[FR Doc. 98–24028 Filed 9–4–98; 8:45 am]

BILLING CODE 7405–01–P

DEPARTMENT OF STATE

[Public Notice No. 2880]

Advisory Committee on International Communications and Information Policy Notice of Committee Renewal

The Department of State has renewed the Charter of the Advisory Committee on International Communications and Information Policy for another two years, effective August 17, 1998. This Committee will continue to provide a formal channel for regular consultation and coordination on major economic, social, and legal issues and problems in

international communications and information policy, especially as these issues and problems involve users of information and communication services, providers of such services, technology research and development, foreign industrial and regulatory policy, the activities of international organizations with regard to communications and information, and developing country interests.

The Committee consists of representatives of the communications and information technology industries who are selected by the U.S. Coordinator for International Communications and Information Policy to serve generally for a two-year term. The Committee will continue to follow the procedures prescribed by the Federal Advisory Committee Act (FACA). Meetings will continue to be open to the public unless a determination is made in accordance with section 10(d) of the FACA, 5 U.S.C. Secs. 552B(c)(1) and (4), that a meeting or a portion of the meeting should be closed to the public. Notice of each meeting will continue to be provided for publication in the **Federal Register** as far in advance as possible prior to the meeting.

For further information on the renewal of the Committee, please contact Timothy C. Finton, Executive Secretary of the Committee, at (202) 647–5385.

Dated: August 26, 1998.

Timothy C. Finton,

Executive Secretary.

[FR Doc. 98–24027 Filed 9–4–98; 8:45 am]

BILLING CODE 4710–45–M

DEPARTMENT OF STATE

[Public Notice 2883]

Director General of the Foreign Service and Director of Personnel State Department Performance Review Board Members (at Large Board)

In accordance with section 4314(c)(4) of the Civil Service Reform Act of 1978 (Pub. L. 95–454), the Executive Resources Board of the Department of State has appointed the following individuals to the State Department Performance Review Board (At Large Board) register.

Margaret Grafeld, Director, Information Resources Management Programs & Services, Bureau of Information Resources Management, Department of State

Linda Jacobson, Assistant Legal Adviser for Diplomatic Law and Litigation,

Office of the Legal Adviser,
Department of State
Katherine Lee, Chief, Training and Development Division, United States Information Agency
Ruth A. Whiteside, Deputy Director, Foreign Service Institute, Department of State
William B. Wood, Geographer, Bureau of Intelligence and Research, Department of State

Dated: August 28, 1998.

Alex De La Garza,

Acting Director General of the Foreign Service and Director of Personnel.

[FR Doc. 98–24049 Filed 9–4–98; 8:45 am]

BILLING CODE 4710–15–M

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Reports, Forms and Recordkeeping Requirements

AGENCY: Office of the Secretary, DOT.

ACTION: Notice.

SUMMARY: This notice lists those forms, reports, and recordkeeping requirements imposed upon the public which were transmitted by the Department of Transportation to the Office of Management and Budget (OMB) for its approval in accordance with the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). Section 3507 of Title 44 of the United States Code, requires that agencies prepare a notice for publication in the **Federal Register**, listing information collection request submitted to OMB for approval or renewal under that Act. OMB reviews and approves agency submissions in accordance with criteria set forth in that Act. In carrying out its responsibilities, OMB also considers public comments on the proposed forms and the reporting and recordkeeping requirements. OMB approval of an information collection requirement must be renewed at least once every three years.

The **Federal Register** Notice with a 60-day comment period soliciting comments on information collection 2120–0040 was published on June 16, 1998 (63 FR 32909).

DATES: Comments on this notice must be received on or before October 8, 1998.

FOR FURTHER INFORMATION CONTACT:

Copies of the DOT information collection requests submitted to OMB may be obtained by telephoning FRA's clearance officers, Robert Brogan (telephone number (202) 493–6292) or Maryann Johnson (telephone number (202) 493–6136).

SUPPLEMENTARY INFORMATION:

Federal Railroad Administration (FRA)

Title: Railroad Safety Culture Survey.

OMB Control Number: 2130-0546.

Form(s): N/A.

Type of Request: Extension of a currently approved collection.

Affected Public: Railroad workers, Railroad managers.

Abstract: These ICRs are intended to (i) identify the rail industry current safety programs among small class I and class II railroads; and (ii) identify any outstanding operational safety culture issues that could be addressed through on-going efforts in partnership with FRA.

Estimated Burden: The estimated total annual burden is 50 hours.

Addresses: Written comments on the DOT information collection request should be forwarded, within 30 days of publication, to Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Room 10102, Washington, DC 20503, ATTN: FRA Desk Officer. A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. If you anticipate submitting substantive comments, but find that more than 10 days from the date of publication are needed to prepare them, please notify the OMB official of your intent immediately.

Comments are invited on: Whether the proposed collections of information are necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collections; ways to enhance the quality, utility and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Issued in Washington, DC, on August 31, 1998.

Phillip A. Leach,

Clearance Officer, United States Department of Transportation.

[FR Doc. 98-24034 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-62-P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary**Aviation Proceedings, Agreements filed during the week ending August 28, 1998**

The following Agreements were filed with the Department of Transportation under the provisions of 49 U.S.C. Sections 412 and 414. Answers may be filed within 21 days of date of filing.

Docket Number: OST-98-4393.

Date Filed: August 28, 1998.

Parties: Members of the International Air Transport Association.

Subject: PTC2 Telex Mail Vote 952 r1, PEX fares between Europe and Southern Africa, PTC3 Telex Mail Vote 953 r2, Solomon Islands-Australia fares, Intended effective date: September 8, 1998.

Dorothy W. Walker,

Federal Register Liaison.

[FR Doc. 98-24033 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-62-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration**Proposed Revisions to Advisory Circular—Equipment, Systems, and Installations in Part 23 Airplanes**

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed revisions to advisory circular and request for comments.

SUMMARY: This notice requests comments regarding proposed revisions to Advisory Circular (AC) 23.1309-1C, "Equipment, Systems, and Installations in Part 23 Airplanes." The AC provides guidance and information for an acceptable means for showing compliance with the requirements of § 23.1309(a) and (b) (Amendment 23-49) for equipment, systems, and installations in Title 14 CFR Part 23 airplanes. The AC defines the appropriate airplane systems probability levels for airplanes designed to 14 CFR Part 23 standards.

DATES: Comments must be received on or before November 4, 1998.

ADDRESSES: Send all comments on the proposed AC revisions to the Federal Aviation Administration, Attention: Ervin Dvorak, ACE-111, Regulations and Policy Branch, Small Airplane Directorate, Aircraft Certification Service, 601 East 12th Street, Kansas City, Missouri 64106.

FOR FURTHER INFORMATION CONTACT: Terre Flynn, Regulations and Policy

Branch, ACE-111, at the above address, telephone number (816) 426-6941, or facsimile (816) 426-2169.

SUPPLEMENTARY INFORMATION:

Comments Invited

A copy of the proposed revisions to the AC may be obtained by contacting the person name above under **FOR FURTHER INFORMATION CONTACT**. Interested persons are invited to comment on the proposed AC revisions by submitting comments to the address specified above. All comments received on or before the closing date will be considered by the Small Airplane Directorate, 1201 Walnut, Room 900, Kansas City, Missouri 64106, between 7:30 a.m. and 4:00 p.m. weekdays, except Federal holidays.

Background

This AC includes a matrix that categorizes new certification probability levels for four certification classes of Part 23 airplanes. The four certification classes of airplanes are as follows: Class I (typically single, reciprocating engine airplanes under 6,000 pounds), Class II (typically multi, reciprocating engine and single-engine turbine airplanes under 6,000 pounds), Class III (typically airplanes over 6,000 pounds), and Class IV (typically commuter category). Also, the related Software Development Assurance Levels for the various Failure Conditions for each certification class are part of the matrix. The Small Airplane Directorate based the new probability levels on historical accident data for each class.

Issued in Kansas City, Missouri, on August 27, 1998.

James E. Jackson,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98-23786 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration**Proposed Revisions to Advisory Circular—Installation of Electronic Displays in Part 23 Airplanes**

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed revisions to advisory circular and request for comments.

SUMMARY: This notice requests comments regarding proposed revisions to Advisory Circular (AC) 23.1311-1A, "Installation of Electronic Displays in Part 23 Airplanes." The AC provide an

acceptable means of showing compliance with Title 14 of the Code of Federal Regulations (14 CFR) applicable to the installation of electronic displays in Part 23 airplanes.

DATES: Comments must be received on or before November 4, 1998.

ADDRESSES: Send all comments on the proposed AC revisions to the Federal Aviation Administration, Attention: Ervin Dvorak, ACE-111, Regulations and Policy Branch, Small Airplane Directorate, Aircraft Certification Service, 601 East 12th Street, Kansas City, Missouri 64106.

FOR FURTHER INFORMATION CONTACT:

Terre Flynn, Regulations and Policy Branch, ACE-111, at the above address, telephone number (816) 426-6941, as facsimile (816) 426-2169.

SUPPLEMENTARY INFORMATION:

Comments Invited

A copy of the proposed revisions to the AC may be obtained by contacting the person named above under **FOR FURTHER INFORMATION CONTACT**. Interested persons are invited to comment on the proposed AC revisions by submitting comments to the address specified above. All comments received on or before the closing date will be considered by the Small Airplane Directorate before issuing the revised AC. Comments may be examined at the Small Airplane Directorate, 1201 Walnut, Room 900, Kansas City, Missouri 64106, between 7:30 a.m. and 4:00 p.m. weekdays, except Federal holidays.

Background

The planned revision to AC 23.1311-1 will update guidance for electronic displays in the areas of human factors, navigation, moving maps, weather displays, alerts for warnings and caution, terrain awareness, propulsion, flight instruments, and color.

Issued in Kansas City, Missouri, on August 17, 1998.

Michael Gallagher,

Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98-23787 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Notice of Application for Approval of Discontinuance or Modification of a Railroad Signal System or Relief From the Requirements of Title 49 Code of Federal Regulations Part 236

Pursuant to Title 49 Code of Federal Regulations (CFR) Part 235 and 49 U.S.C. App. 26, the following railroad has petitioned the Federal Railroad Administration (FRA) seeking approval for the discontinuance or modification of the signal system or relief from the requirements of 49 CFR Part 236 as detailed below.

BS-AP-No. 3490

Applicant: CSX Transportation, Incorporated, Mr. R. M. Kadlick, Chief Engineer Train Control, 500 Water Street (S/C J-350), Jacksonville, Florida 32202

CSX Transportation, Incorporated seeks approval of the proposed temporary discontinuance of the signal system, on the main tracks, between Ensel, milepost CH-90.4 and Trowbridge, milepost CH-84.1, near Lansing, Michigan, on the Saginaw Subdivision, Detroit 2 Service Lane, for approximately 30 days. The proposal is associated with major modifications in track and signal arrangements, and all train movements will be governed under the direction of a dispatcher, utilizing a switch tender to operate power-operated switches within the construction area.

The reason given for the proposed changes is to provide a safe and reliable method of operation during construction, and to expedite track and signal modifications and cut over.

Any interested party desiring to protest the granting of an application shall set forth specifically the grounds upon which the protest is made, and contain a concise statement of the interest of the Protester in the proceeding. The original and two copies of the protest shall be filed with the Associate Administrator for Safety, FRA, 400 Seventh Street, S.W., Mail Stop 25, Washington, D.C. 20590 within 30 calendar days of the date of publication of this notice. Additionally, one copy of the protest shall be furnished to the applicant at the address listed above.

FRA expects to be able to determine these matters without an oral hearing. However, if a specific request for an oral hearing is accompanied by a showing that the party is unable to adequately present his or her position by written statements, an application may be set for public hearing.

Issued in Washington, D.C. on September 2, 1998.

Edward R. English,

Director, Office of Safety Assurance and Compliance.

[FR Doc. 98-24001 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-06-P

Department of Transportation

National Highway Traffic Safety Administration

[Docket No. NHTSA-98-4383; Notice 1]

Kolcraft Enterprises, Inc.; Receipt of Application for Decision of Inconsequential Noncompliance

Kolcraft Enterprises of Chicago, Illinois, has determined that 706,068 child restraint systems fail to comply with 49 CFR 571.213, Federal Motor Vehicle Safety Standard (FMVSS) No. 213, "Child Restraint Systems," and has filed an appropriate report pursuant to 49 CFR Part 573, "Defects and Noncompliance Reports." Kolcraft has also applied to be exempted from the notification and remedy requirements of 49 U.S.C. Chapter 301—"Motor Vehicle Safety" on the basis that the noncompliance is inconsequential to motor vehicle safety.

This notice of receipt of an application is published under 49 U.S.C. 30118 and 30120 and does not represent any agency decision or other exercise of judgement concerning the merits of the petition.

FMVSS No. 213, S5.6.1.8, requires:

In the case of each child restraint system that can be used in a position so that it is facing the rear of the vehicle, the instructions shall provide a warning against using rear-facing restraints at seating positions equipped with air bags, and shall explain the reasons for, and consequences of not following the warning. The instructions shall also include a statement that owners of vehicles with front passenger side air bags should refer to their vehicle owner's manual for child restraint installation instructions.

In adopting the above requirement that certain vehicle owners be directed to their owner's manual for installation instructions, the National Highway Traffic Safety Administration (NHTSA) stated that such instructions would "complement" the requirement that owner's manuals of vehicles having a front passenger side air bag provide information regarding "proper positioning of occupants, including children, at seating positions equipped with an air bag." 59 FR 7643, 7646 (Feb. 16, 1994)(final rule). This requirement

appears in S4.5.1(e) of FMVSS No. 208, which was added in 1993. 58 FR 46551, 46564 (Sep. 2, 1993)(final rule).

The items affected by the noncompliance are the instructions for proper use that were provided after August 15, 1994, with certain models of Kolcraft's child restraints in order to comply with S5.6 of FMVSS No. 213. Kolcraft's instructions provided the appropriate warning against using rear-facing restraints at seating positions equipped with air bags, as well as the reason for the warning and the consequences of not following it. However, Kolcraft's instructions did not include a statement expressly referring owners of vehicles with front passenger side air bags to their vehicle owner's manual for child restraint installation instructions. The noncompliance began August 15, 1994, the effective date of S5.6.1.8. The following models of child restraints were affected by the noncompliance: Rock "n Ride (until April 1996); Auto-Mate (until June 1997); Traveler 700 (until December 1995); Performa (until June 1997); and Secure Fit (until June 1997). The total number of child restraints involved is 706,068. In response to an April 17, 1997 letter from NHTSA concerning miscellaneous compliance issues, Kolcraft has subsequently revised its instructions to conform to S5.6.1.8.

Kolcraft supports its application for inconsequential noncompliance with the following:

S4.5.1(e) of FMVSS No. 208 requires owner's manuals to provide information regarding "proper positioning of occupants, including children, at seating positions equipped with air bags." (Emphasis supplied.) It does not, however, require a vehicle manufacturer to include "child restraint installation instructions" in general. Indeed, for rear-facing infant restraints such as Kolcraft's Rock "n Ride, there should be no child restraint installation instructions for "seating positions equipped with air bags," because rear-facing restraints should not be used in air bag equipped seats. And not surprisingly, no owner's manual we reviewed contains installation instructions for rear-facing infant seats at "seating positions equipped with air bags"; rather, they consistently warn against installation of a rear-facing restraint at an air bag equipped seating position. While some owner's manuals contain child restraint installation instructions for other (non-air bag) seating positions, not all owner's manuals contain such information. Thus, since the vehicle owner's manual will not always yield the "child restraint installation" information

apparently contemplated by S5.6.1.8 of FMVSS No. 213, the inadvertent omission from the Kolcraft instruction sheets of a reference to the vehicle owner's manual is not consequential to motor vehicle safety.

Moreover, although Kolcraft does not question the usefulness of a statement directing vehicle owners to their owner's manual for "complement[ary]" (59 Fed. Reg. at 7,646) information relating to the positioning of occupants "especially children" at seat positions equipped with air bags, Kolcraft's inadvertent failure to include such a statement in its instructions is inconsequential because Kolcraft's instructions set forth in detail the very information about child restraint installation and the proper positioning of children that is contemplated in S5.6.1.8 and the final rule promulgating the regulation, and, in many cases, exceed that information. In short, the omission of the statement directing owners of vehicles with front passenger side air bags to their owner's manual would not deprive vehicle owners using Kolcraft child restraints from any information germane to the safe installation of child restraints in vehicles equipped with air bags.

For example, Kolcraft's instructions include warnings not to place a rear-facing child restraint in a seat equipped with air bags, as well as a statement explaining the reason for the warning and the consequences of ignoring it. The instructions provide information regarding appropriate seating positions. The instructions also provide elaborate information about how to install child restraints with a variety of seat belts, and they illustrate a number of different seat belt configurations, explaining which are and which are not appropriate for use in installing child restraints. The instructions also explain why certain configurations are inappropriate and what vehicle owners should do if a seat belt will not hold a child restraint tightly. Thus, Kolcraft's instructions provide all the information concerning installation and positioning of children that S5.6.1.8 apparently contemplates would be provided in owner's manuals, and, in many respects, exceed the information described in S5.6.1.8. Accordingly, Kolcraft's inadvertent noncompliance with S5.6.1.8's requirement of a statement referring to the vehicle owner's manual is inconsequential as it relates to motor vehicle safety.

Kolcraft does not question the usefulness or importance of S5.6.1.8's requirement that the instructions for child restraints direct owners of vehicles with front passenger side air

bags to their vehicle owner's manual for child restraint installation instructions. As soon as it learned of its noncompliance with the requirement, Kolcraft revised its instructions to conform exactly to S5.6.1.8. However, because Kolcraft's noncompliant instructions provide detailed information relating to the installation of child restraints with a variety of seat belt configurations, as well as information concerning the proper positioning of children in vehicles equipped with air bags, the omission of a statement referring to the owner's manual in Kolcraft's instructions was inconsequential with respect to vehicle safety.

Interested persons are invited to submit written data, views, and arguments on the application of Kolcraft described above. Comments should refer to the docket number and be submitted to: U.S. Department of Transportation Docket Management, Room PL-401, 400 Seventh Street, SW, Washington, DC 20590. It is requested, but not required, that two copies be submitted.

All comments received before the close of business on the closing date indicated below will be considered. The application and supporting materials, and all comments received after the closing date, will also be filed and will be considered to the extent possible. When the application is granted or denied, the notice will be published in the **Federal Register** pursuant to the authority indicated below.

Comment closing date: October 8, 1998.

(49 U.S.C. 30118 and 30120; delegations of authority at 49 CFR 1.50 and 501.8)

Issued on: September 1, 1998.

L. Robert Shelton,

Associate Administrator for Safety Performance Standards.

[FR Doc. 98-23966 Filed 9-4-98; 8:45 am]

BILLING CODE 4910-59-P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Docket No. AB-550X]

R.J. Corman Railroad Company/ Allentown Lines, Inc.—Abandonment Exemption—in Lehigh County, PA

R.J. Corman Railroad Company/Allentown Lines, Inc. (RJCN) has filed a notice of exemption under 49 CFR 1152 Subpart F—*Exempt Abandonments* to abandon a 1.945-mile line of railroad known as the Barber's Quarry Industrial Track between milepost 93.144 in the vicinity of Union and 3rd Streets in

Allentown and milepost 95.089 in the vicinity of Lawrence Street and Lehigh Parkway in the township of Salisbury, Lehigh County, Pa. The line traverses United States Postal Service Zip Codes 18102 and 18103.

RJCN has certified that: (1) No local traffic has moved over the line for at least 2 years; (2) there is no overhead traffic on the line; (3) no formal complaint filed by a user of rail service on the line (or by a state or local government entity acting on behalf of such user) regarding cessation of service over the line either is pending with the Surface Transportation Board (Board) or with any U.S. District Court or has been decided in favor of complainant within the 2-year period; and (4) the requirements at 49 CFR 1105.7 (environmental reports), 49 CFR 1105.8 (historic reports), 49 CFR 1105.11 (transmittal letter), 49 CFR 1105.12 (newspaper publication), and 49 CFR 1152.50(d)(1) (notice to governmental agencies) have been met.

As a condition to this exemption, any employee adversely affected by the abandonment shall be protected under *Oregon Short Line R. Co.*—

Abandonment—*Goshen*, 360 I.C.C. 91 (1979). To address whether this condition adequately protects affected employees, a petition for partial revocation under 49 U.S.C. 10502(d) must be filed. Provided no formal expression of intent to file an offer of financial assistance (OFA) has been received, this exemption will be effective on October 8, 1998, unless stayed pending reconsideration. Petitions to stay that do not involve environmental issues,¹ formal expressions of intent to file an OFA under 49 CFR 1152.27(c)(2),² and trail use/rail banking requests under 49 CFR 1152.29 must be filed by September 18, 1998. Petitions to reopen or requests for public use conditions under 49 CFR 1152.28 must be filed by September 28, 1998, with: Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, NW, Washington, DC 20423.

A copy of any petition filed with the Board should be sent to applicant's representative: Kevin M. Sheys,

Oppenheimer Wolff Donnelly & Bayh LLP, 1350 Eye Street, NW, Suite 200, Washington, DC 20005-3324.

If the verified notice contains false or misleading information, the exemption is void *ab initio*.

RJCN has filed an environmental report which addresses the effects of the abandonment, if any, on the environment and historic resources. The Section of Environmental Analysis (SEA) will issue an environmental assessment (EA) by September 11, 1998. Interested persons may obtain a copy of the EA by writing to SEA (Room 500, Surface Transportation Board, Washington, DC 20423) or by calling SEA, at (202) 565-1545. Comments on environmental and historic preservation matters must be filed within 15 days after the EA becomes available to the public.

Environmental, historic preservation, public use, or trail use/rail banking conditions will be imposed, where appropriate, in a subsequent decision.

Pursuant to the provisions of 49 CFR 1152.29(e)(2), RJCN shall file a notice of consummation with the Board to signify that it has exercised the authority granted and fully abandoned the line. If consummation has not been effected by RJCN's filing of a notice of consummation by September 8, 1999, and there are no legal or regulatory barriers to consummation, the authority to abandon will automatically expire.

Board decisions and notices are available on our website at "WWW.STB.DOT.GOV."

Decided: September 1, 1998.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,
Secretary.

[FR Doc. 98-24050 Filed 9-4-98; 8:45 am]

BILLING CODE 4915-00-P

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

Information Collection; Submission for OMB Review; Comment Request

AGENCY: Office of the Comptroller of the Currency, Treasury.

ACTION: Submission for OMB review; Comment request.

SUMMARY: In accordance with the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Office of the Comptroller of the Currency (OCC) hereby gives notice that it has sent to the Office of Management and Budget

(OMB) for review an information collection titled Uniform Form for Registration and Amendment to Registration as a Transfer Agent—Form TA-1.

DATES: Comments regarding this information collection are welcome and should be submitted to the OMB Reviewer and the OCC. Comments are due on or before October 8, 1998.

ADDRESSES: A copy of the submission may be obtained by calling the OCC Contact listed. Direct all written comments to the Communications Division, Attention: 1557-0124, Third Floor, Office of the Comptroller of the Currency, 250 E Street, SW, Washington, DC 20219. In addition, comments may be sent by facsimile transmission to (202)874-5274, or by electronic mail to REGS.COMMENTS@OCC.TREAS.GOV.

SUPPLEMENTARY INFORMATION:

OMB Number: 1557-0124.

Form Number: TA-1.

Type of Review: Reinstatement, with change, of a previously approved collection.

Title: Uniform Form for Registration and Amendment to Registration as a Transfer Agent—Form TA-1.

Description: This notice covers a renewal with change of a currently approved information collection titled Uniform Form for Registration and Amendment to Registration as a Transfer Agent—Form TA-1. Section 17A(c) of the Securities Exchange Act of 1934 (Act), as amended by the Securities Act Amendments of 1975, provides that all those authorized to transfer securities registered under Section 12 of the Act (transfer agents) shall register by filing with the appropriate regulatory agency an application for registration in such form and containing such information and documents as such appropriate regulatory agency may prescribe to be necessary or appropriate in furtherance of the purposes of this section. Form TA-1 was developed by the OCC, Federal Deposit Insurance Corporation, and the Board of Governors of the Federal Reserve to satisfy this statutory requirement. National bank transfer agents use Form TA-1 to register or amend registration as transfer agents. The OCC uses the information to determine whether to allow, deny, accelerate, or postpone an application. An amendment to Form TA-1 must be filed with the OCC within sixty calendar days following the date on which any information reported on Form TA-1 becomes inaccurate, misleading or incomplete. The OCC also uses the data to more effectively schedule and plan

¹ The Board will grant a stay if an informed decision on environmental issues (whether raised by a party or by the Board's Section of Environmental Analysis in its independent investigation) cannot be made before the exemption's effective date. See *Exemption of Out-of-Service Rail Lines*, 5 I.C.C.2d 377 (1989). Any request for a stay should be filed as soon as possible so that the Board may take appropriate action before the exemption's effective date.

² Each offer of financial assistance must be accompanied by the filing fee, which currently is set at \$1000. See 49 CFR 1002.2(f)(25).

transfer agent examinations. Amendments to Form TA-1 are used by the OCC to schedule and plan examinations. The Securities and Exchange Commission maintains complete files on the registration data of all transfer agents registered pursuant to the Act. It utilizes the data to identify transfer agents and to facilitate development of rules and standards applicable to all registered transfer agents.

Respondents: Businesses or other for-profit; individuals.

Number of Respondents: 50.

Total Annual Responses: 50.

Frequency of Response: On occasion.

Estimated Total Annual Burden: 25 hours.

OCC Contact: Jessie Gates or Camille Dixon, (202)874-5090, Legislative and Regulatory Activities Division, Office of the Comptroller of the Currency, 250 E Street, SW, Washington, DC 20219.

OMB Reviewer: Alexander Hunt, (202)395-7340, Paperwork Reduction Project 1557-0124, Office of Management and Budget, Room 10226, New Executive Office Building, Washington, DC 20503.

The OCC may not conduct or sponsor, and respondent is not required to respond to, an information collection that has been extended, revised, or implemented on or after October 1, 1995, unless it displays a currently valid OMB control number. Comments are invited on: (a) Whether the proposed revisions to the following collections of information are necessary for the proper performance of the OCC's functions, including whether the information has practical utility; (b) the accuracy of the OCC's estimate of the burden of the information collection as it is proposed to be revised; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of information collection on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or startup costs and costs of operation, maintenance, and purchase of services to provide information.

Dated: September 1, 1998.

Mark J. Tenhundfeld,

Assistant Director, Legislative & Regulatory Activities Division.

[FR Doc. 98-24014 Filed 9-4-98; 8:45 am]

BILLING CODE 4810-33-p

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

Proposed Agency Information Collection Activities; Comment Request

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to comment on proposed and continuing information collections, as required by the Paperwork Reduction Act of 1995, Pub. L. 104-13. Today, the Office of Thrift Supervision within the Department of the Treasury solicits comments on the information collection entitled Loans in Areas Having Special Flood Hazards.

DATES: Submit written comments on or before November 9, 1998.

ADDRESSES: Send comments to Manager, Dissemination Branch, Records Management and Information Policy, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552, Attention 1550-0088. Hand deliver comments to 1700 G Street, NW. from 9:00 A.M. to 5:00 P.M. on business days. Send facsimile transmissions to FAX Number (202) 906-7755 or (202) 906-6956 (if the comment is over 25 pages). E-mail to public.info@ots.treas.gov and include your name and telephone number. Interested persons may inspect comments at 1700 G Street, NW., from 9:00 A.M. until 4:00 P.M. on business days.

FOR FURTHER INFORMATION CONTACT:

Larry A. Clark, Compliance Policy, Office of Supervision, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552, (202) 906-5628.

SUPPLEMENTARY INFORMATION:

Title: Loans in Areas Having Special Flood Hazards (12 CFR 572).

OMB Number: 1550-0088.

Form Number: Not Applicable.

Abstract: Savings and Loan

Associations are required by statute and by 12 CFR Part 572 to file reports, make certain disclosures, and keep records regarding flood insurance. Borrowers use the information received from the associations to make valid purchase decisions. OTS uses the records to verify the associations' compliance.

Current Actions: OTS proposes to renew this information collection without revision.

Type of Review: Extension of an already approved collection.

Affected Public: Business or For Profit.

Estimated Number of Respondents: 1,182.

Estimated Time Per Respondent: 26.25 average hours.

Estimated Total Annual Burden Hours: 31,027.5 hours.

Request for Comments

The OTS will summarize comments submitted in response to this notice or will include these comments in its request for OMB approval. All comments will become a matter of public record. The OTS invites comment on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality; and (d) ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Dated: September 1, 1998.

Catherine C. M. Teti,

Director, Records Management and Information Policy.

[FR Doc. 98-23993 Filed 9-4-98; 8:45 am]

BILLING CODE 6720-01-P

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

Submission for OMB Review; Comment Request

September 1, 1998.

The Office of Thrift Supervision (OTS) has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Pub. L. 104-13. Interested persons may obtain copies of the submission(s) by calling the OTS Clearance Officer listed. Send comments regarding this information collection to the OMB reviewer listed and to the OTS Clearance Officer, Office of Thrift Supervision, 1700 G Street, NW, Washington, DC 20552.

OMB Number: 1550-0004.

Form Number: OTS Form 248.

Type of Review: Extension of an already approved collection.

Title: Annual Survey of Deposits; Deposits by Office.

Description: This survey provides deposit data for each thrift office which is essential for OTS' analysis of market share of deposits required in evaluating the competitive impact of mergers, acquisitions, and branching

applications. This information is shared with the Federal Reserve Board, the Federal Deposit Insurance Corporation, the Office of the Comptroller of the Currency and the Department of Justice.

Respondents: Savings and Loan Associations and Savings Banks.

Estimated Number of Reporters: 1,182.

Estimated Burden Hours per Reporter: 1 hour average.

Frequency of Response: Annually.

Estimated Total Reporting Burden: 1,182 hours.

Clearance Officer: Colleen M. Devine, (202) 906-6025, Office of Thrift Supervision, 1700 Street, NW, Washington, DC 20552.

OMB Reviewer: Alexander Hunt, (202) 395-7860, Office of Management and Budget, Room 10202, New Executive Office Building, Washington, DC 20503.

Catherine C. M. Teti,

Director, Records Management and Information Policy.

[FR Doc. 98-23992 Filed 9-4-98; 8:45 am]

BILLING CODE 6720-01-P

DEPARTMENT OF VETERANS AFFAIRS

Research and Development Cooperative Studies Evaluation Committee; Notice of Meeting

The Department of Veterans Affairs gives notice under Public Law 92-463

(Federal Advisory Committee Act) as amended, by section 5(c) of Public Law 94-409, that a meeting of the Research and Development Cooperative Studies Evaluation Committee will be held at the Marriott Residence Inn, 500 Army Navy Drive, Arlington, VA 22202, October 14-15, 1998. The session on October 14 is scheduled to begin at 7:30 a.m. and end at 4:15 p.m. and on October 15 from 7:30 a.m. to 1:00 p.m. The meeting will be for the purpose of reviewing the following four new proposals: Cost effectiveness of alternative management strategies in patients with dyspepsia, Vitamins to lower homocysteinemia in kidney and end stage renal disease, Multi-model therapy in Veterans with Gulf War illnesses and Antibiotic treatment of Gulf War Syndrome. The Committee will also review the progress of one ongoing study on cost and outcome of telephone care.

The Committee advises the Chief Research and Development Officer through the Chief of the Cooperative Studies Program on the relevance and feasibility of the studies, the adequacy of the protocols, and the scientific validity and propriety of technical details, including protection of human subjects.

The meeting will be open to the public from 7:30 a.m. to 8:00 a.m. on both days to discuss the general status of the program. Those who plan to

attend should contact Dr. Ping Huang, Coordinator, Research and Development Cooperative Studies Evaluation Committee, Department of Veterans Affairs, Washington, DC, (202.273.8295), prior to October 9, 1998.

The meeting will be closed from 8:45 a.m. to 4:15 p.m. on October 14, 1998 and from 8:00 a.m. to 1:00 p.m., on October 15, 1998. These portions of the meeting involve consideration of specific proposals in accordance with provisions set forth in section 10(d) of Public Law 92-463, as amended by sections 5(c) of Public Law 94-409, and 5 U.S.C. 552b(c)(6). During the closed sessions of the meeting, discussions and recommendations will deal with qualifications of personnel conducting the studies, staff and consultant critiques of research protocols, and similar documents, and the medical records of patients who are study subjects, the disclosures of which would constitute a clearly unwarranted invasion of personal privacy.

Dated: August 27, 1998.

By Direction of the Secretary.

Heyward Bannister,

Committee Management Officer.

[FR Doc. 98-24000 Filed 9-4-98; 8:45 am]

BILLING CODE 8320-01-M

Final Rule

Tuesday
September 8, 1998

Part II

**Department of
Health and Human
Services**

Health Care Financing Administration
Office of Inspector General

42 CFR Part 409, et al.
Medicare Program; Prospective Payment
System for Hospital Outpatient Services;
Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Office of Inspector General

42 CFR Parts 409, 410, 411, 412, 413, 419, 489, 498, and 1003

[HCFA-1005-P]

RIN 0938-A156

Medicare Program; Prospective Payment System for Hospital Outpatient Services

AGENCY: Health Care Financing Administration (HCFA), HHS, and Office of Inspector General (OIG), HHS.

ACTION: Proposed rule.

SUMMARY: As required by sections 4521, 4522, and 4523 of the Balanced Budget Act of 1997, this proposed rule would eliminate the formula-driven overpayment for certain outpatient hospital services, extend reductions in payment for costs of hospital outpatient services, and establish in regulations a prospective payment system for hospital outpatient services (and for Medicare Part B services furnished to inpatients who have no Part A coverage). The prospective payment system would simplify our current payment system and apply to all hospitals, including those that are excluded from the inpatient prospective payment system. The Balanced Budget Act provides for implementation of the prospective payment system effective January 1, 1999, but delays application of the system to cancer hospitals until January 1, 2000. The hospital outpatient prospective payment system would also apply to partial hospitalization services furnished by community mental health centers.

Although the statutory effective date for the outpatient prospective payment system is January 1, 1999, implementation of the new system will have to be delayed because of year 2000 systems concerns. The demands on intermediary bill processing systems and HCFA internal systems to become compliant for the year 2000 preclude making the major systems changes that are required to implement the prospective payment system. The outpatient prospective payment system will be implemented for all hospitals and community mental health centers as soon as possible after January 1, 2000, and a notice of the anticipated implementation date will be published in the **Federal Register** at least 90 days in advance.

This document also proposes new requirements for provider departments and provider-based entities. These proposed changes, as revised based on our consideration of public comments, will be effective 30 days after publication of a final rule.

This proposed rule would also implement section 9343(c) of the Omnibus Budget Reconciliation Act of 1986, which prohibits Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital, unless the services are furnished under an arrangement with the hospital. This section also authorizes the Department of Health and Human Services' Office of Inspector General to impose a civil money penalty, not to exceed \$10,000, against any individual or entity who knowingly and willfully presents a bill for non-physician or other bundled services not provided directly or under such an arrangement.

This proposed rule also addresses the requirements for designating certain entities as provider-based or as a department of a hospital.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 9, 1998.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1005-P, P.O. Box 26688, Baltimore, MD 21207-0488.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA-1005-P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders,

Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is \$8. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is <http://www.access.gpo.gov/nara/index.html>, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then login as guest (no password required). Dial-in users should use communications software and modem to call 202-512-1661; type swais, then login as guest (no password required).

FOR FURTHER INFORMATION CONTACT:

Janet Wellham, (410) 786-4510 (for general information). Joel Schaer (OIG), (202) 619-0089 (for information concerning civil money penalties).

Kitty Ahern, (410) 786-4515 (for information related to the classification of services into ambulatory payment classification (APC) groups).

Suzanne Letsch (410) 786-4558 (for information related to volume control measures and updates).

George Morey (410) 786-4653 (for information related to the determination of provider-based status).

Janet Samen (410) 786-9161 (for information on the application of APCs to community mental health centers).

SUPPLEMENTARY INFORMATION: To assist readers in referencing sections contained in this document, we are providing the following table of contents.

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In addition, because there are many terms to which we refer by acronym in this rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

APC Ambulatory payment classification
 APG Ambulatory patient group
 ASC Ambulatory surgical center
 BBA Balanced Budget Act of 1997
 CAH Critical access hospital
 CCI [HCFA's] Correct Coding Initiative
 CCR Cost center specific cost-to-charge ratio
 CHAMPUS Civilian Health and Medical Program of the Uniformed Services
 CMHC Community mental health center
 CMP Civil money penalty
 CORF Comprehensive outpatient rehabilitation facility
 CPT [Physicians'] Current Procedural Terminology, 4th Edition, 1998, copyrighted by the American Medical Association
 DME Durable medical equipment
 DMEPOS DME, orthotics, prosthetics, prosthetic devices, prosthetic implants and supplies
 DRG Diagnosis-related group
 EACH Essential access community hospital
 ESRD End-stage renal disease
 FDO Formula-driven overpayment
 FQHC Federally qualified health center
 HCPCS HCFA Common Procedure Coding System
 HHA Home health agency
 ICD-9-CM International Classification of Diseases, Ninth Edition, Clinical Modification
 IME Indirect medical education
 IOL Intraocular lens
 MDC Major diagnostic category
 MDH Medicare dependent hospital
 MedPAC Medicare Payment Advisory Commission
 MSA Metropolitan statistical area
 NECMA New England County Metropolitan Area
 OBRA Omnibus Budget Reconciliation Act
 PPS Prospective payment system
 RHC Rural health clinic
 RPCH Rural primary care hospital
 RRC Rural referral center
 SCH Sole community hospital
 SGR Sustainable growth rate
 SNF Skilled nursing facility
 TEFRA Tax Equity and Fiscal Responsibility Act of 1982

I. Background

As the Medicare statute was originally enacted, Medicare payment for hospital services (inpatient and outpatient) was based on hospital-specific reasonable costs attributable to serving Medicare beneficiaries. Later, the law was amended to limit payment to the lesser of a hospital's reasonable costs or to its customary charges. In 1983, section 601 of the Social Security Amendments of 1983 (Public Law 98-21) completely revised the cost-based payment system for most hospital inpatient services by enacting section 1886(d) of the Social

Security Act (the Act). This section provided for a prospective payment system (PPS) for acute inpatient hospital stays, effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although payment for most inpatient services became subject to a PPS, hospital outpatient services continued to be paid based on hospital-specific costs, which provided little incentive for hospital efficiency for outpatient services. At the same time, advances in medical technology and changes in practice patterns were bringing about a shift in the site of medical care from the inpatient to the outpatient setting. During the 1980s, the Congress took steps to control the escalating costs of providing outpatient care. The Congress amended the statute to implement across-the-board reductions of 5.8 percent and 10 percent to the amounts otherwise payable for hospital operating costs and capital costs, respectively, and legislated a number of different payment methods for specific types of hospital outpatient services. These methods included fee schedules for clinical diagnostic laboratory tests, orthotics, prosthetics, and durable medical equipment (DME); composite rate payment for dialysis for persons with end-stage renal disease (ESRD); and payments based on blends of hospital costs and the rates paid in other ambulatory settings such as separately certified ambulatory surgical centers (ASCs) or physician offices for certain surgery, radiology, and other diagnostic procedures. Nevertheless, Medicare payment for services performed in the hospital outpatient setting remains largely cost-based.

In section 9343(f) of the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) (Public Law 99-509) and in section 4151(b)(2) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), the Congress required the Secretary to develop a proposal to replace the current hospital outpatient payment system with a PPS and to submit a report to the Congress on the proposed system. In OBRA 1986, the Congress paved the way for development of a PPS, under section 9343(g), by requiring fiscal intermediaries to require hospitals to report claims for services under the HCFA Common Procedure Coding System (HCPCS), and, under section 9343(c), by extending the prohibition against unbundling of hospital services under section 1862(a)(14) of the Act to include outpatient services as well as inpatient services. HCPCS coding enabled us to determine what specific procedures and services were being

billed, while the extension of the prohibition against unbundling ensured that all nonpractitioner services provided to hospital outpatients would be billed only by the hospital, not by an outside supplier, and, therefore, would be reported on hospital bills and captured in the hospital outpatient data that could be used to develop an outpatient PPS.

Section 1866(g) of the Act, as added by section 9343(c) of OBRA 1986, and amended by section 4085(i)(17) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Public Law 100-203), also authorizes the Department of Health and Human Services' Office of Inspector General to impose a civil money penalty (CMP), not to exceed \$2,000, against any individual or entity who knowingly and willfully presents a bill in violation of an arrangement (as defined in section 1861(w)(1) of the Act).

A proposed rule to implement section 9343(c) was published in the **Federal Register** on August 5, 1988. However, those regulations were never published as a final rule, so we are including them in this regulation and will implement them as part of the final regulation implementing the hospital outpatient PPS.

The Secretary submitted a Report to Congress on March 17, 1995. The report summarized the research HCFA conducted in searching for a way to classify outpatient services for purposes of developing an outpatient PPS. The report cited Ambulatory Patient Groups (APGs), developed by 3M-Health Information Systems under a cooperative grant with HCFA, as the most promising classification system for grouping outpatient services and recommended that APG-like groups be used in designing a hospital outpatient PPS.

The report also presented a number of options that could be used, once a PPS was in place, for addressing the issue of rapidly growing beneficiary copayment. As a separate issue, we recommended that the Congress amend the provisions of the law pertaining to the blended payment methods for ASC surgery, radiology, and other diagnostic services to correct an anomaly that resulted in a less than full recognition of the amount paid by the beneficiary in calculating program payment (referred to as the formula-driven overpayment).

The Balanced Budget Act of 1997 (BBA) (Public Law 105-33), enacted on August 5, 1997, contains a number of provisions that affect Medicare payment for hospital outpatient services. The purpose of this proposed rule is to implement sections 4521, 4522, and

4523 of the BBA and section 9343(c) of OBRA 1986. Section 4521 of the BBA eliminates the formula-driven overpayment effective for services furnished on or after October 1, 1997. Because of the October 1, 1997 effective date, HCFA has already taken action to implement this provision. Section 4522 extends the current cost reductions of 5.8 percent and 10 percent (applicable to hospital outpatient operating costs and hospital capital costs, respectively) through and including December 31, 1999.

Section 4523 of the BBA amends section 1833 of the Act by adding subsection (t), which provides for implementation of a PPS for most hospitals for outpatient services furnished on or after January 1, 1999 and for cancer hospitals that are excluded from inpatient PPS for services furnished on or after January 1, 2000. We note that while the statutory effective date for the outpatient PPS is January 1, 1999, implementation of the new payment system will have to be delayed because of year 2000 systems concerns. The demands on intermediary bill processing systems and HCFA internal systems to become compliant for the year 2000 preclude making the major systems changes that are required to implement the PPS. See Section XI of this preamble ("Delay in Implementation") for a more detailed explanation of the reasons for delay. The outpatient PPS will be implemented as soon as possible after January 1, 2000. A notice of the anticipated implementation date will be published in the **Federal Register** at least 90 days in advance. The rates that will go into effect on the implementation date will apply to all hospitals including cancer hospitals described in section 1886(d)(1)(B)(v) of the Act. The rates will be based on the rates that would have been in effect January 1, 1999 updated by the rate of increase in the hospital market basket minus one percentage point.

Section 1833(t)(1)(B) of the Act authorizes the Secretary to designate the hospital outpatient services that would be paid under the PPS. Section 1833(t)(1)(B) also requires that the outpatient PPS include inpatient services covered under Part B for beneficiaries who are entitled to Part A benefits but who have exhausted their Part A benefits or otherwise are not in a covered Part A stay. However, section 1833(t)(1)(B) specifically excludes as covered services under the outpatient PPS ambulance services and physical and occupational therapy, and speech-language pathology services, for which separate fee schedules are required by

statute. (See section 4531 of the BBA for amendments pertaining to ambulance services and section 4541 for amendments pertaining to outpatient rehabilitation services.)

Section 1833(t)(2) of the Act stipulates certain requirements for the hospital outpatient PPS. The Secretary is required to develop a classification system for covered outpatient services which may consist of groups arranged so that the services within each group are comparable clinically and with respect to the use of resources. In addition, this section specifies data requirements for establishing relative payment weights, which are to be based on median hospital costs determined by data from the most recent available cost reports; requires that the portion of the Medicare payment and the beneficiary copayment that are attributable to labor and labor-related costs be adjusted for geographic wage differences; and authorizes the establishment of other adjustments, such as outlier adjustments or adjustments for certain classes of hospitals, that are necessary to ensure equitable payments. All adjustments are required to be made in a budget neutral manner. This section concludes with the requirement that a control on unnecessary increases in the volume of covered services be established.

Section 1833(t)(3) provides for a new method of calculating beneficiary copayment. It freezes beneficiary copayment at 20 percent of the national median charges for covered services (or group of covered services) furnished during 1996 and updated to 1999 using the Secretary's estimated charge growth from 1996 to 1999. This section specifies how beneficiary deductibles are to be treated in calculating the Medicare payment and beneficiary copayment amounts and requires that rules be established regarding determination of copayment amounts for covered services that were not furnished in 1996. Further, it prescribes the formula for calculating the initial conversion factor used to determine Medicare payment amounts for 1999 and the method for updating the conversion factor in subsequent years.

Sections 1833(t)(4) and (t)(5) describe the basis for determining the Medicare payment amount and the beneficiary copayment amount for services covered under the outpatient PPS. The latter section requires the Secretary to establish a procedure whereby hospitals may voluntarily elect to reduce beneficiary copayment for some or all covered services to an amount not less than 20 percent of the Medicare payment amount. Hospitals are further allowed to advertise any such

reductions of copayment amounts. Section 4451 of the BBA added section 1861(v)(1)(T) to the Act, which stipulates that bad debts will not be recognized on any copayment the hospital elects to reduce.

Section 1833(t)(6) authorizes periodic review and revision of the payment groups, relative payment weights, wage index, and conversion factor.

Section 1833(t)(7) describes how payment is to be made for ambulance services, which are specifically excluded from the outpatient PPS under section 1833(t)(1)(B).

Section 1833(t)(8) provides that the Secretary may establish a separate conversion factor for determining services furnished by cancer hospitals excluded from inpatient PPS under this PPS.

Section 1833(t)(9) prohibits administrative or judicial review of the PPS classification system, the groups, relative payment weights, adjustment factors, other adjustments, calculation of base amounts, periodic adjustments, and the establishment of a separate conversion factor for those cancer hospitals excluded from inpatient PPS.

Section 4523(d) of the BBA amends section 1833(a)(2)(B) of the Act to require payment under the PPS for some services described in section 1832(a)(2) that are currently paid on a cost basis and furnished by providers of services such as comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), hospices, and community mental health centers (CMHCs). This amendment requires that partial hospitalization services furnished by CMHCs beginning January 1, 1999 be paid under the PPS. As noted earlier, implementation of the PPS will be delayed. Implementation will occur as soon as possible after January 1, 2000.

II. Elimination of Formula-Driven Overpayment

Before enactment of section 4521 of the BBA, under the blended payment formulas for ASC procedures, radiology, and other diagnostic services, the ASC or physician fee schedule portion of the blends was calculated as if the beneficiary paid 20 percent of the ASC rate or physician fee schedule amount instead of the actual amount paid, which was 20 percent of the hospital's billed charges. Section 4521 corrects this anomaly by changing the blended calculations so that all amounts paid by the beneficiary are subtracted from the total payment in determining the amount due from the program. Effective for services furnished on or after October 1, 1997, payment for surgery, radiology, and other diagnostic services

under blended payment methods will be calculated by subtracting the full amount of copayment due from the beneficiary (based on 20 percent of the hospital's billed charges).

III. Extension of Cost Reductions

Section 1861(v)(1)(S)(ii) of the Act requires that the amounts otherwise payable for hospital outpatient operating costs and capital costs be reduced by 5.8 percent and 10 percent, respectively. These reductions were scheduled to sunset at the end of fiscal year 1998, but section 4522 of the BBA extended the reductions through December 31, 1999.

IV. Prohibition Against Unbundling of Hospital Outpatient Services

A. Background

The Social Security Amendments of 1965 (Public Law 89-97), enacted on July 30, 1965, established title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of health care services furnished to eligible beneficiaries. Part A of the program (Hospital Insurance) provides basic health insurance protection against the costs of inpatient or home health care. Part B of the program (Supplementary Medical Insurance) provides voluntary supplementary insurance covering most physician services and certain other items and services not covered under Part A, including hospital outpatient services.

Before the enactment of Public Law 98-21 on April 7, 1983, which established the Medicare PPS for inpatient hospital services, nonphysician services furnished to Medicare beneficiaries who were hospital patients were generally billed by the hospitals. Under certain circumstances, however, Part B of the Medicare statute permitted payments to be made to an outside supplier or another provider for certain nonphysician services otherwise covered by Medicare Part B that were furnished to a hospital patient. When payments were made under these circumstances, some nonphysician services were billed as hospital services in one hospital and billed by an outside supplier in another. The practice of billing by suppliers outside the hospital for these services has been referred to in the legislative history as the "unbundling" of hospital services.

Since the enactment of Public Law 98-21 and the publication of implementing regulations on September 1, 1983 (48 FR 39752), the Medicare program has required that nonphysician

services furnished to hospital inpatients be covered and paid for under Medicare as hospital services. This practice of covering nonphysician services furnished to hospital inpatients by an outside supplier as hospital services is referred to as "bundling." Under the PPS for inpatient hospital services, a single predetermined payment is made for a case based on the diagnosis-related group (DRG) to which the case is assigned. Bundling ensures that the DRG payments to all hospitals cover a comparable "bundle" of services related to the hospital stay.

Specifically, Public Law 98-21 added section 1862(a)(14) to the Act to prohibit payment for services (other than physician services) furnished to an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under an arrangement (as defined in section 1861(w)(1) of the Act). (Section 1861(w)(1) of the Act specifies that the term "arrangements" is limited to arrangements under which receipt of payment by the hospital or other provider for Medicare-covered services to an individual discharges the liability of the individual or any other person to pay for the services.) Public Law 98-21 also added section 1866(a)(1)(H) to the Act to provide that a hospital is eligible to participate in the Medicare program only if the hospital agrees to furnish to inpatients either directly or under an arrangement all Medicare-covered items and services, other than physician services.

Regardless of whether the hospital furnishes the services directly or arranges for furnishing the services, the hospital assumes financial responsibility for the services. The Medicare program makes payment only to hospitals and not to other providers or suppliers that furnish inpatient services on behalf of the hospitals.

In Public Law 98-21, the Congress addressed only nonphysician services furnished to Medicare beneficiaries who are hospital inpatients. The Congress did not address at that time nonphysician services furnished to Medicare beneficiaries who are hospital outpatients, for which payment is made, usually on a cost basis, under Part B of Medicare. Thus, services to hospital outpatients continued to be unbundled in some hospitals. Subsequently, in section 9343(c) of OBRA 1986, the Congress extended the bundling provision to all nonphysician services furnished to hospital "patients," thus also including nonphysician services furnished to Medicare beneficiaries who are hospital outpatients.

Sections 9343(c)(1) and (c)(2) of OBRA 1986 amended sections

1862(a)(14) and 1866(a)(1)(H) of the Act, respectively. As revised, section 1862(a)(14) of the Act prohibits payment for nonphysician services furnished to hospital patients (inpatients and outpatients), unless the services are furnished by the hospital, either directly or under an arrangement (as defined in section 1861(w)(1) of the Act). As revised, section 1866(a)(1)(H) of the Act requires each Medicare-participating hospital to agree to furnish directly all covered nonphysician services required by its patients (inpatients and outpatients) or to have the services furnished under an arrangement (as defined in section 1861(w)(1) of the Act). Section 9338(a)(3) of OBRA 1986 affected implementation of the bundling mandate by amending section 1861(s)(2)(K) of the Act to permit services of physician assistants to be covered and billed separately.

Bundling of outpatient hospital services was required in order to provide a basis for implementing another provision of OBRA 1986, which required the development of a prospective payment methodology for outpatient hospital services. Section 9343(f) of OBRA 1986 amended section 1135 of the Act to require the Secretary to submit to the Congress by April 1, 1988, an interim report concerning development of a fully prospective payment system for ambulatory surgery. The legislation also specified that a final report was due to the Congress no later than April 1, 1989, with recommendations concerning implementation of a fully prospective payment mechanism for ambulatory surgery services by October 1, 1989. We released an interim report in June of 1988 and the final report in September of 1990. The final report summarized our research findings relating to hospital outpatient prospective payment and did not contain specific recommendations regarding a PPS for ambulatory surgical services. Later, in section 4151(b)(2) of OBRA 1990, the Congress expanded its earlier request and required HCFA to develop a PPS that included all hospital outpatient services. That legislation also directed us to submit a report to the Congress concerning this proposal. We submitted a report to the Congress on March 17, 1995.

In order for us to be able to develop a PPS for hospital outpatient services, it was necessary to have available clear and consistent rules about the range of services that would be included in this payment system. Previous policies on coverage of hospital outpatient services permitted services to be unbundled and thus allowed providers to vary their practices concerning the furnishing of

services. The Congress recognized the inconsistencies of the current payment system and required bundling as a first step toward payment reform.

B. Previous Medicare Regulations Affecting Bundling

Previous regulations set forth at 42 CFR 405.310(m) concerning noncoverage of certain services furnished to hospital inpatients (redesignated as § 411.15(m)) implemented the statutory requirement for bundling of inpatient hospital services. They excluded from coverage nonphysician services furnished to hospital inpatients by an entity other than the hospital, unless the services were furnished under an arrangement. The exclusion from coverage in effect at that time did not apply to physician services that met the conditions for payment for physician services to provider patients in § 405.550(b) (redesignated as § 415.102(a)), or services of anesthetists employed by physicians that met the conditions for payment in § 405.553(b)(4) concerning reasonable charges for anesthesiology services furnished by the anesthesiologist or by an anesthetist employed by the anesthesiologist. (The regulation is now deleted as the payment structure for anesthesiologists has changed.) The exception for physician services is required by section 1862(a)(14) of the Act. Services of physician-employed anesthetists were exempted from bundling as an administrative measure to prevent disruption of long-standing physician-anesthetist team relationships. However, in a final rule published on May 26, 1993 (58 FR 30630), the regulations set forth at § 411.15(m) and § 489.20(d) were revised to reflect the statutory exclusion of certified registered nurse anesthetist (CRNA) services (including services of anesthesiologist assistants), physician assistant services, certified nurse midwife services, and qualified psychologist services from the inpatient bundling requirement. Section 411.15(m) concerns services to hospital inpatients excluded from coverage, and § 489.20(d) concerns a provider agreement in the case of a hospital or critical access hospital (CAH) to furnish directly or make arrangements for Medicare-covered services to inpatients of a hospital or a CAH.

C. Office of Inspector General (OIG) Civil Money Penalty Authority

In order to prevent the unbundling of nonphysician hospital services, section 9343(c)(3) of OBRA 1986 amended section 1866 of the Act by adding a new paragraph (g). Specifically, this

authority provided for the imposition of a civil money penalty (CMP), not to exceed \$2,000, against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service under Part B of Medicare that violates the requirement for billing under arrangements specified in section 1866(a)(1)(H) of the Act. Section 1866(g) was further amended by section 4085(i)(17) of OBRA 1987. Section 4085(i)(17) of OBRA 1987 deleted all references to hospital outpatient services under Part B of Medicare and authorized imposition of a CMP when arrangements should have been made but were not. Section 1866(g) of the Act authorizes imposition of a CMP against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under section 1866(a)(1)(H) or in violation of the requirement for an arrangement. The result of this amendment is that the CMP is now applicable for all services furnished to hospital patients, whether paid for under Medicare Part A or B. The statute also requires that a CMP be imposed in the same manner as other CMPs are imposed under section 1128A of the Act. Section 231(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) revised section 1128A of the Act to increase the CMP maximum amount for each false claim or prohibited practice from \$2,000 to \$10,000. Implementing regulations for this authority are set forth in 42 CFR parts 1003 and 1005.

To implement the provisions of section 9343(c) of OBRA 1986, we published a proposed rule in the **Federal Register** on August 5, 1988 (53 FR 29486). Those regulations have not been published in final, but we are proposing revised implementing regulations as part of this regulation.

D. Proposed Regulations Published August 5, 1988

1. Bundling of Hospital Outpatient Services

We proposed to implement the requirement for bundling of outpatient hospital services by amending then existing Medicare regulations (§ 405.310 concerning particular services excluded from coverage, and part 410 concerning supplementary medical insurance benefits) to exclude coverage of any services that are furnished in a hospital to an outpatient of the hospital by an entity other than the hospital during or as a result of an encounter in the hospital, unless the services are

furnished under an arrangement. In addition, we proposed to require bundling of those diagnostic procedures or tests (for example, magnetic resonance imaging procedures) that are furnished outside the hospital by an entity other than the hospital but are ordered during an encounter in the hospital with the patient or as a result of such an encounter.

In the proposed rule, in § 405.310(n)(1) concerning definitions of services to hospital outpatients excluded from coverage (now redesignated as § 411.15(m)), we defined a hospital outpatient as an individual who is not an inpatient of the hospital but who is registered as an outpatient.

We proposed to define, in § 410.2 ("Definitions"), the term "encounter" as a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, where applicable, by hospital staff bylaws, to order or furnish services for the patient for the purpose of diagnosis or treatment of the patient. The use of the "encounter" as a basis for identifying the services to be bundled is not specifically required by OBRA 1986 but is needed in order to implement the bundling requirement in a uniform and equitable manner, as explained further in section III. of the preamble of the August 5, 1988 proposed rule (53 FR 29489).

As in the case of services to hospital inpatients, physician services that meet the conditions for payment for services of physicians to provider patients in § 415.102(a) would not be bundled under our proposal. (The exception for physician services is required by section 1862(a)(14) of the Act.) We also proposed, as an administrative measure, to exempt from outpatient bundling the services of physician-employed anesthetists that meet the conditions for payment for services furnished by an anesthesiologist or by an anesthetist employed by the anesthesiologist in § 405.553(b)(4). These services were exempted from bundling to prevent disruption of long-standing physician-anesthetist team relationships. We also proposed to exempt physician assistant services as defined in section 1861(s)(2)(K)(i) of the Act from inpatient and outpatient bundling. We proposed this change to help accomplish the objective of section 1861(s)(2)(K)(i) of the Act, as amended by section 9338(a)(3) of OBRA 1986, which permits physician assistant services to be covered and to be billed separately. As noted earlier, we have made the changes in the types of services excluded from bundling of inpatient services in the May 1993 final rule (58 FR 30630).

We also proposed to revise the regulations set forth at § 489.20, which describe the basic commitments included in the provider agreement. They would require a hospital that furnishes services to a beneficiary who is not currently an inpatient of a hospital but who is registered by the hospital as an outpatient to agree either to furnish directly or to make arrangements (in accordance with section 1861(w)(1) of the Act) for all items and services for which bundling is required under the proposed revision described above, and for which the beneficiary is entitled to have payment made under Medicare.

We proposed in the August 5, 1988 proposed rule that if a Medicare outpatient is referred to another provider or supplier for further diagnostic testing or other diagnostic services as a result of an encounter that occurs in the hospital, the hospital would be responsible for arranging with the other entity for the furnishing of services. (We have now changed our view on bundling of these services as discussed in the following section IV.E.) Also, the hospital would be responsible for furnishing or arranging for the furnishing of prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses (IOLs)) and are implanted or fitted during an encounter. For example, in the absence of a bundling provision, the physician who implants an IOL during surgery performed on an outpatient of a hospital also could be the supplier of the IOL and could bill Medicare under Part B for it. As proposed in our August 1988 rule, this practice would be prohibited, and the hospital would have to furnish the IOL, either directly or under an arrangement (that is, would have to pay for the lens). The same policies would apply to other items and services, such as artificial limbs, knees, and hips; orthotics; equipment and supplies covered under the prosthetic device benefit; and services incident to physician services. Thus, hospitals would be required to assume financial liability for prostheses and prosthetic devices (which are regarded as "services" for Medicare coverage purposes) and for other services furnished by an outside entity to their outpatients, and the practice of unbundling these services would be prohibited.

Sometimes a hospital may furnish an item or service for which a patient will have a continuing need. For example, a hospital may furnish a DME item such as a wheelchair. When this situation occurs, the proposed rule required that

the hospital would be responsible for bundling the items and services it furnishes on-site. In adopting the view that these types of items are subject to bundling, we did not discount the patient's continuing need for them after leaving the hospital. However, the bundling provisions in sections 1862(a)(14) and 1866(a)(1)(H) of the Act prohibit unbundling of services to an individual who is a patient of a hospital and do not provide any specific exception to these provisions for DME. Therefore, we did not believe it would be appropriate to exclude DME from bundling when it was furnished to a hospital patient. (We have now changed our previous position on bundling of DME as discussed in section IV.E.)

2. Civil Money Penalties for Unbundling Hospital Outpatient Services

In order to implement section 1866(g) of the Act, in our August 5, 1988 proposed rule, we proposed that the OIG would impose a CMP against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service under Part B of Medicare that violates the billing arrangement under section 1866(a)(1)(H) of the Act or the requirement for an arrangement. The amount of the CMP was to be limited to \$2,000 for each improper bill or request, even if the bill or request included more than one item or service. However, in accordance with the Health Insurance Portability and Accountability Act of 1996, which increased the minimum penalty amount to \$10,000, the increased amount will now be reflected in the regulations.

E. Revised Proposed Regulations on Bundling of Hospital Services

This proposed rule incorporates most of the provisions of the August 5, 1988 proposed rule. The following describes how the regulations published in this proposed rule to implement the rebundling of outpatient hospital services differ from the regulations we proposed and published on August 5, 1988:

- We are not including any of the changes in the regulations relating to payment for physician laboratory services (§§ 405.555(a) through (c), and 405.556(c) of the August 5, 1988 proposed rule), because these regulations were deleted as a result of publication of regulations to implement the Medicare physician fee schedule published on November 25, 1991 (56 FR 59502).

- We are revising § 409.10(b), which describes services that are not included in the definition of "hospital inpatient

or inpatient CAH services" to include all of the services that are now exceptions from the bundling rule under section 1862(a)(14) of the Act. Section 4511 of the BBA revised sections 1862(a)(14) and 1866(a)(1)(H) of the Act to exclude services of nurse practitioners and clinical nurse specialists described in section 1861(s)(2)(K) of the Act from the bundling requirement.

- As previously indicated, proposed § 410.2 had been revised in the earlier proposed rule to include a definition of an "encounter." The definition of an encounter is expanded to include encounters in a CAH. That section is further amended to include a definition of an "outpatient" as a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. The revision to include CAHs in these definitions is made to comply with sections 1862(a)(14) and 1866(a)(1)(H) of the Act, which require that CAHs be treated as hospitals for purposes of the bundling provisions. (The BBA eliminated rural primary care hospitals (RPHs) and created CAHs. The Congress intended, under section 4201(c) of the BBA, that CAHs be subject to the same Medicare requirements to which RPHs were subject.)

- The revision to § 410.27 is the same as in the earlier proposed rule except that the revision is now designated as paragraph (e) instead of paragraph (c).

- We are removing paragraph (a)(4) of § 410.28 ("Hospital or CAH diagnostic services furnished to outpatients: Conditions") to reflect a change made by section 4085(i)(11) of OBRA 1987 regarding provisions of diagnostic services furnished to outpatients.

- Proposed § 410.30 (redesignated as § 416.39 in this proposed rule) is being significantly revised. In § 410.30(a) and (b) (now § 410.39 (a) and (b) of regulations published on August 5, 1988, we proposed to require the hospital to furnish directly or under arrangements all services furnished to its outpatients during an encounter as well as any diagnostic services furnished outside the hospital that were ordered during or as a result of an encounter in the hospital. In this rule, we are not extending the bundling requirements to include diagnostic services ordered during an encounter in the hospital that are furnished outside the hospital. Thus, the hospital will not be required to furnish such diagnostic services directly or under arrangements. We are proposing a more limited

approach to bundling because the PPS we are proposing involves less "packaging" than we anticipated when we published the August 1988 proposed regulations. At that time, we believed that a PPS payment for a surgical procedure was likely to include preoperative tests and that payment for a clinic visit was likely to include the ancillary services (for example, laboratory tests and x-rays) that were needed to make a diagnosis. Therefore, by requiring bundling of off-site diagnostic tests that were ordered during an outpatient encounter at the hospital, we believed we could ensure that: (1) We had sufficient data to set payment rates that included the ancillary tests, and (2) once the system was implemented, the bundling rules would prevent any duplication of program payments. That is, a service packaged into a PPS payment to the hospital could not also be billed to the program as an ancillary test by an outside entity.

As noted above, the PPS we are proposing now does not include extensive packaging; therefore, the payment for related diagnostic tests is not included in the payments under the ambulatory payment classification (APC) groups for surgical procedures, clinic visits, emergency room visits, etc. Any diagnostic tests that are furnished will result in a separate payment. The program will pay the entity that actually furnishes the service—the hospital, if the service is provided directly or under arrangements made by the hospital; or another Medicare recognized entity, if the patient leaves the hospital and obtains the service elsewhere. Because diagnostic tests are not being packaged into another hospital service, we no longer need to require that a hospital furnish directly or under arrangements the services ordered during, or as a result of, an encounter, but furnished outside the hospital. If the PPS is changed in future years to require a more packaged approach to payment, the bundling regulations will be revised. Proposed § 410.30 (now § 410.39) is also revised to require that the bundling rules apply to CAHs, and the list of services that are excepted from the bundling requirements, in § 410.30(b) (now § 410.39(b)) (previously designated in the August 5, 1988, proposed rule as § 410.30(c)), is expanded to include all of the services that are currently excepted under section 1862(a)(14) of the Act.

- We are revising § 411.15(m) (previously designated as § 405.310(m)) significantly. We are eliminating proposed § 405.310(n). That section, which had described the hospital

outpatient services that were excluded from coverage if not furnished directly or under arrangements, has been revised so that we will not require that hospitals bundle diagnostic services ordered during or as a result of an encounter in the hospital if furnished outside the hospital. The requirements of that section have been incorporated into § 411.15(m)(1). We are revising § 411.15(m)(2), which describes the services that are exceptions to the bundling rule, to include all of the services that are now exceptions under section 1862(a)(14) of the Act. We are further revising § 411.15(m)(3), "Scope of exclusion," to delete the reference to DME as a service that must be bundled. DME is defined under section 1861(n) of the Act as equipment used in the patient's home or in another institution used as his home other than a hospital or skilled nursing facility (SNF). By definition, DME is not something that is provided for use in the hospital setting. Therefore, we do not believe that the DME benefit provides for any item or service that is expected to be used by the patient while in the hospital as an inpatient or outpatient. Section 1862(a)(14) of the Act requires the hospital to provide directly or under arrangements services furnished to the patients of a hospital or CAH. We did not provide an exception for DME in our earlier proposed rule, because the bundling requirements under sections 1862(a)(14) and 1866(a)(1)(H) of the Act did not provide an exception for DME. However, we now believe that a statutory exception is not required because the bundling requirements apply to the services a hospital furnishes to its patients, and DME is not a hospital service. The covered Part B benefit for DME as described under section 1861(n) of the Act is intended for equipment used in the home, so a hospital that furnishes DME to its patients is not providing a hospital service to its patients, but is acting in the capacity of a supplier of DME, not a provider of hospital services. For these reasons, we will not require bundling of DME for hospital patients.

- Section 412.50 was not amended in the earlier proposed rule, but we are revising it in this rule to specify that hospital inpatient services do not include the services that are exceptions to the bundling requirements under section 1862(a)(14) of the Act.

- We are revising proposed § 489.20(d) to incorporate as exceptions to the bundling requirements all of the services that are now exceptions under section 1866(a)(1)(H) of the Act.

- In addition to minor wording changes in introductory paragraph (b),

proposed § 1003.102 remains the same as in the August 5, 1988 proposed rule, with the exception that the revision is now designated as paragraph (b)(14) rather than as paragraph (b)(4), as originally indicated in the August 5, 1988 proposed rule. Paragraphs (b)(11) through (b)(13) of § 1003.102 are being reserved. We are also amending § 1003.103(a) to indicate, in accordance with section 231(c) of the Health Insurance Portability and Accountability Act, that the maximum CMP for each improper bill or request has been increased to \$10,000.

- We are also amending § 1003.105 (Exclusion from participation in Medicare and State health care programs) by revising paragraph (a)(1)(i) to reflect that this basis for imposition of a CMP is also a basis for an exclusion from participation in Medicare and the State health care programs.

V. Hospital Outpatient Prospective Payment System (PPS)

In this proposed rule, we delineate the services that are covered under the hospital outpatient prospective payment system (PPS) that we are required to establish under section 1833(t) of the Act. We also propose Medicare payment rates when those services are ordered or furnished for diagnosis or treatment of a Medicare beneficiary who is registered on hospital records as an outpatient, and who receives services directly from the hospital.

In this section, we explain the framework for the hospital outpatient PPS. This framework rests on Medicare's definition of an outpatient, which we discuss in section IV.E, above, and on Medicare's definition of what constitutes a hospital outpatient department or clinic. In section VI., below, we address requirements to define and distinguish among the various sites where services that are covered under the hospital outpatient PPS could be furnished. For example, a service furnished at an outpatient department or clinic located within a hospital can also be furnished at a "provider-based" entity, at a site away from a hospital that functions as though it were a department within the hospital, at an ASC, and at a physician office. Under the statute as it is currently written, in order to determine whether Medicare makes payment for a service under the hospital outpatient PPS that is the subject of this proposed rule or under another provision of Medicare Part B, such as the ASC benefit or the physician fee schedule, it is essential to clarify exactly where and under what conditions the service was furnished.

This PPS will apply to covered hospital outpatient services furnished by any hospital participating in the Medicare program, except for those hospitals discussed below. Partial hospitalization services in community mental health centers (CMHCs) will also be paid under this PPS.

The cancer hospitals that are excluded from inpatient PPS will be paid under hospital outpatient PPS. Although the BBA provides for a separate conversion factor if necessary, we intend to pay cancer hospitals using the same conversion factor and rates as all other hospitals. Certain hospitals in Maryland furnish services that are exempt from this system because they qualify under section 1814(b)(3) of the Act for payment under the State's payment system. Such excluded services are limited to the services paid under the State's payment system as described in section 1814(b)(3) of the Act. Any other outpatient services furnished by the hospital will be paid under the outpatient PPS. Critical access hospitals are excluded from the outpatient PPS because they are paid under a reasonable cost based system, as required under section 1834(g) of the Act. All other participating hospitals will be paid under hospital outpatient PPS.

Distinct parts of hospitals that are excluded under inpatient PPS will be included in the outpatient PPS, to the extent that outpatient services are furnished by the hospital. For example, a hospital with an excluded inpatient psychiatric unit will have payment made under this PPS for outpatient psychiatric services including to inpatients who are not in a covered Part A stay.

A. Scope of Services Within the Outpatient PPS

Section 1833(t)(1)(B)(i) of the Act gives the Secretary the authority to designate which services are to be covered under the hospital outpatient PPS. In this section, we indicate the types of services for which we are proposing to make payment under the hospital outpatient PPS and the types of services we are proposing to exclude from the scope of the hospital outpatient PPS.

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for the services that she designates are covered under the hospital outpatient PPS. Section 1833(t)(2)(B) of the Act allows the Secretary to classify covered outpatient services by groups so that the services within each are comparable clinically and with respect to the use of resources.

We refer to the hospital outpatient PPS classification system that we have developed as the Ambulatory Payment Classification (APC) system. The APC system consists of 346 groups of services that are covered under the hospital outpatient PPS.

In section V.B., below, we explain how we assigned services and procedures to APC groups and in sections V.C. and V.D., below, we explain how we used the APC groups to determine hospital outpatient PPS payment rates.

1. Services Excluded From the Hospital Outpatient PPS

Section 1833(t)(1)(B)(iii) of the Act excludes the following from payment under the hospital outpatient PPS: ambulance services, physical and occupational therapy, and speech-language pathology services. These services will be paid under fee schedules in all settings.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary the authority to designate which hospital outpatient services are covered under the outpatient PPS. In considering which services to include under the outpatient PPS, we wanted to ensure that all hospital outpatient services are paid under a prospectively determined amount. Some hospital outpatient services (for example, clinical diagnostic laboratory services, orthotics and prosthetics, ESRD dialysis services) are currently paid based on fee schedules or other prospective rates. Payments under these fee schedules apply not only to hospital outpatient services, but the same or very similar payment rates apply across a number of sites of ambulatory care. Such similar payments across various settings creates a level playing field where HCFA pays virtually the same payment for the same service, without regard to where the service is furnished. So that we do not disrupt an existing level playing field, we propose to exclude from our PPS, hospital outpatient services that are currently paid prospectively determined rates that are the same rates paid in other settings.

We are proposing to exclude from the hospital outpatient PPS the following:

a. Certain services already paid for under fee schedules or other payment systems including, but not limited to, services for patients with ESRD that are paid for under the ESRD composite rate; laboratory services paid under the clinical diagnostic laboratory fee schedule; and DME, orthotics, prosthetics, prosthetic devices, prosthetic implants and supplies (DMEPOS) paid for under the DMEPOS

fee schedule when the hospital is acting as a supplier of these items. An item such as crutches or a walker that is given to the patient to take home, but that may also be used while the patient is at the hospital, would be billed to the DME regional carrier rather than being paid for under the hospital outpatient PPS.

b. Hospital outpatient services furnished to inpatients of an SNF regardless of whether the person is in a Part A covered stay and furnished pursuant to the resident assessment or comprehensive care plan and that are covered under the SNF PPS, furnished "under arrangements" and billable only by the SNF.

c. Services and procedures that require inpatient care.

MedPAC Recommendation: In its March 1998 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommends that costs associated with allied health professions training, such as nursing schools and paramedical education, be excluded from the calculation of the relative weights and the conversion factor used to set outpatient PPS payment rates. MedPAC further recommends that Medicare make separate payment for these costs, consistent with the manner in which Medicare pays for allied health professions training costs under the inpatient PPS.

Response: We agree with MedPAC's recommendation. We did not include costs associated with allied health professions training in the calculation of outpatient PPS relative weights and conversion factors. We propose to pay hospitals that have allied health professions training programs on a cost-pass-through basis similar to the way we treat these costs under the hospital inpatient PPS.

2. Services Included Within the Scope of the Hospital Outpatient PPS

a. Services for Patients Who Have Exhausted Their Part A Benefits

Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the hospital outpatient PPS for certain services furnished to inpatients who have exhausted Part A benefits or otherwise are not in a covered Part A stay. Examples of services covered under this provision include diagnostic x-rays and certain other diagnostic services and radiation therapy covered under section 1832 of the Act.

b. Partial Hospitalization Services

Section 1833(a)(2)(B) of the Act provides that partial hospitalization

services furnished in CMHCs be paid for under the hospital outpatient PPS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients with profound and disabling mental health conditions an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

c. Services Designated by the Secretary

Under the authority established by the statute at section 1833(t)(1)(B)(i), we further are proposing to include within the scope of services for which payment is made under the hospital outpatient PPS the following:

- Services that are included within the outpatient PPS system are all hospital outpatient services that have not been identified for exclusion as described in section V.A.1., above. Among the types of services that we have classified into APC groups for payment under the hospital outpatient PPS are the following: surgical procedures; radiology, including radiation therapy; clinic visits; emergency department visits; diagnostic services and other diagnostic tests; partial hospitalization for the mentally ill; surgical pathology; cancer chemotherapy.

- Services furnished to SNF inpatients that are not packaged into SNF consolidated billing precisely because they are services that are commonly furnished by hospital outpatient departments and that SNFs would not be able to provide, such as CT scans, magnetic resonance imaging, or ambulatory surgery requiring the use of an operating room.

- Supplies such as surgical dressings that can be used during surgery or other treatments in the hospital outpatient setting that are also on the DMEPOS fee schedule. Payment for such supplies, when they are used in the hospital, is packaged into the APC payment rate for the procedure or service with which the items are associated.

- Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

Section 4523(d)(3) of the BBA provides that we will make Part B payment for certain medical and other health services, when furnished by a provider of services or by others under arrangement with a provider of services, under the outpatient PPS, if we would otherwise pay those providers on a reasonable cost basis for those services. Specifically, we are proposing that we would pay for the following medical and other health services under the

outpatient PPS when furnished by a provider of services:

- Antigens (as defined in 1861(s)(2)(G) of the Act);
- Splints and casts (1861(s)(5));
- Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine (1861(s)(10)).

We make Part B payment for the above services under the outpatient PPS when those services are provided by a CORF, HHA, or hospice program. However, this provision does not apply to services, furnished by a CORF, that fall within the definition of CORF services at section 1861(cc)(1) of the Act. It also does not apply to services furnished by a hospice within the scope of the hospice benefit. Nor does it apply to services furnished by HHAs to individuals under an HHA plan of treatment within the scope of the home health benefit.

3. Hospital Outpatient PPS Payment Indicators

Column B in Addendum B indicates the payment status of each HCPCS code. Addendum B displays all HCPCS codes, including those incidental services that are packaged into APC payment rates. Addendum G identifies inpatient services not payable under outpatient PPS.

- We use "A" to indicate services that are paid under some other method such as the DMEPOS fee schedule or the physician fee schedule.
- We use "E" to indicate services for which payment is not allowed under the hospital outpatient PPS or is not covered by Medicare.
- We use "C" to indicate inpatient services that are not payable under the outpatient PPS.
- We use "N" to indicate services that are incidental, with payment packaged into another service or APC group.
- We use "P" to indicate services that are paid only in partial hospitalization programs.

• We use "S" to indicate significant procedures for which payment is allowed under the hospital outpatient PPS but to which the multiple procedure reduction does not apply.

• We use "T" to indicate surgical services for which payment is allowed under the hospital outpatient PPS. Services with a payment indicator "T" are the only services to which the multiple procedure payment reduction applies.

• We use "V" to indicate medical visits for which payment is allowed under the hospital outpatient PPS. Providers must use ICD-9-CM (International Classification of Diseases, Ninth Edition, Clinical Modification) codes to determine the level of payment for services with a payment indicator "V".

• We use "X" to indicate ancillary services for which payment is allowed under the hospital outpatient PPS.

The table below lists all of the outpatient PPS indicators and what they designate.

STATUS INDICATORS

[How Medicare Pays for Various Services When They Are Billed for Hospital Outpatients]

Indicator	Service	Status
A	Pulmonary Rehabilitation; Clinical Trial	Non-paid.
C	Inpatient Procedures	Bill as Inpatient.
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS Fee Schedule.
E	Non-covered Items and Services	Non-paid.
A	Physical, Occupational and Speech Therapy	Rehab Fee Schedule.
A	Ambulance	Ambulance Fee Schedule.
A	EPO for ESRD patients	National Rate.
A	Clinical Diagnostic Laboratory Services	Lab Fee Schedule.
A	Physician Services for ESRD patients	Bill to carrier.
A	Screening Mammography	Lower of Charge or National Rate.
N	Incidental Services, packaged into APC Rate	Packaged; no additional payment allowed.
P	Partial Hospitalization Services	Paid per diem.
S	Significant Procedure, not reduced when multiple	Paid under hospital outpatient PPS (APC rate).
T	Significant Procedure, multiple procedure reduction applies	Paid under hospital outpatient PPS (APC rate).
V	Visit to Clinic or Emergency Department	Paid under hospital outpatient PPS (APC rate).
X	Ancillary Service	Paid under hospital outpatient PPS (APC rate).

B. Description of the Ambulatory Payment Classification (APC) Groups

In response to OBRA 1986 and OBRA 1990 requirements to develop a hospital outpatient PPS, we examined systems that were in place or under development, and we entered into a cooperative agreement with 3M-Health Information Systems to develop a classification system for outpatient services. The results of our review of existing systems are outlined in a Report to Congress dated March 17, 1995. The report identified the Ambulatory Patient Groups (APGs), which were developed by 3M-Health Information Systems, as the most promising classification system, and we recommended that APG-

like groups be used as the basis for the hospital outpatient PPS. Soon after the report was submitted to the Congress, 3M-Health Information Systems released an updated version (known as Version 2.0) of the APGs. Since the release of Version 2.0, HCFA has revised the APGs based on more recent Medicare data. These revisions constitute what we are calling the Ambulatory Payment Classification (APC) system or groups that are proposed in this rule. Services within the APC system are identified by HCPCS codes and descriptions.

1. Setting Payment Rates Based on Groups of Services Rather Than on Individual Services

MedPAC Recommendation: In its March 1998 report to the Congress entitled "Report to the Congress: Medicare Payment Policy," MedPAC recommends that payment rates under the hospital outpatient PPS be based upon relative weights for each individual service rather than upon groups of similar services to help ensure consistent payments across ambulatory settings. MedPAC gives several reasons to support this recommendation:

- If services in a group are not homogeneous, a single payment rate for

all services in the group would not be accurate.

- Hospitals whose case mix includes a greater than average volume of higher-cost procedures in a group with a payment rate based on median costs for all procedures in the group could face losses and would have a financial incentive to provide only the lower-cost procedures within a group and to avoid the higher-cost procedures.

- Grouping services creates considerable administrative burdens and problems related to data consistency, provider education, the need for extensive technical assistance, and modification of claims processing systems.

- If costs for services in a group change at different rates, the price for the group may become distorted over time, necessitating periodic rebasing of group weights.

- Using groups to set rates for services under the hospital outpatient PPS moves away from standardizing payment systems across ambulatory settings.

Response: We have carefully reviewed MedPAC's concerns about using groups of services rather than individual services as the basis for setting weights under the hospital outpatient PPS, and we believe that we have addressed most of these concerns in our approach to ratesetting using APC groups.

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups, so that services within each group are comparable clinically and with respect to the use of resources. The statute refers to "each such service (or group of services)," implying that we may choose or not choose to group services. We have chosen to set rates for groups of similar services rather than setting rates for individual services for several reasons:

- The composition of the APC groups is based on two premises: the procedures within each group must be similar clinically, and the procedures must be similar in terms of resource costs. As we explain below, we used 3M's APGs as a starting point, but we have subsequently made changes to most of the 3M groups, taking into account 1996 outpatient claims data; data collected in a 1994 survey of ASC costs and charges; data collected in 1995 and 1996 to establish resource-based practice expense relative values under the Medicare physician fee schedule; comments on surgical groupings following an ASC town meeting held at

HCFA in July 1996 at which participants reviewed 3M's Version 2.0 surgical APGs for consistency in terms of clinical characteristics and resource costs; and the medical judgment of HCFA's medical advisors. Further, we invite comments on the composition of all the APC groups that are presented in this proposed rule and whether readers believe that further refinements are needed. We request that commenters support their recommendations for changes in the APC groups with data regarding resource costs (time, supplies, equipment, labor requirements) as well as clinical arguments.

We have also solicited comments on the same surgical APC groups that are proposed in this rule as part of a proposed rule entitled "Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Surgical Procedures for Ambulatory Surgical Centers Effective October 1, 1998" (HCFA-1885-P), published in the **Federal Register** June 12, 1998 (63 FR 32290). We intend to coordinate our review of all comments submitted timely during the comment period for the hospital outpatient PPS proposed rule and the ASC proposed rule. Any subsequent changes to the APC groups will be used by both payment systems when we set their respective final rates. We have a high level of confidence in the homogeneity of the APC groups that will emerge from this exhaustive review process.

- We have found that, in this context, setting weights at a single code level suggests a level of precision that is often not warranted due either to low procedure volume or questionable cost data.

- Of the 10,500 codes in the HCPCS, over 5,000 describe services that are covered under the hospital outpatient PPS. However, an examination of outpatient claims data for 1997 reveals that as few as 100 HCPCS codes account for more than a third of all coded services billed during that year. MedPAC states in its report to the Congress that its analysis of physician claims for 1996 revealed that more than 90 percent of hospital outpatient volume was accounted for by 300 high volume services. Because so many codes were billed infrequently or not at all, we found ratesetting to be facilitated by grouping together the data that were available for codes that are similar clinically. We disagree with MedPAC's suggestion that we establish payment groups composed only of low-volume procedures. If we were to establish such groups, we would either have to except these groups from the principle of clinical consistency that applies to other

APC groups or greatly increase the number of APC groups within the outpatient PPS. And, this approach does not solve the problem of how to establish weights for procedures, whether they are taken individually or in groups, for which we have inadequate cost data. Placing low Medicare volume procedures in APC groups with which they are similar clinically and in terms of resource consumption does not affect the weight established for the group to any appreciable extent because the weight derives from the higher volume procedures within the group.

- Grouping closely related services, and paying the median cost of the group, discourages the upcoding that occurs when individual services that are similar have disparate median costs.

- Using APC groups to set outpatient weights is consistent with the ratesetting method we are proposing for ASCs. In a proposed rule entitled "Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Surgical Procedures for Ambulatory Surgical Centers Effective October 1, 1998" (HCFA-1885-P), published in the **Federal Register** June 12, 1998 (63 FR 32290), we propose payment rates for surgical procedures performed in Medicare-approved ASCs using APC surgical groups proposed in this rule.

- Payment rates for new or redefined services can be more reliably established by assigning codes for these services to an existing group of several codes that share characteristics with the new code rather than trying to match it to an equivalent single procedure for which we may or may not have reliable cost data.

- Our experience basing ASC payment rates on groups of codes has proved to be no more burdensome administratively than has our experience with setting weights on a single code basis under the Medicare physician fee schedule. Under the outpatient PPS, with weights set by APC groups, hospitals will continue to use the same HCPCS coding and the same claims forms that they use currently. Any burdens on HCFA or on hospitals necessitating additional technical assistance or systems changes are more a function of implementing an entirely new payment system than of our setting weights on the basis of groups of services instead of on the basis of single procedures or services.

We invite comments on our setting rates on the basis of groups of services rather than on individual codes.

2. How the Groups Were Constructed

3M created APGs by combining procedure codes and diagnosis codes into groups that were clinically related (such as all codes for repair of fractured legs) and analyzing claims data to determine if the codes that were clinically similar also used resources in similar ways (for example, surgical repair would likely be more resource intensive than closed manipulation and casting). The resources that were examined were based on a 3-month sample of all Medicare claims for outpatient services. The sample of nearly 15 million claims was selected from claims paid in 1992 with the charges on each claim matched to departmental cost-to-charge ratios from the hospital that provided the services. The costs that were calculated using billed charges and department cost-to-charge ratios included direct costs, as well as the overhead for performing the services. The APGs were clustered into significant procedures (both surgical and nonsurgical), medical visits (in both clinics and emergency departments), and ancillary services. Other groups captured incidental services (those that would not be paid separately) and procedures for which no payment is made, such as services specifically excluded from Medicare payment by statute.

Our Report to Congress recommended the use of APG-like groups for a hospital outpatient prospective payment system. When the time came to update payment groups for ASCs, which already were paid under a PPS, we decided to propose the use of APG-like groups. The ASC industry was accustomed to eight payment groups, with rates ranging from about \$300 to about \$900 in roughly \$75 increments, without clinical coherence. While interested in our proposal, the ASCs were concerned about perceived misclassifications, with groups containing codes they believed represented divergent resources. To accommodate these concerns, we regrouped many surgical codes, creating more levels within some ranges of groups and otherwise changing 3M's system. We also found it necessary to change the medical APGs. The medical visit groups, which under the APGs were grouped based on the patient's diagnosis, were clearly distinct when laboratory services and plain film x-rays were packaged in, but were much less distinct when those ancillary services related to the visit were not packaged, as will be the case initially under our system. We therefore investigated other approaches to categorizing medical visits that would result in clearly

defined payment groups without extensive packaging. We discuss these approaches in section V.B.4., below.

This process of revising 3M's APGs resulted in the development of the set of 346 mutually-exclusive and exhaustive service categories called ambulatory payment classification groups or APCs. The weights of the groups proposed in this rule are based on new data, as required by the BBA. We matched the database of 98 million hospital outpatient claims paid in 1996 to the most recent available cost reports for each hospital, and constructed the groups using these cost data. We defined each outpatient service under the PPS by a HCPCS code and classified it either into one of the APC groups for which an outpatient PPS payment rate is established or into a non-payment category of services that are excluded from the outpatient PPS. A weight is associated with each APC group. See section V.C. of this rule for details on how we calculated the weights. Procedures and services assigned a non-payment classification include services that can be provided only on an inpatient basis; codes or services that are not covered by Medicare; and procedures and services paid under fee schedules or other payment method.

3. Packaging Under the Groups

Packaged services are those that are recognized as contributing to the cost of the services in an APC, but that we do not pay for separately. Under the APC system, packaged services include the operating room, recovery room, anesthesia, medical/surgical supplies, pharmaceuticals, observation, blood, intraocular lenses, casts and splints, donor tissue, and various incidental services such as venipuncture. We "packaged" the services (and their costs) within the APC group of procedures with which they were delivered in the base year. Below is a list of the hospital revenue centers from which we derived costs that were packaged within the APC groups. For example, a given surgical procedure would have a cost for the use of the operating and recovery rooms in every case. However, supply costs might vary, with some patients requiring special drains and dressings and others needing minimal dressings. The average packaged cost for supplies might represent, for example, \$200 for the former group 40 percent of the time, and \$150 for the rest. Thus, the APC would include \$170 for supplies. Similarly, only a few cases would have included observation in the base year, but each case in the group would include a small

amount for the times we associated observation with the cases in the group.

We have packaged the cost of pharmaceuticals and biologicals within APC groups. We did this because we believe drugs are usually provided in connection with some other treatment or procedure. We have captured aggregate cost data on all drugs that were billed with HCPCS codes and those billed with revenue center codes, whether or not a HCPCS was entered. Thus, historical patterns of drug use are captured within the APC groups with which the drugs were billed during the base year. The only separate drug groups we have created are for chemotherapeutic agents, because those were separately identified in 3M's APG system. Because we intended to use an APG-like system, we required detailed coding of chemotherapeutic agents in order to be able to capture the costs of the specific drugs. We did not require HCPCS coding of other drugs, so we cannot specifically identify costs of non-chemotherapy drugs. We understand, however, that some rarely-used drugs are both expensive and used in only a few hospitals. In those instances, APC payment rates may not adequately represent costs for hospitals that treat patients who require infusions of very costly drugs or biologicals. Because we do not have bills that were coded to identify these high-cost drugs individually, we cannot evaluate the impact of paying separately for high-cost drugs. We could require HCPCS coding of all drugs or certain categories of drugs in order to gather the data, but we know hospitals could find such a requirement burdensome. We solicit comments on this issue.

Currently, drugs that can be self-administered are not covered under Part B of Medicare (with certain specific exemptions for blood-clotting factors, immunosuppressives, erythropoietin for dialysis patients, and certain oral chemotherapeutic agents and antiemetics). This presents problems in the outpatient hospital setting because even a pain killer given to a groggy patient postoperatively would not be covered. The only way such drugs can be paid for is for the hospital to bill the beneficiary. In many cases, the hospital does not, both because keeping track of such small charges for billing purposes is burdensome and because beneficiaries would not understand why they are being asked to pay for, for example, pain medication that was clearly related to the procedure they had undergone.

We propose to allow hospitals to provide drugs to patients without requiring that the hospital bill the

patient, and without Medicare's paying the hospital. Normally, hospitals are not allowed to waive such billing, since not charging a patient could be seen as an inducement to the patient to use other services at the hospital, for which the hospital would be paid. However, if the benefit is not advertised, we believe that provision of the self-administered drugs at no charge to the beneficiary need not constitute an inducement in violation of the anti-kickback rules. The hospital may not advertise this to the public or in any other way induce patients to use the hospital's service in return for forgoing payment.

Recommendation: MedPAC recommends that the unit of payment under the outpatient PPS be the individual service or procedure that is furnished and that payment for services and supplies integral to the individual service or procedure be bundled within that single unit of payment.

Response: We agree both with MedPAC's recommendation regarding what should constitute the unit of payment under the outpatient PPS, and with MedPAC's recommendation regarding the "bundling" of payment, which we call "packaging," for supplies and services that are integral to the individual service or procedure that constitutes the unit of payment. All services and procedures for which payment is to be made under the outpatient PPS are identified by HCPCS codes and descriptions. This approach of identifying individual services by HCPCS as the unit for payment parallels the unit for payment under both the Medicare physician fee schedule and the ASC facility services benefit. In addition, as we explain above, the payment amount for each HCPCS code is a packaged payment that takes into account the costs associated with services and supplies that are integral to the primary HCPCS-coded service or procedure and that are furnished at the same time and in the same place as the primary service or procedure. Because we modeled the outpatient PPS package of services for surgical procedures on the package of services that is the basis for payments for facility services furnished by Medicare approved ASCs, the definition of packaging will become standardized across both settings upon implementation of the outpatient PPS.

MedPAC cites as a disadvantage of using individual services or procedures as the unit for payment the limited options that are available to control the volume of unnecessary ancillary services. We discuss in section V.J. how we intend to address volume control under the outpatient PPS. While a broader definition of packaging that

includes related ancillaries such as diagnostic x-rays and other diagnostic tests that are furnished in other settings or at a different time than the primary service or procedures may have potential benefits not realized by the more limited packaging that we are using, we are concerned that applying different definitions of packaging to payments for the same primary service furnished in different settings would defeat the goal of establishing a unified payment structure across sites. One component of achieving this goal is to employ a consistent definition of packaging across all sites of ambulatory services. We solicit comments on the packaging options and the implications for ratesetting and volume control of using the same or different definitions of packaging across different settings.

The following table identifies by revenue code the services and items that are packaged into the various categories of APC groups (surgery, radiology, other diagnostic, medical visits, and all other APC groups).

PACKAGED SERVICES BY REVENUE CENTER

SURGERY	
250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
360	OPERATING ROOM.
361	MINOR SURGERY.
369	OTHER.
370	ANESTHESIA.
379	OTHER.
380	"BLOOD, GENERAL CLASS".
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESS- ING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
490	"AMBULATORY SURGERY, GENERAL CLASS".
491	OTHER AMBULATORY SURGICAL CARE.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED COD- ING.
700	CAST ROOM.
709	OTHER.
710	RECOVERY ROOM.
719	OTHER.
720	LABOR ROOM.
721	LABOR.
722	DELIVERY.
723	CIRCUMCISION.
724	BIRTHING CENTER.

PACKAGED SERVICES BY REVENUE CENTER—Continued

729	OTHER.
750	GASTROINTESTINAL.
759	OTHER.
760	OBSERVATION ROOM.
761	TREATMENT ROOM.
762	OBSERVATION ROOM.
769	OTHER TREATMENT ROOM.
890	OTHER DONOR BANK.
891	BONE.
892	ORGAN.
893	SKIN.
899	OTHER.
920	"OTHER DIAGNOSTIC SERVICES, GENERAL CLASS".
929	OTHER DIAGNOSTIC SERVICES.
940	"OTHER THERAPEUTIC SERVICES, GENERAL CLASS".
949	OTHER THERAPEUTIC SERVICES.

MEDICAL VISIT

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
279	OTHER.
380	"BLOOD, GENERAL CLASS".
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESS- ING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED COD- ING.
762	OBSERVATION ROOM.

DIAGNOSTIC

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
254	INCIDENT TO OTHER DIAGNOSTIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
360	OPERATING ROOM.
361	MINOR SURGERY.
369	OTHER.
370	ANESTHESIA.
372	INCIDENT TO OTHER DIAGNOSTIC.
379	OTHER.
380	"BLOOD, GENERAL CLASS".
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESS- ING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.

PACKAGED SERVICES BY REVENUE
CENTER—Continued

450	ER.
459	OTHER.
622	INCIDENT TO OTHER DIAGNOSTIC.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED COD- ING.
710	RECOVERY ROOM.
719	OTHER.
762	OBSERVATION ROOM.

RADIOLOGY

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
255	INCIDENT TO RADIOLOGY.
257	NON-PRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
360	OPERATING ROOM.
361	MINOR SURGERY.
369	OTHER.
370	ANESTHESIA.
371	ANESTHESIA INCIDENT TO RADIOL- OGY.
379	OTHER.
380	"BLOOD, GENERAL CLASS".
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESS- ING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
621	SUPPLIES INCIDENT TO RADIOLOGY.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED COD- ING.
710	RECOVERY ROOM.
719	OTHER.
762	OBSERVATION ROOM.

ALL OTHER APC GROUPS

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
279	OTHER.
380	"BLOOD, GENERAL CLASS".
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESS- ING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.

PACKAGED SERVICES BY REVENUE
CENTER—Continued

636	DRUGS REQUIRING DETAILED COD- ING.
762	OBSERVATION ROOM.

4. Treatment of Clinic and Emergency
Visits

The major issue we face in determining payment for clinic and emergency room visits is whether to include diagnosis as well as *Physicians' Current Procedural Terminology* (CPT) codes in setting payment rates. We solicit comments on the approaches that we discuss below and on other possible alternatives.

Determining payment for clinic and emergency room visits requires a variety of considerations and trade-offs. These include:

- The impact of packaging on setting payment rates (for example, the more packaging, the greater the difference among APC payments; however, we are not proposing a fully packaged system initially, which reduces payment differences and may necessitate additional policies to increase differences across payment groups);
- How to code visits in a manner that recognizes variations in service intensity and levels of resource consumption (for example, how to pay more for visits that cost more);
- How to keep the system administratively manageable (for payment purposes, we assign 31 CPT codes that describe different levels of evaluation and management services to 7 APC groups);
- How to define critical care in terms of facility as opposed to physician inputs (for example, what is an appropriate facility payment for critical care when critical care CPT codes are currently determined to reflect physician inputs);
- Data problems associated with identifying costs from claims that list multiple services (for example, the data analysis we have conducted so far reflects only data from claims for single visits; we are analyzing data from multiple visit claims to glean additional information relevant to these policies);
- How to move toward greater uniformity of payments across ambulatory settings so as to remove payment as an incentive for determining site of service (for example, the trade-off that could result if, by enhancing differentiation of payments for services within the hospital outpatient setting, we were to increase payment differences across settings for services that are provided in both hospital outpatient departments and physician offices).

Given the range of issues surrounding payments for clinic and emergency room visits, we are continuing to weigh different options. We are concerned that using diagnosis coding to set rates for hospital outpatient clinic visits could increase disparities in payment methodology between outpatient departments and physician offices, for which a new system of resource based practice costs is just now being proposed. (These concerns do not extend as much to emergent and critical care, which are not routinely furnished in physician office settings.) Diagnostic coding has not been used in the past to adjust payments in the physician office setting and there is no general evidence that practice expense (or work) in physician office settings varies by the patient's diagnosis. Moreover, because patients in the hospital outpatient department can be shifted easily to alternative outpatient settings, adjustment of facility costs to take diagnosis into account in one setting but not others may create incentives to shift patients among ambulatory settings in unknown ways.

Coding Visits

We have considered several approaches to setting prospective payment rates for hospital clinic and emergency visits. We reviewed the medical visit groups in 3M's version 2.0 of APGs that are based solely on ICD-9 diagnosis codes, with 80 APGs providing several groups for each body system; we analyzed the effect on ratesetting of defining clinic and emergency visits solely by CPT code; and, we analyzed the effect of using a matrix that combines patient diagnosis with a CPT code to describe the nature of the outpatient encounter. We discuss these various approaches in more detail here and some of the advantages and disadvantages of each. Again, we solicit comments on these approaches to setting payment rates for clinic and emergency room visits as well as comments on alternative approaches that are not mentioned here.

Approach 1: Using Diagnosis Codes
Only

3M's approach of using only ICD-9 diagnosis codes with extensive packaging results in a wide range of group payment rates. The group that pays the most is almost 13 times as costly as the lowest-paid group. However, when we removed minor laboratory tests, x-rays, and certain other minor procedures that had been packaged into 3M's medical visit APGs in order to conform with the packaging that we propose in this proposed rule,

the difference between the highest and the lowest paid group dropped to not quite five times. (Fully packaged APGs are sufficiently differentiated for payment purposes, while partially packaged APGs are not; therefore, if we were to move to a fully packaged system, we would re-evaluate approaches using diagnosis.)

We also found that grouping clinic and emergency visits solely on the basis of diagnoses tends to result in visits that require major resources for critical cases clustering together with less resource-intensive follow-up visits after the crisis has passed.

Approach 2: Using CPT Codes Only

The APC groups that we propose in this proposed rule as the basis for setting rates for surgical services consist solely of CPT codes. We looked at using only CPT codes to establish payment groups for outpatient clinic and emergency room visits, but we found that the variation between the most costly and the least costly encounter was quite flat, with the former only 4.5 times greater than the latter. When basing payment on CPT codes alone, the range reflects hospitals' billing patterns in increasing level of intensity, but cases at the margin are overwhelmed by the numbers of visits billed so that individual cases with low or high costs are not discernible. Also, billing patterns reflect standard bills, not the resources used in any particular case.

Approach 3: CPT and Diagnosis Hybrid

We looked at another approach that bases payment rates on a hybrid of CPT codes and patient diagnoses. We first assigned 31 CPT codes that describe physician encounters with patients in the outpatient setting to seven APC groups: three for clinic visits, three for emergency department visits, and one for critical care. We also collapsed approximately 12,000 ICD-9 codes into 20 major diagnostic categories (MDCs), arranged generally by body system. Classifying services in this fashion produces a more manageable number of groups, and results in a matrix of 121 CPT/diagnosis combinations, in which the most costly combination is more than 10 times as costly as the least.

Our grouping of evaluation and management CPT codes was based on several factors. As we note above, we grouped 31 CPT codes that represent different levels of physician "evaluation and management" of patients into seven APC groups. (For a more complete discussion, refer to the evaluation and management services guidelines in *Physicians' Current Procedural Terminology* 1998 edition (CPT '98)

published by the American Medical Association.) CPT codes are more descriptive of physician effort than of facility use, and our cost data showed little difference between level 1 and level 2 visits or between level 4 and level 5 visits. Therefore, we elected to combine some of the CPT codes into a single group, for example, the two least intensive outpatient visit codes, 99201 and 99202, are both in APC 911, which is the lowest level of clinic visits, etc. Grouping CPT codes together in this fashion reduces administrative burden, and our data analysis shows only small additional cost differences among the complete set of CPT medical visit codes. Moreover, we found that grouping CPT codes in this fashion evens out certain anomalies that arise when an emergency department furnishes services that would not typically be thought of as emergency care, such as suture removal, or treatment of a skin disease. Even though suture removal or treatment of conditions such as impetigo, conjunctivitis, etc. is performed in emergency departments, these types of services are more appropriately furnished at a clinic because they do not require the more elaborate resources of the emergency department. Assigning codes to APC groups would allow us to set payment for care of patients with minor problems in the emergency department at a level equivalent to payment for the same care when it is furnished at a clinic. We welcome comments on payment for services that do not require emergency room use.

Using a matrix of evaluation and management codes with patient diagnosis would offset the disadvantages noted above of grouping solely by CPT code (too little payment variation) or solely by patient diagnosis (reduced payment variation and commingling of resource intensive and non-resource intensive visits). Defining a clinic or emergency visit APC in terms of both CPT code and diagnosis, even when grouping codes to provide a manageable number of groups, would better recognize the facility resources consumed in providing emergency and critical care visits. Many such visits, of course, cluster around the same dollar amount, but this is expected because many visits involve typical care and standard resources. The cases that represent care at higher or lower levels of intensity appear to represent real differences in resource consumption. We used the CPT/patient diagnosis hybrid to model impacts. We do not believe that payment to individual hospitals would be significantly affected, whether we base payment rates

on groups of CPT codes only or on groups that combine CPT codes and patient diagnosis.

Using a matrix that combines CPT codes with patient diagnosis to set payment rates for clinic and emergency department visits would also improve the coding of diagnoses in the hospital outpatient setting generally. Such improved diagnosis coding is critical to evaluating future degrees of packaging in the APC system, and we have already noted that more packaging tends to increase the measured cost differences across APC groups.

However, as we discussed earlier, there are also problems with using a matrix that includes diagnosis codes for hospital outpatient visits. We are concerned about the effect of using a method to pay for clinic visits in the hospital outpatient setting that is at variance with the method we use to pay for the same service in a physician office. A possible alternative to using diagnosis codes as an indicator of resource consumption in connection with medical visits in hospital outpatient departments is to create a uniform fee schedule for physician visits across all ambulatory settings, paying the site at which the service is furnished the physician practice expense component as a "facility fee." However, the latter option would require legislation and a possible reallocation of the overhead currently associated with medical visits in the outpatient department to other outpatient services. Given the complexity of these issues, it may not be desirable to introduce additional differences, such as diagnosis, among payments in medical visits at this time. We invite public comment on all of the issues raised in the discussion in this section. In addition, after this rule is published, we will be reexamining our outpatient database and extending our analysis to multiple visit data. We will incorporate the findings of these additional analyses into our final decision.

Hypothetical Case Using the Hybrid

The following is a hypothetical case presented to illustrate how payment would be determined using the CPT code/diagnosis code hybrid. A new patient, an elderly woman who has recently come to live with her family in the area, presents to the primary care clinic complaining of fatigue, shortness of breath, swollen ankles, and loss of vision. The physician spends 45 minutes eliciting the patient's medical, family, and social history and performing an extensive physical examination. Suspecting cataracts as the

cause of her loss of vision, the physician suggests she make an appointment in the eye clinic. Suspecting congestive heart failure as the cause of her other symptoms, but also suspicious of coexisting diabetes and hypertension, the physician orders laboratory tests and an electrocardiogram (ECG) to be performed that day, and schedules an appointment in the cardiovascular clinic for a later date. If payment to the hospital were to be made on the basis of a CPT code/ICD-9 code matrix, the hospital's claim for services furnished in connection with this visit would identify the following information: CPT code 99204, comprehensive outpatient visit, new patient, and ICD-9 diagnosis code 401.1, benign hypertension. Payment would be determined by mapping CPT code 99204 to APC group 915, levels 4 and 5 clinic visit, and ICD-9 code 4011 to MDC 36, cardiovascular system diseases. Payment would be the rate established for the resulting hybrid group identifier, 91536. Addendum A lists the payment rates for the proposed hospital clinic and emergency room payment groups. Separate payment would be made under the clinical diagnostic laboratory fee schedule for the laboratory work; the ECG would be paid for separately on the basis of the payment rate established for APC 950.

Several months later, the same patient, who now is known to have congestive heart failure, returns to the primary care clinic complaining of a cough and runny nose. The physician, having determined that the symptoms are due to a virus, recommends using a humidifier and drinking extra fluids. The hospital would code this visit with CPT code 99212 (problem-focused outpatient visit, established patient) and with ICD-9 diagnosis code 460 (acute nasopharyngitis, or common cold). This combination, in turn, would map to APC 911, levels 1 and 2 clinic visit, plus MDC 31, ear, nose, mouth and throat diseases, and payment for this patient's second visit to the hospital clinic would be based on the rate established for hybrid group 91131.

Payment for Screening Services

Every patient who presents to an emergency department and requests (or has requested on his or her behalf) a screening must be screened in accordance with section 1867(a) of the Act. If the physician or other hospital staff who performs the screening determines that no medical emergency exists, the patient can be referred to one of the hospital's clinics or to another provider such as a physician office for further treatment, or the emergency department personnel can decide to

treat the patient in the emergency department. We propose to create a HCPCS code to be used to bill the screening. Payment for this new code will be low because no treatment is included in the screening. Payment for the screening APC is made only when no additional services are furnished by the emergency department. If non-emergency treatment is furnished, the appropriate emergency room visit should be billed, and *not* the screening. Similarly, if the screening reveals that an emergency does exist and treatment is instituted immediately, the screening should not be billed; the screening is subsumed into the further treatment. If an emergency room physician feels the need to consult with another physician before deciding whether the patient needs emergency treatment, the consultation is part of the original screening, and the hospital should bill for only one screening visit, if a bill for screening is appropriate, as described above.

Payment for Critical Care

We propose to have hospitals use CPT code 99291 to bill for outpatient encounters in which critical care services are furnished. We use the CPT definition of "critical care," which is the evaluation and management of the unstable critically ill or injured patient who requires the constant attendance of a physician. Under the outpatient PPS, we would allow the hospital to use CPT 99291 in place of, but not in addition to, a code for a medical visit or for an emergency department service. However, the entire duration of the hospital outpatient department's critical care services for an individual patient is represented by CPT 99291, and we would not allow the facility to use CPT 99292 to bill for critical care services extended in 30-minute increments, as would the attending physician. (We have packaged the costs associated with subsequent hours of critical care billing into the APG group of services with which the critical care hours were billed in the base year.) If other services, such as surgery, x-rays, or cardiopulmonary resuscitation, are furnished on the same day as the critical care services, we would allow the hospital to bill for them separately.

We expect that the numbering scheme proposed in this rule to distinguish clinic and emergency room visits would be changed in the final rule. Although we believe the 5-digit identifier used in this proposal makes it easier to see the relationship between the CPT code for the level of the visit and the ICD-9-CM code for the diagnosis, for claims processing purposes, we would have to

replace 5-digit identifiers with 3-digit ones.

5. Treatment of Partial Hospitalization Services

In accordance with section 1861(ff) of the Act, partial hospitalization services may be furnished only by a hospital to its outpatients or by a community mental health center (CMHC). We published an interim final rule on February 11, 1994 (59 FR 6570) to establish coverage criteria and payment requirements for partial hospitalization programs. In that rule, we indicated that physician services and certain nonphysician practitioner services are not considered to be partial hospitalization services. Payment for these services is outside the scope of this proposed rule.

The partial hospitalization program of services is organized and furnished similarly, whether the program is administered by a hospital or by a CMHC. Section 1833(a)(2)(B) of the Act requires that payment for CMHC partial hospitalization services be based on the hospital outpatient PPS. Thus, the methodology we are proposing would apply to hospital outpatient and to CMHC partial hospitalization programs. The current rules governing CMHC payment appear in 42 CFR part 413. This proposed rule would amend § 413.1 to indicate that payment for partial hospitalization services furnished by CMHCs is made in accordance with the hospital outpatient prospective payment system described in part 419 of this chapter.

Patients eligible for the Medicare partial hospitalization benefit comprise two groups: patients who have been discharged from a psychiatric hospital for whom partial hospitalization services are provided in lieu of continued inpatient treatment; and patients who exhibit disabling psychiatric/psychological symptoms as a result of an acute exacerbation of a severe and persistent mental illness for whom the partial hospitalization services are provided in lieu of admission to an inpatient psychiatric hospital.

As required by section 1835(a)(2) of the Act, admission to a partial hospitalization program is limited to patients whose physicians certify that: (1) the individual would require inpatient psychiatric care in the absence of partial hospitalization services; (2) an individualized, written plan of care has been established by a physician and is reviewed periodically by a physician; and (3) the patient is or was under the care of a physician. This certification would be made when the physician

believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.

The acute psychiatric condition being treated by a partial hospitalization program must require intensive active treatment, including a combination of medical and nursing interventions, individual and group psychotherapy, occupational therapy, family counseling, and various adjunctive therapeutic activities that are not primarily recreational or diversionary. The patient's degree of impairment must be severe enough to require a multidisciplinary structured day program, but not so severe that patients are incapable of participating in and benefitting from an active treatment program. Patients must require partial hospitalization services at levels of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses. In addition, the patient must have an adequate community-based network to support the patient outside the partial hospitalization program.

Typically, patients admitted to a partial hospitalization program initially require full-time participation in order to provide crisis stabilization, that is, 6 hours of programming for 5 days per week. In some cases, the patient may ultimately require inpatient psychiatric care despite the partial hospitalization services. However, in most cases, as the patient's symptoms diminish and functional goals are achieved, the frequency of attendance is reduced to 4 days and, later, to 3 days. Once the patient's participation drops to this level, the need for partial hospitalization services in lieu of inpatient psychiatric care is not generally indicated and the patient would be discharged to a lower level of outpatient psychiatric care.

Under the current reasonable cost payment system, providers report the total number of units for each partial hospitalization service furnished during the billing period. As noted earlier, hospitals are also required to report claims for services using HCPCS codes. Payment for the additional overhead cost of supportive staff and recordkeeping for a comprehensive day program of services would be built into the provider's charge structure for covered partial hospitalization services and paid through the cost report settlement process.

Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we believe that a per diem payment for

partial hospitalization services is a more appropriate methodology than billing for each component of a partial hospitalization program. A packaged, per diem approach is used by other governmental and private payers when paying for partial hospitalization services. In order to determine the median cost for the partial hospitalization APC group, we analyzed the components reported for each partial hospitalization service over the course of a billing period and established a per diem payment rate. This analysis resulted in an APC payment rate of \$208.25 per day, of which \$46.78 is the beneficiary's copayment.

As noted above, partial hospitalization providers currently report the total number of units for each service billed. We have revised the billing instructions to require CMHCs to report HCPCS codes and to require hospitals and CMHCs to report the date of each service, effective October 1, 1998. We welcome information from the public to assist us in refining the median cost for a day of partial hospitalization. We are particularly interested in information concerning the mix of services that constitute a typical partial hospitalization day.

We have not established a group to represent a half-day of partial hospitalization, although we are aware that other governmental and private payers have adopted both a full and half-day rate for partial hospitalization. For example, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) recognizes a day with at least 6 hours of programming as a full day, while days with at least 3 programmed hours, but less than 6, are paid a per diem rate equal to 75 percent of the full day rate. However, the CHAMPUS per diem is not tied to the cost of certain covered services, but rather to the number of programmed hours the patient attends. As noted above, we will begin to collect information October 1, 1998, regarding which services are furnished each day. Once we have analyzed this information, we will be able to determine the extent to which half-days are used typically in partial hospitalization treatment planning. We are interested in public comments regarding whether we should establish a half-day partial hospitalization group.

We have also decided not to propose a minimum number of hours or units of covered services that constitute a partial hospitalization day at this time. However, we are concerned that a low frequency of participation, either very few days per week or few covered

services per day, indicate that the partial hospitalization program is no longer reasonable and necessary and the patient could be managed in a less intensive level of outpatient treatment or periodic office visits. Fiscal intermediaries in performing medical review of claims will continue to make decisions regarding whether the services furnished a patient are covered and payable as partial hospitalization services. As noted above, CHAMPUS has established a minimum of 3 hours of service for payment of their partial hospitalization per diem amount. We are specifically requesting public comment on adopting a minimum number of services for Medicare payment purposes.

We note that many other payers have established an annual limit on the number of covered partial hospitalization days. There is currently no duration limit on the Medicare partial hospitalization benefit. Rather, in order to be covered by Medicare, partial hospitalization services must be reasonably expected to improve or maintain the patient's condition and to prevent relapse or hospitalization. For most psychiatric patients, particularly those with long term, chronic conditions, control of symptoms and maintenance of a functional level to avoid hospitalization is an acceptable expectation of improvement. It is not necessary for a course of partial hospitalization services to have, as its goal, restoration of the patient to the level of functioning exhibited prior to the onset of the illness. Some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant improvement is not expected. Continued coverage after this point may be dependent upon evidence that the patient is not able to maintain stability with less intensive treatment. Although we are not proposing a duration standard for partial hospitalization at this time, we are concerned that there is significant variation in duration of treatment. We solicit data that show treatment duration from providers of partial hospitalization services. We are also considering specifying a timeframe for periodic physician recertification of need for partial hospitalization services as a method to ensure that a patient's individual needs continue to require the intensity of a partial hospitalization program.

Finally, we are concerned about the impact of establishing a per diem payment for partial hospitalization on the provision of other outpatient mental health services. Patients should be

referred to the outpatient mental health treatment program that best suits their individual needs. Partial hospitalization programs differ from other outpatient mental health treatment programs in the intensity of the program, the frequency of participation, and the patient's need for a comprehensive structured program of services. Upon discharge from a partial hospitalization program, a patient's symptoms and level of functioning will have stabilized to the point that the intensity of a partial hospitalization program is no longer necessary. We are concerned that providing a per diem payment for partial hospitalization services may discourage timely discharge. For this reason, medical review by fiscal intermediaries will continue to focus on patients' initial and continued eligibility for partial hospitalization services.

As noted previously, once we have complete encounter data on which to base the per diem partial hospitalization rate, the per diem will represent the median cost of services furnished on a typical day. As such, it will not be based on the cost of each service furnished on a particular day. Since partial hospitalization represents the most intensive outpatient program and we will have established the median cost of furnishing a day of partial hospitalization services, it does not seem appropriate to pay more for other, less intensive outpatient psychiatric programs. For this reason, we are specifically requesting public comment on establishing a limit on routine outpatient mental health services furnished on a given day to equal the partial hospitalization per diem amount.

6. Comments on Specific APCs

APCs 061–064. We created separate (that is, unpackaged) groups for various chemotherapeutic agents because we believed that some agents had high costs that would not be recognized if those drugs were packaged into the median cost for the chemotherapy administration. We solicit comment on whether to package these costs into the chemotherapy delivery codes in the final rule. We request that commenters identify high-cost chemotherapeutic agents that would not be adequately recognized if packaged or that may require a separate payment or higher payment grouping.

APC 226: This group represents the facility costs for making custom maxillofacial prosthetics. There are few claims, and the median cost is very low compared to the practice expenses associated with these claims on the Medicare physician fee schedule. We assume poor coding accounts for the

anomalous cost. However, it may be that these services are not performed in hospital outpatient departments; they may actually be performed by maxillofacial surgeons in their offices or by dental laboratories. We welcome comments on whether these services are actually provided in the outpatient hospital setting and the resources involved.

APC 317 (Cochlear device implantation): The few claims in our database for this procedure have such disparate costs that we are uncertain of the appropriate assignment of the surgery. The device is paid for from the DMEPOS fee schedule. We solicit comments on whether the implant procedure itself resembles procedures in another APC group to which it could be appropriately assigned.

APCs with a status indicator of "V": The groups that represent medical visits in clinics and emergency departments are based on a matrix, with intensity represented by six levels of CPT codes combined with 20 categories of ICD–9 codes indicating diagnosis or condition. Although current instructions require hospitals to use a CPT code to bill for medical visits, we permit hospitals to bill for all medical visits under a single code (99201) unless a hospital chooses to be more specific. In 1997, our data show code 99201 accounting for 22 percent of all medical visits billed, which we surmise is an overstatement of the incidence of the lowest level clinic visit. With the implementation of the hospital outpatient PPS, we will require hospitals to begin coding medical visits with greater specificity. As a result, we expect to see an increase in the relative incidence of higher level medical visits and emergency visits and a proportional decrease in the relative incidence of the lowest level clinic visit. We will monitor claims by provider for unexplained increases in the total number of visits or in the proportion of visits billed at the highest levels. Use of HCPCS codes should conform with the CPT clinical examples of cases in each code level.

Because the layout of the outpatient claim form does not allow a HCPCS code to be linked to more than one ICD–9–CM code, the form properly accounts for only one medical visit per claim. When two or more medical visits occur on the same day for different diagnoses, a separate claim would be created for each visit, showing the appropriate level of CPT code and the related diagnosis. We would expect this to occur only in those hospitals that operate many outpatient clinics dedicated to various conditions, such as a diabetes clinic, arthritis clinic, etc. Clinics in which a

patient is seen for one or a number of conditions by one health care professional, such as in a primary care clinic, would bill for only one clinic visit for that encounter.

A medical visit would not be billed simply because a patient has presented to a hospital for a service such as chemotherapy, cardiac rehabilitation, an x-ray, etc.

We propose not to pay for a medical visit that takes place on the same date of service as a scheduled outpatient surgery. Registration of the patient, taking of vital signs, insertion of an IV, preparation for surgery, etc., are packaged into and paid for as part of the APC group to which the surgical procedure or service is classified.

In cases where a surgical procedure or service is performed as the immediate result of an outpatient visit (such as the removal of skin lesions following a visit to a dermatology clinic) or from an emergency department visit, the visit would be billed with a modifier –25, indicating that a separately identifiable evaluation and management service was furnished.

APCs 667 and 668: These groups, for cataract surgery without and with insertion of an IOL, should require different resources, because 667 should not include the cost of an IOL. Because the median costs of the two groups are identical, we assume that hospitals were not correctly coding some cases. Therefore, we have reduced the median cost of 667 by \$200 to reflect the resources associated with an IOL. We arrived at this figure by allowing the \$150 that was allowed for an IOL as the ASC portion of the blended amount formerly paid, and by assuming that the recognition of hospitals' costs under the blend would result in the hospital IOL "allowance" being higher than the ASC's. This reduction will have a very small overall effect, because the services in APC 668 were billed more than 225 times as often as those in APC 667. This also leads us to believe that the data we have for the services in APC 668 are more likely to represent accurate information.

APC 670: This group packages payment for the acquisition costs of corneal tissue with the payment for the corneal transplant surgery. It has been brought to our attention that the costs of acquiring corneal tissue vary widely from one locality to another, so that packaging may not be a reasonable way to handle these costs. We are specifically soliciting comments on the issue of packaging corneal tissue costs. We are also soliciting suggestions for alternate ways to pay for corneal tissue, if the comments and supporting data we

receive indicate that packaging is not an appropriate way to treat these costs.

APCs 761 and 762, and 791 and 792: These groups are anomalous, because the group entitled "Complex" in each case has a lower weight than the one entitled "Standard." This has to do with the cost of the procedure itself compared to the cost of the radionuclide involved. We are working with the Society for Nuclear Medicine to correct these anomalies.

APCs 902 and 903: We had very few bills for the vaccines in these groups (902 includes polio vaccine and DPT; 903 includes vaccines for rabies and plague). We are considering combining the two groups. We solicit comments on vaccine costs to supplement our data.

APCs 091 and 91191: Brief psychotherapy encounters can be identified by either a CPT code (as in APC 091) or a low- or mid-level visit with a psychiatric diagnosis (APC 91191). We determined the median costs for these bills taken together, because we believe that there are no differences in the facility resources used in these instances. In the case of other psychiatric encounters, we believe that clinic services at the highest level should be the equivalent of an extended psychotherapy encounter. Mid- and high-level emergency room encounters should be billed by evaluation and management CPT codes and psychiatric diagnoses.

APC 921: Although the addenda refer to this APC, in fact diabetic education services will be paid under the physician fee schedule, which will establish rates for one-on-one sessions and group sessions. The addenda will be corrected in the final rule. (A proposed rule titled "Medicare Program; Expanded Coverage for Diabetes Outpatient Self-Management Training Services" is under development.)

APCs 981 and 982: These groups represent nerve and muscle tests. We are continuing to evaluate whether these two groups should be combined in the final rule, because there is very little distinction between them in our cost data.

We are still examining ways to pay for drugs outside the composite rate for ESRD patients, and the services to be paid under our system in CORFs, HHAs, and hospices. These will be APCs, based on services that are packaged in our system.

7. Discounting of Surgical Procedures

Under hospital outpatient PPS, we will discount payment amounts when more than one procedure is performed during a single operative session or when a surgical procedure is terminated

prior to completion. The discount policy explained below is consistent with Medicare policy and regulations governing payment for physician and ASC surgical services.

a. Reduced Payment for Multiple Procedures

When more than one surgical procedure (defined as those HCPCS codes in APC groups with status "T") is performed during a single operative session, we propose that the full Medicare payment amount and beneficiary copayment amount would be paid for the procedure having the highest APC payment rate. Fifty percent of the normal Medicare payment amount and beneficiary copayment amount would be paid for all other procedures performed during the same operative session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

b. Discounted Payment for Terminated Procedures

Under outpatient PPS, the hospital will use modifiers to indicate procedures that are terminated prior to completion. Modifier-52 (Reduced Services) is used to identify a procedure that is terminated after the patient has been prepared for surgery, including sedation when provided, and taken to the room where the procedure is to be performed, but *before* anesthesia is induced (for example, local, regional block(s), or general anesthesia). Fifty percent of the normal Medicare payment amount and beneficiary copayment amount would be paid for a procedure terminated before anesthesia is induced.

Modifier-53 (Discontinued Procedure) is used to indicate that a surgical procedure was started but discontinued *after* the induction of anesthesia (for example, local, regional block, or general anesthesia), or *after* the procedure was started (incision made, intubation begun, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient. To recognize the costs incurred by the hospital to prepare the patient for surgery and the resources expended in the operating room and recovery room, the full Medicare payment amount and beneficiary copayment amount would be paid for a procedure that was started but discontinued after the induction of anesthesia or after the procedure was started, as indicated by a modifier-53.

The elective cancellation of procedures would not be reported. If multiple procedures were planned, only the procedure actually initiated would be billed. A pattern of canceled procedures will prompt medical review of the reasons for cancellation and may trigger review of the appropriateness of patient selection for outpatient surgery.

8. Inpatient Care

In recent years, the distinction between inpatient and outpatient care has been blurred by the retention of outpatients in the hospital overnight, sometimes for many days in a row. Medicare paid for observation services while the hospital determined whether an outpatient needed admission for further treatment. Frequently, the patients did not understand that they were not inpatients until they were billed for 20 percent of outpatient charges as copayment. In November 1996, we put in place a policy limiting outpatient observation services to a maximum of 48 hours. We made clear at that time that observation was not a means to make it possible to perform inpatient surgery on an outpatient basis, nor was it appropriate to retain chemotherapy patients in long-term observation. Because observation is not provided as the sole service a patient receives, we packaged costs associated with observation into the median costs for the services, for example, surgery or chemotherapy, with which they were furnished in 1996.

There are procedures that, by their nature, require inpatient care. Open abdominal surgery requires a postoperative recovery period, for example, to ensure that bowel function resumes. Certain major surgeries require monitoring in an intensive care unit until the patient's neurological or other function returns. Yet other surgeries involve large or delicate surgical wounds that require monitoring, skilled dressing changes, and fluid replacement. These procedures obviously require inpatient care, and performing them on an outpatient basis would clearly jeopardize patient health and safety. Other procedures are not as clearly defined as inpatient, but we have classified them as inpatient because they are performed on an inpatient basis virtually all the time for the Medicare population, either because of the invasive nature of the procedures, the need for postoperative care, or the underlying physical condition of the patient who would require such surgery. These procedures are not classified in an outpatient APC group, and no payment is provided for these procedures under the hospital

outpatient PPS. We will deny payment for claims that are submitted for these procedures furnished as outpatient services because performing these procedures on an outpatient basis is not safe or appropriate, and therefore not reasonable and necessary under Medicare rules. Because we base these denials on the exclusion in section 1862(a)(1)(A) of the Act and in § 411.15(k)(1), beneficiaries may be protected from liability by the limitation on liability provision of section 1879 of the Act.

The procedures that we consider appropriate and safe only in an inpatient setting and for which we are excluding payment under the hospital outpatient PPS are listed in Addendum H to enable hospitals to make appropriate site of care decisions. This list represents national Medicare policy and is binding on fiscal intermediaries and peer review organizations, as well as on hospitals and Medicare participating ASCs.

We acknowledge that we have classified in outpatient APC groups some procedures that may seem closely related to procedures that we are excluding from the outpatient PPS on the basis of their status as inpatient procedures. We expect that when the former are performed in the outpatient setting, they will be only the simplest, least intense cases. The fact that a service is included in an APC group under the hospital outpatient PPS should not be construed to mean that the procedure may only be performed in an outpatient setting. In every case, we expect the surgeon and the hospital to assess the risk to the individual patient and to act in that patient's best interests.

C. Calculation of Group Weights and Rates

1. Group Weights

Section 1833(t)(2)(C) of the Act requires the Secretary to develop relative payment weights for covered groups of hospital outpatient services. The statute requires that such weights be developed using 1996 hospital outpatient claims and the most recent available hospital cost reports. We are required to base these weights on median hospital costs. In constructing the database to model the outpatient PPS proposal, we used a universe of approximately 98 million calendar year 1996 final action claims for hospital outpatient department services received through June 1997 to match to the most recent hospital cost reports available.

To derive weights based on median hospital costs for services in the hospital outpatient APC groups, we

needed to convert billed charges to costs and aggregate them to the procedure or visit level. To do this, we first identified the cost-to-charge ratio that was specific to each hospital's cost centers ("cost center specific cost-to-charge ratios" or CCRs). We then developed a crosswalk to match the hospital's CCRs to revenue centers used on the hospital's 1996 outpatient bills. The CCRs included operating and capital costs but excluded costs associated with direct graduate medical education and allied health education. (Medicare payment for direct graduate medical education is made as a pass-through under the inpatient PPS and includes the costs associated with approved educational activities for residents assigned to the hospital's outpatient department. We discuss in elsewhere in this proposed rule how we would make payment for allied health education.)

Our next task was to identify each hospital's most recent available cost report from which to determine the hospital's CCRs. Because there is generally a 2-year lag between claims adjudication and cost report filing, the most recent cost reports that we could expect to be available to associate with calendar year 1996 claims were those from PPS-12 (cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995). We searched the PPS-12 period first to match the 1996 final action claims to a cost report. If we achieved a match, no other action was needed. However, if no match was found, we next searched for a cost report in the PPS-11 period and subsequently in the PPS-10 period, if necessary.

If the most recent available cost report that we used for a provider was one that had been submitted but not settled, we calculated an adjustment factor to adjust for the differences that exist between settled and "as submitted" cost reports. We determined the adjustment factor by dividing the outpatient department cost-to-charge ratio from the hospital's most recent settled cost report by the outpatient department cost-to-charge ratio from the hospital's "as submitted" cost report for the same period. We used the resulting ratio to adjust each of the CCRs in the hospital's most recent "as submitted" cost report. We repeated this process for every hospital for which the most recent available cost report was a cost report that had not been settled.

The Office of Inspector General (OIG) is concerned that the cost reports we are using may reflect some unallowable costs. Therefore, the OIG, in conjunction with HCFA, is proposing to examine the extent to which the cost reports used reflect costs that were inappropriately

allowed. If this examination reveals excessive inappropriate costs, we would address this issue in a future proposed rule, or perhaps seek legislation to adjust future payment rates downward.

When this process was completed, we were able to match revenue centers from approximately 83 million claims to CCRs of approximately 5,600 hospitals. We excluded from the crosswalk approximately 15 million claims in which the bill type denoted services that would not be covered under the PPS, for example, bill type 72X for dialysis services for patients with ESRD. The table below shows the three cost reporting periods we used and the percentage of the cost reports within each PPS period with which we were able to match 1996 claims. The most recent cost reports available to us were from the hospital inpatient PPS-12 period, and 95.8 percent of the most recent cost reports available to us matched the 1996 claims that we are required to use as the basis for establishing relative payment weights for the APC groups in the outpatient PPS.

Reporting period	Percentage of cost reports matched
PPS-12 (cost reporting period beginning on or after 10/1/94 and before 10/1/95)	95.8
PPS-11 (cost reporting period beginning on or after 10/1/93 and before 10/1/94)	3.7
PPS-10 (cost reporting period beginning on or after 10/1/92 and before 10/1/93)	0.5
	100.0

We next separated the estimated 83 million claims that we had matched with a cost report into two distinct groups: single-procedure claims and multiple-procedure claims. Single-procedure claims are those for which the HCPCS to be grouped to an APC is the only code that appears on the bill, other than laboratory and incidentals such as venipuncture. Multi-procedure claims included more than one HCPCS code that could be mapped to an APC. There were approximately 37 million single-procedure claims and 46 million multiple-procedure claims.

To calculate median costs for services within an APC, we used only the single-procedure bills. (Of the roughly 37 million single-procedure claims, about 11 million were excluded from the conversion process largely because the only HCPCS codes reported on the claims were for laboratory procedures.)

This approach was taken because of our inability to specifically allocate charges or costs for packaged items and services such as anesthesia, recovery room, drugs, or supplies to a particular procedure when more than one significant procedure or medical visit was billed on a claim. Use of the single-procedure bills minimizes the risk of improperly assigning costs to the wrong procedure or visit. Although single-procedure/visit bills were used for determining APC relative payment weights, the multiple-procedure bills were used in the service mix calculations, regressions, and impact analyses.

For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. If the appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or to the hospital's overall cost-to-charge ratio for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as noncovered under this PPS, for example, laboratory, ambulance, and therapy services.

To calculate the per-procedure or per-visit costs, we used the charges shown in the revenue centers that contained items integral to performing the procedure or visit. These included those items that we previously discussed as being subject to our proposed packaging provision. For example, in calculating the surgical procedure cost, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, blood, pharmacy, anesthesia, cast and splints, and donor tissue, bone, and organ. For medical visit cost estimates, we included charges for items such as medical and surgical supplies, drugs, observation, and blood. A complete listing of the revenue centers we used is included elsewhere in this preamble.

To standardize costs for geographic wage variation, we divided the labor-related portion of the operating and capital costs for each billed item by the hospital inpatient prospective payment system wage index published in the **Federal Register** on May 8, 1998 (63 FR 25575). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor, but this factor is sensitive to other payment adjustments. Therefore, we will restandardize costs in the final rule using FY 1999 hospital inpatient PPS wage index values and the final labor market share value. A more detailed

discussion of wage index adjustments is found below (section V.E. of this document).

We then added the standardized labor-related cost to the non-labor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit. We trimmed standardized procedure and visit costs to remove extremely unusual costs that appeared to be errors in the data. The trimming methodology is analogous to that used in calculating the DRG weights for the inpatient PPS: any bills with costs outside of 3 standard deviations from the geometric mean were eliminated. The geometric mean and the associated standard deviation are used because the distribution of costs more closely resembles a lognormal distribution than a normal distribution; there are no negative costs, and the average cost is greater than the median cost. Using the geometric mean has the effect of minimizing the impact of the most unusual bills in the determination of the mean. The geometric mean is calculated by taking the mean of the natural logarithm cost. Since the distribution of the natural logarithms of a set of numbers is more compact than the distribution of the numbers themselves, bills with extreme costs do not appear as extreme as they would if non-logged costs were examined. This ensures that only the most unusual data will be removed from the calculation.

After we trimmed the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC. We calculated the median cost for each APC weighted by procedure volume.

Using these median APC costs, we then calculated the relative payment weights for each APC. We decided to scale all the relative payment weights to APC 91336, a mid-level clinic visit for cardiovascular services because it is one of the most frequently performed services. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. By assigning APC 91336 a relative payment weight of "1.0," hospitals can easily compare the relative relationship of one APC to another. Next, we divided the median cost for each APC by the median cost for APC 91336 to derive the relative payment weight for each APC.

2. Conversion Factor

Section 1833(t)(3)(C)(i) of the Act requires that we establish a conversion factor for 1999 to determine the Medicare amounts for each covered group of services. The statute mandates

that the conversion factor be established on the basis of the weights and aggregate projected utilization for 1999 and based on the base amount of payments described in section 1833(t)(3)(A) of the Act. Such base amount is calculated for the services included in the outpatient PPS, as an estimate of the sum of (1) total payments that would be payable from the Trust Fund under the current (non-PPS) payment system in 1999 plus (2) the beneficiary copayments that would have been made under the new (PPS) system in 1999. Section 1833(t)(3)(C)(ii) of the Act further requires that the Medicare amount take into account all appropriate adjustments.

Although section 1833(t)(2)(C) of the Act requires us to project utilization for hospital outpatient services, we were unable to project precisely increases in the volume and intensity of services because we were not able to quantify some of the factors that affect utilization. For instance, we would anticipate that Medicare beneficiaries that choose to migrate to managed care plans may be healthier than those who choose to stay in fee-for-service plans. Thus, we could assume a decrease in the volume of services but an increase in the intensity of services furnished for Medicare beneficiaries enrolled in fee-for-service plans. Another factor that we believe will affect future utilization is the incentive to code HCPCS accurately to receive payment. Currently, hospitals are paid for the majority of the outpatient services they furnish on a cost basis. Claims without a HCPCS or an invalid HCPCS are not always rejected. In contrast, under the new PPS, hospitals would be required to use HCPCS codes and, for medical visits and emergency room services, ICD-9 codes, in order to receive payment. We expect that frequencies may increase as a result of the coding requirements. All in all, these are factors we believe will affect the reporting of volume and intensity of services, but we were not able to quantify these assumptions individually to project 1999 utilization. Therefore, we used what we believe to be a more reliable and valid approach to computing the conversion factor under the methodology described below.

Setting the Rates

In order to convert the relative weights determined for each APC (see previous section) into payment rates, we calculated a conversion factor that would result in payments to hospitals under the PPS in 1999 equaling the total projected payment specified in section 1833(t)(3)(A) of the Act. The prospective payment rate set for each APC is

calculated by multiplying the APC's relative weight by a conversion factor. We computed the conversion factor by first adding together for calendar year 1996 the aggregate Medicare hospital outpatient payments paid under the current cost-based payment system (referred to in this section as current law payments) plus the estimated beneficiary copayment amounts that would be paid under the outpatient PPS for the same services. We then divided that amount by the sum of the relative weights for all APCs under the hospital outpatient PPS. The methodology we followed to determine current law Medicare hospital outpatient payments and beneficiary copayments is discussed in section V.C.2.a., below, which is followed in section V.C.2.b. by a discussion of the sum of the relative weights.

a. Calculating Aggregate Calendar Year 1996 Medicare and Beneficiary Payments for Hospital Outpatient Services (Current Law)

First, to calculate Medicare hospital outpatient payment amounts under current law (that is, before PPS), we identified calendar year 1996 single and multiple procedure bills for all the services that we will recognize under the outpatient PPS. As we identified services that will be paid under the outpatient PPS, we eliminated invalid or noncovered HCPCS codes.

Hospital payments include both operating and capital costs for the HCPCS coded services for which payment is to be made under the outpatient PPS. We summed both of these types of costs by HCPCS at the provider level. Summarizing the data in this manner allows us to simulate provider payment on an aggregate basis. We then applied the legislated capital cost reductions of 10 percent and operating cost reductions of 5.8 percent, as required by section 4522 of the BBA.

We determined for each HCPCS code the applicable payment methodology under current law. We then calculated current law payment for procedures in the baseline using one of the following equations, as appropriate:

- For radiology procedures paid for under the radiology fee schedule, payment is determined in the aggregate for each provider as the lower of cost, charge, or blended amount. The radiology blended amount is determined by the following equation: $(0.42 \times \text{lower of cost or charge minus beneficiary copayment}) + (0.58 \times ((0.62 \times \text{global physician fee schedule amount}) - \text{beneficiary copayment}))$

- For surgical procedures for which Medicare pays an ASC facility fee, payment is determined in the aggregate for each provider as the lower of the cost, charge, or blended amount. The ASC blended amount is determined by the following equation:

$$(0.42 \times \text{lower of cost or charge minus beneficiary copayment}) + (0.58 \times (\text{ASC payment rate} - \text{beneficiary copayment}))$$

- For diagnostic procedures paid under the diagnostic fee schedule, payment is determined in the aggregate for each provider as the lower of cost, charge, or blended amount. The blended amount is determined by the following equation:

$$(0.50 \times \text{lower of cost or charge minus beneficiary copayment}) + (0.50 \times ((0.42 \times \text{global physician fee schedule amount}) - \text{beneficiary copayment}))$$

For all other covered services not subject to one of the blended payment method categories, payment is determined to be the lower of costs or charges less beneficiary copayment. Because the formula-driven overpayment (FDO) was corrected beginning October 1, 1997, the blended equations eliminate FDO.

We then determined each provider payment. We summed the aggregate amounts computed for each of the four types of payment methodologies discussed above to determine the Medicare payment amount for each provider. In addition, we also determined the amount of the beneficiary copayment for each provider using the beneficiary copayment amounts that would be paid under the PPS. Summing both the Medicare payment and the beneficiary copayment amounts at the provider level is necessary in order to determine the impact of the outpatient PPS on individual hospitals. In addition to calculating provider payments under the current law and PPS payment systems, we calculated the aggregate Medicare payments under the current system and beneficiary copayments under the PPS for all hospitals for services that are within the scope of the outpatient PPS. The total amount reflects the amount hospitals would be paid under the PPS in accordance with section 1833(t)(3)(A) of the Act and is the numerator in the equation for calculating the unadjusted conversion factor.

b. Sum of the Relative Weights

Next we summed the relative weights. Specifically, we multiplied the volume of procedures or visits (excluding the volume of packaged services) for each

group by the relative weights for each group. We then calculated the conversion factor by dividing the sum of the volume multiplied by the relative weights for each APC into the total payment explained above, including both Medicare payment and beneficiary copayment. The calendar year 1996 conversion factor is \$46.32. To trend forward the 1996 conversion factor to 1999, HCFA's Office of the Actuary estimated an update factor of 1.0939. The update factor represents the estimated per service increase in outpatient Medicare payments and beneficiary copayment between 1996 and 1999 net of changes in the volume and intensity of services. Medicare payments per service were increased by projected CPI-medical items for cost-based services and for blend services mandated updates. Beneficiary copayments were increased by projected increases in CPI-outpatient charges. In estimating the update factor, HCFA's Office of the Actuary assumed that using the national median of the charges for PPS services to establish the unadjusted copayment amount would result in beneficiaries paying 6.9 percent less in coinsurance payments in 1999 than what they would have been expected to pay otherwise, which would create an incentive for a behavioral offset by hospitals of 10 percent of the coinsurance reduction. It was assumed that 45 percent of this offset would apply to the services subject to the PPS and, therefore, would be included in setting the 1999 conversion factor. The remaining 55 percent of the offset would be reflected in expenditures for non-PPS services with both the beneficiary and Medicare absorbing this impact. The adjusted 1999 conversion factor is \$50.67.

D. Calculation of Medicare Payment Amount and Copayment Amount

1. Introduction

In the previous section, section V.C, we explain how we determined national prospective payment rates, standardized for area wage variations, for the APC groups. In this section, we explain how we are proposing to calculate Medicare program payment amounts and beneficiary copayment amounts for each APC group.

Under the statutory provision currently in effect, copayment for hospital outpatient department services is based on 20 percent of the hospital's billed charges. Because most hospital outpatient services have been paid, at least in part, on the basis of retrospectively calculated cost, Medicare payment amounts for most

hospital outpatient services are not known at the time the services are furnished. For that reason, coinsurance could not be based on 20 percent of the payment amount. Accordingly, the statute required that copayment be based on 20 percent of charges. Because charges for hospital outpatient services have increased faster than costs for those services, beneficiaries' copayments of 20 percent of charges have, for some services, accounted for 50 percent or more of the total (Medicare program plus beneficiary) payments to the hospitals. Because of extensive secondary insurance coverage, a large share of the copayments made to hospitals is not direct out-of-pocket expenditures by the beneficiaries. There has, however, been concern that premiums for Medigap policies may be affected by the growing copayment liability. In addition, copayments most directly affect those beneficiaries who do not have supplemental insurance. This group of beneficiaries cannot afford to purchase supplemental insurance, and high copayment rates can be a hardship for those needing services. The outpatient PPS created by section 4523 of the BBA, which added section 1833(t) to the Act, includes a mechanism that is designed to eventually achieve a beneficiary copayment level equal to 20 percent of the prospectively determined payment rate that has been established for the service.

MedPAC Comment: In its March 1998 report to the Congress, MedPAC expresses concern about the inequity represented by the current level of beneficiary copayment liability, which generally exceeds 20 percent of the total payment to hospitals for outpatient services. MedPAC, recognizing that immediate beneficiary copayment reductions to 20 percent of payments made to hospitals would result either in unacceptable increases in program outlays and/or unacceptable reductions in payments to hospitals, agrees with the need for a phased-in approach to the copayment reductions. However, MedPAC recommends that the Congress specify a shorter timeframe than that which results from the provisions of the BBA to phase in fully the appropriate beneficiary copayment contribution of 20 percent for hospital outpatient services paid for under the outpatient PPS.

Response: While we do not disagree with MedPAC's recommendation with respect to beneficiary copayment, because of the budgetary implications and the existing statutory requirements resulting from the BBA, implementation of this recommendation would

ultimately require action by the Congress.

The next sections describe the steps that we followed in accordance with statutory requirements to determine the beneficiary copayment amount and the Medicare program payment amount for services paid for under the hospital outpatient PPS.

2. Determination of Unadjusted Copayment Amount, Program Payment Percentage, and Copayment Percentage

In order to calculate program payment amounts and beneficiary copayment amounts, we first determined for each APC group two base amounts, in accordance with statutory provisions:

- An *unadjusted copayment amount*, described in section 1833(t)(3)(B) of the Act.
- The "pre-deductible payment percentage," which we call the *program payment percentage*, described in section 1833(t)(3)(E).

The steps that we followed to calculate these two base amounts for each APC group are explained below.

(a) Calculate the unadjusted copayment amount for each APC group.

(i) Determine the national median of the charges billed in 1996 for the services that constitute the APC group after standardizing charges for geographic variations attributable to labor costs. (To make the labor adjustment, we divided the portion of each charge that we estimated was attributable to labor costs (60 percent) by the provider's hospital inpatient wage index value, and we added the result to the non-labor portion of the charge (40 percent). Section V.F. provides a detailed discussion of the adjustments made within the outpatient PPS to offset regional differences in labor costs.)

(ii) Update charge values to projected 1999 levels by multiplying the 1996 median charge for the APC group by 29.2 percent, which the HCFA Office of the Actuary estimates to be the rate of growth of charges between 1996 and 1999.

(iii) Multiply the estimated 1999 national median charge for the APC group by 20 percent, which becomes the *unadjusted copayment amount* for the APC group. The *unadjusted copayment amount* is frozen at the 1999 level until such time as the program payment percentage (see below) equals or exceeds 80 percent (section 1833(t)(3)(B)(ii) of the Act).

(b) Calculate the *program payment percentage* (pre-deductible payment percentage). In this proposed rule, we use the term *program payment percentage* to replace the term "pre-

deductible payment percentage," which is referred to in section 1833(t)(3)(E) of the Act. The *program payment percentage* is calculated annually for each APC group, until the value of the program payment percentage equals 80 percent. To determine the program payment percentage for each APC group, we followed these steps:

- (i) Subtract the APC group's unadjusted copayment amount from the payment rate set for the APC group;
- (ii) Divide the difference [(APC payment rate) minus (unadjusted copayment amount)] by the APC payment rate, and multiply by 100. The resulting percentage is the program payment percentage.

Calculation of the program payment percentage allows us to determine a "copayment percentage," which equals the difference between the program payment percentage and 100 percent. As the program payment percentage for an APC group approaches 80 percent due to annual market basket increases of the APC payment rates, the copayment percentage, conversely, approaches 20 percent, which is ultimately the target copayment percentage for all services paid for under the hospital outpatient PPS. When the copayment percentage equals 20 percent of the APC payment rate, we consider the copayment amount for that APC to be fully phased in at the standard Medicare copayment level, as we explain in the next section.

3. Calculation of Medicare Payment Amount and Beneficiary Copayment Amount

a. Calculate the Medicare payment amount. A Medicare payment amount is calculated for every APC group. The Medicare payment amount takes into account wage index and other applicable adjustments and applicable beneficiary deductible amounts. The Medicare payment amount calculated for an APC group applies to all the services that are classified within that APC group. The Medicare payment amount for a specific service classified to an APC group under the outpatient PPS is calculated as follows:

(i) Apply to the national payment rate that is set annually for each APC group the appropriate wage index adjustment (see section V.E. for a discussion of how national APC rates are to be adjusted for geographic wage differences) and any other adjustments applicable to the provider;

(ii) Subtract from the adjusted APC group payment rate the amount of any applicable deductible as provided under § 410.160; and

(iii) Multiply the adjusted APC group payment rate, from which the applicable

deductible has been subtracted, by the program payment percentage determined for the APC group or 80 percent, whichever is lower. The result is the Medicare payment amount.

b. Calculate the copayment amount.

A *copayment amount* is calculated annually for each APC group. The copayment amount calculated for an APC group applies to all the services that are classified within the APC group. The copayment amount for an APC is calculated as follows:

Subtract the APC group's Medicare payment amount from the adjusted APC group payment rate less deductible, for example, $\text{COPAYMENT AMOUNT} = [(\text{adjusted APC group payment rate less deductible}) - (\text{APC group Medicare payment amount})]$. The resulting difference is the beneficiary copayment amount.

Again, as soon as the Medicare program payment percentage of an adjusted APC payment rate less deductible equals or exceeds 80 percent, we set the copayment amount at 20 percent of the adjusted APC group payment rate, and we consider the standard Medicare 20 percent copayment level to be fully phased in for that APC group (section 1833(t)(3)(B)(ii) of the Act). Thereafter, for those APC groups whose program payment percentage has become 80 percent of the APC payment rate (and whose copayment percentage is 20 percent), the unadjusted copayment amount for the APC ceases to be frozen at the 1999 level. The copayment amount for the APC group is permanently established at 20 percent of the adjusted APC group payment rate. Because the copayment amount is now tied directly to the APC payment rate, the copayment dollar amount increases as annual updates increase the APC group payment rate.

For example, assume that the wage-adjusted payment rate for an APC is \$300; the program payment percentage for the APC group is 60 percent; the wage-adjusted copayment amount for the APC group is \$120; and the beneficiary has not yet satisfied any portion of his or her annual \$100 deductible.

- (A) Adjusted APC payment rate: \$300
- (B) Subtract the applicable deductible: $\$300 - \$100 = \$200$
- (C) Multiply the remainder by the program payment percentage to determine the Medicare payment amount: $0.6 \times \$200 = \$120$
- (D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the copayment amount: $\$200 - \$120 = \$80$

In this case, the beneficiary pays a deductible of \$100 and an \$80 copayment. The program also pays \$120, for a total payment to the hospital of \$300. Applying the program payment percentage ensures that the program and the beneficiary pay the same proportion of payment that they would have paid if no deductible were taken.

In the event that the annual deductible has already been satisfied, the calculation runs as follows:

- (A) Adjusted APC payment rate: \$300
- (B) Subtract the applicable deductible: N/A
- (C) Multiply by the program payment percentage to determine the Medicare payment amount: $0.6 \times \$300 = \$180$
- (D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the copayment amount: $\$300 - \$180 = \$120$

In this case, the beneficiary makes a \$120 copayment. The program also pays \$180, for a total payment to the hospital of \$300.

4. Hospital Election To Offer Reduced Copayment

The transition to the standard Medicare copayment rate (20 percent of the wage-adjusted APC payment rate) will obviously be gradual. For those APC groups for which copayment is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. Therefore, the Act offers hospitals the option of electing to reduce copayment amounts and allows the hospital to advertise these reduced rates. In this section, we discuss the procedure by which hospitals can elect to offer a reduced copayment amount, and the effect of such election on calculation of the program payment and beneficiary copayment.

Section 1833(t)(5)(B) of the Act requires the Secretary to establish a procedure under which a hospital, before the beginning of a year, may elect to reduce the copayment amount otherwise established for some or all hospital outpatient department services to an amount that is not less than 20 percent of the hospital outpatient prospective payment amount. The statute further provides that the election of a reduced copayment amount will apply without change for the entire year, and that the hospital may advertise its reduced copayment levels. Section 1833(t)(5)(C) of the Act provides that deductibles cannot be waived. Finally, section 1861(v)(1)(T) of the Act (as established by section 4451 of the BBA)

provides that no reduction in copayment elected by the hospital under section 1833(t)(5)(B) may be treated as a bad debt.

In this rule, we are proposing that a hospital may make the election to reduce copayments on a calendar year basis. The hospital must notify its fiscal intermediary of its election to reduce copayments no later than 90 days prior to the start of the calendar year. This 90-day notification requirement is necessary in order to give the intermediaries sufficient time to make the systems changes required to implement the hospital's election. The hospital's notification must be in writing. It must specifically identify the APC groups to which the hospital's election will apply and the copayment level (within the limits identified below) that the hospital has selected for each group. The election of reduced copayment must remain in effect unchanged during the year for which the election was made. The hospital may advertise and otherwise disseminate information concerning the reduced level of copayment that it has elected.

We also are proposing that a hospital may elect to reduce the copayment amount for any or all APC groups. A hospital may *not* elect to reduce the copayment amount for some, but not all, services within the same APC group.

A hospital may not elect for an APC group a copayment amount that is less than 20 percent of the adjusted APC payment rate for that hospital. In determining whether to make such an election, hospitals should note that the national copayment amount under this system, based on 20 percent of national median charges for each APC, may yield copayment amounts that are significantly higher or lower than the copayment that the hospital has previously collected. This is because the median of the national charges for an APC group, from which the copayment amount is ultimately derived, may be higher or lower than the hospital's historic charges. We, therefore, advise that hospitals, in determining whether to exercise the option of electing lower copayment and the level at which to make the election, carefully study the annual copayment amounts for each APC group in relation to the copayment amount that the hospital has previously collected.

Calculation of copayment amounts on the basis of a hospital's election of reduced copayment for the most part follows the formula described previously. For example, assume that the adjusted APC payment rate is \$300; the program payment percentage for the

APC group is 60 percent; the hospital has elected a \$60 adjusted *reduced* copayment amount for the APC group; and the beneficiary has not satisfied the annual deductible.

- (A) Adjusted APC payment rate: \$300
- (B) Subtract the applicable deductible:
\$300 - \$100 = \$200
- (C) Multiply by the program payment percentage to determine the Medicare payment amount: $0.6 \times \$200 = \$120$
- (D) Beneficiary's copayment is the difference between the APC payment rate reduced by any deductible amount and the Medicare payment amount, but not to exceed the adjusted reduced copayment amount: $\$200 - \$120 = \$80$ (limited to \$60 because of the hospital-elected reduced copayment amount)

In this case, Medicare makes its regular payment of \$120, but the beneficiary pays a \$100 deductible and a reduced copayment amount of \$60, for a total payment to the hospital of \$280 instead of the \$300 that the hospital would have received if it had not made its election.

E. Adjustment for Area Wage Differences

1. Proposed Wage Index

Section 1833(t)(2)(D) of the Act requires that, as part of the methodology for determining prospective payments to hospitals for outpatient services, the Secretary must determine a wage adjustment factor to adjust the portion of payment and copayment attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget-neutral manner.

To determine which wage adjustment factor to incorporate into the hospital outpatient department PPS, we considered several options. One choice would be to use a wage index specific to hospital outpatient department labor costs. However, the Congress did not require us to nor did we have either the time or resources necessary to construct a hospital-outpatient-department-specific wage index.

We next considered the hospital inpatient PPS wage index that HCFA maintains under the Medicare program. The hospital inpatient PPS wage index is well established, and it is constructed specifically for the purpose of "reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level" (section 1886(d)(3)(E) of the Act), a requirement that is analogous to that set forth under

the hospital outpatient department PPS in section 1833(t)(2)(D) of the Act. The data upon which the hospital inpatient PPS wage index is based are collected from Medicare cost reports, and the wage index is updated annually. Any changes in hospital inpatient PPS wage index values must be made in such a manner as to assure budget neutrality (section 1886(d)(3)(E) of the Act). The hospital inpatient PPS wage index for fiscal year 1998 reflects the following:

- Total salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Fringe benefits associated with hospital and home office salaries.
- Direct patient care contract labor costs and hours.
- The exclusion of salaries and hours for nonhospital type services such as SNF services, home health services, or other subprovider components that are not subject to the PPS.

A detailed description of the fiscal year 1999 hospital inpatient PPS wage index is contained in the proposed rule entitled "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 Rates (HCFA-1003-P)" published in the **Federal Register** on May 8, 1998 (63 FR 25575).

We decided that using the hospital inpatient PPS wage index as the source of an adjustment factor for geographic wage differences for the hospital outpatient department PPS was both reasonable and logical, given the inseparable, subordinate status of the outpatient department within the hospital overall. We then had to determine which version of the hospital inpatient PPS wage index to use. There are several possible wage indices that can be developed from the basic wage and salary data taken from hospital cost reports, depending on changes that are applied to the data. One modification takes into account the effect of hospital redesignation under 1886(d)(8)(B) of the Act and hospital reclassification under 1886(d)(10). A second modification results from assigning to an urban hospital the statewide rural wage index value for the State in which that hospital is located when the wage index of the urban hospital would otherwise be lower than the statewide rural wage index value (the "floor"). (In fiscal year 1998, this particular "hold harmless" provision affected 128 hospitals in 32 metropolitan statistical areas (MSAs).) Given the choice between the wage index that we use under the hospital inpatient PPS, which reflects reclassification and other changes, and a wage index that does not incorporate these changes, we are proposing to adopt the wage index that is used to

determine payments to hospitals under the hospital inpatient PPS to adjust for relative differences in labor and labor-related costs across geographic areas under the hospital outpatient department PPS. We note that hospital outpatient department services do not fall under the category of either "nonhospital type services" or of "other subprovider components," which are excluded from consideration in developing the hospital inpatient PPS wage index. We also note that because hospital staff frequently provide services in both the inpatient and outpatient departments, labor costs associated with hospital outpatient department services are generally reflected in the hospital wage and salary data that are the basis of the hospital inpatient PPS wage index.

By statute, we implement the annual updates of the hospital inpatient PPS on a fiscal year basis. However, updates to the hospital outpatient department PPS will be made on a calendar year basis. We are proposing to update the wage index values used to calculate hospital outpatient department PPS Medicare payment and beneficiary copayment amounts on a calendar year basis. In other words, the hospital inpatient PPS wage index values that are updated annually on October 1 will be implemented for the hospital outpatient department PPS on the January 1 immediately following. We are proposing this schedule so that wage index changes are implemented concurrently with any other revisions, such as changes in the APC groups resulting from new or deleted CPT codes, that are implemented on a calendar year basis.

2. Labor-Related Portion of Hospital Outpatient Department PPS Payment Rates

In calculating payments to hospitals under the hospital inpatient PPS, the labor-related portion of expenses within the standardized amounts used to establish the prospective payment rates is multiplied by the hospital wage index value to offset regional wage differences. The fiscal year 1998 labor-related portion under the hospital inpatient PPS is 71.1 percent. The manner in which this portion was calculated is explained in detail in the August 29, 1997 **Federal Register** (62 FR 45993). We note that compensation for wages, salaries, and employee benefits accounts for 61.4 percent of expenses, with the other 9.7 percent attributable to professional fees, postal services, and all other labor-intensive services, as explained in the August 29, 1997 **Federal Register** (62 FR 45995).

Current ASC payment rates are standardized for regional wage differences, and carriers adjust the base rates to calculate payments to individual facilities by multiplying the labor-related portion of the base rate by the appropriate hospital inpatient PPS wage index factor. The labor-related portion of current ASC payment rates is 34.45 percent based on 1986 ASC survey data.

Because of the sequence of steps that we followed to construct the hospital outpatient department services PPS database, we had to estimate the percentage of hospital outpatient department costs attributable to labor in order to standardize hospital outpatient department costs for geographic wage differences. We decided that 60 percent represented a reasonable estimate of outpatient costs attributable to labor, as it falls between the hospital inpatient PPS operating cost labor factor of 71.1 percent and the ASC labor factor of 34.45 percent and is within a percentage point of the labor-related costs under the hospital inpatient operating cost PPS attributed directly to wages, salaries, and employee benefits (61.4 percent) under the rebased 1992 hospital market basket that was used to develop the fiscal year 1997 update factor for inpatient PPS rates (published August 30, 1996 at 61 FR 46187). In addition to considering what percentage of costs is attributed to labor by other payment systems, we considered health care market factors such as the shift of more complex services from the inpatient to the outpatient setting, which could influence labor intensity and costs, and 60 percent seemed appropriate. (As we explain in section V.I. below, regression analysis confirmed the labor percentage to be 60 percent.) We calculated 60 percent of each hospital's total operating and capital costs. We then divided that amount by the provider's 1996 hospital inpatient PPS wage index value to standardize differences in costs that are attributable to geographic wage differences. The total cost of performing a procedure/visit, therefore, includes wage-standardized operating and capital costs, as well as bundled ancillary costs (that is, operating room time, medical/surgical supplies, pharmaceuticals, anesthesia, recovery room, observation, biologicals, etc.) and minor ancillary procedures (for example, venipuncture), as explained in greater detail in section V.C.

The final hospital outpatient department PPS payment rates that would have been effective January 1, 1999 may differ slightly from those proposed in this rule because we intend

to adjust APC payment rates using the fiscal year 1999 hospital inpatient PPS wage index values that are implemented October 1, 1998. The hospital inpatient PPS wage index values proposed for fiscal year 1999 are in the **Federal Register** proposed rule published May 8, 1998 entitled "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 Rates (HCFA-1003-P)" (63 FR 25575).

We are proposing to use the annually updated hospital inpatient PPS wage index values to adjust both program payment and copayment amounts for area wage variations, as we explain below.

3. Adjustment of Hospital Outpatient Department PPS Payment and Copayment Amounts for Geographic Wage Variations

To adjust the APC payment rates and beneficiary copayment rates for outpatient services for geographic wage variations, we are proposing to use the same labor-related percentage (60 percent) that we used initially to standardize costs for geographic wage differences. When intermediaries calculate actual payment amounts, they will multiply the prospectively determined APC payment rate and copayment amount by that labor-related percentage to determine the labor-related portion of the base payment and copayment rates that is to be adjusted using the appropriate wage index factor. That labor-related portion will then be multiplied by the hospital's inpatient PPS wage index factor, and the resulting wage-adjusted labor-related portion will be added to the non-labor-related portion, resulting in wage-adjusted payment and copayment rates. The wage-adjusted copayment amount is then subtracted from the wage-adjusted APC payment rate, and the result is the Medicare payment amount for the service or procedure. Note that even if a hospital elects to discount the copayment, the full copayment amount is assumed for purposes of determining Medicare program payments. (See section V.D. for a discussion of how Medicare program payments are calculated when the Part B deductible applies.)

The following is an example of how an intermediary would calculate the Medicare payment for a surgical procedure with a hypothetical APC payment rate of \$300 that is performed in the outpatient department of a hospital located in Heartland, USA. The copayment amount for the procedure is \$105. The hospital inpatient PPS wage index value for hospitals located in Heartland, USA is 1.0234. The labor-

related portion of the base payment rate is \$180 ($\$300 \times 60$ percent), and the non-labor-related portion of the base payment rate is \$120 ($\$300 \times 40$ percent). The labor-related portion of the base copayment rate is \$72 ($\$120 \times 60$ percent), and the non-labor-related portion of the base copayment rate is \$48 ($\$120 \times 40$ percent). It is assumed that the beneficiary deductible has been met.

Wage-Adjusted Base Payment Rate

(rounded to nearest dollar):

$$= (\$180 \times 1.0234) + \$120$$

$$= \$184 + \$120$$

$$= \$304$$

Wage-Adjusted Base Copayment Rate

(rounded to nearest dollar):

$$= (\$72 \times 1.0234) + \$48$$

$$= \$74 + \$48$$

$$= \$122$$

Calculate Medicare Program Payment Amount:

$$\$304 - \$122 = \$182$$

F. Claims Submission and Processing

Hospitals will receive detailed instructions on claims submission over the coming year. This section provides a brief overview of the process.

In order for APCs to properly capture services furnished, hospitals must assign HCPCS codes to services. Revenue center codes will capture only packaged services (operating and recovery room, pharmaceuticals, medical/surgical supplies, etc.). Correct assignment of codes requires an understanding of the differences among surgical procedures, a knowledge of the extent of effort expended in a clinic visit, etc. We believe that many hospitals currently have surgical records coded using HCPCS in the medical records department. However, many hospital coders are much more familiar with the ICD-9-CM system of classification than they are with HCPCS. Among the sources of education available to update skills, hospitals may want to explore in-service education from a credentialed coder with experience in billing for physicians' and surgeons' services, classes available from local hospital associations or medical record associations, formal classes in local colleges, etc.

Coding conventions in the outpatient setting differ slightly from those in use in inpatient settings. The diagnosis identified on the claim need not be the "principal" diagnosis, as required under DRGs. Instead the diagnosis is the reason for the visit as identified at the time of the visit. It is not necessary to wait to submit the claim until laboratory or x-ray results are known, in an effort to more clearly identify the diagnosis. In billing for clinic and emergency

department visits, the diagnosis should relate to the reason for the visit. A patient who attends several different clinics in one day should have separate claims submitted for each clinic visit, since at this time only one diagnosis can be associated with each claim. We will seek a change to the UB-92 allowing diagnoses to be identified by number, so that each line item can have a diagnosis associated with it.

Another difference from inpatient reporting is that the DRG GROUPER can take every procedure coded and identify the one highest in the surgical hierarchy applicable to the diagnosis, then ignore those that do not affect the DRG. The HCPCS codes, however, are both more numerous and very specific and should be used appropriately, since each code will trigger a payment.

We propose to apply to hospital outpatient claims HCFA's Correct Coding Initiative (CCI). One of the purposes of the CCI is to ensure that the most comprehensive of a group of codes is billed instead of the component parts. For example, G0001 (routine venipuncture) is a component part of 36430 (transfusion of blood or blood components) and should not be separately billed. Similarly, 94760 (pulse oximetry) should not be billed with surgical procedures for which it is a common monitoring technique. In 1997, hospital outpatient claims showed it more than 10,000 times with 45378 (diagnostic colonoscopy). The CCI also checks for mutually-exclusive code pairs. For example, 93797 (cardiac rehabilitation without ECG monitoring) should not be billed simultaneously with 93798 (cardiac rehabilitation with ECG monitoring), which happened nearly 12,000 times in 1997 hospital outpatient claims. We propose to use the CCI edits to ensure that only appropriate codes are grouped and priced.

Carriers have used CCI as an editing tool since January 1996, and have discovered that the vast majority of edits are rarely triggered. However, as shown in the examples above, hospitals' coding patterns could result in inappropriate payments unless such edits are applied. Under the cost reimbursement system, these types of errors did not ultimately result in higher payments to the hospitals; nor did providing wrong numbers in the units field (for example, repeating the revenue code). Again, under this PPS, each unit billed will trigger a payment. Thus, we have created a second set of edits limiting the number of units allowed for each HCPCS code. For example, only "1" will be accepted in the units field for cataract surgery, but for most services

the edit allows for the procedure to be performed a number of times in a day, with an upper limit to reduce obvious errors. Of course, hospitals should report only the actual number of times a procedure was performed, keeping in mind that CPT and HCPCS definitions sometimes specify the units. For example, code 11720 is for debridement of nail(s) by any method; one to five. This code should be reported only once for any number of nails debrided between one and five, inclusive. If more than five nails are debrided, the appropriate code is 11721, debridement of nail(s) by any method; six or more, billed only once in place of 11720.

We propose to require that hospital outpatient and CMHC bills that span more than one day indicate the date of the service for each line item on the bill. Line item dates of service are needed in order to implement the CCI and the units' edits, both of which are applied based on services furnished on the same date.

Further information on billing line item dates of service, using HCPCS to code all claims, and editing will be provided by instructions.

G. Updates

1. Revisions to Weights and the Wage and Other Adjustments

Section 1833(t)(6)(A) of the Act gives the Secretary authority to periodically review and update the APC groups, the relative payment weights, and the wage and the other adjustments that are components of the outpatient PPS, to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

We explained above that we intend to update the wage index values used to calculate program payment and copayment amounts on a calendar year basis, adopting effective for services furnished each January 1 the wage index value established for a hospital under the inpatient PPS the previous October 1.

Recalibration of the APC group weights is another type of revision provided for under the statutory review authority. We define recalibration as the updating of all the APC group weights based on more recent information. We do not intend to make this type of update on an annual basis. For example, we are required to rebase ASC payment rates using survey data that are collected every 5 years. At this time, we would like to solicit comments on how frequently to recalibrate the hospital

outpatient APC weights and on the method and data that should be used.

Section 1833(t)(6)(B) of the Act requires that all revisions to APC groupings, weights, and other adjustments be made in a budget-neutral manner. Adjustments made for a particular year may not cause the estimated amount of expenditures under the outpatient PPS to increase or decrease from the expenditures that we estimate would have been made under the outpatient PPS without any updates or revisions.

2. Revisions to APC Groups

It is our intent to use the same APC surgical groups in the payment systems both for hospital outpatient services and for surgical services furnished by Medicare-approved ASCs. A discussion of the use of APC groups to set payment rates for Medicare-approved ASCs can be found in the proposed rule entitled "Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Surgical Procedures for Ambulatory Surgical Centers Effective October 1, 1998" (HCFA-1885-P) that was published in the **Federal Register** June 12, 1998 (63 FR 32290). In order to maintain comparability of the APC groups across both settings, we are proposing to coordinate our review of comments on the composition of the APC groups that are submitted during the public comment period following publication of both this proposed rule and the ASC proposed rule. We are further proposing to coordinate any adjustments to the composition of the APC surgical groups that may result from our analysis of both sets of comments to ensure that the final APC surgical groups not only reflect and take into account both sets of comments, but also remain comparable for ASCs and hospital outpatient departments to the maximum extent possible within the constraints imposed by statutory and regulatory requirements.

Thereafter, we expect the composition of all the APC groups to remain essentially intact from one year to the next with the exception of the few changes that may be necessary as a consequence of annual revisions to HCPCS and ICD-9 codes. We do not plan to routinely reclassify services and procedures from one APC to another. HCFA will make these changes based on evidence that a reassignment would improve the group(s) either clinically or with respect to resource consumption. All changes in APC groups must be budget neutral, and changes in APC groups will only be made through notice and comment when we implement the annual outpatient PPS update.

We are proposing to follow certain conventions when, as a result of annual HCPCS and ICD-9 revisions, we add new services to the hospital outpatient PPS. As part of the notice and comment process accompanying the annual update of the outpatient PPS, we shall propose the assignment of a newly created code to the existing APC that, in the judgment of our medical advisors, is the most similar clinically and in terms of resource requirements to the new service. Because a new service will not have any charge history or cost data associated with it, classification of a new service to an existing APC group will not alter the APC payment rate, relative weight, and program payment and copayment amounts that have been established for that APC group. The new service will assume the same payment rate, relative weight, and program and copayment amounts that have been established for the APC group to which it is classified.

If the annual revision of HCPCS or ICD-9 result in the deletion of a code or service that is classified in an APC group under the outpatient PPS, we shall remove that service from the APC group and discontinue paying for the service under the outpatient PPS. When a CPT code that contributed cost data to our 1996 database is deleted, we will continue to use the cost data in the APC. This in fact did occur in the psychotherapy set of codes. The codes that were in effect in 1996 have been replaced. If we did not capture these data from those codes, we would not be able to assign a weight to brief psychotherapy visits. As long as the new codes belong in the same APC, in terms of clinical coherence and related resource use, the data are relevant. If the code that contributed data to the 1996 database were revised so that it no longer belonged in the APC to which it was originally assigned, the revised code would be placed in an APC that better matched the new description. As in the case of an entirely new code, no cost data would be available for the revised code, so it would be assigned the weight, program payment rate, and copayment rate of the codes in the new APC. We will not create an APC for an entirely new code, but will assign it for at least 2 years to an existing group while accumulating data on its costs relative to the other codes in the APC.

When we do reclassify a service from one APC group to another, the reclassification will affect the payment rate, the weight, and the payment and copayment amounts for both of the "donor" APC group and the "receiving" APC group if the service that is reclassified was recognized in 1996 and

is reflected in our database. As a result of reclassifying a service that was recognized in 1996 and is reflected in our database, we shall recalculate the payment rate, the weight, and the payment and copayment amounts for both the "donor" APC group and the APC group to which the service is reassigned. If the service that is reclassified was not recognized in 1996 and is therefore not reflected in our database, we shall treat it in the same manner that we treat the addition of altogether new services and the removal of services that are deleted from HCPCS and ICD-9, that is, reclassifying the code will have no effect on the payment rate, relative weight, and payment and copayment amounts for either the donor APC or the receiving APC, and the reclassified code will assume the payment rate, relative weight, and payment and copayment amounts of the APC to which the service is reclassified.

3. Annual Update to Conversion Factor

Section 1833(t)(3)(C)(ii) of the Act requires us to update annually the conversion factor used to determine APC payment rates. Section 1833(t)(3)(C)(iii) of the Act provides that the update be equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act, reduced by one percentage point for the years 2000, 2001, and 2002. We also have the option (under section 1833(t)(3)(C)(iii)) of developing a market basket that is specific to hospital outpatient services. We are considering this option, and we solicit comments on possible sources of data that are suitable for constructing a market basket specific to hospital outpatient services.

H. Outlier Payments

Section 1833(t)(2)(E) of the Act requires us to establish in a budget-neutral manner other adjustments that we determine are necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals. We considered several factors to evaluate the necessity of an outlier adjustment policy.

The most relevant factor is that the proposed system has minimal packaging. Unlike the DRG system for inpatient services, where a patient can be classified into only one payment group during an inpatient stay, payment can be made for a number of APC groups for a given patient on a given day. If multiple services are delivered, payments will be made for multiple APCs. Because a hospital will receive payment for each service furnished, we

believe this greatly reduces the need for an outlier adjustment.

Another relevant factor is that critical care services have been isolated into their own APC. Payment for the critical care APC is based on median hospital costs of critical care services. Therefore, payments for this group will reflect the intensity and associated higher costs of this type of medical care.

Even if critical care is not delivered, higher payment will be made for more serious cases. Payments for medical visits to the emergency room will be made at three incremental levels of intensity, and additional payments will be made for any other laboratory work, x-rays, or surgical interventions resulting from the visit.

Upon consideration of the above factors, we do not believe that an outlier adjustment is necessary to ensure equitable payments.

I. Adjustments for Specific Classes of Hospitals

As part of the analysis to determine whether payment adjustments would be proposed for the outpatient prospective payment system, we conducted extensive regression analysis of the relationship between outpatient hospital costs (calculated as hospital outpatient operating and capital cost per unit) and several factors that affect costs. The latter included variables used in estimating similar models for the inpatient PPS, as well as several variables unique to hospital outpatient departments. We considered all costs and services for each hospital relevant to the proposed payment system. Ultimately, we decided not to propose any adjustments to the Federal payment other than the wage index used to adjust for local variation in labor costs at this time. While this reflects a difference in policy relative to inpatient PPS, the proposed outpatient PPS is fundamentally different. Specifically, the outpatient system has limited packaging, so variations in costs are limited to the resources used to produce a single procedure. Cost variations in the inpatient system, however, also can be attributed to variation in the intensity of services bundled under a single rate. Therefore, variations in outpatient cost per unit among hospitals are expected to be small relative to the variations in inpatient cost per discharge that have been estimated in the past.

We began our analysis by examining the distribution of service mix and cost per unit (or cost per service) among various types of hospitals. This analysis revealed some extreme values of cost per unit among types of hospitals, especially major teaching hospitals,

hospitals with trauma centers, and eye and ear hospitals. These costs were 200 percent to 400 percent higher than the average cost per unit for all hospitals. Because costs are measured on a per unit basis, values of this magnitude suggested problems both with identifying procedure codes and properly entering the correct unit of measurement (times performed, minutes of treatment, etc.). Under the current payment system, hospitals will be fully reimbursed for their services even if claims do not contain all the procedure codes that would be associated with revenue centers billed. A consistent practice of such under-coding would lead to very high costs associated with a single unit.

The presence of these extreme values also suggested that a few hospitals could unduly influence the distribution of hospital outpatient cost per unit in our regression analysis. Individual bills were not edited for extreme unit costs. However, even removing cost outliers at the bill-level might not have eliminated these extreme variations at the hospital level. A single under-coded bill might not meet outlier thresholds, but the combined effects of coding differences on all of a hospital's bills could create much higher or lower unit costs.

In light of the lack of trimming for outlier/error costs at the bill level, the possibility of outlier hospitals skewing the distribution of cost per unit, and the hospital-level analysis for payment adjustments argued for an edit on cost per unit at the hospital level. The distribution of cost per unit more closely resembles a lognormal distribution than a normal distribution; there are no negative costs and the average cost is greater than the median cost. We identified outliers using the mean and standard deviation of the natural logarithm of cost per unit. Taking the natural logarithm of any variable compresses the distribution and minimizes the impact of the most unusual bills in the determination of the mean. The compressed distribution also makes it more difficult to identify outliers.

We removed 83 hospitals through an edit of three standard deviations from the mean of the logged unit costs: 51 hospitals with a logged cost per unit exceeding three standard deviations above the mean and 32 hospitals with a logged cost per unit less than three standard deviations below the mean. Removing outlier hospitals greatly improved the distribution of unit costs among types of hospitals. The exempted Maryland hospitals were also excluded from the analysis. However, we included the 10 cancer hospitals. After

we removed the 54 exempted Maryland hospitals, outlier hospitals, and hospitals for which we could not identify payment variables, we were left with 5,419 hospitals for analysis. Our regression analyses use this set of hospitals.

A variety of regression models have become the standard of practice for examining hospital cost variation and analyzing potential payment adjustments. We looked at two standard models: fully specified explanatory models to examine the impact of all relevant factors that might potentially affect outpatient hospital cost per unit and payment models that examine the impacts of those factors used to determine payment rates. The payment models standardize the dependent variable, hospital outpatient cost per unit, by service mix to capture the relationship between the APC weights and payment under the PPS, rather than a statistical relationship between service mix and costs. Both unweighted regressions and regressions weighted by volume were examined. All regressions employed a double log or semi-log specification. References to logs throughout this discussion refer to the natural logarithm, and the geometric mean is the mean of the natural logarithm of values. Our dependent variable was total hospital outpatient cost per unit.

We used payment variables from the inpatient prospective payment system, including disproportionate share patient percentage, both capital and operating teaching variables (resident to average daily census and resident to bed ratios respectively), and dummy variables to account for location in a rural, large urban, and other urban area. We also looked at a modified teaching variable that reflects outpatient volume, several dummy variables unique to outpatient departments, such as the presence of a trauma unit, and the difference in costs among various types of TEFRA hospitals and cancer hospitals. A discussion of the major payment variables and our findings appears below.

Service Mix Index

Using APC weights and the number of services provided in each APC, we calculated an average APC weight, or service mix, for each hospital. We also calculated a "discounted" service mix that considers the reduced weight for additional surgical procedures performed at the same time, which is consistent with the proposed payment system. The national average service mix is 1.43, and the national average service mix discounted for multiple procedures is 1.45. The differences

between the two are negligible due to the low volume of services subject to discounting, and they proved almost interchangeable in the adjustment regressions. We did use the discounted service mix for our regressions because it reflects the proposed policy.

Since APC weights are calculated from costs, we would expect approximately a one to one, or proportional, relationship between service mix and hospital outpatient cost per unit. That is, we expect the coefficient of the service mix to be one in a regression of outpatient cost per unit on the service mix. However, initial payment regressions of hospital outpatient cost per unit on service mix and the wage index revealed a coefficient of 0.68, suggesting that the calculated service mix increases faster than cost per unit; a 10 percent increase in the service mix is associated with a 6.8 percent increase in costs.

This estimated relationship prompted a preliminary analysis of the relationship between geometric means and median cost per unit within each APC. If per unit cost within APCs is distributed log normally, the median and the geometric mean are equivalent. However, if the distribution of costs within APCs is skewed, then the median may differ from the geometric mean. Because the dependent variable in the regression models is the natural log of hospital outpatient cost per unit, a systematic difference between the geometric mean of cost per unit and median cost per unit could explain the lack of one to one relationship between hospital service mix and hospital cost per service. Weighting the regression equation by the volume of services, essentially giving greater weight to the relationship between service mix and unit costs for hospitals with a higher volume of services, increases the relationship to 7.5 percent. Higher volume hospitals tend to have a higher service mix and higher service costs.

A limited analysis of unit costs for selected APCs demonstrated that, in general, in APCs with low relative weights, median hospital cost per unit is lower than the geometric mean of logged hospital cost per unit, and, in APCs with high relative weights, median hospital cost per unit is generally higher than the geometric mean. This would lead to a greater spread in a hospital's service mix than appears in their actual cost per unit, and would provide an explanation for the less than proportional relationship that was estimated to exist between service mix and cost per unit. A regression of cost per unit on a service mix derived from weights based on the geometric

mean and the wage index demonstrated better correlation; a 10 percent increase in service mix led to a 7.7 percent increase in cost per unit. Weighting this regression equation by the volume of services increases the relationship to 9.1 percent, suggesting that the higher service mix of higher volume hospitals better tracks those hospitals' cost per unit.

Labor Share

The coefficient of the hospital wage index is the estimated percentage change in costs attributable to a 1 percent increase in the wage index. This coefficient provides an estimate of the share of outpatient hospital unit costs that are attributable to labor. Depending on the model specification, the coefficient ranged from 0.51 to 0.68 reflecting a labor share between 50 and 70 percent. The coefficient from a fully specified payment regression of the hospital cost per unit standardized for the service mix on the wage index, disproportionate share patient percentage, modified teaching, rural, and urban variables is approximately 0.60, suggesting a labor share of 60 percent. Even though we ultimately decided that we would not propose additional adjustments, we believe that the coefficient from this specification provides the best estimate of the labor share for the proposed system. This judgment was based on a policy to use a labor share that reflected the relationship between the wage index and costs, rather than the effects of correlated factors. The explanatory regression model that has a dependent variable of unstandardized hospital outpatient cost per unit also implies a labor share of 60 percent across most specifications.

Teaching Intensity and Disproportionate Share Patient Percentage

For the inpatient PPS, the intensity of teaching programs has typically been measured by the resident to bed ratio or resident to average daily census ratio. Early in our regression analysis, we used resident to the average daily census of inpatient days, the teaching variable from inpatient capital PPS. The results suggested that costs increase somewhat with the size of the teaching program ($p < 0.05$). However, we believed that this ratio could not adequately represent teaching hospitals with large outpatient departments relative to the size of their inpatient operations. We modified the resident to average daily census variable to reflect the ratio of residents to combined inpatient and outpatient utilization. To accomplish

this, we calculated the ratio of inpatient costs per day to outpatient costs per unit for each hospital, and we used this ratio to convert hospital services into inpatient day equivalents. We combined both inpatient days and outpatient day equivalents to get a ratio of residents to inpatient and outpatient days. Since we cannot, at this time, allocate residents to inpatient and outpatient settings, we could not estimate a teaching variable based on residents to outpatient volume alone.

We created the disproportionate share patient percentage variable by adding the percentage of inpatient days attributable to Medicaid patients to the percentage of Medicare patients receiving Supplemental Security Income. In most regression specifications, the disproportionate share percentage was positive, small in magnitude, and significant ($p < 0.05$). These coefficients imply that a hospital with a 40 percent disproportionate share percentage would be approximately 4.5 percent [calculated $(e^{DSHP*0.11} - 1) * 100$] more costly than hospitals without any low-income patients. Teaching intensity variables were not significant in unweighted regressions ($p > 0.05$). However, they were positive and significant in regressions weighted by number of services. The teaching coefficient implies that a hospital with a resident to combined inpatient and outpatient "days" ratio of 0.35 would be 2.4 percent [calculated $((1 + IME)^{0.08} - 1) * 100$] more costly than hospitals with no residents.

We also estimated several regression specifications to determine if there were thresholds for the estimated impacts of teaching and disproportionate share patient percentage on costs. We determined that positive and significant estimated differences do not occur for hospitals whose disproportionate share percentage is less than 0.40. Significant effects for the teaching variable do not occur for hospitals whose ratio of residents to inpatient and outpatient days is less than 0.32. We used these results to estimate a new disproportionate share patient percentage based on a 0.30 threshold and a ratio of residents to inpatient and outpatient "days" based on a 0.28 threshold. We chose these thresholds by identifying the point at which the relationship between the unit costs and the teaching intensity or disproportionate share patient percentage becomes positive rather than significant because of the lack of significance associated with the teaching variable and because the small coefficient for the disproportionate share variable led to intermittent

significance for higher values. We subtracted these thresholds from the original variable to create new teaching and disproportionate share patient percentage variables. Subtracting the threshold removes the effect of values that are not significantly related to cost per unit and eliminates the sudden increase (notch effect) in the disproportionate share patient percentage and teaching variable at the threshold level. The new variables suggest that a hospital with a disproportionate share patient percentage 10 points higher than the 30 percent threshold is approximately 2.3 percent more costly [calculated $(e^{DSHP*0.23} - 1) * 100$] and that a hospital with a ratio of residents to inpatient and outpatient utilization 0.07 higher than the 0.28 threshold is approximately 0.75 percent more costly [calculated $((1 + IME)^{0.11} - 1) * 100$].

Urban and Rural Location

We also estimated difference in hospital outpatient costs between rural, large urban, and other urban areas. In almost all of the regression models, both explanatory and payment, the rural dummy variable was positive and significant ($p < 0.05$). Rural hospitals had approximately 8 percent higher standardized unit costs than urban hospitals. In all of the regression models, large urban hospitals were not significantly different from other urban hospitals.

TEFRA and Cancer Hospitals

We also found that some types of TEFRA hospitals (long-term care, children's, and psychiatric) and the ten cancer hospitals have significantly ($p < 0.05$) higher unit costs standardized for service mix. Cancer, children's, and long term care hospitals demonstrated standardized unit costs that were at least 20 percent higher than other hospitals. We believe that these significantly higher costs largely can be attributed to under-coding because proper coding is not required for the payment of many services under the current system, especially medical visits. Poor coding would affect calculations of both service mix and cost per unit.

Estimated Payments

The appropriateness of potential payment adjustments must be based on both cost effects estimated by regression analysis and other factors including simulated payment impacts. We simulated the impact of the proposed system on hospitals by calculating the percentage difference between payments made under current law and payments

under the proposed system (column 3). Section X. contains a more complete table that considers the impact of proposed payments on additional classes of hospitals, including TEFRA and cancer hospitals. Although Column 3 represents the net effect of the new PPS on hospitals, we thought it was necessary to show the impacts on hospitals of simply changing the payment system without including the effects of the overall reduced payment to hospitals because the PPS system is not budget neutral to current payment. To reiterate, the conversion factor is set by summing Medicare payments under the current system and beneficiary copayment under the new system and dividing by the sum of the relative weights. Beneficiary copayments under

the new system will reduce overall payments to most hospitals because 20 percent of the median group charges is less than 20 percent of actual charges. Therefore, we simulated the impacts as though the conversion factor were set as if the system were to be budget neutral. Column 4 demonstrates the distributional impacts resulting from implementing the new system after eliminating the overall reduction in payment most hospitals will experience due to the effect of the methodology used to set the conversion factor. We believe the column 4 percentage differences are what we should examine since any adjustment we would consider should correct for inequities caused by moving to a PPS (not the legislated reduction in total payment).

Therefore, we based our decision about adjustments on these percentage differences rather than percentages combining the PPS and the overall reduction in coinsurance amounts required by law. We also estimated payment to cost ratios associated with the new payment methods and the percent change in total Medicare payments. All simulations used a labor share of 60 percent. The table below shows the results of two simulations. The first contains only the wage index adjustment to the APC rates. The second also includes the threshold adjustments for disproportionate share patient percentage and teaching intensity discussed above.

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CHANGES FOR 1999 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals (1)	Outpatient percent (2)	No Teaching and DSH Adjustments				Teaching and DSH Adjustments			
			Percent change in Medicare Outpatient payment (3)	Conversion Factor removed (4)	Standardized payment to cost ratio (5)	Percent change in total Medicare payments (6)	Percent change in Medicare Outpatient payment (7)	Conversion Factor removed (8)	Standardized payment to cost ratio (9)	Percent change in total Medicare payments (10)
ALL HOSPITALS	5,419	9.9	-3.8	-0.0	1.0000	-0.4	-3.8	-0.0	1.0000	-0.4
NON-TEFRA HOSPITALS	4,864	10.0	-3.7	0.1	1.0011	-0.4	-3.7	0.1	1.0012	-0.4
GEOGRAPHIC LOCATION: URBAN HOSPITALS	2,677	9.3	-3.3	0.5	1.0057	-0.3	-3.2	0.6	1.0069	-0.3
LARGE URBAN AREAS	1,516	9.1	-5.0	-1.3	0.9868	-0.5	-4.6	-0.8	0.9915	-0.4
OTHER URBAN AREAS	1,161	9.6	-0.9	3.0	1.0332	-0.1	-1.3	2.6	1.0293	-0.1
RURAL HOSPITALS	2,187	14.7	-5.2	-1.5	0.9816	-0.8	-5.7	-1.9	0.9770	-0.8
VOLUME (URBAN) 0 - 4,999 UNITS	278	12.1	-15.6	-12.3	0.8164	-1.9	-14.8	-11.4	0.8244	-1.8
5,000 - 10,999 UNITS	442	9.8	-6.3	-2.6	0.9559	-0.6	-5.8	-2.1	0.9607	-0.6
11,000 - 20,999 UNITS	599	9.1	-5.8	-2.1	0.9574	-0.5	-5.6	-1.9	0.9593	-0.5
21,000 - 42,999 UNITS	780	8.7	-3.6	0.2	1.0071	-0.3	-3.9	-0.1	1.0040	-0.3
43,000 OR MORE UNITS	578	9.7	-2.0	1.9	1.0266	-0.2	-1.7	2.2	1.0299	-0.2
VOLUME (RURAL) 0 - 4,999 UNITS	816	18.2	-17.0	-13.7	0.7799	-3.1	-17.2	-13.9	0.7781	-3.1
5,000 - 10,999 UNITS	694	15.8	-10.0	-6.5	0.9144	-1.6	-10.3	-6.7	0.9122	-1.6
11,000 - 20,999 UNITS	420	14.6	-5.8	-2.1	0.9848	-0.8	-6.2	-2.5	0.9812	-0.9
21,000 - 42,999 UNITS	215	13.5	-1.8	2.0	1.0368	-0.2	-2.5	1.3	1.0294	-0.3
43,000 OR MORE UNITS	42	13.2	5.3	9.4	1.1263	0.7	4.6	8.7	1.1190	0.6

			No Teaching and DSH Adjustments			Teaching and DSH Adjustments				
			(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
TEACHING STATUS	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare Outpatient payment	Conversion Factor Effect removed	Stand- arized payment to cost ratio	Percent change in total Medicare payments	Percent change in Medicare Outpatient payment	Conversion Factor Effect removed	Standardized payment to cost ratio	Percent change in total Medicare payments
NON-TEACHING	3,847	11.2	-3.1	0.7	1.0031	-0.3	-3.7	0.1	0.9973	-0.4
FEWER THAN 100 RESIDENTS	766	9.1	-1.8	2.0	1.0326	-0.2	-2.4	1.5	1.0266	-0.2
100 OR MORE RESIDENTS	250	9.2	-9.4	-5.8	0.9331	-0.9	-6.4	-2.7	0.9643	-0.6
DISPROPORTIONATE SHARE PATIENT RATIO										
0	25	25.1	-0.3	3.6	0.9250	-0.1	-1.2	2.7	0.9175	-0.3
0.001- 0.099	916	10.3	-4.9	-1.1	0.9780	-0.5	-5.8	-2.1	0.9682	-0.6
0.100- 0.159	1,016	10.9	-0.9	3.0	1.0447	-0.1	-1.9	1.9	1.0337	-0.2
0.160- 0.299	1,613	10.1	-3.0	0.8	1.0113	-0.3	-3.7	0.0	1.0039	-0.4
GREATER THAN 0.299	1,294	9.2	-6.6	-2.9	0.9617	-0.6	-3.5	0.3	0.9934	-0.3

Based on our analyses, we are not proposing to make adjustments to the outpatient payment rates for disproportionate share patient percentage and teaching intensity and rural location for the following reasons.

1. Estimated effects of teaching intensity and disproportionate share patient percentage on costs were small and, in some cases, not statistically significant.

2. Payment impacts without such adjustments do not vary considerably, the largest being a reduction of 5.8 percent for major teaching hospitals. These impacts should also be evaluated in terms of the overall effect on Medicare payments since on average, outpatient services account for 10 percent of hospitals' Medicare payments. For example, the associated reduction of total Medicare payments for major teaching hospitals would be about 1 percent.

3. With the threshold adjustments we considered, estimated payment reductions for rural hospitals would be 1.9 percent under the proposed system, rather than 1.5 percent. These hospitals also receive a greater percent of their Medicare income (14.7 percent) from providing outpatient services. Similarly, payment reductions for low-volume rural hospitals would be 13.9 percent of current payments, rather than 13.7 percent, and these hospitals also earn a greater percentage of their Medicare income (18.2 percent) from providing outpatient services. Because of these potential shifts in payments, any adjustment should be based on stronger analytic results than those found with the current data.

4. We also believe the issue of payment adjustments should be reexamined using data from initial years of the implemented system because current cost calculations and relationships among key factors and costs probably are affected by variation in coding patterns.

5. HCFA is working towards standardizing payment across all sites of service. Fewer adjustments to the outpatient PPS would allow HCFA to move ahead more quickly with this approach.

6. We believe that we should further analyze the impact of basing APC weight calculations on the median rather than the geometric mean because better correlation between costs and service mix would impact the size of adjustments.

Although the payment simulations show potentially large percentage losses and low payment to cost ratios for low-volume hospitals, we are not proposing an adjustment for volume. The low-

volume hospitals get a much greater percent of their Medicare income from the provision of outpatient services than the average, and total Medicare payments would drop by 3.1 percent for rural low-volume hospitals and 1.8 percent for urban low-volume hospitals. Low-volume hospitals have higher than average standardized unit costs, which may be attributable to economies of scale, under-coding, or cost allocations to the outpatient departments that are not volume related. However, an adjustment to the rates based on volume alone might reward inefficiency and create adverse incentives such as a reduction in services in order to increase payment rates. Moreover, these hospitals do not comprise a large enough proportion of other hospital types to substantially benefit from other adjustments (for example, teaching or disproportionate share).

We are particularly concerned about the potential impact of the outpatient PPS on low-volume rural hospitals that are sole community hospitals or Medicare-dependent hospitals. Approximately 60 percent of the rural hospitals furnishing fewer than 5,000 visits fall into these categories. We are investigating the reasons for their higher costs and are assessing whether a temporary adjustment is needed to moderate the impact of moving to an outpatient PPS. One option we are considering would be to phase-in the outpatient PPS for low-volume Medicare-dependent and sole community hospitals by paying a portion of the payment based on PPS rates and a portion based on the current payment system. For example, payment could be based on 75 percent of payments under the current system and 25 percent on PPS rates in the first year, 50 percent current system payments and 50 percent PPS rates in the second year, 25 percent current system payments and 75 percent PPS rates in the third year, and completely on PPS rates in subsequent years. Another option we are considering would phase-in outpatient PPS if a low-volume sole community hospital or Medicare-dependent hospital has a negative Medicare margin for outpatient services. For example, payment could be based on the amount payable under outpatient PPS plus a percentage of the difference between those amounts and the amounts payable under the current system. The percentage of the difference that would be payable could phase down, for example, 75 percent in year one of implementation, 50 percent in year 2, 25 percent in year 3, and no adjustment in year 4 and subsequent

years. We solicit comment on this and other alternatives we might consider. By statute, any adjustment would have to be budget neutral.

We also are not proposing adjustments for cancer or TEFRA hospitals at this time. We believe that claims from cancer and TEFRA hospitals have been under-coded for many of the services cancer hospitals provide due to the lack of payment incentives for proper coding of these services under the current system. Further analysis will be conducted to determine if current coding practices explain the negative impact. If we determine that cancer hospitals would be unduly harmed because of the new outpatient PPS, we will consider whether an adjustment or perhaps a transition period is needed to moderate the impact. By statute, any adjustment would have to be budget neutral.

We do not believe that this action will restrict beneficiary access because other hospitals provide many of the same services provided at TEFRA hospitals. In addition, children's and free-standing psychiatric hospitals are less dependent than other hospitals on Medicare revenues. Finally, the remaining classes of TEFRA hospitals, rehabilitation and long-term care, lose a much smaller percentage of their total Medicare income, 3.7 and 3.5 percent respectively than the average for all facilities.

We are not proposing adjustments for any eye and ear or trauma hospitals because payment simulations demonstrated an increase in payments under the proposed PPS. We will assess the need for additional adjustments and make any appropriate changes as data become available under the new system.

J. Volume Control Measures

Section 1833(t)(2)(F) of the Act requires us to develop a method for controlling unnecessary increases in the volume of covered outpatient department services, including partial hospitalization services in CMHCs. If the volume of services paid for increases beyond amounts established through methodologies determined in section 1833(t)(2)(F), section 1833(t)(6)(C) provides that the update to the conversion factor may be adjusted. MedPAC recommends in its report to the Congress that we implement an expenditure cap to help control spending for hospital outpatient services and that we monitor hospital outpatient volume to ensure that access to services and quality of care are not reduced under a cap.

In this proposed rule, we are proposing a volume control measure for services furnished in CY 2000. In the

proposed rule for rates that would be effective in CY 2001, we plan to propose an appropriate method for determining expenditure targets for services furnished in CY 2001 and subsequent years, following completion of further analysis of how that target should be computed. Later in this section, we discuss several possible approaches for controlling the volume of hospital outpatient services furnished in CY 2001 and subsequent years.

Pursuant to section 1833(t)(2)(F) and consistent with section 1833(t)(6)(C), we are proposing to update the target amount specified under section 1833(t)(3)(A) for CY 1999 as an expenditure target for services furnished in CY 2000. We will update the CY 1999 target for inflation (based on the projected change in the hospital market basket minus one percentage point) and estimated changes in the volume and intensity of hospital outpatient services and estimated Part B fee-for-service changes in enrollment. If volume exceeds the target for CY 2000, we are proposing to adjust the update to the conversion factor for CY 2002. We will compare the CY 2000 target to an estimate of CY 2000 actual payments to hospitals. (HCFA's Office of the Actuary will determine the CY 2000 actual payments using the best available data.) If unnecessary volume increases, as reflected by expenditure levels, cause payments to exceed the target, we will determine the percentage by which the target is exceeded, and adjust the CY 2002 update to the conversion factor by the same percentage.

In conjunction with the Office of Inspector General, we are proposing to do further work to assure that only payments made in accordance with existing Medicare law and regulations were used in the calculation of the target amount. If this work reveals that adjustments to the target amount and expenditure ceiling are warranted, we will address this issue in a future rule.

When the inpatient PPS was implemented, the packaging of all services provided during an admission under a single rate was the primary method of volume control. This method was appropriate because the concern was the intensity of services per admission, rather than the number of admissions, which was generally stable. For outpatient department services, there has been rapid growth in the intensity of ancillary services per procedure. We believe that greater packaging of these services might provide volume control. However, because the hospital outpatient PPS will not initially include a significant degree of packaging, we are examining a

number of mechanisms to control unnecessary increases, as reflected by expenditure levels, in the volume of covered outpatient department services. The volume of services is a significant concern, particularly during the first few years of the outpatient PPS, because of the possible incentives under PPS to increase utilization.

Although the updated target amount provides a basis against which we can measure year 2000 actual payments, we need to develop an approach for establishing a volume control measure for years 2001 and beyond. Because of the complexities involved in developing such a system, we do not plan to propose a method for future years (2001 and beyond) until we issue our notice of proposed rulemaking for CY 2001, but we want to open a discussion now, so that we can obtain comments that we can use in developing a proposal.

One possible mechanism to control unnecessary increases in the volume of outpatient services paid for under the outpatient PPS is to expand the sustainable growth rate (SGR) system for physician services, which is required under section 1848(d)(3) of the Act, as amended by section 4502 of the BBA, to take into account hospital outpatient services. Physicians typically are responsible for ordering medical services and are thus responsible for determining a substantial portion of hospital outpatient volume. Expanding the SGR system for physician services to include hospital outpatient services would provide added incentives for physicians to evaluate the necessity of orders for hospital outpatient services.

A second possible mechanism would be to expand the SGR system for physician services to include all ambulatory services, for example, services in hospital outpatient departments and ASCs, and to use this expanded SGR system to establish updates for the ambulatory facility payments as well as for physician fee schedule updates. This method would spread volume control incentives more evenly across the ambulatory sector. It would more closely align physician and facility incentives and be less sensitive than a hospital-outpatient-department-only SGR to shifts in site of service.

A third approach to controlling unnecessary growth in the volume of hospital outpatient services is to modify the physician SGR method and incorporate it into the hospital outpatient department payment system. That is, as in the physician payment context, an SGR value for hospital outpatient services would be calculated and payment updates for these services would be reduced if volume increases

result in expenditures above target levels.

We believe the third option of linking updates of the outpatient department conversion factor to an SGR system is the most feasible approach to take initially. Additional study, analysis, and possible legislative modification would be necessary before we could consider implementing either of the first two options discussed above. We acknowledge that, to the extent that hospital outpatient volume is physician driven, an outpatient SGR could arguably be viewed as unnecessarily and unfairly penalizing facilities. Moreover, because sites of ambulatory care are relatively interchangeable with respect to the delivery of outpatient services, setting appropriate targets for hospital outpatient departments alone could be difficult. However, an outpatient SGR system would parallel the SGR system created for physician services under section 4502 of the BBA. Physician volume issues have been extensively analyzed by MedPAC, and the SGR system for physicians has evolved as a feasible method for volume control. Many outpatient PPS issues are similar to physician issues because changes in technology and places of service can affect expenditures for both hospital outpatient departments and physicians.

The outpatient SGR system would base volume and intensity growth allowances for services under the outpatient PPS on the growth in the general economy. Other factors in determining the target rate of growth include medical inflation, changes in enrollment, and changes in spending due to changes in the law or regulations. The outpatient SGR would be calculated as the product of—

(1) The annual update to the conversion factor (described in section V.G.3. of this preamble), which is the outpatient market basket percentage increase reduced by one percentage point for the years 2000, 2001, and 2002.

(2) The percentage increase or decrease in Part B enrollees (excluding those enrolled in Medicare+Choice) from one year to the next;

(3) The projected growth in the real gross domestic product per capita (or real gross domestic product per capita plus an appropriate factor for recent outpatient department services growth) from the previous year to the year involved; and

(4) The percentage change in spending for outpatient department services resulting from changes in law and regulations from one year to the next.

This growth rate system would be used in setting annual updates to the conversion factor for hospital outpatient services. Pursuant to section 1833(t)(2)(F) of the Act, and consistent with section 1833(t)(6)(C), we would lower the annual update to the conversion factor for a given year if volume increases cause expenditures to exceed the target amount in a previous year. While we think using an outpatient department SGR is the most feasible option in the short term, in the long term we would like to develop a more integrated approach that addresses physicians and ASCs, as well as outpatient departments. In addition to requesting comments on our proposed volume control measure for services furnished in CY 2000, we specifically solicit comments on the appropriateness of applying the SGR method directly to payments made under the outpatient PPS for future years. We also welcome comments on the development of a long-term integrated system that we would consider as we develop possible future proposals. In our final rule, we will respond to comments on our proposed volume control measure for services furnished in CY 2000. We do not intend to respond to comments concerning the development of an SGR system for services furnished after CY 2000, an integrated system, or any other approach. However, we will use any comments we receive in developing a proposal we will make next year for volume control measures to be applied to services furnished after CY 2000.

K. Prohibition Against Administrative or Judicial Review

Section 1833(t)(9) of the Act prohibits administrative or judicial review of the PPS classification system, the groups, relative payment weights, adjustment factors, other adjustments, volume control methods, calculation of base amounts, periodic control methods, periodic adjustments, and the establishment of a separate conversion factor for cancer hospitals.

VI. Hospital Outpatient Clinics and Other Provider-Based Entities

A. Background

The Medicare law (section 1861(u) of the Act) lists the types of facilities that are regarded as providers of services, but does not use or define the term "provider-based." However, from the beginning of the Medicare program, some providers, which are referred to in this section as "main providers," have owned and operated other facilities, such as SNFs or HHAs, that were administered financially and clinically

by the main provider. The subordinate facilities may have been located on the main provider campus or may have been located away from the main provider. In order to accommodate the financial integration of the two facilities without creating an administrative burden, we have permitted the subordinate facility to be considered provider-based. The determination of provider-based status allowed the main provider to achieve certain economies of scale. To the extent that overhead costs of the main provider, such as administrative, general, housekeeping, etc. were shared by the subsidiary facility, these costs were allowed to flow to the subordinate facility through the cost allocation process in the cost report. This was considered appropriate because these facilities were also operationally integrated, and the provider-based facility was sharing the overhead costs and revenue producing services controlled by the main provider.

Before implementation of the hospital inpatient PPS in 1983, there was little incentive for providers to affiliate with one another merely to increase Medicare revenues or to misrepresent themselves as being provider-based, since at that time each provider was paid primarily on a retrospective, cost-based system. At that time, it was in the best interest of both the Medicare program and the providers to allow the subordinate facilities to claim provider-based status, because the main providers achieved certain economies, primarily on overhead costs, due to the low incremental nature of the additional costs incurred. For example, the billing department of a main provider could usually accommodate the additional workload associated with a provider-based facility by hiring an additional billing clerk, instead of incurring the cost of a separate billing department for the provider-based facility. This economy of scale would usually extend to the other overhead costs incurred by the main provider, because the free-standing facility was generally more costly to maintain than one that was provider-based. This was due primarily to the savings on overhead costs that were accomplished by the merging of the free-standing facility into the main provider and having it integrated with the main provider. Although there were several limited guidelines outlining the conditions for certain provider-based situations, we devoted few resources to reviewing provider compliance, because there was little incentive for providers to use this designation inappropriately.

Since 1983, the number of provider-based facilities has increased

significantly. For example, in July of 1982, there were 481 provider-based HHAs as compared with 2,577 provider-based HHAs in October of 1996. This was an increase of 435.75 percent in the 13 years since the PPS was established. In addition, many hospitals now have a large number of outpatient clinics, often located at various sites.

We believe the growth in the number of facilities and organizations claiming to be provider-based has occurred for several reasons. First, the PPS established payment rates using base year costs that included provider overhead. Health care providers, looking for ways to increase their Medicare revenues, realized that if they established provider-based facilities or organizations that were still subject to the reasonable cost principles, they would then be able to shift some of the overhead from the hospital inpatient operating costs to these provider-based facilities or organizations. The PPS main provider would be paid a PPS payment that was intended to cover overhead costs, as well as being reimbursed on a reasonable cost basis based on Medicare's share of the overhead costs for the services furnished by the provider-based facility or organization. A main provider that is excluded from PPS and subject to the rate-of-increase limits would also benefit from shifting its overhead to the subordinate provider-based facility or organization. This cost shifting would enable it to increase its payment by being paid for the Medicare share of the diverted overhead on a cost-based methodology, as well as bringing its costs below the rate-of-increase limit. The main provider could then share in the incentive payment by having its costs come in below the target rate.

More recently, other factors have combined to create incentives for providers to affiliate with one another and to acquire control of nonprovider treatment settings, such as physician offices. Integrated delivery systems offer a wide variety of health care services and can assume responsibility for entire episodes of a patient's illness. These systems are attractive to patients, who seek continuity of care, and to businesses seeking a single source of health services for their employees. The resulting growth in the number of patients enrolled by these integrated delivery systems has created a powerful incentive for affiliations. In addition, hospitals rely on referrals from physicians to assure a steady stream of patients, and they have begun to purchase physician practices and integrate them into their outpatient operations. This trend also has created

incentives for hospitals to affiliate with physician practices.

B. Effects on Medicare

For several reasons, it is essential that we ensure that decisions regarding provider-based status are made appropriately, and that facilities or organizations are not recognized as provider-based unless they are in fact integral and subordinate parts of the main provider. As noted earlier, in cases where main providers are paid under the PPS and subordinate facilities or organizations are paid under the reasonable cost reimbursement method (section 1861(v)(1)(A) of the Act and 42 CFR part 413), a provider-based determination could allow the main provider to shift overhead costs to cost centers that are paid on a cost basis and thereby increase Medicare payments with no commensurate benefit to the Medicare program or its beneficiaries.

Payments for services furnished in a hospital outpatient clinic generally include both a facility payment and payment for the professional services of a physician. The combined payments are typically higher than the payment for comparable services furnished in a physician office, where a separate facility fee is not payable. In many cases, there is also an increase in beneficiaries' out-of-pocket expenses compared to services furnished in a physician office. For example, when a beneficiary is treated in a physician office, the only payment made is Part B payment to the physician for his or her professional services, under the physician fee schedule. The single payment made under the physician fee schedule pays for the physician's work and includes a component for practice expense. The beneficiary's coinsurance is based on 20 percent of the physician fee schedule amount. However, if the same service is furnished in a hospital outpatient clinic, Medicare Part B payment for a facility fee is also made to the hospital, in addition to the physician's payment (which may include a smaller practice expense component). Thus, for the same visit, the beneficiary is also subject to the Part B coinsurance for the hospital's facility fee. Beneficiaries are responsible for coinsurance based on 20 percent of the hospital's charges (or, the applicable coinsurance amounts under the hospital outpatient PPS).

Provider-based status also raises issues of Medicare coverage. Generally, the services of nonphysician staff furnished in a physician office are covered only as services "incident to" the professional services of a physician under section 1861(s)(2)(A) of the Act.

This means that a physician must be available on the premises when the service is furnished, in order to provide direct supervision of that service. In hospital outpatient departments, however, we presume that the "incident to" requirements are met with respect to hospital services incident to physician services to outpatients (section 1861(s)(2)(B)). The policy assumed the outpatient department was co-located on the hospital premises and staff physicians would be available nearby to provide necessary oversight. It is possible that a hospital outpatient clinic may not be in the immediate vicinity of the hospital and may furnish nonphysician services without actually providing for direct physician supervision of those services. We do not believe that such services should be presumed to meet applicable "incident to" requirements. As explained below, it could also present a health and safety risk at a time when the office is staffed with nonphysician personnel who are furnishing medical care with no physician present and available to attend to any unexpected emergency situation that may arise.

Provider-based status for a facility or organization can have other implications for the health and safety of its patients. Hospital outpatient facilities are subject to the Medicare conditions of participation in 42 CFR part 482, including specific requirements covering such crucial areas as adequacy of physician care (§ 482.22, "Conditions of participation: Medical staff"), and the safety of the physical environment, including compliance with fire safety requirements (§ 482.41, "Conditions of participation: Physical environment"). Beneficiaries have the right to expect that any outpatient department of a hospital meets applicable conditions of participation and that the facility is capable of providing care commensurate with the general level of care furnished in a hospital outpatient department that is co-located with the inpatient setting. However, the facility claimed as an outpatient department may not have been surveyed for compliance with the conditions of participation and, in some cases, we may not even have been notified of its existence.

The BBA includes several new provisions that can be implemented appropriately only if clear distinctions are made between free-standing and provider-based facilities. Section 4205(a)(1) of the BBA amended section 1833(f) of the Act to extend the per-visit payment limit for rural health clinics (RHCs), which previously applied only to free-standing RHCs, to most provider-

based RHCs as well. (The law provides that the limit does not apply to RHCs located in hospitals with less than 50 beds.)

Section 4541 of the BBA amended section 1833 of the Act to establish a prospective system of payment for outpatient physical therapy services (including outpatient speech-language pathology services) and outpatient occupational therapy services furnished after 1998, and to establish a \$1,500 annual limit on the amount of payment for such services to each beneficiary. Under sections 1833(g)(1) and (g)(2) of the Act, however, that limit does not apply to services furnished in hospital outpatient departments. Moreover, as explained later in this section of the preamble, there are differences in payment for ambulatory surgical services, depending on whether the services are furnished in a hospital, by an approved ASC, or in a physician office. Further, higher composite rate payments are made to hospital-based ESRD facilities than to free-standing ESRD facilities. Thus, it is essential that we have clear rules for identifying provider-based facilities.

C. Relationship of the "Provider-Based" Proposals to Prospective Payment for Outpatient Hospital Services and Effective Date of "Provider-Based" Proposals

Although the proposed regulations set forth in new § 413.65 and in the amendment to § 413.24 relate to providers generally, their implementation is crucial to successful implementation of a PPS for outpatient hospital services. No outpatient PPS can succeed if it does not clearly define the services to which it applies. Experience suggests that under the existing policies defining provider-based status, many ambulatory services may be characterized either as physician office services or as services of hospital outpatient departments or clinics or an ASC, depending on the financial incentives involved. Thus, we are publishing these proposed rules to permit clearer distinctions to be made between various types of services, and to ensure that services paid for under the outpatient PPS are of the same type as those included in the data on which the system is based.

As explained in the previous section of this preamble, it is essential that provider-based decisions be made appropriately in all cases, not just those involving outpatient hospital services paid for under a PPS. Therefore, the effective date of these proposals will not be delayed until after an outpatient PPS is in effect. On the contrary, we plan to

implement proposed §§ 413.24(d)(6)(i) and (ii), 413.65, 489.24(b), and 498.3, as revised based on our consideration of public comments, with respect to services furnished on or after 30 days following publication of a final rule.

D. Basis for Current Provider-Based Policy

Although there is no direct statutory requirement to maintain explicit criteria for determination as to provider-based status, there are statutory references acknowledging the existence of this payment outcome. For example, section 1881(b) of the Act provides for separate payment rates for hospital-based (ESRD) facilities.

There is currently no general definition of "provider-based facility" in the CFR. However, various sections of the CFR do contain provisions for recognition of specific types of entities as provider-based.

Section 405.2462(a) authorizes payment for RHCs and Federally qualified health centers (FQHCs) as provider-based, if:

(1) The clinic or center is an integral and subordinate part of a hospital, SNF, or HHA participating in Medicare, (that is, a provider of services); and

(2) The clinic or center is operated with other departments of the provider under common licensure, governance, and professional supervision.

Definitions of hospital-based HHAs and SNFs were published in final notices on cost limits for HHAs and SNFs, in the June 5, 1980 (45 FR 38014) and September 4, 1980 (45 FR 58699) issues of the **Federal Register**, respectively. These criteria were identical to one another and were similar to the RHC and FQHC definition but they provided considerably more detail in their description of common governance.

Further, we have provided additional detail regarding the factors to be considered in making determinations regarding provider-based status in our manuals. The Medicare Regional Office Manual at section 6860 provides a list of criteria that should be considered in making a determination regarding provider-based status for clinics. Also, section 2186 of the State Operations Manual provides direction regarding provider-based designation for HHAs.

Program Memorandum A-96-7, published on August 27, 1996, pulled together the instructions previously manualized for specific entity types into a general instruction for the designation of provider-based status to all facilities or organizations. In developing this Program Memorandum, we took information from the State Operations

Manual (sections 2024, 2186, and 2242), the Regional Office Manual (section 1060, 2020 and 6865), and §§ 405.2462 and 413.170 of the CFR.

Under the policy we set forth in Program Memorandum A-96-7, the following applicable requirements must be met before an entity can be designated as provider-based for Medicare payment purposes:

1. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (for example, from the same service, or catchment area);

2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the State separately licenses the provider-based entity);

3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body) and the accrediting body recognizes the entity as part of the provider;

4. The entity is operated under common ownership and control (that is, common governance) by the provider where it is based, as evidenced by the following:

- The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;
- The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; and
- The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment, and service personnel on a daily basis.

5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:

- The entity director or individual responsible for day-to-day operations at the entity maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual to the governing body of the provider where the entity is based; and
- Administrative functions of the entity, for example, records, billing, laundry, housekeeping and purchasing are integrated with those of the provider where the entity is based.

6. Clinical services of the entity and the provider where it is located are

integrated as evidenced by the following:

- Professional staff of the provider-based entity have clinical privileges in the provider where it is based;
- The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the chief medical officer or other similar official of the provider where it is based;
- All medical staff committees or the professional committees at the provider where the entity is based are responsible for all medical activities in the provider-based entity;
- Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based;
- Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and
- Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

7. The entity is held out to the public as part of the provider where it is based (for example, patients know they are entering the provider and will be billed accordingly).

8. The entity and the provider where it is based are financially integrated as evidenced by the following:

- The entity and the provider where it is based have an agreement for the sharing of income and expenses, and
- The entity reports its cost in the cost report of the provider where it is based using the same accounting system and the same cost reporting period as the provider where it is based.

Our policy will continue to follow the principles we articulated in Program Memorandum A-96-7 until 30 days after this rule is published as final in the **Federal Register**. After that date, we will apply the policies set forth in the final regulations.

E. Provisions of This Proposed Rule

This proposed rule would add a new § 413.65, stating the appropriate definitions of, and the general requirements for, the determination of "provider-based" status. In paragraph (a), we are proposing to define the following terms for purposes of this section: department of a provider, free-standing facility, main provider, provider-based entity, and provider-based status. The definitions used are as follows.

Department of a provider means a facility or organization or clinic that is

either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and financial and administrative control of the main provider in accordance with the provisions of proposed § 413.65. A department of a provider is not licensed or certified to provide services in its own right, and Medicare conditions of participation do not apply to the department as an independent entity. The term "department of a provider" does not include an RHC or FQHC; however, an RHC or FQHC could qualify as a provider-based entity.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries, and that is not integrated with any other entity as a main provider, a department of a provider, or a provider-based entity.

Main provider means a provider that either creates or acquires ownership of another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider, or an RHC or FQHC as defined in § 405.2401(b), that is either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and administrative and financial control of the main provider in accordance with the provisions of proposed § 413.65. A provider-based entity is certified to provide services in its own right.

Provider-based status means the relationship between a main provider and a provider-based entity, or a department of a provider, that is in compliance with the provisions of proposed § 413.65.

We are proposing to state explicitly, in new paragraph (b), that a facility or organization is not entitled to be treated as provider-based simply because it or the provider believe it to be provider-based. We also would state that, if a facility or organization seeking provider-based status is located off the campus of a provider, or inclusion of the costs of the facility or organization on the provider's cost report would increase the total costs on that report by at least 5 percent, HCFA will not treat the facility or organization as provider-based for purposes of billing or cost reporting unless the provider has contacted HCFA and obtained a determination of provider-based status. This means that we would not accept billings from the facility or organization as if it were provider-based, and the provider will not be permitted to include costs of the facility or organization on its cost report, unless

the acquisition or creation of the facility or organization has been reported to us and we have determined that it is either a department of a provider or a provider-based entity. Further, a facility not located on the campus of a hospital and used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility unless it is determined by HCFA to have provider-based status. For example, a physician office practice purchased by a main provider would not qualify for provider-based status unless it meets all applicable criteria in proposed § 413.65.

We are proposing to require, in new paragraph (c), that a main provider that acquires a facility or organization for which it wishes to claim provider-based status must report its acquisition of the facility or organization to HCFA and furnish all information needed for a determination as to whether the facility or organization meets the criteria in this section for provider-based status. A main provider that has had one or more facilities or organizations determined to have provider-based status also must report to HCFA any material change in the relationship between it and any department or provider-based entity, such as a change in ownership of the entity or entry into a new or different management contract, that could affect the provider-based status of the department or entity.

In new paragraph (d), we propose the requirements for a determination of "provider-based status." In paragraph (d)(1), we would set forth licensure requirements for facilities or organizations seeking provider-based status. Any facility or organization seeking to be a department of a provider would have to be operated under the same license as the main provider. We note that if a State's licensure laws establish restrictions on the type or location of facilities or organizations that can be licensed as part of a provider, we would defer to those restrictions in determining whether a particular facility is a department of the provider. For example, if the hospital licensure laws of a particular State precluded facilities located more than 5 miles from a hospital from being licensed as part of the hospital, we also would not consider those facilities to be a part of the hospital. Provider-based entities would not have to be operated under the same license as the main provider, since in most cases we expect that they would be separately licensed by the State. To take account of possible State-by-State differences in licensure, however, we would require only that a prospective provider-based entity be

licensed in accordance with the law of the State in which it is located.

In addition, if a State health facilities' cost review commission, or other agency that has authority to regulate the rates charged by hospitals or other providers in a State, finds that a particular facility or organization is not part of a provider, we also would determine that the facility or organization does not have provider-based status. We believe it would be inappropriate for a facility or organization to be considered free-standing for State ratesetting purposes, but provider-based status under Medicare.

In paragraph (d)(2), we would require that a facility or organization be under the ownership and control of the main provider. In particular, we would require that the facility or organization be 100 percent owned by the provider, that the main provider and a facility or organization seeking provider-based status have the same governing body, and that the facility or organization be operated under the same organizational documents as the main provider. For example, the facility seeking provider-based status would have to be subject to the bylaws and operating decisions of the governing body of the main provider. In addition, we would require that the main provider have final responsibility for administrative decisions, final approval for outside contracts, final responsibility for personnel policies, and final approval for medical staff appointments in the department or entity.

In paragraph (d)(3), with respect to administration and direct supervision of the main provider, we are proposing to require that a facility or organization seeking provider-based status have a reporting relationship to the main provider that is characterized by the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments. As evidence of this relationship, we would look to whether the facility is under the direct supervision of the provider where it is located, whether it is operated under the same monitoring and oversight as any other department of the provider, and is operated as any other department with respect to supervision and accountability. We would expect the director or individual responsible for daily operations at the facility or organization to maintain a day-to-day reporting relationship with a manager at the main provider and to be accountable to the main provider's governing body in the same manner as any department head of the provider. We also would require integration of certain

administrative functions, in particular, billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employee or group of employees would have to handle these administrative functions for both the facility or organization and the main provider, or the administrative functions for the entity and the main provider would have to be contracted out under the same contractual agreement, or be handled under different contract agreements, with the entity's contract being managed by the main provider's billing department.

In paragraph (d)(4), we are proposing that a facility or organization seeking provider-based status and the main provider share integrated clinical services, as evidenced by privileging of the professional staff of the department or entity at the main provider, and the main provider's maintenance of the same monitoring and oversight of the department or entity as of other departments. Also, the medical director of the department or entity must maintain a day-to-day reporting relationship with the chief medical officer (or equivalent) of the main provider, and be under the same supervision as any other director of the main provider. We also would expect medical staff committees or other professional committees of the main provider to be responsible for medical activities in the department or entity, including quality assurance, utilization review, and the coordination and integration of services. We also would expect medical records to be integrated into a unified retrieval system. We would expect that inpatient and outpatient services of the facility or organization and the main provider be integrated and that patients treated at the facility or organization who require further care have full access to all services of the main provider, including all inpatient or outpatient services of the main provider.

In paragraph (d)(5), we would require that the proposed department or entity and the main provider be fully financially integrated within the main provider's financial system, as evidenced by the sharing of income and expenses. The department's or entity's costs should be reported in a cost center of the provider, and the department's or entity's financial status should be incorporated into, and readily identifiable in, the main provider's trial balance.

In paragraph (d)(6), we would require that the main provider and the facility seeking status as a department of the

provider be held out to the public as a single entity, so that when patients enter the department they are aware that they are entering the provider and will be billed accordingly. (This requirement would not apply to a provider-based entity that is itself a provider, such as a SNF.)

In paragraph (d)(7), we would require that the department of a provider or provider-based entity and the main provider be located on the same campus. Alternatively, the main provider and facility seeking provider-based status must demonstrate that they serve the same patient population. The department or entity and the main provider would be required to demonstrate that they serve the same patient population by submitting patient lists and/or demographic data showing that a high percentage of the patients of both come from the same geographic area, or that patients of the entity also receive a preponderance of services from the main provider. We would specify that a facility or organization is not considered to be in the "immediate vicinity" of the main provider if it is located in a different State than the main provider. We welcome comments as to whether an exception should be made for areas where a single metropolitan area may include two or more States.

New paragraph (e) would specifically prohibit the approval of provider-based status for any proposed department or entity that is owned by two or more providers engaged in a joint venture. Some hospitals, under joint venture arrangements, are jointly purchasing or jointly creating free-standing facilities. Although the facility or organization is operated by two or more hospitals, the dominant hospital claims the free-standing facility or organization as a department or provider-based entity. This is clearly unallowable, because the facility or organization is owned by more than one hospital, and in its own right must be considered as free-standing, subject to all of the rules and certifications that govern that type of operation.

In proposed paragraph (f), we would state that facilities or organizations operated under management contracts will be considered provider-based only if specific requirements for staff employment, administrative functions, day-to-day control of operations, and holding of the management contract by the provider itself rather than by a parent organization are met. Generally, we believe it would be difficult for any facility or organization operated under a management contract to provide all services to be able to demonstrate the

degree of integration with a provider that would be needed to qualify for provider-based status. Thus, we are proposing to adopt these requirements, which are designed to ensure that we treat a facility or organization under a management contract as provider-based only if it clearly is operated by the provider, not by the management company or by a common parent organization.

In proposed paragraph (g), we would specify nine obligations of hospital outpatient departments and hospital-based entities. These obligations are spelled out in detail to help us ensure that facilities seeking recognition as hospital outpatient departments or hospital-based entities are in fact what they represent themselves as being, and are not simply the private offices of individual physicians or of physicians in group practices. The obligations are—

- In the case of hospital outpatient departments located off the main provider campus, compliance with the anti-dumping requirements in §§ 489.20 (l), (m), (q), and (r) and 489.24. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24, the hospital must comply with the anti-dumping requirements in § 489.24. We would also revise § 489.24(b) to clarify that for purposes of the anti-dumping rules set forth in that section, hospital property means the entire main hospital campus, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined under § 413.65 to be a department of the hospital.
- Billing of physician services in hospital outpatient departments or hospital-based entities (other than RHCs) with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied;
- In the case of hospital outpatient departments, compliance with all the terms of the provider agreement;
- Compliance by physician staff with the nondiscrimination provisions in § 489.10(b) of this chapter;
- In the case of hospital outpatient departments (other than RHCs), representation to other payers as an outpatient department of the hospital, and treatment of all patients, for billing purposes, as hospital outpatients;

- In the case of hospital outpatient departments or hospital-based entities, compliance with the payment window provisions applicable under § 412.2(c)(5) (for PPS hospitals) or § 413.40(c)(2) (for PPS-excluded hospitals);
- In the case of hospital outpatient departments or hospital-based entities (other than RHCs), notice to each beneficiary treated that he or she will be liable for coinsurance for a facility visit as well as for the physician service; and
- In the case of hospital outpatient departments, compliance with applicable Medicare hospital conditions of participation for hospitals in part 482 of this chapter.

We would also preclude any facility or organization that furnishes all services under arrangements from qualifying as provider-based. We believe the provision of services under arrangement was intended to be allowed only to a limited extent, in situations where cost-effectiveness or clinical considerations, or both, necessitate the provision of services by someone other than the provider's own staff. The "under arrangement" provision in section 1861(w)(1) of the Act and § 409.3 is not intended to allow a facility merely to act as a billing agent for another. We are concerned that this would be the case if all services at a facility or organization seeking provider-based status were furnished under arrangement. We believe use of arranged-for services could, if not limited, become a means of circumventing the provider-based requirements. We are proposing in paragraph (g)(10) that a facility or organization may not qualify for provider-based status if all of the services furnished at the facility are furnished under arrangements. We note that this approach is consistent with existing policy under which a hospital outpatient is expected to receive services, rather than supplies, directly from the hospital.

Proposed paragraph (h) states that if we learn of a provider that has inappropriately treated a facility or organization as provider-based, before obtaining our determination of provider-based status, we would reconsider all payments to that main provider for periods subject to reopening, investigate, and determine whether the designation was appropriate. If we find it was not provider-based, we will recover all payments in excess of those payments that should have been made in the absence of the provider-based status. As explained further below,

however, recovery will not be made for any period prior to the effective date of this rule if during all of that period the management of the facility or organization made a good-faith effort to operate it as a department of a provider or provider-based entity.

In proposed paragraph (i), we would detail the application of the principles in paragraph (h) to situations involving inappropriate billing for services furnished in a physician office or other facility or organization as if they had been furnished in a hospital outpatient or other department of a provider or in a provider-based entity. Generally, when such cases of inappropriate billing are found, we will recover any overpayments as described in the preceding paragraph. Under certain circumstances, however, we will determine that the management of a facility or organization has made a good faith effort to operate it as a department of a provider or a provider-based entity and will not recover past payments. We would take this action if we determine that the requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) are met, all facility services were billed as if they had been furnished by a department of the main provider or a provider-based entity of the main provider, and all professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(4).

We are also proposing to add a new paragraph (j) that would allow HCFA to review past determinations. If we find that a designation was in error, and the facility or organization in question does not meet the requirements of this section, we will notify the main provider that the provider-based status will cease as of the first day of the next cost report period following notification of the redetermination.

In addition, we are proposing to add to § 413.24(d) new paragraphs (6)(i) and (6)(ii) to clarify that main providers, in completing their Medicare cost reports, may not allocate overhead costs to the provider-based or other cost centers that incur similar costs directly through management contracts or other arrangements. These changes are needed to prevent mis-allocation of management costs, which would result in excessive payment to those types of providers paid on a reasonable cost basis.

As the number of affiliation agreements among various entities has increased, there has been a noticeable shift in the way the HHAs and clinics have been managed, resulting in increased Medicare payments. Today,

there are many management companies that enter into contracts with main providers to manage their provider-based entities, and the costs of these management services are being directly assigned to the department or provider-based entity receiving the service. The contracts typically call for the management company to provide the billing and accounting services, and to procure services, such as housekeeping, laundry and linen, to enable the department or provider-based entity to operate away from the campus and supervision of the main provider, even though these management companies must report to the board of the main provider. In addition to directly assigning these costs to the department or provider-based entity, the main provider, through the cost report, is still allocating overhead costs to the department or provider-based entity, even though these services are being performed through the management contract and not through the main provider. Under these circumstances, the provider could be paid three times for the same overhead cost. The first payment would be made through the PPS payment, which reflects overhead cost. The second payment would come through the cost of the management contract, and the third would come through the allocation of a share of the main provider's overhead cost to the department or provider-based entity. Our proposed changes to § 413.24 are needed to prevent this result.

To provide an administrative appeals process for entities that have been denied provider-based status, we are proposing to revise the regulations on provider appeals at § 498.3. As revised, these rules would specify that a provider seeking a determination that a facility or an organization is a department of the provider or a provider-based entity under proposed § 413.65 will be included in the definition of "prospective provider" for purposes of part 498, and will be afforded the same appeal rights as a prospective provider, such as a hospital or SNF, that has been found by HCFA not to qualify for participation as a provider. We believe it is in the best interest of both HCFA and health care organizations to have an explicit procedure for handling these appeals.

F. Requirements for Payment

The following discussion sets out the requirements that must be met to allow us to make payment under the outpatient PPS for various services.

1. Prerequisites for Payment for Outpatient Hospital Services and Supplies Incident to Physician Services

Medicare Part B benefits include payment for services and supplies that are furnished incident to the professional services of a physician. Medicare makes payment for services and supplies furnished in physician offices that are incident to a professional service of a physician under the provisions of the Medicare physician fee schedule (section 1848 and section 1861(s)(2)(A) of the Act; 42 CFR part 414). Payment for the "incident to" services furnished in physician offices is generally included within the fee for the physician services. Medicare also makes payment for hospital services and supplies that are incident to a physician service furnished to outpatients (section 1861(s)(2)(B) of the Act). Payment for "incident to" services furnished to hospital outpatients is *in addition to* payment for the professional services of a physician. The place where "incident to" services are furnished determines how Medicare pays for them.

We are proposing to add to the regulations certain prerequisites that the hospital must fulfill before it can receive Medicare payment under section 1861(s)(2)(B) of the Act for services and supplies furnished "incident to" physician services at a site that is off the premises of the main hospital complex. These prerequisites are intended to adapt our current policy regarding payment for "incident to" services furnished to hospital outpatients to address the special circumstances presented by a hospital outpatient department or clinic that is not co-located on the hospital campus or within a short distance of the hospital and that HCFA has designated as a department of the hospital or "provider-based."

The first prerequisite is that the office/clinic meet the responsibilities and criteria incumbent upon a provider-based entity as defined in § 413.65(g). We are proposing this requirement because the fact that a hospital owns and/or operates a clinic does not automatically make that clinic an integral, subordinate part of the hospital. If the clinic does not conform with the responsibilities and criteria at § 413.65(g), that clinic would be paid as a physician office, and Medicare payment for services furnished at that site would be made accordingly.

The second prerequisite is that the hospital seek an official determination from HCFA that the provider-based designation applies to the proposed off-site hospital outpatient department/

clinic as required by § 413.65(d). The authority to determine whether or not an entity has provider-based status rests solely with HCFA. The criteria and obligations that are a prerequisite of a provider-based hospital outpatient designation are discussed earlier in this section.

Current regulations require that, in order to be paid for as "incident to" services, outpatient hospital services and supplies are to be furnished as an integral though incidental part of a physician service (§ 410.27(a)(1)(ii)). In addition, as a matter of policy, we require that the services and supplies be furnished on a physician's order by hospital personnel and under a physician's supervision (Intermediary Manual, section 3112.4(A)). When "incident to" services are furnished on hospital premises, we assume the physician supervision requirement to be met because staff physicians would be present nearby within the hospital. We also allow staff in a department of the hospital other than that of the ordering physician to supervise the services. We equate the location of the hospital outpatient department or hospital clinic within the hospital's walls, or their co-location on the same campus, with being "on the hospital premises," and we assume physician supervision is always at hand. In the interests of beneficiary health and safety, we do not believe it is reasonable, safe, or appropriate to extend these assumptions to a hospital outpatient department or hospital clinic that is located off-site and that is not on the hospital premises, even if that outpatient department or clinic is accorded provider-based status. Therefore, we are proposing as the third prerequisite for a hospital to receive payment for "incident to" services under section 1861(s)(2)(B) of the Act, when these services are furnished at a hospital outpatient department or clinic that HCFA designates as provider-based: that the "incident to" services and supplies always be furnished under the direct supervision of a physician.

Unless the three prerequisites are met, we are proposing to continue to regard a clinic, even if it is owned or operated by a hospital, as a physician office or physician clinic for Medicare payment purposes. Payment for services and supplies incident to physician services that are furnished to Medicare beneficiaries at that site would only be paid in accordance with section 1848 and section 1861(s)(2)(A) of the Act, and payment would be subject to Medicare physician fee schedule payment policies and regulations (part 410; part 414).

2. Prerequisites for Payment for Hospital or Critical Access Hospital Diagnostic Services Furnished to Outpatients

Prerequisites for payment for diagnostic services furnished to hospital outpatients are addressed in § 410.28. We are proposing to add a new paragraph to the regulation that would require, at a minimum, a general level of physician supervision, and in some cases, direct or personal physician supervision, when diagnostic x-ray tests and other diagnostic tests are furnished at a hospital outpatient department or clinic that HCFA has determined meets the criteria and obligations of a provider-based entity in accordance with § 413.65. The definitions of general, direct, and personal supervision are contained in § 410.32. Although the levels of supervision defined in § 410.32 apply specifically to diagnostic x-ray and other tests that are payable under the Medicare physician fee schedule, we believe the same levels of supervision are equally relevant and reasonable and necessary to ensure that beneficiary health and safety are protected and that diagnostic x-ray and other diagnostic tests are safe and effective when they are furnished at a hospital outpatient department or clinic that HCFA has designated to be provider-based.

We are also proposing to exclude from the supervision requirement in provider-based outpatient settings the same three types of diagnostic tests that are excluded from the supervision requirement under the physician fee schedule:

- Diagnostic mammography procedures, which are regulated by the Food and Drug Administration.
- Diagnostic tests personally furnished by a "qualified audiologist" as defined in section 1861(ll)(3) of the Act. These include "audiology services" as defined in section 1861(ll)(2) of the Act. We exclude these diagnostic tests from the physician supervision requirement because the Congress has defined these services without requiring physician supervision of their performance.
- Diagnostic psychological testing services personally performed by a qualified psychologist practicing independently of an institution, agency, or physician office as currently defined in section 2070.2 of the Medicare Carriers Manual (HCFA Pub. 14-3). These services are distinguished from services of a clinical psychologist, which are covered under section 1861(ii) of the Act, rather than section 1861(s)(3).

We are proposing to coordinate changes to the physician supervision requirements for diagnostic tests performed in outpatient settings that HCFA has designated to be provider-based with changes made to these requirements under the Medicare physician fee schedule. Refer to the final rule governing the 1998 physician fee schedule that was published in the October 31, 1997 **Federal Register** ("Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule, Other Part B Payment Policies, and Establishment of the Clinical Psychologist Fee Schedule for Calendar Year 1998" (BPD-884-FC) (62 FR 59048)) for a full discussion. Implementing instructions for physician supervision of diagnostic tests are being developed. We note that these implementing instructions will contain revisions in the supervision levels required for many ultrasound services, stress tests, and some other services.

When diagnostic x-rays and other diagnostic tests are performed at a hospital-owned and/or operated office or clinic that is off-site and that HCFA does *not* designate as provider-based, we are proposing to pay for these services under the provisions of the Medicare physician fee schedule and the requirements of § 410.32 or under the provisions of § 410.33, if applicable.

3. Payment for Ambulatory Surgical Services

Upon implementation of the hospital outpatient PPS, Medicare payment for resource costs incurred in connection with performing ambulatory surgical procedures would be made either under the provisions of the hospital outpatient PPS; or, under the benefit established at section 1832(a)(2)(F) of the Act for facility services furnished by an approved ASC in connection with surgical procedures specified by the Secretary; or, under the physician fee schedule as established under section 1848 of the Act.

When ambulatory surgery is performed at the hospital on Medicare beneficiaries who are registered at the hospital as outpatients, Medicare would allow payment under the outpatient PPS, as explained in this proposed rule. However, Medicare would make payment under the outpatient PPS for surgical procedures performed at an off-site clinic that the hospital owns and operates and for which it submits claims only if the off-site clinic has been designated by HCFA as a department of the hospital in accordance with proposed § 413.65.

Alternatively, if the hospital-owned off-site facility is certified or accredited

in accordance with ASC conditions of coverage and the requirements at part 416, Medicare would make payment for covered surgical procedures performed at the off-site facility under the ASC benefit.

However, for Medicare payment purposes, we consider an off-site office, clinic, organization, or facility that is owned and operated by a hospital but that does not meet the requirements at proposed § 413.65 or in part 416, to be a physician office or clinic, and Medicare payment for surgical procedures performed at that site would be limited to what Medicare allows for physician services furnished in connection with the surgical procedure under the Medicare physician fee schedule.

VII. MedPAC Recommendations

We reviewed the March 1998 report submitted by MedPAC to the Congress and gave its recommendations careful consideration in establishing the framework for the outpatient PPS that is the subject of this proposed rule. We responded earlier to several MedPAC recommendations that pertained directly to specific features of the outpatient PPS. In this section, we address the more general MedPAC recommendations on hospital outpatient payment policies.

Recommendation: MedPAC expresses its concern about the effects of inappropriate payment levels that could, if they are too low, restrict beneficiary access to care or prompt shifts of services for financial rather than clinical reasons, or that could, if they are too high, stimulate growth in the volume of outpatient services that is unrelated to patient needs. MedPAC states that the initial level of payment established in the BBA is a reasonable starting point for the outpatient PPS, but recommends that the Secretary monitor access to hospital outpatient services to ensure that the aggregate level of payment under the outpatient PPS is appropriate.

Response: We agree with MedPAC that monitoring service patterns not only in hospital outpatient departments but across all ambulatory settings subsequent to implementation of the outpatient PPS is essential in order to detect sudden changes and to identify variant trends in where services are being furnished to Medicare beneficiaries. As is MedPAC, we too are aware of how vividly any differences in payment for services furnished in different ambulatory settings will be revealed once the outpatient PPS is implemented, and we expect that these differences will, not surprisingly,

precipitate shifts in services from one setting to another. It is the recognition of this likely outcome that makes it all the more urgent that we resolve the dilemma posed by two conflicting policy determinations raised by MedPAC: whether to set Medicare payments to reflect the cost of providing a service regardless of where the service is furnished or whether to set Medicare payments to acknowledge that the site where a service is furnished could affect the cost of furnishing the service. As we discuss below, we clearly are inclined toward a position that Medicare should determine payment on the basis of the service that is furnished rather on the setting where that service is furnished, but there are many factors still to be considered before making such a determination final. In the meantime, we believe that the adjustments provided for under the outpatient PPS will contribute to ensuring that Medicare is paying adequately for services, especially in areas where a hospital is the only provider of services to which beneficiaries have access. We particularly welcome comments and suggestions regarding methods by which we can enhance our monitoring of service delivery patterns to ensure that the outpatient PPS is not adversely affecting beneficiary access to hospital outpatient care in accordance with MedPAC's recommendation. We agree with MedPAC's concern that payment levels under the outpatient PPS be sufficient to support the provision of services, especially in areas where a hospital is the only provider of such services, but that payment levels under the outpatient PPS not exceed payments for the same services at other ambulatory sites to such a degree as to cause shifts in where services are provided for financial rather than clinical reasons.

Recommendation: MedPAC recommends that HCFA continue to investigate service classification systems that could be applied consistently to all ambulatory care settings. In its 1998 report to Congress, MedPAC expresses concern about the impact on service delivery of paying different amounts for the same service based on where the service is furnished. MedPAC appears to favor Medicare ambulatory care payment systems that are standardized across hospital outpatient, physician office, and ASC settings. MedPAC equates "standardized" with "policies that are comparable for the same service, regardless of setting," (p. 83) and "consistency of payment across all ambulatory settings" (p. 84).

Response: In principle, we agree that establishing Medicare payment

uniformity across ambulatory care settings is important. We have, to the extent permitted by the statute, incorporated into the outpatient PPS elements of Medicare payment policy for ASCs and for physician services.

Upon implementation of the outpatient PPS, the same unit of payment (HCPCS codes and descriptors) will be used for all three settings. Packaging under the outpatient PPS parallels that for ASCs. At least initially, volume control under the outpatient PPS parallels that which is applied to physician services. The policy for discounting multiple procedures will be comparable under the outpatient PPS, the ASC benefit, and the physician fee schedule. APC groups will be used to set rates for ASC payments and for hospital outpatient surgical services, and we propose to pay for the same surgical procedures in both settings. Notwithstanding these similarities, payment rates for most procedures will not be the same for ASCs and under the outpatient PPS. We use different data and methods to set rates for ASC services, for physician services, and for hospital outpatient services. The latter is attributable primarily to the fact that the statute sets forth criteria that are to be considered when setting payment mechanisms that are specific to each site of service.

Several fundamental issues must be addressed before we achieve the goal of making consistent payment for the same service across all ambulatory sites of service. First, consensus must be reached on what constitutes "consistent payment." Even MedPAC equivocates on this point, noting that while it believes that "Medicare's payment should reflect the cost of efficiently providing a service, regardless of where it is delivered * * * (b)ecause of access or quality concerns * * * it may be appropriate to continue to pay different amounts for the same service, depending on the setting in which it is furnished." Does "consistent" or "comparable" payment mean the *same* payment for a service regardless of setting? Or would consistency be achieved by using the same group weights for hospital outpatient and ASC payment rates even though we used site-specific conversion factors, resulting in different payment rates? Should we use ASC groups as the basis for setting payments for physician services? Is there a single index that is appropriate to standardize variations in costs attributable solely to geographical differences? And which legislative changes would be required to standardize payment for services across ambulatory settings? These are but a few

of the issues and options that we and stakeholders across the spectrum of ambulatory care must thoroughly examine and analyze as we move towards standardizing payments across ambulatory sites of service. We solicit comments on this issue, on options to be considered in restructuring Medicare payment provisions towards the goal of establishing payment uniformity across ambulatory sites, and on strategies for achieving consensus on the definition of both goals and the means of attaining them.

VIII. Collection of Information Requirements

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 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.

We are soliciting public comment on each of these issues for the provisions summarized below that contain information collection requirements:

Section 413.65 Requirements for a Determination That a Facility or an Organization is a Department of a Provider or a Provider-Based Entity

Section 413.65(c)(1) and (c)(2) states that a main provider that acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to HCFA and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status. This requirement applies, however, only if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization on the provider's cost report would increase

the total costs on the report by at least 5 percent. Furthermore, a main provider that has had one or more entities considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

The burden associated with this requirement is the time for the main provider to report its acquisition to HCFA, furnish all information needed for a determination, report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization. It is estimated that 105 main providers will take 10 hours for a total of 1,050 hours.

Section 419.42 Hospital Election To Reduce Copayment

Section 419.42(b) and (c) states that a hospital must notify its fiscal intermediary of its election to reduce copayments no later than 90 days prior to the start of the calendar year. The hospital's election must be properly documented. It must specifically identify the ambulatory payment classification to which it applies and the copayment level (within the limits identified below) that the hospital has selected for each group.

The burden associated with these requirements is the time it takes a hospital to compile, review, and analyze data for both revenues and copayments; prepare and present the data to the hospital board; make a business decision as to whether the hospital would elect to reduce copayments; and then notify its fiscal intermediary of its election. A hospital would notify its fiscal intermediary of its election to reduce copayments only if there were other providers, in close proximity, that would attract a majority of the hospital's business if they did not reduce their copayments. Since hospitals do not want to lose money by absorbing copayments, we anticipate that this requirement will affect 750 hospitals and take them 10 hours each for a total of 7,500 hours.

Section 419.42(e) states that the hospital may advertise and otherwise disseminate information concerning the reduced level(s) of coinsurance that it has elected.

The burden associated with this requirement is the time for the hospital to disseminate information concerning its coinsurance election. It is estimated that 750 hospitals will each take 10 hours annually to disseminate this information via newsletters and information sessions at senior citizen centers for a total of 7,500 hours.

While the information collection requirements listed below are subject to the Paperwork Reduction Act, the burden associated with these requirements is captured under § 413.65(c)(1) and (c)(2).

Section 413.65(b)(2) states that a provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider begins billing for services of the facility or organization as if they were furnished by a department of the provider-based entity, or before it includes costs of those services on its cost report.

Section 413.65(d)(7)(i) requires that the facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and

demonstrates that it serves the same patient population as the main provider, either by submitting records such as common patient lists and/or demographic data showing that a high percentage of patients of both the main provider and the applicant entity come from the same geographic area, or by submitting data substantiating that the patients served by the entity also receive services from the main provider (for example, the patients of an RHC receive inpatient hospital services from the main provider).

While the information collection requirements listed below are subject to the Paperwork Reduction Act, we believe the burden associated with these requirements is not subject to the Act, as defined by 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with these requirements would be incurred by persons in the normal course of their activities.

Section 413.65(g)(7) states that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity, the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the

beneficiary's potential financial liability (that is, a coinsurance liability for a facility visit as well as for the physician service).

We believe the information collection requirement below is exempt from the Paperwork Reduction Act, as defined by 5 CFR 1320.4(a)(2), since this activity is pursuant to the conduct of an investigation or audit against specific individuals or entities.

Section 413.65(i)(1) states that if HCFA determines that a provider has been inappropriately billing Medicare for services furnished in a physician office or other facility or organization as if they had been furnished in a hospital outpatient department or other department of a provider or in a provider-based entity, HCFA stops all payments to the provider for outpatient services until the provider can demonstrate which payments are proper.

The table below indicates the annual number of responses for each regulation section in this proposed rule containing information collection requirements, the average burden per response in minutes or hours, and the total annual burden hours.

ESTIMATED ANNUAL BURDEN

CFR section	Responses	Average burden per response (hours)	Annual burden hours
413.65(c)(1) and (c)(2)	105	10	1,050
419.42(b) and (d)	750	10	7,500
419.42(f)	750	10	7,500
Total			16,050

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements. These requirements are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Health Care Financing Administration,
Office of Information Services,
Information Technology Investment
Management Group, Division of
HCFA Enterprise Standards, Room
C2-26-17, 7500 Security Boulevard,
Baltimore, MD 21244-1850, Attn:
Louis Blank HCFA-1005-P, Fax
number: (410) 786-1415 and,
Office of Information and Regulatory
Affairs, Office of Management and

Budget, Room 10235, New Executive
Office Building, Washington, DC
20503, Attn.: Allison Herron Eydt,
HCFA Desk Officer, Fax numbers:
(202) 395-6974 or (202) 395-5167.

IX. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, 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 preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

X. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this proposed rule as required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when 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 annually). Because the projected savings resulting from this proposed rule are

expected to exceed \$100 million, it is considered a major rule.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits for any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million. This proposed rule does not mandate any requirements for State, local, or tribal governments. However, our estimations indicate that the loss of income to the private sector as a result of this rule should exceed \$300 million total to all hospitals.

We generally prepare a regulatory flexibility analysis that is consistent with the RFA (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an 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 define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98-21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the proposed prospective payment system, we classify these hospitals as urban hospitals.

B. Estimated Impact on Medicare Program

According to HCFA's Office of the Actuary, the benefit impacts of the hospital outpatient PPS (including elimination of the formula-driven overpayment (FDO) effective as of October 1, 1997, extension of the 10 percent reduction in payments for hospital outpatient capital cost and the 5.8 percent reduction for outpatient services paid on a cost basis through CY 1999, and the implementation of a PPS for hospital outpatient services on January 1, 1999 would be as follows:

Fiscal year	Impact (\$ millions)
1998	- 940
1999	- 1650
2000	- 1330
2001	- 1070
2002	- 990
2003	- 680

The use of the national median of the charges for PPS services to establish the unadjusted copayment amount would have resulted in the beneficiaries paying 6.9 percent less in coinsurance payments in 1999 than what they would have been expected to pay otherwise. It was assumed that there would have been a behavioral offset by the hospitals of 10 percent of the coinsurance reduction. It was assumed that 45 percent of this offset would apply to the services subject to the PPS and, therefore, would have been included in setting the 1999 conversion factor. The remaining 55 percent of the offset would be reflected in expenditures for non-PPS services with both the beneficiary and Medicare absorbing this impact. With the delay in implementation of the outpatient PPS, the behavioral offset will not occur in 1999, and, therefore, there will be slightly higher program savings.

C. Objectives

The primary objective of the proposed prospective payment system is to simplify the payment system while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of deficit reduction and restraints on government spending in general.

We believe the proposed changes would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

D. Limitations of our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes, on various hospital groups. We use the best data available; in addition, we do not make adjustments for future changes in such variables as volume and intensity. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects

of these changes on hospitals and our methodology for estimating them.

E. Hospitals Included in and Excluded From the Prospective Payment System

The outpatient prospective payment system encompasses nearly all hospitals that participate in the Medicare program. However, those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the PPS. Critical access hospitals (CAHs) are also excluded and are paid at cost under section 1834(g).

F. Quantitative Impact Analysis of the Proposed Policy Changes Under the Prospective Payment System for Operating Costs and Capital Costs

Basis and Methodology of Estimates

The data used in developing the quantitative analyses presented below are taken from the CY 1996 cost and charge data and the most current provider-specific file that is used for payment purposes. Our analysis has several qualifications. First, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using CY 1996 cost and charge data, we simulated payments using the current and proposed payment methodologies. We used both single and multiple bills to calculate current and proposed Medicare and beneficiary hospital outpatient payment amounts. Both current and proposed payment estimates include operating and capital costs. The exempted Maryland hospitals were excluded from the simulations; however, we included the 10 cancer hospitals that will be paid under the proposed system.

We also trimmed outlier hospitals from the impact analysis because we had indications that hospitals with extreme unit costs would not allow us to assess the impacts among the various classes of hospitals accurately. First, we identified all the outlier hospitals by using an edit of three standard deviations from the mean of the logged unit costs. Trimming the data in this manner ensures that only the hospitals with extremely high and low costs are eliminated from the impacts. In doing this, we removed 83 hospitals of which 32 hospitals had extremely low unit costs and 51 hospitals had extremely

high unit costs. We conducted a thorough analysis of these hospitals to ensure that we did not remove any particular type of hospital (for example, teaching hospitals) that would further harm the integrity of the data. We speculate many of these hospitals are not coding accurately, and we will continue to perform further analysis in this area after implementation of the new APC system.

After removing the 54 exempted Maryland hospitals, outlier hospitals, and hospitals for which we could not identify payment variables, we included 5,419 hospitals in our analysis. The impact analysis focuses on this set of hospitals. The table below demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The first column represents the number of hospitals in each category. The second column is the hospitals' Medicare outpatient payments as a percentage of the hospitals' total Medicare payment. The third column shows the percentage change in Medicare outpatient payments comparing the current and proposed payment systems. The fourth column shows the change in total Medicare payments, resulting from implementing the PPS for outpatient services.

The top row of the table shows the overall impact on the 5,419 hospitals included in the analysis. We included as much of the data as possible to the extent that we were able to capture all the provider information necessary to determine payment. Further, our estimates include the same set of services for both current and proposed APC payments so that we could determine the impact as accurately as possible. Since payment under the proposed APC system can only be determined if bills are accurately coded, the data upon which the impacts were developed do not reflect all CY 1996 hospital outpatient services, but only those that were coded using valid HCPCS.

The second row identifies the hospitals in our analysis with the exception of psychiatric, long-term care, children, and rehabilitation hospitals, which account for 4,864 hospitals.

The next four rows of the table contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,677 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are

1,516 hospitals located in large urban areas (populations over 1 million), and 1,161 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,187 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The next category includes the volume of outpatient services, also shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an indirect medical education (IME) adjustment), receive disproportionate share hospital (DSH) payments, or some combination of these two adjustments. There are 3,847 non-teaching hospitals in our analysis, 766 teaching hospitals with fewer than 100 residents, and 250 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status. The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither. The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (rural referral centers (RRCs), sole community hospitals/essential access community hospitals (SCHs/EACHs), Medicare dependent hospitals (MDHs), and SCHs and RRCs), as well as rural hospitals not receiving a special payment designation. The RRCs (168), SCH/EACHs (625), MDHs (365), and SCH and RRCs (55) shown here were not reclassified for purposes of the standardized amount.

The next grouping is based on type of ownership. These data are taken primarily from the FY 1995 Medicare cost report files, if available (otherwise, FY 1994 data are used).

The next groupings are the specialty hospitals. The first set includes the categorizations of eye and ear hospitals and trauma hospitals (hospitals having a level one trauma center) and cancer hospitals. The final groupings are the TEFRA hospitals, specifically rehabilitation, psychiatric, long-term care, and children hospitals.

G. Estimated Impact of the New APC System

Column 3 compares our estimate of payments, incorporating statutory and

policy changes reflected in this proposed rule for CY 1996, to our estimate of payments in CY 1996 under the current payment system. Percent differences between current and proposed payment reflect the combined impact of a proportionally equal reduction in payments due to the calculation of the conversion factor and distributional differences attributable to variation in cost and charge structures among hospitals. The methodology described in section 1833(t)(3)(C) of the Act outlining the calculation of the conversion factor reduces payment to hospitals overall by 3.8 percent relative to current law. As noted, section 1833(t)(3)(C) of the Act requires us to set the conversion factor so that total 1999 payments to hospitals under the proposed PPS system equal Medicare payment amounts as calculated under the current payment system plus beneficiary copayments as calculated under the proposed system (20 percent of the APC median charge or, at minimum, 20 percent of the APC rate). The 3.8 percent loss implies that the difference between the median and charges higher than the median was proportionally larger than the difference between the median and charges lower than the median. Because this reduction is incorporated into the conversion factor, the 3.8 percent is distributed among hospitals proportional to their total payments. After removing the effect of the conversion factor calculation on total payments, the remaining percent differences demonstrate the redistribution of payments among hospitals and can be attributed to variation in both costs and charge structures. Variation in costs among hospitals results in differences between current and proposed Medicare payments, and variation in charge structures results in differences between current and proposed beneficiary copayment.

Redistributions may also occur as a result of current payment methods. Total Medicare outpatient payments are less than reported total costs because (in addition to the 5.8 and 10 percent reductions for operating and capital costs) the blended payment methods applicable to many surgical and diagnostic services often result in payments that are less than reported costs. Other services such as medical visits, chemotherapy services, partial hospitalization services, and non-ASC approved surgeries are paid based on hospital costs. The new system redistributes the current total Medicare payments, based in part on cost-based payments and in part on blended

payment amounts, across all services. Hospitals, in the aggregate, will receive proportionately less for services that are currently paid based on costs and more for services that had been paid under blended payment methods.

The impact on TEFRA hospitals is shown separately at the end of the table; however, these hospitals were not included in determining the impact on any of the other categories (for example, geographic location, bed size, volume, etc.). These hospitals demonstrated a very low service mix, but an average unit cost that is only somewhat smaller than the national average. We believe that billing practices may account for this phenomenon. Some TEFRA hospitals appear to under-code HCPCS and units. This may be because correct coding is not required for payment or because they bill an all-inclusive rate. Undercoding or billing an all-inclusive rate could account for their low volume, low service mix, and almost average cost per unit. We expect that once these hospitals begin to code HCPCS according to the new payment system, new payments will better reflect current payments.

In general, differences among hospital classifications for short-term acute care hospitals were relatively small. That is, payments under the proposed outpatient system were within a few percentage points of payments made under current law. The following discussion highlights some of the variation in payments among hospital classifications.

Based on comparing current and proposed payment estimates, minor teaching hospitals lose 1.8 percent,

while major teaching hospitals experience a reduction of 9.4 percent. Non-teaching hospitals experience a decrease of 3.1 percent. However, major teaching hospitals gain less of their total Medicare income (9.2 percent) from outpatient services than the national average (10 percent). This results in a less than 1 percent loss in their total Medicare income.

Hospitals with a high percentage of low income patients (disproportionate share patient percentage ≤ 0.35) appear to experience payment reductions of 6.8 percent relative to current law. These hospitals have lower than average volume, and, like major teaching hospitals, they receive a smaller than average percent of their Medicare income from outpatient services.

Rural hospitals would lose about 5.2 percent and large urban hospitals would lose about 5.0 percent under the new system while other urban hospitals would lose 0.9 percent. These small differences illustrate fairly equitable payment among these geographical settings. However, rural hospitals get a greater percentage of their Medicare income (14.7 percent) from outpatient services compared to the national average of 10 percent.

Low-volume hospitals appear to lose a large percentage of their payments under the new payment system (17 percent for rural and 15.6 percent for urban hospitals with less than 5,000 units of service). We believe several factors are contributing to this outcome, including undercoding, lack of economies of scale, and underpayment due to the reliance on the median instead of the geometric mean in the

calculation of APC weights. The majority of these hospitals (about 75 percent) are rural. These hospitals also have a service mix (1.03) lower than the national average (1.45) and higher than average hospital cost per unit standardized for service mix. For these small hospitals, some of the higher standardized unit costs could be attributed to economies of scale. These low-volume rural hospitals also receive a greater percentage of their Medicare income (18.2 percent) from outpatient services than the average. SCHs and MDHs comprise about 60 percent of these low-volume rural hospitals.

As discussed previously in section V.I, the Adjustments section, we are particularly concerned about the potential impact on the approximately 60 percent of low-volume rural hospitals that are sole community hospitals or Medicare-dependent hospitals. As previously discussed, one option would be to phase-in the outpatient PPS for low-volume Medicare-dependent and sole community hospitals by paying a portion of the payment based on PPS rates and a portion based on the current payment system. For example, payment could be based on 75 percent of payments under the current system and 25 percent on PPS rates in the first year, 50 percent current system payments and 50 percent PPS rates in the second year, 25 percent current system payments and 75 percent PPS rates in the third year, and completely on PPS rates in subsequent years. If such an approach were adopted, the impact on Medicare outpatient payment for these hospitals would be as follows:

ESTIMATED IMPACT OF A TRANSITION POLICY ON MEDICARE OUTPATIENT PAYMENTS FOR MEDICARE-DEPENDENT AND SOLE COMMUNITY HOSPITALS

[In percent]

	Year 1	Year 2	Year 3	Year 4
MDH	-2.1	-4.3	-6.4	-8.5
SCH	-1.7	-3.3	-5.0	-6.7
SCH/RRC	-0.5	-1.0	-1.6	-2.1

Another option discussed earlier in the adjustments section would phase-in outpatient PPS if a low-volume sole community or Medicare-dependent hospital has a negative Medicare margin for outpatient services. For example, payment could be based on the amount payable under outpatient PPS plus a percentage of the difference between those amounts and the amounts payable under the current system. The percentage of the difference that would be payable could phase down, for

example, 75 percent in the first year, 50 percent in the second year, 25 percent in the third year, and no additional payment in subsequent years. We solicit comments on these and other alternatives we could consider.

As noted above, rural hospitals lose a larger percent of their payments than urban hospitals. Among the census divisions, rural New England hospitals experience the largest negative payment impact of 13.6 percent. This could be attributed to higher non-labor costs in

New England. West North Central hospitals also would experience a 7.7 percent payment loss.

Urban census division breakouts reveal that Middle Atlantic urban hospitals lose 11.3 percent of payments while the other urban census regions gain or lose modestly.

Hospitals located in Puerto Rico gain because of the change in the beneficiary copayment. Previously these hospitals received 20 percent of their charges from the beneficiary, whereas under the

new PPS they would receive 20 percent of the APC median charge or, at minimum, they would receive 20 percent of the payment rate. Hospitals in Puerto Rico gain under the new proposed system because 20 percent of their charges are lower than 20 percent of the APC median charges or 20 percent of the rates.

Among special categories of rural hospitals, MDHs and SCHs/EACHs would experience decreases of 8.5 and 6.7 percent, respectively. Some of this decrease may be attributed to the impact on low-volume rural hospitals.

Cancer hospitals experience a 29.2 percent loss. Several factors may contribute to this loss. Under-coding could be a factor contributing to the

percentage loss. In addition, the current requirements for batch billing of services such as chemotherapy and radiation therapy and the fact that we used only single procedure bills to calculate group weights may also have contributed to the impact on these hospitals. Further analysis will be conducted to determine if current coding practices explain the negative impact. We will be verifying the accuracy of the rates for these types of procedures. Specifically, the APC weights were calculated using single bill procedures. Using single bill procedures to compute a weight for services which are not typically billed as a single procedure could result in rates that are not accurate for these services. We will

verify the accuracy of the rates for these types of procedures by analyzing the costs from the multiple bills. If further analysis reveals that cancer hospitals would be unduly harmed because of the new outpatient PPS, we will consider whether an adjustment or perhaps a transition period is needed to moderate the impact. By statute, any adjustment would have to be budget neutral. Until further analysis can be conducted we are not proposing an adjustment for cancer hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

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**CHANGES FOR
OUTPATIENT PROSPECTIVE PAYMENT SYSTEM**

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
ALL HOSPITALS	5,419	9.9	-3.8	-0.4
NON-TEFRA HOSPITALS	4,864	10.0	-3.7	-0.4
<u>NON-TEFRA HOSPITALS:</u>				
LOCATION				
GEOGRAPHIC LOCATION				
URBAN HOSPITALS	2,677	9.3	-3.3	-0.3
LARGE URBAN AREAS	1,516	9.1	-5.0	-0.5
OTHER URBAN AREAS	1,161	9.6	-0.9	-0.1
RURAL HOSPITALS	2,187	14.7	-5.2	-0.8
BED SIZE (URBAN)				
0- 99 BEDS	654	15.5	-7.4	-1.1
100-199 BEDS	917	10.4	-2.5	-0.3
200-299 BEDS	542	9.2	-0.7	-0.1
300-499 BEDS	425	8.6	-3.3	-0.3
500 OR MORE BEDS	139	8.3	-7.0	-0.6
BED SIZE (RURAL)				
0- 49 BEDS	1,149	19.6	-9.8	-1.9
50- 99 BEDS	644	15.5	-6.9	-1.1
100-149 BEDS	229	13.5	-4.6	-0.6
150-199 BEDS	91	13.0	-2.0	-0.3
200 OR MORE BEDS	74	11.4	0.1	0.0
VOLUME (URBAN)				
0- 4,999 UNITS	278	12.1	-15.6	-1.9
5,000- 10,999 UNITS	442	9.8	-6.3	-0.6

	Number of hospitals	Outpatient percent	Percent change in Medicare outpatient payments	Percent change in total Medicare payments
	(1)	(2)	(3)	(4)
11,000- 20,999 UNITS	599	9.1	-5.8	-0.5
21,000- 42,999 UNITS	780	8.7	-3.6	-0.3
43,000 OR MORE UNITS	578	9.7	-2.0	-0.2
VOLUME (RURAL)				
0- 4,999 UNITS	816	18.2	-17.0	-3.1
5,000- 10,999 UNITS	694	15.8	-10.0	-1.6
11,000- 20,999 UNITS	420	14.6	-5.8	-0.8
21,000- 42,999 UNITS	215	13.5	-1.8	-0.2
43,000 OR MORE UNITS	42	13.2	5.3	0.7
URBAN BY CENSUS DIV.				
NEW ENGLAND	152	10.7	-4.9	-0.5
MIDDLE ATLANTIC	399	8.3	-11.3	-0.9
SOUTH ATLANTIC	400	8.6	-3.8	-0.3
EAST NORTH CENTRAL	451	10.7	-0.5	-0.1
EAST SOUTH CENTRAL	158	7.9	0.9	0.1
WEST NORTH CENTRAL	189	9.5	-1.6	-0.2
WEST SOUTH CENTRAL	340	9.7	-2.2	-0.2
MOUNTAIN	122	10.2	1.3	0.1
PACIFIC	429	9.3	0.1	0.0
PUERTO RICO	37	6.8	8.3	8.6
RURAL BY CENSUS DIV.				
NEW ENGLAND	56	16.9	-13.6	-2.3
MIDDLE ATLANTIC	81	13.5	-1.9	-0.3
SOUTH ATLANTIC	283	11.8	-5.7	-0.7
EAST NORTH CENTRAL	288	15.8	-3.3	-0.5
EAST SOUTH CENTRAL	267	11.2	-5.6	-0.6

	Number of hospitals	Outpatient percent	Percent change in Medicare outpatient payments	Percent change in total Medicare payments
	(1)	(2)	(3)	(4)
WEST NORTH CENTRAL	516	19.6	-7.7	-1.5
WEST SOUTH CENTRAL	339	14.1	-6.1	-0.9
MOUNTAIN	216	16.7	-3.5	-0.6
PACIFIC	137	16.4	0.8	0.1
PUERTO RICO	4	6.6	34.6	2.3
TEACHING STATUS				
NON-TEACHING	3,847	11.2	-3.1	-0.3
FEWER THAN 100 RESIDENTS	766	9.1	-1.8	-0.2
100 OR MORE RESIDENTS	250	9.2	-9.4	-0.9
DISPROPORTIONATE SHARE PATIENT RATIO				
0	25	25.1	-0.3	-0.1
0.001- 0.099	916	10.3	-4.9	-0.5
0.100- 0.159	1,016	10.9	-0.9	-0.1
0.160- 0.229	977	10.2	-2.9	-0.3
0.230- 0.349	966	9.6	-4.2	-0.4
0.350 AND GREATER	964	9.2	-6.8	-0.6
URBAN TEACHING AND DSH				
BOTH TEACHING AND DSH	957	9.0	-4.6	-0.4
TEACHING AND NO DSH	2	19.8	-18.6	-3.7
NO TEACHING AND DSH	1,708	9.8	-1.9	-0.2
NO TEACHING AND NO DSH	10	28.6	40.8	11.7
RURAL HOSPITAL TYPES				
NONSPECIAL STATUS HOSPITALS	950	15.0	-6.6	-1.0
RRC	168	12.4	-1.9	-0.2
SCH/EACH	625	16.4	-6.7	-1.1

	Number of hospitals	Outpatient percent	Percent change in Medicare outpatient payments	Percent change in total Medicare payments
	(1)	(2)	(3)	(4)
MDH	365	18.2	-8.5	-1.5
SCH/EACH AND RRC	55	13.7	-2.1	-0.3
TYPE OF OWNERSHIP				
VOLUNTARY	2,877	9.9	-4.0	-0.4
PROPRIETARY	680	7.9	-1.1	-0.1
GOVERNMENT	1,307	12.3	-4.0	-0.5
SPECIALTY HOSPITALS				
EYE AND EAR	13	33.6	1.4	0.5
TRAUMA	160	9.1	-5.9	-0.5
CANCER	10	22.0	-29.2	-6.4
TEFRA HOSPITALS:				
REHABILITATION	141	3.7	-24.1	-0.9
PSYCHIATRIC	304	10.4	-11.7	-1.2
LONG-TERM CARE	70	3.5	-4.1	-0.1
CHILDREN'S	40	9.9	-34.8	-3.4

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XI. Delay in Implementation Date

Like other public and private organizations that depend upon the smooth functioning of computer systems, the Medicare program faces the challenge making changes to assure that computers can recognize dates in the year 2000 and later. Computer programming, which has commonly employed only two digits to record the year in the date for transactions and other entries, will not be able to distinguish the year 2000 from the year 1900 without reprogramming. Such confusion in the context of Medicare enrollment and claims processing could create massive errors, as computers could mistakenly determine that beneficiaries are not eligible for benefits or that services were rendered before the effective date of benefit provisions.

For Medicare, achieving year 2000 (Y2K) compliance involves renovating all computer and information systems. The year 2000 especially affects HCFA because of our extensive reliance on multiple computer systems. More than 183 systems are used in administering the Medicare and Medicaid programs, and 98 of these are considered "mission critical" for establishing beneficiary eligibility and making payments to providers, plans, and states. Medicare is the most automated health care payer in the country. The Medicare program processes nearly one billion claims each year, or about 17 million transactions each week. Fully 98 percent of inpatient hospital and other Medicare Part A claims are processed electronically, as are 85 percent of physician and other Medicare Part B claims.

The renovation process is complicated because each piece in the systems used by Medicare, its 60-plus claims processing contractors, interfaces with state Medicaid programs, and some 1.6 million providers must be thoroughly reviewed and renovated by those responsible for each particular system. Programs must be tested, both alone and for the complicated interfaces among them. To fix only the Medicare systems, 49 million lines of code must be renovated. All Medicare-specific software must be renovated, and tested to assure that it continues to work with new versions of vendor-supplied software, including operating systems that drive the hardware. Some hardware must be upgraded, and our telecommunications equipment and software must be compliant. We must assure that all data exchanges with thousands of partners are compliant. Testing of year 2000 changes presents a far greater burden than testing of routine system changes because we must test

multiple times on a range of different dates. For example, February 29, 2000 and March 1, 2000 must both be tested because CY 2000 is a leap year.

Because this process is necessary to keep program payments going out to beneficiaries and providers, year 2000 work must take precedence over other projects that require systems changes, including some Balanced Budget Act provisions. The Y2K project must be completed before other projects simply because activity on these other projects would divert resources from the Y2K project and could even compromise the effort to assure Y2K compliance if implemented in tandem. Many other private and public organizations, including most major insurance companies, have reached the same conclusion and are halting other projects involving information technology changes to clear the decks for the year 2000.

HCFA's independent year 2000 verification and validation contractor, Intermetrics, has advised the agency to delay all projects that could interfere with year 2000 work. Intermetrics specifically advised the agency to "seek necessary relief from Congressional mandates, system transitions and version releases to allow near-term, focused attention to achieving Y2K compliant systems." This includes projects that are complex, or which would occur during a critical window between October 1999 and March 2000. Otherwise, they warned, "many of your most critical system renovations have risk of significant schedule slippage."

Implementation of outpatient PPS is one of the projects that must be delayed by the year 2000 system renovations, because it requires massive system changes. Major contractor systems will be affected: the Fiscal Intermediary Standard Systems (FISS), the Arkansas Part A Standard System (APASS), the Common Working File (CWF), the Outpatient Code Editor (OCE), and the various systems operated by Fiscal Intermediaries and their corporate entities. Several HCFA systems will also be affected, including the National Claims History (NCH), the Provider Statistical & Reimbursement System (PS&R), and the Electronic Data Interchange (EDI). The scope of the required changes is also substantial. Among the required changes are:

- Expansion of the claim record of FISS, APASS, EDI, NCH and CWF to accept and retain specific information related to how a service is being paid or why it's denied.
- Conversion of all claims history to correspond with expanded format.

- Rewriting the program for FISS to process claims using line item dates of service.

- Rewriting the program for CWF to accept non covered charges by claim and line item.

- Developing, installing and testing an outpatient PRICER which determines payment amounts based on the HCFA Common Procedural Codes (HCPCS).

- Revision of interfaces with the fiscal intermediaries, providers, Billing Agents, EDI, OCE, PS&R and NCH and create an interface for PRICER.

- Developing, installing and testing a program to calculate the variable co-insurance per payment code grouping for each provider who elects to accept a reduced co-insurance.

- Revision of all claims processing output and interfaces including: Medicare Summary Notices (MSN), Beneficiary Denial Letters (BDL), Explanation of Medicare Benefits (EOMB), Notice of Utilization (NOU), Remittance Advice (RA).

The consequence of all these required changes to basic systems will be to change the entire way Fiscal Intermediaries process and pay hospital outpatient and community mental health center claims. There is also a major impact on the many systems that are required to receive this revised output. Changes of this magnitude require massive testing by all of the systems maintainers as well as each Fiscal Intermediary. Additionally, the impact on the Fiscal Intermediary systems has a domino effect. The intermediaries are doing business for Medicare under the auspices of their respective corporate entities. These corporate systems must be modified to accept, edit and relay the new information necessary to process outpatient PPS claims. They are also working toward becoming millennium compliant and competing for the same resources to scope, program, test and rework these changes, as well as the multitude of other BBA changes and Y2K. In the light of this, HCFA has no choice but to suspend implementing such massive change while the Intermediaries, their respective corporate entities, the standard systems maintainers as well as the provider community are working diligently to become Y2K compliant. It would be irresponsible to continue activity that would create a real danger that basic enrollment and claims processing activities will be disrupted, with far worse consequences for providers and beneficiaries than delay in implementation of outpatient PPS will cause.

We analyzed whether existing systems could be used to mimic processing of bills under the outpatient PPS. In every case, there were insuperable obstacles. In no case, for example, could these other systems compute the coinsurance correctly: the other available systems compute coinsurance as 20 percent of charges or 20 percent of a fee schedule amount. We have therefore reluctantly concluded that there is no alternative to a delay in implementation. As previously noted, the outpatient PPS will be implemented as soon as possible after January 1, 2000. A notice of the anticipated implementation date will be published in the **Federal Register** at least 90 days in advance.

We expect that there will be no negative impact on hospitals generally from the delay in implementation. The effect on individual hospitals will, of course, vary depending on how their current cost-based reimbursement compares to the total payments they would receive under the proposed system. Hospitals altogether should receive about the same level of Medicare program payments under the existing payment system, as they would have received in program payments under the outpatient PPS. When beneficiary coinsurance is taken into account, we expect that hospitals generally will receive about 3.8 percent more in total payments under the existing payment system, than they would have received in total payments under the outpatient PPS. We should note that payment rates will be established at the level they would have been if the PPS had been implemented on January 1, 1999.

The major impact of the delay in implementation will be on beneficiaries who will continue to pay coinsurance based on 20 percent of the hospital's charges. In the aggregate, we estimate beneficiary coinsurance would have been 6.9 percent lower under the outpatient prospective payment system in 1999 than under the current system. Under the prospective payment system, coinsurance will be based on our estimate of the median coinsurance amount for each APC under the current system in 1999. In the aggregate, estimated median coinsurance amounts are 6.9 percent lower than estimated mean coinsurance amounts for each APC. The actual impact will depend on the extent to which hospitals raise their charges in 1999. For example, the impact on beneficiaries would be moderated if hospitals show restraint in increasing charges (which have been increasing more rapidly than cost). We will actively encourage hospitals to voluntarily restrain from increasing

their current charges. The actual impact on a given beneficiary will also depend on the hospital's charge structure relative to national charge levels. A beneficiary receiving services from a hospital with relatively low charges could be advantaged by the delay whereas a hospital with relatively high charges would be disadvantaged by the delay. We note that the impact will not be carried over to the prospective payment system.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Health facilities, Hospitals, Medicare.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 1003

Administrative practice and procedure, Archives and records, grant program—social programs, Maternal and Child Health, Medicaid, Medicare, Penalties.

For the reasons set forth in the preamble, 42 CFR chapters IV and V would be amended as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

A. Part 409 is amended as set forth below:

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

2. In § 409.10, paragraph (b) is revised to read as follows:

§ 409.10 Included services.

* * * * *

(b) *Inpatient hospital services* does not include the following types of services:

(1) Post-hospital SNF care, as described in § 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.

(2) Nursing facility services, described in § 440.155 of this chapter, that may be furnished as a Medicaid service under title XIX of the Act in a swing-bed hospital that has an approval to furnish nursing facility services.

(3) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(6) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(7) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(8) Services of an anesthetist, as defined in § 410.69 of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Part 410 is amended as set forth below:

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 1395(hh)), unless otherwise indicated.

Subpart A—General Provisions

2. In § 410.2, the following definitions are added in alphabetical order to read as follows:

§ 410.2 Definitions.

As used in this part—

* * * * *

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

* * * * *

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

* * * * *

Subpart B—Medical and Other Health Services

3. In § 410.27, the section heading is revised, the introductory text to paragraph (a) is revised, the introductory text to paragraph (a)(1) is republished, and new paragraphs (a)(1)(iii), (e), and (f) are added to read as follows:

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if—

(1) They are furnished—

* * * * *

(iii) In the hospital or at a location (other than an RHC or an FQHC) that HCFA designates as qualifying as a department of a provider under § 413.65 of this chapter; and

* * * * *

(e) Services furnished by an entity other than the hospital are subject to the limitations specified in § 410.39(a).

(f) Services furnished at a location (other than an RHC or an FQHC) that HCFA designates as having provider-based status under § 413.65 of this chapter must be under the direct supervision of a physician as defined in § 410.32(b)(3)(ii).

4. In § 410.28, paragraph (a)(4) is removed, paragraph (c) is redesignated as paragraph (d), and new paragraphs (c) and (e) are added to read as follows:

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

* * * * *

(c) Diagnostic services furnished by an entity other than the hospital or CAH are subject to the limitations specified in § 410.39(a).

* * * * *

(e) Medicare Part B makes payment under section 1833(t) of the Act for diagnostic tests performed at a facility (other than an RHC or an FQHC) that HCFA designates as having provider-based status only when the diagnostic tests are furnished under the appropriate level of physician supervision specified by HCFA in

accordance with the definitions in § 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii).

5. A new § 410.39 is added to read as follows:

§ 410.39 Limitations on coverage of certain services furnished to hospital outpatients.

(a) Except as provided in paragraph (c) of this section, Medicare Part B does not pay for any item or service that is furnished to a hospital outpatient (as defined in § 410.2) during an encounter (as defined in § 410.2) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to its patients.

(b) As used in paragraph (a) of this section, the term “hospital” includes a CAH.

(c) The limitations stated in paragraphs (a) and (b) of this section do not apply to the following services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

C. Part 411 is amended as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart A—General Exclusions and Exclusion of Particular Services

2. In § 411.15, the introductory text is republished; the section heading to paragraph (m) is revised; paragraph (m)(1) is revised; the introductory text to paragraph (m)(2) is republished; paragraphs (m)(2)(iii), (m)(2)(iv), and (m)(2)(v) are redesignated as paragraphs (m)(2)(iv), (m)(2)(v), and (m)(2)(vi), respectively; and new paragraphs (m)(2)(iii) and (m)(3) are added to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

(m) *Services to hospital patients*—(1) *Basic rule.* Except as provided in paragraph (m)(2) of this section, any service furnished to an inpatient of a hospital or to a hospital outpatient (as defined in § 410.2 of this chapter) during an encounter (as defined in § 410.2 of this chapter) by an entity other than the hospital, unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the hospital's patients. (As used in this paragraph (m)(1), the term “hospital” includes a CAH.)

(2) *Exceptions.* The following services are not excluded from coverage:

* * * * *

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

(3) *Scope of exclusion.* Services subject to exclusion under the provisions of this paragraph (m) include, but are not limited to, clinical laboratory services; pacemakers and other prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses); artificial limbs, knees, and hips; equipment and supplies covered under the prosthetic device benefits; and services incident to a physician service.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

D. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. In § 412.50, paragraphs (a) and (b) are revised to read as follows:

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10

of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) HCFA does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

E. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart A—Introduction and General Rules

§ 413.1 [Amended]

2. In § 413.1, paragraph (a)(2)(viii) is removed.

Subpart B—Accounting Records and Reports

3. In § 413.24, the heading to paragraph (d) is published, and a new paragraph (d)(6) is added to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Management contracts.* (i) If the main provider purchases services for a department of the provider or a provider-based entity through a management contract or otherwise directly assigns costs to the department

or entity, the like costs of the main provider must be carved out to ensure that they are not allocated to the department of the provider or provider-based entity. However, if the like costs of the main provider cannot be separately identified, the costs of the services purchased through a management contract must be included in the main provider's administrative and general costs and allocated among the provider's overall statistics.

(ii) Costs of free-standing entities may not be shown in the provider's trial balance for purposes of stepping down overhead costs to such entities. The provider must develop detailed work papers showing the exact cost of the services (including overhead) provided to or by the free-standing entity and show those carved out costs as non-reimbursable cost centers in the provider's trial balance.

* * * * *

Subpart E—Payments to Providers

4. A new § 413.65 is added to read as follows:

§ 413.65 Requirements for a determination that a facility or an organization is a department of a provider or a provider-based entity.

(a) *Definitions.* In this subpart E, unless the context indicates otherwise—

Department of a provider means a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider may not be licensed to provide health care services in its own right, and Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term "department of a provider" does not include an RHC or an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC or an FQHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main

provider for the purpose of furnishing health care services under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, that complies with the provisions of this section.

(b) *Responsibility for obtaining provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) A provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider begins billing for services of the facility or organization as if they were furnished by a department of the provider or provider-based entity, or before it includes costs of those services on its cost report.

(3) A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility, unless it is determined by HCFA to have provider-based status.

(c) *Reporting.* (1) A main provider that acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to HCFA and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status.

(2) A main provider that has had one or more facilities or organizations considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

(d) *Requirements.* An entity must meet the following requirements to be determined by HCFA to be a provider-based entity or a department of a provider:

(1) *Licensure.* The department of the provider and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of

the provider. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, HCFA will determine that the facility or organization does not have provider-based status.

(2) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the facility or organization.

(3) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the provider where it is located.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a day-to-day reporting relationship with a manager at the main provider; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider's billing department.

(4) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a day-to-day reporting relationship with the Chief Medical Officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(5) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of the facility or organization are reported in a cost center of the provider, and the financial status of the facility or organization is incorporated and readily identified in the main provider's trial balance.

(6) *Public awareness.* The facility or organization seeking status as a department of a provider is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except where the following requirements are met:

(i) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, either by submitting records such as common patient lists and/or demographic data showing that a high percentage of patients of both the main provider and the applicant entity come from the same geographic area, or by submitting data substantiating that the patients served by the entity also receive services from the main provider (for example, the patients of an RHC receive inpatient hospital services from the main provider).

(ii) A facility or organization is not considered to be in the "immediate vicinity" of the main provider if the facility or organization and the main provider are located in different States.

(e) *Provider-based status not applicable to joint ventures.* A facility or organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created free-standing facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the free-standing facility as a provider-based entity.

(f) *Management contracts.* Facilities and organizations operated under management contracts are considered provider-based if all of the following criteria are met:

(1) The staff of the facility or organization are employed by the

provider or by another organization other than the management company.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (b)(3)(iii) of this section.

(3) The main provider has significant day-to-day control over the operations of the facility or organization as determined under criteria in paragraph (b)(3)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(g) *Obligations of hospital outpatient departments and hospital-based entities.* (1) Hospital outpatient departments located either on or off the main premises of the hospital must comply with the anti-dumping rules in §§ 489.20(l), (m), (q), and (r) and 489.24 of this chapter. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus, and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24, the hospital must comply with the anti-dumping rules in § 489.24.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied.

(3) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(4) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provisions in § 489.10(b) of this chapter.

(5) Hospital outpatient departments (other than RHCs) must hold themselves out to other payers as outpatient departments of that hospital, and must treat all patients, for billing purposes, as hospital outpatients. The department must not treat some patients as hospital outpatients and others as physician office patients.

(6) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at

§ 412.2(c)(5) of this chapter and at § 413.40(c)(2), respectively.

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC), the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the beneficiary's potential financial liability (that is, a coinsurance liability for an outpatient visit to the hospital as well as for the physician service).

(8) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

(9) A facility or organization may not qualify for provider-based status if all services furnished at the facility are furnished under arrangement.

(h) *Inappropriate treatment of a facility or organization as provider-based.* If HCFA learns of a provider treating a facility or organization as provider-based without notifying HCFA to obtain a determination of provider-based status, HCFA reconsiders all payments to that provider for all cost reporting periods subject to re-opening in accordance with §§ 405.1885 and 405.1889 of this chapter. HCFA then investigates and determines whether the requirements in paragraph (d) of this section were met. If the facility or organization did not qualify for a provider-based determination, HCFA recovers the difference between the amount of payments that actually were made and the amount of payments that should have been made in the absence of a determination of provider-based status, except that recovery will not be made for any period prior to [insert the effective date of final rule] if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (i)(2) of this section.

(i) *Inappropriate billing.* (1) If HCFA determines that a provider has been inappropriately billing Medicare for services furnished in a physician office or other facility or organization as if they had been furnished in a hospital outpatient department or other department of a provider or in a provider-based entity, HCFA stops all payments to the provider for outpatient services until the provider can demonstrate which payments are proper. If overpayments have been made, HCFA recovers the difference between the amount of payments that actually were made and the amount of the payments that should have been made in the absence of the determination of provider-based status.

However, past payments attributable to treatment as a department of a provider or a provider-based entity for any period prior to [insert effective date of final rule] are not recovered if during all of that period the management of a facility or an organization made a good faith effort to operate it as a department of a provider or a provider-based entity, as described in paragraph (i)(2) of this section, prior to [insert effective date of final rule].

(2) HCFA determines that the management of a facility has made a good faith effort to operate it as a provider-based entity if—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) of this section are met;

(ii) All facility services were billed as if they had been furnished by a department of a provider or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(7) of this section.

(j) *Correction of errors.* HCFA may review a past determination of provider-based status if it believes that the determination may be inappropriate, based on the provisions of this section. If HCFA determines that a previous determination was in error, and the entity should not be considered provider-based, HCFA notifies the main provider. Treatment of the facility or organization as provider-based ceases with the first day of the next cost report period following notification of the redetermination.

Subpart F—Specific Categories of Costs

5. In § 413.118, the heading to paragraph (d) is republished, and a new paragraph (d)(5) is added to read as follows:

§ 413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

* * * * *

(d) *Blended payment amount.* * * *

(5) For portions of cost reporting periods beginning on or after October 1, 1997, for purposes of calculating the blended payment amount under paragraph (d)(4) of this section, the ASC payment amount is the sum of the standard overhead amounts reduced by deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

* * * * *

6. In § 413.122, the heading to paragraph (b) is republished, a new

paragraph (b)(5) is added, the heading to paragraph (c) is republished, and a new paragraph (c)(4) is added to read as follows:

413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

* * * * *

(b) *Payment for hospital outpatient radiology services.* * * *

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* * * *

(4) For other diagnostic services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 50 percent of the hospital-specific amount; and

(ii) 50 percent of the fee schedule amount calculated as 42 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

7. In § 413.124, paragraph (a) is revised to read as follows:

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92 of this chapter, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of such services) are reduced by 5.8 percent for services furnished during portions of cost reporting periods occurring on or after October 1, 1990 and before January 1, 2000.

* * * * *

Subpart G—Capital-Related Costs

8. In § 413.130, the heading to paragraph (j) and the introductory text to paragraph (j)(1) are republished, and paragraph (j)(1)(ii) is revised to read as follows:

§ 413.130 Introduction to capital-related costs.

* * * * *

(j) *Reduction to capital-related costs.*

(1) Except for sole community hospitals and critical access hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

* * * * *

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991 through December 31, 1999 and before January 1, 2000.

* * * * *

F. A new part 419, consisting of §§ 419.1, 419.2, 419.20, 419.21, 419.22, 419.30, 419.31, 419.32, 419.40, 419.41, 419.42, 419.43, 419.44, 419.50, 419.51, and 419.60, is added to read as follows:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

Sec.

419.1 Scope of part.

419.2 Basis of payment.

Subpart B—Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

419.20 Hospitals subject to the hospital outpatient prospective payment system.

419.21 Hospital outpatient services subject to the outpatient prospective payment system.

419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

419.30 Base expenditure target for calendar year 1999.

419.31 Ambulatory Payment Classification (APC) system and payment weights.

419.32 Calculation of prospective payment rates for hospital outpatient services.

Subpart D—Payments to Hospitals

419.40 Payment concepts.

419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

419.42 Hospital election to reduce copayment.

419.43 Adjustments to national program payment and beneficiary copayment amounts.

419.44 Payment reductions for surgical procedures.

Subpart E—Updates

419.50 Revisions to groups, weights, and other adjustments.

419.51 Volume control measures for services furnished in CY 2000.

Subpart F—Limitations on Review

419.60 Limitations on administrative and judicial review.

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395(hh)).

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

§ 419.1 Scope of part.

(a) *Purpose.* This part implements section 1833(t) of the Act by establishing a prospective payment system for services furnished by hospital outpatient departments to Medicare beneficiaries who are registered on hospital records as outpatients, effective for services furnished on or after the implementation date.

(b) *Summary of content.* This subpart describes the basis of payment for outpatient hospital services under the prospective payment system. Subpart B sets forth the categories of hospitals and services that are subject to the outpatient hospital prospective payment system and those categories of hospitals and services that are excluded from the outpatient hospital prospective payment system. Subpart C sets forth requirements and the basic methodology by which prospective payment rates for hospital outpatient services are determined. Subpart D describes Medicare payment amounts, beneficiary copayment amounts, and methods of payment to hospitals under the hospital outpatient prospective payment system. Subpart E describes how the hospital outpatient prospective payment system may be revised to take into account changes in medical practice and technology, the addition or deletion of services, new cost data, and other relevant information and factors.

§ 419.2 Basis of payment.

(a) *Unit of payment.* Under the hospital outpatient prospective payment system, hospitals are paid a predetermined amount for designated services, which are identified by codes established under the Health Care Financing Administration Common Procedure Coding System (HCPCS), furnished to Medicare beneficiaries. The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) *Costs included in determination of hospital outpatient department payment rates.* The prospective payment system establishes a national payment rate,

standardized for geographic wage differences, for 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—

- (1) Use of an operating suite, procedure room, or treatment room;
- (2) Use of recovery room;
- (3) Use of an observation bed;
- (4) Anesthesia, drugs, biologicals, other pharmaceuticals, and blood; medical and surgical supplies and equipment; surgical dressings; splints, casts, and other devices used for reduction of fractures and dislocations;
- (5) Supplies and equipment for administering and monitoring anesthesia or sedation;
- (6) Intra-ocular lenses (IOLs);
- (7) Incidental services such as venipuncture;
- (8) Capital-related costs.

(c) *Costs excluded from determination of hospital outpatient prospective payment rates.* The following costs are excluded from the hospital outpatient prospective payment rates:

- (1) Medical education costs for approved nursing and allied health education programs.

- (2) Costs for services listed in § 419.22.

Subpart B—Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after the implementation date.

(b) *Hospitals excluded from the outpatient prospective payment system.* (1) Those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the hospital outpatient prospective payment system.

(2) Critical access hospitals (CAHs) are excluded from the hospital outpatient prospective payment system.

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

Beginning on the implementation date, except for services described in § 419.22, payment is made under the hospital outpatient prospective payment system for—

- (a) Medicare Part B services furnished to hospital outpatients designated by

HCFA under this part that are not otherwise excluded under § 419.22;

(b) Services that are covered under Medicare Part B when furnished to hospital inpatients who are either not entitled to benefits under Part A or who have exhausted their Part A benefits, but are entitled to benefits under Part B of the program;

(c) Partial hospitalization services furnished by community mental health centers (CMHCs);

(d) The following medical and other health services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they fall outside the definition of CORF services at section 1861(cc)(1) of the Act; or by a home health agency (HHA) to patients who are not under an HHA plan or treatment; or, by a hospice program furnishing services to patients outside the hospice benefit:

- (1) Antigens.
- (2) Splints and casts.
- (3) Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine.

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

- (a) Physician services.
- (b) Nurse practitioner services.
- (c) Physician assistant services.
- (d) Certified nurse-midwife services.
- (e) Services of qualified psychologists.
- (f) Services of an anesthetist as defined in § 410.69 of this chapter.
- (g) Clinical social worker services as defined in section 1861(hh)(2) of the Act.
- (h) Rehabilitation services described in section 1833(a)(8) of the Act.
- (i) Ambulance services.
- (j) Prosthetics and prosthetic supplies, prosthetic devices, prosthetic implants (except IOLs), and orthotic devices.
- (k) Durable medical equipment supplied by the hospital for the patient to take home.

(l) Clinical diagnostic laboratory services.

(m) Dialysis services furnished to ESRD patients.

(n) Services and procedures that are not safely furnished in an outpatient setting or that require inpatient care.

(o) Services specific to other sites such as nursing homes.

(p) Services furnished to persons who are inpatients of a SNF and furnished pursuant to the resident assessment or comprehensive care plan but that are covered under the SNF prospective payment system, furnished “under arrangement,” and billable only by the SNF.

(q) Services that are not covered by Medicare by statute.

(r) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§ 419.30 Base expenditure target for calendar year 1999.

(a) HCFA estimates the aggregate amount that would be payable for hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of copayments estimated to be paid by beneficiaries, under the prospective payment system described in this part, to hospitals for covered hospital outpatient services.

(b) The aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

§ 419.31 Ambulatory Payment Classification (APC) system and payment weights.

(a) *APC groups.* (1) HCFA classifies hospital outpatient services and procedures that are comparable clinically and similar in terms of resource use into APC groups.

(2) The payment rate determined for an APC group in accordance with § 419.32 and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part apply to every individual service or procedure within the APC group.

(b) *APC weighting factors.* (1) Using hospital claims data from calendar year 1996 and data from the most recent available hospital cost reports, HCFA determines the median costs for the services and procedures within each APC group.

(2) HCFA assigns to each APC group an appropriate weighting factor to reflect the relative median costs for the services within the APC group compared to the median costs for the services in all APC groups.

(c) *Standardizing amounts.* (1) HCFA determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is known as the “labor-related portion” of hospital outpatient costs.

(2) HCFA standardizes the median costs determined in paragraph (b)(1) of

this section by adjusting for variations in hospital labor costs across geographic areas.

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) *Conversion factor for 1999.* HCFA calculates a conversion factor in such a manner as to ensure that payment for hospital outpatient services furnished in 1999 would have equalled the base expenditure target calculated in § 419.30, taking APC group weights and estimated service volume into account.

(b) *Conversion factor for calendar years 2000, 2001, and 2002.* (1) Subject to paragraph (c)(2) of this section, the conversion factor for each of the calendar years 2000, 2001, and 2002 is equal to the conversion factor calculated under paragraph (a) of this section for the previous year adjusted by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act for fiscal years 2000, 2001, and 2002, respectively, reduced by one percentage point.

(2) Beginning in calendar year 2000, HCFA may substitute for the hospital inpatient market basket percentage in paragraph (c)(1) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) *Payment rates.* The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

Subpart D—Payments to Hospitals

§ 419.40 Payment concepts.

In addition to the payment rate described in § 419.32, for each APC group there is a predetermined beneficiary copayment amount as described in § 419.41(a). The Medicare payment for each APC is calculated by applying the program payment percentage as described in § 419.41(b).

(b) For purposes of this section—
Copayment percentage is calculated as the difference between the program payment percentage and 100 percent. The copayment percentage in any year is thus defined for each APC group as the *greater* of the following: the ratio of the APC group unadjusted copayment amount to the annual APC group payment rate, or 20 percent.

Program payment percentage is calculated as the *lower* of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, to the APC group payment rate, or 80 percent.

Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

(a) *Calculation of the national beneficiary copayment amount.* To calculate the unadjusted copayment amount for each APC group, HCFA—

(1) Standardizes 1996 hospital charges for the services within each APC group to offset variations in hospital labor costs across geographic areas;

(2) Identifies the median of the wage-neutralized 1996 charges for each APC group; and,

(3) Determines the value equal to 20 percent of the wage-neutralized 1996 median charge for each APC group and multiplies that value by an actuarial projection of increases in charges for hospital outpatient department services during the period 1996 to 1999. The result is the unadjusted beneficiary copayment amount for the APC group.

(b) *Calculation of the program payment amount for each APC group.*

(1) HCFA calculates annually the program payment percentage for every APC group on the basis of each group's unadjusted copayment amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(2) The Medicare program payment amounts are calculated annually by multiplying the updated APC group payment rates by the program payment percentage.

(c) To determine payment amounts due for a service paid for under the hospital outpatient prospective payment system, HCFA makes the following calculations:

(1) Makes the wage index adjustment and any other adjustments that are appropriate in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the program payment amount.

(4) Subtracts the program payment amount from the amount determined in

paragraph (c)(2) of this section to determine the copayment amount.

§ 419.42 Hospital election to reduce copayment.

(a) A hospital may elect to reduce copayments for any or all APC groups on a calendar year basis. A hospital may *not* elect to reduce copayment for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce copayments no later than 90 days prior to the start of the calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment level (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced copayment must remain in effect unchanged during the year for which the election was made.

(e) The hospital may advertise and otherwise disseminate information concerning the reduced level(s) of copayment that it has elected.

(f) In electing reduced copayment, a hospital may elect a level that is less than that year's national copayment amount for the group, but not less than 20 percent of the APC payment rate as determined in § 419.32.

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

(a) *General rule.* HCFA determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* HCFA determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the "labor-related portion" of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) *Wage index factor.* HCFA uses the hospital inpatient prospective payment system wage index established in accordance with section 1886(d)(3)(E) of the Act and part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) *Other adjustments.* Any other adjustments to payment amounts made by HCFA to ensure equitable payments are made in a budget neutral manner.

§ 419.44 Payment reductions for surgical procedures.**(a) Multiple surgical procedures.**

When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One half of the full program and beneficiary payment amounts for all other covered procedures.

(b) Terminated procedures. When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; and

(2) One-half of the full program and beneficiary payment amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed, but before anesthesia is induced.

Subpart E—Updates**§ 419.50 Revisions to groups, weights, and other adjustments.**

(a) HCFA periodically reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(1) *Changes in the APC system.* HCFA may make a change in the group composition of the APC system or recalibrate any APC weight, as needed, but not more frequently than once a year. HCFA makes these changes based on evidence that a reassignment would improve the consistency of the group(s) either clinically or with respect to resource consumption.

(2) *New services.* HCFA assigns a new service to the APC group that is most similar clinically and with respect to resource consumption.

(3) *Budget neutrality.* HCFA adjusts the conversion factor so that any adjustments determined under paragraphs (a)(1) through (a)(3) of this section do not increase or decrease the amount of expenditures that would have been made under this section if the adjustments had not been made.

(b) *Annual update to conversion factor.* HCFA updates the conversion factor annually as specified in § 419.32.

§ 419.51 Volume control measures for services furnished in CY 2000.

HCFA uses the target amount specified under section 1833(t)(3)(A) of the Act as an expenditure target for services furnished in CY 1999. HCFA updates the target amount to CY 2000 based on the adjustment to the conversion factor in § 419.32(b), estimated changes in the volume and intensity of hospital outpatient services, and estimated changes in beneficiary enrollment. HCFA compares the CY 2000 target to an estimate of CY 2000 actual payments to hospitals. If unnecessary volume increases cause payments to exceed the target, HCFA determines the percentage by which the target is exceeded, and adjusts the CY 2002 update to the conversion factor by the same percentage.

Subpart F—Limitations on Review**§ 419.60 Limitations on administrative and judicial review.**

There can be no administrative or judicial review under sections 1869 and 1878 of the Act, or otherwise of—

(a) The development of the APC system, including—

(1) Establishment of the groups and relative payment weights;

(2) Wage adjustment factors;

(3) Other adjustments; and

(4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act;

(c) Periodic adjustments described in section 1833(t)(6) of the Act; and

(d) The establishment of a separate conversion factor for hospitals described in section 1886(d)(1)(B)(v) of the Act.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

G. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Essentials of Provider Agreements

2. In § 489.20, the introductory text to the section is republished; the introductory text to paragraph (d) is revised; paragraphs (d)(3), (d)(4), and (d)(5) are redesignated as paragraphs (d)(4), (d)(5), and (d)(6), respectively;

and a new paragraph (d)(3) is added to read as follows:

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(d) In the case of a hospital or a CAH that furnishes services to Medicare beneficiaries, either to furnish directly or to make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services to inpatients and outpatients of a hospital or a CAH except the following:

* * * * *

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

3. In § 489.24(b), the definition for “Comes to the emergency department” is revised to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Comes to the emergency department means, with respect to an individual requesting examination or treatment, that the individual is on the hospital property. For purposes of this section, “property” means the entire main hospital campus, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined under § 416.35 of this chapter to be a department of the hospital. Property also includes ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds. An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the hospital’s emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital’s emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In such situations, the hospital may deny access if it is in “diversionary status,” that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital’s instructions and transports the individual on to hospital property, the individual is considered to have come to the emergency department.

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

H. Part 498 is amended as set forth below:

1. The authority citation for part 498 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

2. In § 498.2, the introductory text is republished, and the definition of "Provider" is revised to read as follows:

§ 498.2 Definitions.

As used in this part —

* * * * *

Provider means a hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that has in effect an agreement to participate in Medicare, that has in effect an agreement to participate in Medicaid, or a clinic, rehabilitation agency, or public health agency that has a similar agreement but only to furnish outpatient physical therapy or outpatient speech pathology services, and *prospective provider* means any of the listed entities that seeks to participate in Medicare as a provider or to have any facility or organization determined to be a department of the provider or provider-based entity under § 412.65 of this chapter.

* * * * *

3. In § 498.3, the introductory text to paragraph (b) is republished; paragraphs (b)(2) through (b)(14) are redesignated as paragraphs (b)(3) through (b)(15), respectively; and a new paragraph (b)(2) is added to read as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) *Initial determinations by HCFA.* HCFA makes initial determinations with respect to the following matters:

* * * * *

(2) Whether a prospective department of a provider or provider-based entity qualifies as a department of a provider or provider-based entity under § 413.65 of this chapter.

* * * * *

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

I. Part 1003 is amended as set forth below:

1. The authority citation for part 1003 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320–7, 1320a–7a, 1320b–10, 1395u(j), 1395u(k), 1395cc(g), 1395dd(d)(1), 1395mm, 1395nn(g), 1395ss(d), 1396b(m), 11131(c) and 11137(b)(2).

2. Section 1003.100 is amended by revising paragraph (a) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1102, 1128(c), 1128A, 1140, 1842(j), 1842(k), 1866(g), 1876(i)(6), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act, and sections 421(c) and 427(b)(2) of Pub. L. 99–660 (42 U.S.C. 1302, 1320a–7, 1320a–7a, 1320b–10, 1395u(j), 1395u(k), 1395cc(g), 1395mm(i)(6), 1395nn(g), 1395ss(d), 1396d(m)(5), 11131(c) and 11137(b)(2)).

* * * * *

3. Section 1003.102 is amended by republishing the introductory text to paragraph (b), by reserving paragraphs (b)(11) through (b)(13), and by adding a new paragraph (b)(14) to read as follows:

§ 1003.102 Basis for civil money penalties and assessments.

* * * * *

(b) The OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

* * * * *

(11) [Reserved]

(12) [Reserved]

(13) [Reserved]

(14) Has knowingly and willfully presented, or caused to be presented, a bill or request for payment for an item or service furnished to a hospital patient for which payment may be made under the Medicare or another Federal health care program, if that bill or request is inconsistent with an arrangement under section 1866(a)(1)(H) of the Act, or violates the requirements for such an arrangement.

* * * * *

4. Section 1003.103 is amended by revising paragraph (a) to read as follows:

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b) through (f) of this section, the OIG may impose a penalty of not more than \$10,000 for each item or service that is subject to a determination under § 1003.102.

* * * * *

5. Section 1003.105 is amended by revising paragraph (a)(1)(i) to read as follows:

§ 1003.105 Exclusion from participation in Medicare and State health care programs.

(a)(1) * * *

(i) Any person who is subject to a penalty or assessment under § 1003.102(a), (b)(1) through (b)(4), or (b)(14).

* * * * *

(Catalog of Federal Domestic Assistance 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 29, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: June 29, 1998.

June G. Brown,

Inspector General, Department of Health and Human Services.

Approved: August 15, 1998.

Donna E. Shalala,

Secretary.

Note: The following addenda will not appear in the Code of Federal Regulations.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS

APC ^{1,2}	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
020	Partial Hospitalization per diem	S	4.11	\$208.01	\$46.78	\$41.60
031	Dental procedures	S	1.34	\$67.90	\$13.58	\$13.58
061	Level I Chemotherapeutic agents	X	1.04	\$52.70	\$36.61	\$10.54
062	Level II Chemotherapeutic agents	X	1.69	\$85.63	\$36.61	\$17.13

¹*APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.

²+APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC ^{1,2}	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
063	Level III Chemotherapeutic agents	X	2.89	\$146.43	\$110.97	\$29.29
064	Level IV Chemotherapeutic agents	X	4.17	\$211.29	\$140.12	\$42.26
089	Neuropsychological Testing	X	2.54	\$128.70	\$37.29	\$25.74
090	Monitoring psychiatric drugs	X	0.85	\$43.07	\$12.43	\$8.61
091	Brief Individual Psychotherapy	S	1.09	\$55.23	\$14.01	\$11.05
092	Extended Individual Psychotherapy	S	1.57	\$79.55	\$21.92	\$15.91
093	Family Psychotherapy	S	1.54	\$78.03	\$20.11	\$15.61
094	Group Psychotherapy	S	1.24	\$62.83	\$20.11	\$12.57
121	Level I needle biopsy/aspiration	T	0.67	\$33.95	\$20.91	\$6.79
122	Level II needle biopsy/aspiration	T	4.87	\$246.76	\$115.03	\$49.35
131	Level I incision & drainage	T	1.94	\$98.30	\$36.61	\$19.66
132	Level II incision & drainage	T	6.04	\$306.04	\$134.13	\$61.21
137	Nail procedures	T	0.46	\$23.31	\$4.66	\$4.66
141	Level I Destruction of lesion	T	0.59	\$29.90	\$9.49	\$5.98
142	Level II Destruction of lesion	T	3.77	\$191.02	\$73.00	\$38.20
151	Level I debridement/destruction	T	1.74	\$88.16	\$35.71	\$17.63
152	Level II debridement/destruction	T	10.43	\$528.48	\$261.71	\$105.70
161	Level I excision/biopsy	T	3.50	\$177.34	\$75.48	\$35.47
162	Level II excision/biopsy	T	5.67	\$287.30	\$125.43	\$57.46
163	Level III excision/biopsy	T	10.69	\$541.66	\$264.65	\$108.33
181	Level I skin repair	T	2.19	\$110.97	\$43.84	\$22.19
182	Level II skin repair	T	4.00	\$202.68	\$84.98	\$40.54
183	Level III skin repair	T	11.17	\$565.98	\$286.46	\$113.20
184	Level IV skin repair	T	15.17	\$768.66	\$396.40	\$153.73
197	Incision/excision breast	T	12.13	\$614.62	\$310.75	\$122.92
198	Breast reconstruction/mastectomy	T	19.17	\$971.33	\$530.20	\$194.27
200	Arthrocentesis & Ligament/Tendon Injection	T	1.89	\$95.77	\$39.10	\$19.15
207	Closed treatment fracture finger/toe/trunk	T	1.70	\$86.14	\$31.64	\$17.23
209	Closed treatment fracture/dislocation/ex- cept finger/toe/trunk.	T	1.94	\$98.30	\$37.29	\$19.66
210	Bone/joint manipulation under anesthesia ..	T	10.46	\$530.00	\$283.40	\$106.00
216	Open/percutaneous treatment fracture or dislocation.	T	20.13	\$1,019.98	\$520.82	\$204.00
217	Arthroplasty	T	20.48	\$1,037.71	\$526.81	\$207.54
218	Arthroplasty with prosthesis	T	27.49	\$1,392.90	\$715.52	\$278.58
*226	Maxillofacial prostheses	T	1.59	\$80.56	\$21.92	\$16.11
231	Level I skull and facial bone procedures	T	12.02	\$609.05	\$299.90	\$121.81
232	Level II skull and facial bone procedures ...	T	23.93	\$1,212.52	\$639.35	\$242.50
251	Level I Musculoskeletal Procedures	T	14.26	\$722.55	\$366.12	\$144.51
252	Level II Musculoskeletal Procedures	T	19.39	\$982.48	\$509.18	\$196.50
253	Level III Musculoskeletal Procedures	T	26.33	\$1,334.13	\$699.24	\$266.83
254	Level IV Musculoskeletal Procedures	T	34.37	\$1,741.51	\$937.11	\$348.30
261	Level I Hand Musculoskeletal Procedures ..	T	10.54	\$534.06	\$261.48	\$106.81
262	Level II Hand Musculoskeletal Procedures ..	T	18.35	\$929.78	\$480.82	\$185.96
271	Level I Foot Musculoskeletal Procedures ...	T	14.41	\$730.15	\$368.38	\$146.03
272	Level II Foot Musculoskeletal Procedures ...	T	16.56	\$839.09	\$409.74	\$167.82
276	Bunion Procedures	T	19.19	\$972.35	\$500.14	\$194.47
280	Diagnostic Arthroscopy	T	22.20	\$1,124.86	\$581.72	\$224.97
281	Level I Surgical Arthroscopy	T	22.65	\$1,147.66	\$590.20	\$229.53
282	Level II Surgical Arthroscopy	T	23.94	\$1,213.03	\$614.04	\$242.61
286	Arthroscopically-Aided Procedures	T	26.76	\$1,355.91	\$802.41	\$271.18
311	Level I ENT Procedures	T	1.43	\$72.46	\$20.57	\$14.49
312	Level II ENT Procedures	T	7.26	\$367.86	\$178.31	\$73.57
313	Level III ENT Procedures	T	15.81	\$801.08	\$411.09	\$160.22
314	Level IV ENT Procedures	T	25.65	\$1,299.67	\$693.37	\$259.93
*317	Implantation of Cochlear Device	T				
318	Nasal Cauterization/Packing	T	2.07	\$104.89	\$38.65	\$20.98
319	Tonsil/Adenoid Procedures	T	17.30	\$876.58	\$480.02	\$175.32
320	Thoracentesis/Lavage Procedures	T	3.17	\$160.62	\$79.33	\$32.12
331	Level I Endoscopy Upper Airway	T	0.69	\$34.96	\$14.01	\$6.99
332	Level II Endoscopy Upper Airway	T	9.74	\$493.52	\$244.98	\$98.70
333	Level III Endoscopy Upper Airway	T	17.24	\$873.54	\$464.20	\$174.71
336	Endoscopy Lower Airway	T	7.44	\$376.98	\$197.98	\$75.40
339	Injection of Sclerosing Solution	T	1.02	\$51.68	\$19.66	\$10.34
341	Level I Needle and Catheter Placement	T	0.13	\$6.59	\$2.94	\$1.32
342	Level II Needle and Catheter Placement	T	3.20	\$162.14	\$80.23	\$32.43
343	Level III Needle and Catheter Placement ...	T	9.52	\$482.37	\$224.87	\$96.47
346	Placement Transvenous Caths/Cutdown	T	4.83	\$244.73	\$120.23	\$48.95
347	Injection Procedures for Interventional Ra- diology.	T	2.93	\$148.46	\$62.15	\$29.69
360	Removal/Revision, Pacemaker/Vascular Device.	T	6.09	\$308.58	\$140.12	\$61.72
367	Vascular Ligation	T	17.59	\$891.28	\$449.06	\$178.26
368	Vascular Repair/Fistula Construction	T	22.83	\$1,156.78	\$648.85	\$231.36
369	Blood and Blood Product Exchange	T	4.33	\$219.40	\$97.18	\$43.88

¹*APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.²*APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC ^{1,2}	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
396	Lymph Node Excisions	T	13.28	\$672.89	\$338.77	\$134.58
397	Thyroid/Lymphadenectomy Procedures	T	18.36	\$930.29	\$496.86	\$186.06
406	Esophageal Dilation without Endoscopy	T	4.31	\$218.39	\$108.48	\$43.68
407	Esophagoscopy	T	7.06	\$357.73	\$189.84	\$71.55
417	Diagnostic Upper GI Endoscopy	T	6.44	\$326.31	\$181.70	\$65.26
418	Therapeutic Upper GI Endoscopy	T	7.59	\$384.58	\$214.25	\$76.92
419	Small Intestine Endoscopy	T	7.13	\$361.27	\$164.08	\$72.25
426	Diagnostic Lower GI Endoscopy	T	6.85	\$347.09	\$187.81	\$69.42
427	Therapeutic Lower GI Endoscopy	T	8.22	\$416.50	\$224.19	\$83.30
437	Therapeutic Anoscopy	T	2.91	\$147.45	\$76.61	\$29.49
446	Diagnostic Sigmoidoscopy	T	2.59	\$131.23	\$65.09	\$26.25
447	Therapeutic Proctosigmoidoscopy	T	6.87	\$348.10	\$184.76	\$69.62
448	Therapeutic Flexible Sigmoidoscopy	T	5.37	\$272.09	\$141.25	\$54.42
449	Complex GI Endoscopy	T	7.80	\$395.22	\$215.38	\$79.04
451	Level I Anal/Rectal Procedures	T	2.56	\$129.71	\$54.24	\$25.94
452	Level II Anal/Rectal Procedures	T	4.82	\$244.23	\$109.61	\$48.85
453	Level III Anal/Rectal Procedures	T	16.87	\$854.79	\$445.22	\$170.96
456	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	9.78	\$495.55	\$257.19	\$99.11
458	Percutaneous Biliary Endoscopic Procedures	T	7.23	\$366.34	\$181.59	\$73.27
459	Peritoneal and Abdominal Procedures	T	18.06	\$915.09	\$496.52	\$183.02
466	Hernia/Hydrocele Procedures	T	21.43	\$1,085.85	\$562.97	\$217.17
470	Tube Procedures	T	2.22	\$112.49	\$54.92	\$22.50
521	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.06	\$256.39	\$112.10	\$51.28
522	Level II Cystourethroscopy and other Genitourinary Procedures	T	10.46	\$530.00	\$262.39	\$106.00
523	Level III Cystourethroscopy and other Genitourinary Procedures	T	16.87	\$854.79	\$447.03	\$170.96
524	Level IV Cystourethroscopy and other Genitourinary Procedures	T	28.89	\$1,463.84	\$833.38	\$292.77
527	Lithotripsy	T	51.56	\$2,612.52	\$1,372.95	\$522.50
529	Simple Urinary Studies and Procedures	T	2.50	\$126.67	\$63.05	\$25.33
530	Genitourinary Procedures	T	2.52	\$127.69	\$54.69	\$25.54
531	Level I Urethral Procedures	T	18.94	\$959.68	\$527.26	\$191.94
532	Level II Urethral Procedures	T	25.50	\$1,292.07	\$602.18	\$258.41
536	Circumcision	T	13.17	\$667.32	\$326.57	\$133.46
537	Penile Procedures	T	28.72	\$1,455.23	\$864.34	\$291.05
538	Insertion of Penile Prosthesis	T	45.59	\$2,310.02	\$1,540.64	\$462.00
546	Testes/Epididymis Procedures	T	17.14	\$868.47	\$453.81	\$173.69
547	Prostate Biopsy	T	4.39	\$222.44	\$125.20	\$44.49
550	Surgical Hysteroscopy	T	16.89	\$855.81	\$447.93	\$171.16
551	Level I Laparoscopy	T	24.78	\$1,255.59	\$711.67	\$251.12
552	Level II Laparoscopy	T	37.71	\$1,910.75	\$1,053.16	\$382.15
561	Level I Female Reproductive Procedures	T	1.52	\$77.02	\$24.63	\$15.40
562	Level II Female Reproductive Procedures	T	12.76	\$646.54	\$330.75	\$129.31
563	Level III Female Reproductive Procedures	T	16.90	\$856.31	\$464.88	\$171.26
567	D & C	T	13.61	\$689.61	\$364.09	\$137.92
568	Infertility Procedures	T	2.49	\$126.17	\$49.49	\$25.23
578	Pregnancy and Neonatal Care Procedures	T	1.26	\$63.84	\$33.90	\$12.77
580	Vaginal Delivery	T	4.59	\$232.57	\$146.34	\$46.51
586	Therapeutic Abortion	T	12.50	\$633.37	\$431.89	\$126.67
587	Spontaneous Abortion	T	13.25	\$671.37	\$347.02	\$134.27
600	Spinal Tap	T	2.63	\$133.26	\$61.47	\$26.65
601	Level I Nervous System Injections	T	3.11	\$157.58	\$74.13	\$31.52
602	Level II Nervous System Injections	T	3.33	\$168.73	\$87.69	\$33.75
616	Implantation of Neurostimulator Electrodes	T	14.43	\$731.16	\$366.57	\$146.23
617	Revision/Removal Neurological Device	T	11.56	\$585.74	\$287.59	\$117.15
618	Implantation of Neurological Device	T	25.56	\$1,295.11	\$780.49	\$259.02
631	Level I Nerve Procedures	T	12.98	\$657.69	\$333.80	\$131.54
632	Level II Nerve Procedures	T	18.13	\$918.64	\$461.04	\$183.73
648	Laser Retinal Procedures	T	3.94	\$199.64	\$95.15	\$39.93
649	Laser Eye Procedures except Retinal	T	4.44	\$224.97	\$111.64	\$44.99
651	Level I Anterior Segment Eye Procedures	T	7.24	\$366.85	\$174.70	\$73.37
652	Level II Anterior Segment Eye Procedures	T	16.48	\$835.03	\$433.69	\$167.01
667	Cataract Procedures	T	15.33	\$776.40	\$521.72	\$155.28
668	Cataract Procedures with IOL Insert	T	19.28	\$976.91	\$530.87	\$195.38
670	Corneal Transplant	T	29.23	\$1,481.07	\$847.50	\$296.21
676	Posterior Segment Eye Procedures	T	6.30	\$319.22	\$140.35	\$63.84
677	Strabismus/Muscle Procedures	T	16.26	\$823.89	\$436.63	\$164.78
681	Level I Eye Procedures	T	1.67	\$84.62	\$30.51	\$16.92
682	Level II Eye Procedures	T	3.54	\$179.37	\$81.36	\$35.87
683	Level III Eye Procedures	T	10.19	\$516.32	\$257.87	\$103.26
684	Level IV Eye Procedures	T	13.48	\$683.02	\$348.94	\$136.60

¹*APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.²+APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC ^{1,2}	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
690	Vitrectomy	T	30.54	\$1,547.45	\$852.02	\$309.49
700	Plain Film	X	0.78	\$39.52	\$22.37	\$7.90
706	Miscellaneous Radiological Procedures	X	1.96	\$99.31	\$57.63	\$19.86
710	Computerized Axial Tomography	S	5.06	\$256.39	\$176.28	\$51.28
716	Fluoroscopy	X	1.59	\$80.56	\$47.91	\$16.11
720	Magnetic Resonance Angiography	S	6.34	\$321.24	\$206.11	\$64.25
726	Magnetic Resonance Imaging	S	7.96	\$403.33	\$258.09	\$80.67
728	Myelography	S	4.07	\$206.22	\$113.23	\$41.24
730	Arthrography	S	2.48	\$125.66	\$72.09	\$25.13
736	Digestive Radiology	S	1.85	\$93.74	\$54.24	\$18.75
737	Diagnostic Urography	S	2.81	\$142.38	\$86.56	\$28.48
738	Therapeutic Radiologic Procedures	S	4.48	\$227.00	\$133.23	\$45.40
739	Diagnostic Angiography and Venography	S	5.83	\$295.40	\$168.71	\$59.08
746	Mammography	S	0.69	\$34.96	\$19.44	\$6.99
747	Diagnostic Ultrasound Except Vascular	S	1.65	\$83.60	\$54.69	\$16.72
749	Guidance under Ultrasound	X	2.44	\$123.63	\$76.16	\$24.73
750	Therapeutic Radiation Treatment Planning	X	0.91	\$46.11	\$25.54	\$9.22
751	Level I Therapeutic Radiation Treatment Preparation	X	1.15	\$58.27	\$33.22	\$11.65
752	Level II Therapeutic Radiation Treatment Preparation	X	3.54	\$179.37	\$88.82	\$35.87
757	Radiation Therapy	S	2.30	\$116.54	\$52.43	\$23.31
758	Hyperthermic Therapies	S	3.41	\$172.78	\$76.84	\$34.56
759	Brachytherapy and Complex Radioelement Applications	S	7.98	\$404.34	\$160.01	\$80.87
760	PET Scans	S	17.26	\$874.55	\$419.46	\$174.91
*761	Standard Non-Imaging Nuclear Medicine	S	2.04	\$103.37	\$61.47	\$20.67
*762	Complex Non-Imaging Nuclear Medicine	S	1.78	\$90.19	\$51.53	\$18.04
771	Standard Planar Nuclear Medicine	S	3.78	\$191.53	\$116.84	\$38.31
772	Complex Planar Nuclear Medicine	S	4.22	\$213.83	\$127.92	\$42.77
781	Standard SPECT Nuclear Medicine	S	5.26	\$266.52	\$145.77	\$53.30
782	Complex SPECT Nuclear Medicine	S	9.28	\$470.21	\$275.04	\$94.04
*791	Standard Therapeutic Nuclear Medicine	S	15.83	\$802.10	\$562.06	\$160.42
*792	Complex Therapeutic Nuclear Medicine	S	4.80	\$243.21	\$144.19	\$48.64
861	Immunology Tests	X	0.13	\$6.59	\$3.62	\$1.32
881	Level I Pathology	X	0.20	\$10.13	\$6.78	\$2.03
882	Level II Pathology	X	0.39	\$19.76	\$11.75	\$3.95
883	Level III Pathology	X	0.65	\$32.94	\$20.34	\$6.59
900	Critical Care	V	7.44	\$376.98	\$144.87	\$75.40
901	Level I Immunization	X	0.07	\$3.55	\$2.49	\$0.71
*902	Level II Immunization	X	1.78	\$90.19	\$41.47	\$18.04
*903	Level III Immunization	X	1.16	\$58.78	\$25.65	\$11.76
906	Infusion Therapy except Chemotherapy	X	1.46	\$73.98	\$42.49	\$14.80
907	Intramuscular Injections	X	0.85	\$43.07	\$11.98	\$8.61
+91111	Low Level Clinic Visits	V	1.06	\$53.71	\$12.66	\$10.74
91118	Low Level Clinic Visits	V	0.83	\$42.06	\$9.27	\$8.41
91124	Low Level Clinic Visits	V	0.87	\$44.08	\$9.49	\$8.82
91131	Low Level Clinic Visits	V	0.81	\$41.04	\$9.04	\$8.21
91133	Low Level Clinic Visits	V	0.80	\$40.54	\$8.59	\$8.11
91136	Low Level Clinic Visits	V	0.85	\$43.07	\$8.61	\$8.61
91141	Low Level Clinic Visits	V	0.98	\$49.66	\$10.40	\$9.93
91153	Low Level Clinic Visits	V	0.91	\$46.11	\$9.27	\$9.22
91156	Low Level Clinic Visits	V	0.93	\$47.12	\$9.42	\$9.42
*91157	Low Level Clinic Visits	V	1.33	\$67.39	\$14.46	\$13.48
91163	Low Level Clinic Visits	V	0.98	\$49.66	\$10.17	\$9.93
*91168	Low Level Clinic Visits	V	0.98	\$49.66	\$10.62	\$9.93
*91172	Low Level Clinic Visits	V	1.06	\$53.71	\$14.24	\$10.74
*91178	Low Level Clinic Visits	V	1.52	\$77.02	\$21.58	\$15.40
91182	Low Level Clinic Visits	V	0.87	\$44.08	\$9.04	\$8.82
*91186	Low Level Clinic Visits	V	1.09	\$55.23	\$11.30	\$11.05
91188	Low Level Clinic Visits	V	0.72	\$36.48	\$8.14	\$7.30
+91191	Low Level Clinic Visits	V	1.09	\$55.23	\$14.01	\$11.05
91197	Low Level Clinic Visits	V	1.02	\$51.68	\$11.53	\$10.34
+91199	Low Level Clinic Visits	V	1.31	\$66.38	\$20.79	\$13.28
+91311	Mid Level Clinic Visits	V	1.06	\$53.71	\$12.66	\$10.74
91318	Mid Level Clinic Visits	V	0.98	\$49.66	\$9.93	\$9.93
91324	Mid Level Clinic Visits	V	0.98	\$49.66	\$9.93	\$9.93
91331	Mid Level Clinic Visits	V	0.94	\$47.63	\$9.53	\$9.53
91333	Mid Level Clinic Visits	V	0.93	\$47.12	\$9.42	\$9.42
91336	Mid Level Clinic Visits	V	1.00	\$50.67	\$10.13	\$10.13
91341	Mid Level Clinic Visits	V	1.00	\$50.67	\$10.13	\$10.13
91353	Mid Level Clinic Visits	V	1.04	\$52.70	\$10.54	\$10.54

¹*APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.²+APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC ^{1,2}	Group title		Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
91356	Mid Level Clinic Visits	Female genital system diseases	V	1.06	\$53.71	\$10.74	\$10.74
*91357	Mid Level Clinic Visits	Pregnancy and neonatal care	V	1.22	\$61.82	\$12.66	\$12.36
91363	Mid Level Clinic Visits	Nervous system diseases	V	1.04	\$52.70	\$10.54	\$10.54
*91368	Mid Level Clinic Visits	Eye diseases	V	0.87	\$44.08	\$8.82	\$8.82
*91372	Mid Level Clinic Visits	Trauma and poisoning	V	1.06	\$53.71	\$10.85	\$10.74
*91378	Mid Level Clinic Visits	Major signs, symptoms and findings	V	1.13	\$57.26	\$11.45	\$11.45
91382	Mid Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	1.00	\$50.67	\$10.13	\$10.13
*91386	Mid Level Clinic Visits	Immunologic and hematologic diseases	V	1.04	\$52.70	\$10.54	\$10.54
91388	Mid Level Clinic Visits	Malignancy	V	0.83	\$42.06	\$8.41	\$8.41
+91391	Mid Level Clinic Visits	Psychiatric disorders	V	1.09	\$55.23	\$14.01	\$11.05
91397	Mid Level Clinic Visits	Infectious disease	V	1.06	\$53.71	\$10.74	\$10.74
+91399	Mid Level Clinic Visits	Unknown cause of mortality	V	1.31	\$66.38	\$20.79	\$13.28
+91511	High Level Clinic Visits	Well care and administrative	V	1.06	\$53.71	\$12.66	\$10.74
91518	High Level Clinic Visits	Skin and breast diseases	V	1.69	\$85.63	\$19.21	\$17.13
91524	High Level Clinic Visits	Musculoskeletal diseases	V	1.37	\$69.42	\$15.37	\$13.88
91531	High Level Clinic Visits	Ear, nose, mouth and throat diseases	V	1.31	\$66.38	\$14.92	\$13.28
91533	High Level Clinic Visits	Respiratory system diseases	V	1.33	\$67.39	\$13.79	\$13.48
91536	High Level Clinic Visits	Cardiovascular system diseases	V	1.43	\$72.46	\$15.37	\$14.49
91541	High Level Clinic Visits	Digestive system diseases	V	1.50	\$76.00	\$16.05	\$15.20
91553	High Level Clinic Visits	Kidney, urinary tract and male genital diseases.	V	1.30	\$65.87	\$14.01	\$13.17
91556	High Level Clinic Visits	Female genital system diseases	V	1.43	\$72.46	\$14.49	\$14.49
91557	High Level Clinic Visits	Pregnancy and neonatal care	V	1.81	\$91.71	\$22.15	\$18.34
91563	High Level Clinic Visits	Nervous system diseases	V	1.50	\$76.00	\$16.72	\$15.20
91568	High Level Clinic Visits	Eye diseases	V	1.31	\$66.38	\$13.79	\$13.28
91572	High Level Clinic Visits	Trauma and poisoning	V	1.69	\$85.63	\$22.15	\$17.13
91578	High Level Clinic Visits	Major signs, symptoms and findings	V	1.89	\$95.77	\$29.15	\$19.15
91582	High Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	1.41	\$71.44	\$15.14	\$14.29
91586	High Level Clinic Visits	Immunologic and hematologic diseases	V	1.65	\$83.60	\$18.98	\$16.72
91588	High Level Clinic Visits	Malignancy	V	1.09	\$55.23	\$12.43	\$11.05
91591	High Level Clinic Visits	Psychiatric disorders	V	1.57	\$79.55	\$21.92	\$15.91
91597	High Level Clinic Visits	Infectious disease	V	1.76	\$89.18	\$19.66	\$17.84
+91599	High Level Clinic Visits	Unknown cause of mortality	V	1.31	\$66.38	\$20.79	\$13.28
919	Electroconvulsive Therapy .....	.....	S	3.17	\$160.62	\$80.00	\$32.12
920	Biofeedback and other Training .....	.....	S	1.17	\$59.28	\$29.61	\$11.86
*921	Diabetes Education .....	.....	S	.....	.....	.....	.....
926	Dialysis for other than ESRD patients .....	.....	S	4.28	\$216.87	\$69.83	\$43.37
928	Alimentary Tests .....	.....	X	3.11	\$157.58	\$83.85	\$31.52
930	Minor Eye Examinations .....	.....	X	1.02	\$51.68	\$22.83	\$10.34
931	Level I Eye Tests .....	.....	X	0.74	\$37.50	\$21.47	\$7.50
932	Level II Eye Tests .....	.....	X	2.52	\$127.69	\$65.09	\$25.54
936	Fitting of Vision Aids .....	.....	X	0.52	\$26.35	\$9.49	\$5.27
940	Otorhinolaryngologic Function Tests .....	.....	X	3.04	\$154.04	\$51.98	\$30.81
941	Level I Audiometry .....	.....	X	0.74	\$37.50	\$13.56	\$7.50
942	Level II Audiometry .....	.....	X	1.48	\$74.99	\$22.15	\$15.00
947	Resuscitation and Cardioversion .....	.....	S	4.07	\$206.22	\$109.61	\$41.24
948	Cardiac Rehabilitation .....	.....	X	0.81	\$41.04	\$16.95	\$8.21
949	Cardiovascular Stress Test .....	.....	X	1.46	\$73.98	\$62.83	\$14.80
950	Electrocardiogram (ECG) .....	.....	X	0.35	\$17.73	\$15.82	\$3.55
+95111	Low Level ER Visits	Well care and administrative	V	1.06	\$53.71	\$12.66	\$10.74
95118	Low Level ER Visits	Skin and breast diseases	V	1.17	\$59.28	\$19.21	\$11.86
95124	Low Level ER Visits	Musculoskeletal diseases	V	1.17	\$59.28	\$19.89	\$11.86
95131	Low Level ER Visits	Ear, nose, mouth and throat diseases	V	1.11	\$56.24	\$17.63	\$11.25
95133	Low Level ER Visits	Respiratory system diseases	V	1.15	\$58.27	\$18.31	\$11.65
95136	Low Level ER Visits	Cardiovascular system diseases	V	1.24	\$62.83	\$19.89	\$12.57
95141	Low Level ER Visits	Digestive system diseases	V	1.30	\$65.87	\$21.02	\$13.17
95153	Low Level ER Visits	Kidney, urinary tract and male genital diseases.	V	1.43	\$72.46	\$24.41	\$14.49
95156	Low Level ER Visits	Female genital system diseases	V	1.41	\$71.44	\$23.73	\$14.29
95157	Low Level ER Visits	Pregnancy and neonatal care	V	1.44	\$72.96	\$24.18	\$14.59
95163	Low Level ER Visits	Nervous system diseases	V	1.31	\$66.38	\$22.83	\$13.28
95168	Low Level ER Visits	Eye diseases	V	1.20	\$60.80	\$20.79	\$12.16
95172	Low Level ER Visits	Trauma and poisoning	V	1.28	\$64.86	\$22.15	\$12.97
95178	Low Level ER Visits	Major signs, symptoms and findings	V	2.02	\$102.35	\$37.97	\$20.47
95182	Low Level ER Visits	Endocrine, nutritional and metabolic diseases.	V	1.50	\$76.00	\$24.63	\$15.20
95186	Low Level ER Visits	Immunologic and hematologic diseases	V	1.43	\$72.46	\$25.76	\$14.49
95188	Low Level ER Visits	Malignancy	V	1.52	\$77.02	\$26.44	\$15.40
95191	Low Level ER Visits	Psychiatric Disorders	V	1.09	\$55.23	\$14.01	\$11.05
95197	Low Level ER Visits	Infectious disease	V	1.24	\$62.83	\$20.57	\$12.57
+95199	Low Level ER Visits	Unknown cause of mortality	V	1.31	\$66.38	\$20.79	\$13.28
+95311	Mid Level ER Visits	Well care and administrative	V	1.06	\$53.71	\$12.66	\$10.74
95318	Mid Level ER Visits	Skin and breast diseases	V	1.89	\$95.77	\$34.80	\$19.15

¹*APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.²+APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC ^{1,2}	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
95324	Mid Level ER Visits Musculoskeletal diseases	V	1.78	\$90.19	\$32.32	\$18.04
95331	Mid Level ER Visits Ear, nose, mouth and throat diseases	V	1.81	\$91.71	\$31.64	\$18.34
95333	Mid Level ER Visits Respiratory system diseases	V	1.91	\$96.78	\$33.67	\$19.36
95336	Mid Level ER Visits Cardiovascular system diseases	V	2.02	\$102.35	\$36.16	\$20.47
95341	Mid Level ER Visits Digestive system diseases	V	2.02	\$102.35	\$36.61	\$20.47
95353	Mid Level ER Visits Kidney, urinary tract and male genital diseases	V	2.06	\$104.38	\$38.19	\$20.88
95356	Mid Level ER Visits Female genital system diseases	V	2.04	\$103.37	\$36.61	\$20.67
95357	Mid Level ER Visits Pregnancy and neonatal care	V	2.06	\$104.38	\$39.78	\$20.88
95363	Mid Level ER Visits Nervous system diseases	V	2.00	\$101.34	\$37.29	\$20.27
95368	Mid Level ER Visits Eye diseases	V	1.69	\$85.63	\$33.00	\$17.13
95372	Mid Level ER Visits Trauma and poisoning	V	2.02	\$102.35	\$38.87	\$20.47
95378	Mid Level ER Visits Major signs, symptoms and findings	V	3.07	\$155.56	\$58.76	\$31.11
95382	Mid Level ER Visits Endocrine, nutritional and metabolic diseases	V	2.30	\$116.54	\$43.62	\$23.31
95386	Mid Level ER Visits Immunologic and hematologic diseases	V	2.39	\$121.10	\$47.01	\$24.22
95388	Mid Level ER Visits Malignancy	V	2.15	\$108.94	\$41.13	\$21.79
95391	Mid Level ER Visits Psychiatric Disorders	V	2.00	\$101.34	\$35.93	\$20.27
95397	Mid Level ER Visits Infectious disease	V	1.98	\$100.33	\$36.61	\$20.07
+95399	Mid Level ER Visits Unknown cause of mortality	V	1.31	\$66.38	\$20.79	\$13.28
+95511	High Level ER Visits Well care and administrative	V	1.06	\$53.71	\$12.66	\$10.74
95518	High Level ER Visits Skin and breast diseases	V	2.61	\$132.25	\$46.56	\$26.45
95524	High Level ER Visits Musculoskeletal diseases	V	2.44	\$123.63	\$41.36	\$24.73
95531	High Level ER Visits Ear, nose, mouth and throat diseases	V	2.56	\$129.71	\$44.07	\$25.94
95533	High Level ER Visits Respiratory system diseases	V	3.19	\$161.64	\$54.69	\$32.33
95536	High Level ER Visits Cardiovascular system diseases	V	3.17	\$160.62	\$54.69	\$32.12
95541	High Level ER Visits Digestive system diseases	V	2.89	\$146.43	\$54.69	\$29.29
95553	High Level ER Visits Kidney, urinary tract and male genital diseases	V	2.89	\$146.43	\$54.69	\$29.29
95556	High Level ER Visits Female genital system diseases	V	2.73	\$138.33	\$50.85	\$27.67
95557	High Level ER Visits Pregnancy and neonatal care	V	2.93	\$148.46	\$54.92	\$29.69
95563	High Level ER Visits Nervous system diseases	V	3.04	\$154.04	\$58.08	\$30.81
95568	High Level ER Visits Eye diseases	V	2.31	\$117.05	\$40.00	\$23.41
95572	High Level ER Visits Trauma and poisoning	V	2.74	\$138.83	\$50.17	\$27.77
95578	High Level ER Visits Major signs, symptoms and findings	V	6.85	\$347.09	\$148.48	\$69.42
95582	High Level ER Visits Endocrine, nutritional and metabolic diseases	V	3.28	\$166.20	\$64.64	\$33.24
95586	High Level ER Visits Immunologic and hematologic diseases	V	3.70	\$187.48	\$74.35	\$37.50
95588	High Level ER Visits Malignancy	V	3.67	\$185.96	\$61.70	\$37.19
95591	High Level ER Visits Psychiatric Disorders	V	3.48	\$176.33	\$62.38	\$35.27
95597	High Level ER Visits Infectious disease	V	2.81	\$142.38	\$53.34	\$28.48
+95599	High Level ER Visits Unknown cause of mortality	V	1.31	\$66.38	\$20.79	\$13.28
956	Continuous ECG and Blood Pressure Monitoring	X	1.11	\$56.24	\$55.82	\$11.25
957	Echocardiography	S	2.83	\$143.39	\$117.07	\$28.68
958	Diagnostic Cardiac Catheterization	T	26.11	\$1,322.98	\$659.47	\$264.60
960	Cardiac Electrophysiologic Tests/Procedures	S	4.24	\$214.84	\$144.41	\$42.97
966	Electronic Analysis of Pacemakers/other Devices	X	0.39	\$19.76	\$12.43	\$3.95
967	Non-Invasive Vascular Studies	X	1.70	\$86.14	\$57.40	\$17.23
968	Vascular Ultrasound	X	2.37	\$120.09	\$79.55	\$24.02
969	Hyperbaric Oxygen	S	2.65	\$134.27	\$141.70	\$26.85
971	Level I Pulmonary Tests	X	0.78	\$39.52	\$21.47	\$7.90
972	Level II Pulmonary Tests	X	1.02	\$51.68	\$29.38	\$10.34
973	Level III Pulmonary Tests	S	1.89	\$95.77	\$55.82	\$19.15
976	Pulmonary Therapy	S	0.44	\$22.29	\$14.92	\$4.46
977	Allergy Tests	X	0.63	\$31.92	\$12.66	\$6.38
978	Allergy Injections	X	0.31	\$15.71	\$3.39	\$3.14
979	Extended EEG Studies and Sleep Studies	S	10.17	\$515.31	\$288.83	\$103.06
980	Electroencephalogram	S	2.15	\$108.94	\$57.86	\$21.79
*981	Level I Nerve and Muscle Tests	X	1.46	\$73.98	\$41.81	\$14.80
*982	Level II Nerve and Muscle Tests	X	1.39	\$70.43	\$38.87	\$14.09
987	Subcutaneous or Intramuscular Chemotherapy	S	0.65	\$32.94	\$13.33	\$6.59
988	Chemotherapy except by Extended Infusion	S	4.15	\$210.28	\$97.52	\$42.06
989	Chemotherapy by Extended Infusion	S	1.72	\$87.15	\$40.68	\$17.43
990	Photochemotherapy	S	0.43	\$21.79	\$8.14	\$4.36
997	Manipulation Therapy	S	0.69	\$34.96	\$7.23	\$6.99
999	Therapeutic Phlebotomy	X	0.43	\$21.79	\$10.85	\$4.36

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
00100	N	Anesth, skin surgery .....	.....	.....	.....	.....	.....
00102	N	Anesth, repair of cleft lip .....	.....	.....	.....	.....	.....
00103	N	Anesth, blepharoplasty .....	.....	.....	.....	.....	.....
00104	N	Anesth for electroshock .....	.....	.....	.....	.....	.....
00120	N	Anesthesia for ear surgery .....	.....	.....	.....	.....	.....
00124	N	Anesthesia for ear exam .....	.....	.....	.....	.....	.....
00126	N	Anesth, tympanotomy .....	.....	.....	.....	.....	.....
00140	N	Anesth, procedures on eye .....	.....	.....	.....	.....	.....
00142	N	Anesthesia for lens surgery .....	.....	.....	.....	.....	.....
00144	N	Anesth, corneal transplant .....	.....	.....	.....	.....	.....
00145	N	Anesth, vitrectomy .....	.....	.....	.....	.....	.....
00147	N	Anesth, iridectomy .....	.....	.....	.....	.....	.....
00148	N	Anesthesia for eye exam .....	.....	.....	.....	.....	.....
00160	N	Anesth, nose, sinus surgery .....	.....	.....	.....	.....	.....
00162	N	Anesth, nose, sinus surgery .....	.....	.....	.....	.....	.....
00164	N	Anesth, biopsy of nose .....	.....	.....	.....	.....	.....
00170	N	Anesth, procedure on mouth .....	.....	.....	.....	.....	.....
00172	N	Anesth, cleft palate repair .....	.....	.....	.....	.....	.....
00174	C	Anesth, pharyngeal surgery .....	.....	.....	.....	.....	.....
00176	C	Anesth, pharyngeal surgery .....	.....	.....	.....	.....	.....
00190	N	Anesth, facial bone surgery .....	.....	.....	.....	.....	.....
00192	C	Anesth, facial bone surgery .....	.....	.....	.....	.....	.....
00210	N	Anesth, open head surgery .....	.....	.....	.....	.....	.....
00212	N	Anesth, skull drainage .....	.....	.....	.....	.....	.....
00214	C	Anesth, skull drainage .....	.....	.....	.....	.....	.....
00215	C	Anesth, skull fracture .....	.....	.....	.....	.....	.....
00216	N	Anesth, head vessel surgery .....	.....	.....	.....	.....	.....
00218	N	Anesth, special head surgery .....	.....	.....	.....	.....	.....
00220	N	Anesth, spinal fluid shunt .....	.....	.....	.....	.....	.....
00222	N	Anesth, head nerve surgery .....	.....	.....	.....	.....	.....
00300	N	Anesth, skin surgery, neck .....	.....	.....	.....	.....	.....
00320	N	Anesth, neck organ surgery .....	.....	.....	.....	.....	.....
00322	N	Anesth, biopsy of thyroid .....	.....	.....	.....	.....	.....
00350	N	Anesth, neck vessel surgery .....	.....	.....	.....	.....	.....
00352	N	Anesth, neck vessel surgery .....	.....	.....	.....	.....	.....
00400	N	Anesth, chest skin surgery .....	.....	.....	.....	.....	.....
00402	N	Anesth, surgery of breast .....	.....	.....	.....	.....	.....
00404	C	Anesth, surgery of breast .....	.....	.....	.....	.....	.....
00406	C	Anesth, surgery of breast .....	.....	.....	.....	.....	.....
00410	N	Anesth, correct heart rhythm .....	.....	.....	.....	.....	.....
00420	N	Anesth, skin surgery, back .....	.....	.....	.....	.....	.....
00450	N	Anesth, surgery of shoulder .....	.....	.....	.....	.....	.....
00452	C	Anesth, surgery of shoulder .....	.....	.....	.....	.....	.....
00454	N	Anesth, collarbone biopsy .....	.....	.....	.....	.....	.....
00470	N	Anesth, removal of rib .....	.....	.....	.....	.....	.....
00472	N	Anesth, chest wall repair .....	.....	.....	.....	.....	.....
00474	C	Anesth, surgery of rib(s) .....	.....	.....	.....	.....	.....
00500	N	Anesth, esophageal surgery .....	.....	.....	.....	.....	.....
00520	N	Anesth, chest procedure .....	.....	.....	.....	.....	.....
00522	N	Anesth, chest lining biopsy .....	.....	.....	.....	.....	.....
00524	C	Anesth, chest drainage .....	.....	.....	.....	.....	.....
00528	N	Anesth, chest partition view .....	.....	.....	.....	.....	.....
00530	C	Anesth, pacemaker insertion .....	.....	.....	.....	.....	.....
00532	N	Anesth, vascular access .....	.....	.....	.....	.....	.....
00534	N	Anesth, cardioverter/defib .....	.....	.....	.....	.....	.....
00540	C	Anesth, chest surgery .....	.....	.....	.....	.....	.....
00542	C	Anesth, release of lung .....	.....	.....	.....	.....	.....
00544	C	Anesth, chest lining removal .....	.....	.....	.....	.....	.....
00546	C	Anesth, lung,chest wall surg .....	.....	.....	.....	.....	.....
00548	N	Anesth, trachea,bronchi surg .....	.....	.....	.....	.....	.....
00560	C	Anesth, open heart surgery .....	.....	.....	.....	.....	.....
00562	C	Anesth, open heart surgery .....	.....	.....	.....	.....	.....
00580	C	Anesth,heart/lung transplant .....	.....	.....	.....	.....	.....
00600	N	Anesth, spine, cord surgery .....	.....	.....	.....	.....	.....
00604	C	Anesth, surgery of vertebra .....	.....	.....	.....	.....	.....
00620	N	Anesth, spine, cord surgery .....	.....	.....	.....	.....	.....
00622	C	Anesth, removal of nerves .....	.....	.....	.....	.....	.....
00630	N	Anesth, spine, cord surgery .....	.....	.....	.....	.....	.....
00632	C	Anesth, removal of nerves .....	.....	.....	.....	.....	.....
00634	C	Anesth for chemonucleolysis .....	.....	.....	.....	.....	.....
00670	C	Anesth, spine, cord surgery .....	.....	.....	.....	.....	.....
00700	N	Anesth, abdominal wall surg .....	.....	.....	.....	.....	.....
00702	N	Anesth, for liver biopsy					
00730	N	Anesth, abdominal wall surg					
00740	N	Anesth, gi visualization					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
00750	N	Anesth, repair of hernia .....	.....	.....	.....	.....	.....
00752	N	Anesth, repair of hernia .....	.....	.....	.....	.....	.....
00754	N	Anesth, repair of hernia .....	.....	.....	.....	.....	.....
00756	N	Anesth, repair of hernia .....	.....	.....	.....	.....	.....
00770	N	Anesth, blood vessel repair .....	.....	.....	.....	.....	.....
00790	N	Anesth, surg upper abdomen .....	.....	.....	.....	.....	.....
00792	C	Anesth, part liver removal .....	.....	.....	.....	.....	.....
00794	C	Anesth, pancreas removal .....	.....	.....	.....	.....	.....
00796	C	Anesth, for liver transplant .....	.....	.....	.....	.....	.....
00800	N	Anesth, abdominal wall surg .....	.....	.....	.....	.....	.....
00802	C	Anesth, fat layer removal .....	.....	.....	.....	.....	.....
00810	N	Anesth, intestine endoscopy .....	.....	.....	.....	.....	.....
00820	N	Anesth, abdominal wall surg .....	.....	.....	.....	.....	.....
00830	N	Anesth, repair of hernia .....	.....	.....	.....	.....	.....
00832	N	Anesth, repair of hernia .....	.....	.....	.....	.....	.....
00840	N	Anesth, surg lower abdomen .....	.....	.....	.....	.....	.....
00842	N	Anesth, amniocentesis .....	.....	.....	.....	.....	.....
00844	C	Anesth, pelvis surgery .....	.....	.....	.....	.....	.....
00846	C	Anesth, hysterectomy .....	.....	.....	.....	.....	.....
00848	C	Anesth, pelvic organ surg .....	.....	.....	.....	.....	.....
00850	C	Anesth, cesarean section .....	.....	.....	.....	.....	.....
00855	C	Anesth, hysterectomy .....	.....	.....	.....	.....	.....
00857	C	Analgesia, labor & c-section .....	.....	.....	.....	.....	.....
00860	N	Anesth, surgery of abdomen .....	.....	.....	.....	.....	.....
00862	N	Anesth, kidney, ureter surg .....	.....	.....	.....	.....	.....
00864	C	Anesth, removal of bladder .....	.....	.....	.....	.....	.....
00865	C	Anesth, removal of prostate .....	.....	.....	.....	.....	.....
00866	C	Anesth, removal of adrenal .....	.....	.....	.....	.....	.....
00868	C	Anesth, kidney transplant .....	.....	.....	.....	.....	.....
00870	N	Anesth, bladder stone surg .....	.....	.....	.....	.....	.....
00872	N	Anesth, kidney stone destruct .....	.....	.....	.....	.....	.....
00873	N	Anesth, kidney stone destruct .....	.....	.....	.....	.....	.....
00880	N	Anesth, abdomen vessel surg .....	.....	.....	.....	.....	.....
00882	C	Anesth, major vein ligation .....	.....	.....	.....	.....	.....
00884	C	Anesth, major vein revision .....	.....	.....	.....	.....	.....
00900	N	Anesth, perineal procedure .....	.....	.....	.....	.....	.....
00902	N	Anesth, anorectal surgery .....	.....	.....	.....	.....	.....
00904	C	Anesth, perineal surgery .....	.....	.....	.....	.....	.....
00906	N	Anesth, removal of vulva .....	.....	.....	.....	.....	.....
00908	C	Anesth, removal of prostate .....	.....	.....	.....	.....	.....
00910	N	Anesth, bladder surgery .....	.....	.....	.....	.....	.....
00912	N	Anesth, bladder tumor surg .....	.....	.....	.....	.....	.....
00914	N	Anesth, removal of prostate .....	.....	.....	.....	.....	.....
00916	N	Anesth, bleeding control .....	.....	.....	.....	.....	.....
00918	N	Anesth, stone removal .....	.....	.....	.....	.....	.....
00920	N	Anesth, genitalia surgery .....	.....	.....	.....	.....	.....
00922	N	Anesth, sperm duct surgery .....	.....	.....	.....	.....	.....
00924	N	Anesth, testis exploration .....	.....	.....	.....	.....	.....
00926	N	Anesth, removal of testis .....	.....	.....	.....	.....	.....
00928	C	Anesth, removal of testis .....	.....	.....	.....	.....	.....
00930	N	Anesth, testis suspension .....	.....	.....	.....	.....	.....
00932	C	Anesth, amputation of penis .....	.....	.....	.....	.....	.....
00934	C	Anesth, penis, nodes removal .....	.....	.....	.....	.....	.....
00936	C	Anesth, penis, nodes removal .....	.....	.....	.....	.....	.....
00938	N	Anesth, insert penis device .....	.....	.....	.....	.....	.....
00940	N	Anesth, vaginal procedures .....	.....	.....	.....	.....	.....
00942	N	Anesth, surgery on vagina .....	.....	.....	.....	.....	.....
00944	C	Anesth, vaginal hysterectomy .....	.....	.....	.....	.....	.....
00946	N	Anesth, vaginal delivery .....	.....	.....	.....	.....	.....
00948	N	Anesth, repair of cervix .....	.....	.....	.....	.....	.....
00950	N	Anesth, vaginal endoscopy .....	.....	.....	.....	.....	.....
00952	N	Anesth, uterine endoscopy .....	.....	.....	.....	.....	.....
00955	C	Analgesia, vaginal delivery .....	.....	.....	.....	.....	.....
01000	N	Anesth, skin surgery, pelvis .....	.....	.....	.....	.....	.....
01110	N	Anesth, skin surgery, pelvis .....	.....	.....	.....	.....	.....
01120	N	Anesth, pelvis surgery .....	.....	.....	.....	.....	.....
01130	N	Anesth, body cast procedure .....	.....	.....	.....	.....	.....
01140	C	Anesth, amputation at pelvis .....	.....	.....	.....	.....	.....
01150	C	Anesth, pelvic tumor surgery .....	.....	.....	.....	.....	.....
01160	N	Anesth, pelvis procedure .....	.....	.....	.....	.....	.....
01170	N	Anesth, pelvis surgery .....	.....	.....	.....	.....	.....
01180	N	Anesth, pelvis nerve removal .....	.....	.....	.....	.....	.....
01190	C	Anesth, pelvis nerve removal					
01200	N	Anesth, hip joint procedure					
01202	N	Anesth, arthroscopy of hip					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
01210	N	Anesth, hip joint surgery .....	.....	.....	.....	.....	.....
01212	C	Anesth, hip disarticulation .....	.....	.....	.....	.....	.....
01214	C	Anesth, replacement of hip .....	.....	.....	.....	.....	.....
01220	N	Anesth, procedure on femur .....	.....	.....	.....	.....	.....
01230	N	Anesth, surgery of femur .....	.....	.....	.....	.....	.....
01232	C	Anesth, amputation of femur .....	.....	.....	.....	.....	.....
01234	C	Anesth, radical femur surg .....	.....	.....	.....	.....	.....
01240	N	Anesth, upper leg skin surg .....	.....	.....	.....	.....	.....
01250	N	Anesth, upper leg surgery .....	.....	.....	.....	.....	.....
01260	N	Anesth, upper leg veins surg .....	.....	.....	.....	.....	.....
01270	N	Anesth, thigh arteries surg .....	.....	.....	.....	.....	.....
01272	C	Anesth, femoral artery surg .....	.....	.....	.....	.....	.....
01274	C	Anesth, femoral embolectomy .....	.....	.....	.....	.....	.....
01300	N	Anesth, skin surgery, knee .....	.....	.....	.....	.....	.....
01320	N	Anesth, knee area surgery .....	.....	.....	.....	.....	.....
01340	N	Anesth, knee area procedure .....	.....	.....	.....	.....	.....
01360	N	Anesth, knee area surgery .....	.....	.....	.....	.....	.....
01380	N	Anesth, knee joint procedure .....	.....	.....	.....	.....	.....
01382	N	Anesth, knee arthroscopy .....	.....	.....	.....	.....	.....
01390	N	Anesth, knee area procedure .....	.....	.....	.....	.....	.....
01392	N	Anesth, knee area surgery .....	.....	.....	.....	.....	.....
01400	N	Anesth, knee joint surgery .....	.....	.....	.....	.....	.....
01402	C	Anesth, replacement of knee .....	.....	.....	.....	.....	.....
01404	C	Anesth, amputation at knee .....	.....	.....	.....	.....	.....
01420	N	Anesth, knee joint casting .....	.....	.....	.....	.....	.....
01430	N	Anesth, knee veins surgery .....	.....	.....	.....	.....	.....
01432	N	Anesth, knee vessel surg .....	.....	.....	.....	.....	.....
01440	N	Anesth, knee arteries surg .....	.....	.....	.....	.....	.....
01442	C	Anesth, knee artery surg .....	.....	.....	.....	.....	.....
01444	C	Anesth, knee artery repair .....	.....	.....	.....	.....	.....
01460	N	Anesth, lower leg skin surg .....	.....	.....	.....	.....	.....
01462	N	Anesth, lower leg procedure .....	.....	.....	.....	.....	.....
01464	N	Anesth, ankle arthroscopy .....	.....	.....	.....	.....	.....
01470	N	Anesth, lower leg surgery .....	.....	.....	.....	.....	.....
01472	N	Anesth, achilles tendon surg .....	.....	.....	.....	.....	.....
01474	N	Anesth, lower leg surgery .....	.....	.....	.....	.....	.....
01480	N	Anesth, lower leg bone surg .....	.....	.....	.....	.....	.....
01482	N	Anesth, radical leg surgery .....	.....	.....	.....	.....	.....
01484	N	Anesth, lower leg revision .....	.....	.....	.....	.....	.....
01486	C	Anesth, ankle replacement .....	.....	.....	.....	.....	.....
01490	N	Anesth, lower leg casting .....	.....	.....	.....	.....	.....
01500	N	Anesth, leg arteries surg .....	.....	.....	.....	.....	.....
01502	C	Anesth, lowerleg embolectomy .....	.....	.....	.....	.....	.....
01520	N	Anesth, lower leg vein surg .....	.....	.....	.....	.....	.....
01522	N	Anesth, lower leg vein surg .....	.....	.....	.....	.....	.....
01600	N	Anesth, shoulder skin surg .....	.....	.....	.....	.....	.....
01610	N	Anesth, surgery of shoulder .....	.....	.....	.....	.....	.....
01620	N	Anesth, shoulder procedure .....	.....	.....	.....	.....	.....
01622	N	Anesth, shoulder arthroscopy .....	.....	.....	.....	.....	.....
01630	N	Anesth, surgery of shoulder .....	.....	.....	.....	.....	.....
01632	C	Anesth, surgery of shoulder .....	.....	.....	.....	.....	.....
01634	C	Anesth, shoulder joint amput .....	.....	.....	.....	.....	.....
01636	C	Anesth, forequarter amput .....	.....	.....	.....	.....	.....
01638	C	Anesth, shoulder replacement .....	.....	.....	.....	.....	.....
01650	N	Anesth, shoulder artery surg .....	.....	.....	.....	.....	.....
01652	C	Anesth, shoulder vessel surg .....	.....	.....	.....	.....	.....
01654	C	Anesth, shoulder vessel surg .....	.....	.....	.....	.....	.....
01656	C	Anesth, arm-leg vessel surg .....	.....	.....	.....	.....	.....
01670	N	Anesth, shoulder vein surg .....	.....	.....	.....	.....	.....
01680	N	Anesth, shoulder casting .....	.....	.....	.....	.....	.....
01682	N	Anesth, airplane cast .....	.....	.....	.....	.....	.....
01700	N	Anesth, elbow area skin surg .....	.....	.....	.....	.....	.....
01710	N	Anesth, elbow area surgery .....	.....	.....	.....	.....	.....
01712	N	Anesth, upperarm tendon surg .....	.....	.....	.....	.....	.....
01714	N	Anesth, upperarm tendon surg .....	.....	.....	.....	.....	.....
01716	N	Anesth, biceps tendon repair .....	.....	.....	.....	.....	.....
01730	N	Anesth, upperarm procedure .....	.....	.....	.....	.....	.....
01732	N	Anesth, elbow arthroscopy .....	.....	.....	.....	.....	.....
01740	N	Anesth, upper arm surgery .....	.....	.....	.....	.....	.....
01742	N	Anesth, humerus surgery .....	.....	.....	.....	.....	.....
01744	N	Anesth, humerus repair .....	.....	.....	.....	.....	.....
01756	C	Anesth, radical humerus surg .....	.....	.....	.....	.....	.....
01758	N	Anesth, humeral lesion surg					
01760	N	Anesth, elbow replacement					
01770	N	Anesth, upperarm artery surg					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
01772	C	Anesth, upperarm embolectomy .....	.....	.....	.....	.....	.....
01780	N	Anesth, upper arm vein surg .....	.....	.....	.....	.....	.....
01782	C	Anesth, upperarm vein repair .....	.....	.....	.....	.....	.....
01784	N	Anesth, av fistula repair .....	.....	.....	.....	.....	.....
01800	N	Anesth, lower arm skin surg .....	.....	.....	.....	.....	.....
01810	N	Anesth, lower arm surgery .....	.....	.....	.....	.....	.....
01820	N	Anesth, lower arm procedure .....	.....	.....	.....	.....	.....
01830	N	Anesth, lower arm surgery .....	.....	.....	.....	.....	.....
01832	N	Anesth, wrist replacement .....	.....	.....	.....	.....	.....
01840	N	Anesth, lowerarm artery surg .....	.....	.....	.....	.....	.....
01842	C	Anesth, lowerarm embolectomy .....	.....	.....	.....	.....	.....
01844	N	Anesth, vascular shunt surg .....	.....	.....	.....	.....	.....
01850	N	Anesth, lower arm vein surg .....	.....	.....	.....	.....	.....
01852	C	Anesth, lowerarm vein repair .....	.....	.....	.....	.....	.....
01860	N	Anesth, lower arm casting .....	.....	.....	.....	.....	.....
01900	N	Anesth, uterus/tube inject .....	.....	.....	.....	.....	.....
01902	C	Anesth, burr holes, skull .....	.....	.....	.....	.....	.....
01904	C	Anesth, skull x-ray inject .....	.....	.....	.....	.....	.....
01906	N	Anesth, lumbar myelography .....	.....	.....	.....	.....	.....
01908	N	Anesth, cervical myelography .....	.....	.....	.....	.....	.....
01910	N	Anesth, skull myelography .....	.....	.....	.....	.....	.....
01912	N	Anesth, lumbar discography .....	.....	.....	.....	.....	.....
01914	N	Anesth, cervical discography .....	.....	.....	.....	.....	.....
01916	C	Anesth, head arteriogram .....	.....	.....	.....	.....	.....
01918	C	Anesth, limb arteriogram .....	.....	.....	.....	.....	.....
01920	N	Anesth, catheterize heart .....	.....	.....	.....	.....	.....
01921	C	Anesth, vessel surgery .....	.....	.....	.....	.....	.....
01922	N	Anesth, cat or MRI scan .....	.....	.....	.....	.....	.....
01990	C	Support for organ donor .....	.....	.....	.....	.....	.....
01995	N	Regional anesthesia, limb .....	.....	.....	.....	.....	.....
01996	N	Manage daily drug therapy .....	.....	.....	.....	.....	.....
01999	N	Unlisted anesth procedure .....	.....	.....	.....	.....	.....
10040	T	Acne surgery of skin abscess	131	1.94	\$102.84	\$36.61	\$20.57
10060	T	Drainage of skin abscess	131	1.94	\$102.84	\$36.61	\$20.57
10061	T	Drainage of skin abscess	131	1.94	\$102.84	\$36.61	\$20.57
10080	T	Drainage of pilonidal cyst	131	1.94	\$102.84	\$36.61	\$20.57
10081	T	Drainage of pilonidal cyst	131	1.94	\$102.84	\$36.61	\$20.57
10120	T	Remove foreign body	131	1.94	\$102.84	\$36.61	\$20.57
10121	T	Remove foreign body	163	10.69	\$565.14	\$264.65	\$113.03
10140	T	Drainage of hematoma/fluid	131	1.94	\$102.84	\$36.61	\$20.57
10160	T	Puncture drainage of lesion	131	1.94	\$102.84	\$36.61	\$20.57
10180	T	Complex drainage, wound	131	1.94	\$102.84	\$36.61	\$20.57
11000	T	Debride infected skin	151	1.74	\$92.07	\$35.71	\$18.41
11001	T	Debride infect skin add	151	1.74	\$92.07	\$35.71	\$18.41
11010	T	Debride skin, fx	163	10.69	\$565.14	\$264.65	\$113.03
11011	T	Debride skin/muscle, fx	163	10.69	\$565.14	\$264.65	\$113.03
11012	T	Debride skin/muscle/bone, fx	163	10.69	\$565.14	\$264.65	\$113.03
11040	T	Debride skin partial	151	1.74	\$92.07	\$35.71	\$18.41
11041	T	Debride skin full	151	1.74	\$92.07	\$35.71	\$18.41
11042	T	Debride skin/tissue	151	1.74	\$92.07	\$35.71	\$18.41
11043	T	Debride tissue/muscle	162	5.67	\$299.71	\$125.43	\$59.94
11044	T	Debride tissue/muscle/bone	162	5.67	\$299.71	\$125.43	\$59.94
11055	T	Trim skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11056	T	Trim 2 to 4 skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
11057	T	Trim over 4 skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
11100	T	Biopsy of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11101	T	Biopsy, each added lesion	161	3.50	\$185.12	\$75.48	\$37.02
11200	T	Removal of skin tags	151	1.74	\$92.07	\$35.71	\$18.41
11201	T	Removal of added skin tags	151	1.74	\$92.07	\$35.71	\$18.41
11300	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11301	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11302	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11303	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11305	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11306	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11307	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11308	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11310	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11311	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11312	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11313	T	Shave skin lesion	151	1.74	\$92.07	\$35.71	\$18.41
11400	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11401	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11402	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11403	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
11404	T	Removal of skin lesion	162	5.67	\$299.71	\$125.43	\$59.94
11406	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11420	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11421	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11422	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11423	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11424	T	Removal of skin lesion	162	5.67	\$299.71	\$125.43	\$59.94
11426	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11440	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11441	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11442	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11443	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11444	T	Removal of skin lesion	162	5.67	\$299.71	\$125.43	\$59.94
11446	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11450	T	Removal, sweat gland lesion	163	10.69	\$565.14	\$264.65	\$113.03
11451	T	Removal, sweat gland lesion	163	10.69	\$565.14	\$264.65	\$113.03
11462	T	Removal, sweat gland lesion	163	10.69	\$565.14	\$264.65	\$113.03
11463	T	Removal, sweat gland lesion	163	10.69	\$565.14	\$264.65	\$113.03
11470	T	Removal, sweat gland lesion	163	10.69	\$565.14	\$264.65	\$113.03
11471	T	Removal, sweat gland lesion	163	10.69	\$565.14	\$264.65	\$113.03
11600	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11601	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11602	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11603	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11604	T	Removal of skin lesion	162	5.67	\$299.71	\$125.43	\$59.94
11606	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11620	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11621	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11622	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11623	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11624	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11626	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11640	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11641	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11642	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11643	T	Removal of skin lesion	161	3.50	\$185.12	\$75.48	\$37.02
11644	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11646	T	Removal of skin lesion	163	10.69	\$565.14	\$264.65	\$113.03
11719	T	Trim nail(s)	137	0.46	\$24.49	\$4.90	\$4.90
11720	T	Debride nail, 1-5	137	0.46	\$24.49	\$4.90	\$4.90
11721	T	Debride nail, 6 or more	137	0.46	\$24.49	\$4.90	\$4.90
11730	T	Removal of nail plate	151	1.74	\$92.07	\$35.71	\$18.41
11731	T	Removal of second nail plate	151	1.74	\$92.07	\$35.71	\$18.41
11732	T	Remove additional nail plate	151	1.74	\$92.07	\$35.71	\$18.41
11740	T	Drain blood from under nail	137	0.46	\$24.49	\$4.90	\$4.90
11750	T	Removal of nail bed	161	3.50	\$185.12	\$75.48	\$37.02
11752	T	Remove nail bed/finger tip	163	10.69	\$565.14	\$264.65	\$113.03
11755	T	Biopsy, nail unit	137	0.46	\$24.49	\$4.90	\$4.90
11760	T	Reconstruction of nail bed	181	2.19	\$115.58	\$43.84	\$23.12
11762	T	Reconstruction of nail bed	181	2.19	\$115.58	\$43.84	\$23.12
11765	T	Excision of nail fold, toe	151	1.74	\$92.07	\$35.71	\$18.41
11770	T	Removal of pilonidal lesion	162	5.67	\$299.71	\$125.43	\$59.94
11771	T	Removal of pilonidal lesion	163	10.69	\$565.14	\$264.65	\$113.03
11772	T	Removal of pilonidal lesion	163	10.69	\$565.14	\$264.65	\$113.03
11900	T	Injection into skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
11901	T	Added skin lesions injection	151	1.74	\$92.07	\$35.71	\$18.41
11920	T	Correct skin color defects	181	2.19	\$115.58	\$43.84	\$23.12
11921	T	Correct skin color defects	181	2.19	\$115.58	\$43.84	\$23.12
11922	T	Correct skin color defects	181	2.19	\$115.58	\$43.84	\$23.12
11950	T	Therapy for contour defects	181	2.19	\$115.58	\$43.84	\$23.12
11951	T	Therapy for contour defects	181	2.19	\$115.58	\$43.84	\$23.12
11952	T	Therapy for contour defects	181	2.19	\$115.58	\$43.84	\$23.12
11954	T	Therapy for contour defects	181	2.19	\$115.58	\$43.84	\$23.12
11960	T	Insert tissue expander(s)	183	11.17	\$590.61	\$286.57	\$118.12
11970	T	Replace tissue expander	183	11.17	\$590.61	\$286.57	\$118.12
11971	T	Remove tissue expander(s)	163	10.69	\$565.14	\$264.65	\$113.03
11975	E	Insert contraceptive cap					
11976	T	Removal of contraceptive cap	131	1.94	\$102.84	\$36.61	\$20.57
11977	E	Removal/reinsert contra cap					
12001	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12002	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12004	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12005	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12006	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12007	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS ²	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
12011	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12013	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12014	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12015	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12016	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12017	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12018	T	Repair superficial wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12020	T	Closure of split wound	181	2.19	\$115.58	\$43.84	\$23.12
12021	T	Closure of split wound	181	2.19	\$115.58	\$43.84	\$23.12
12031	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12032	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12034	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12035	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12036	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12037	T	Layer closure of wound(s)	183	11.17	\$590.61	\$286.57	\$118.12
12041	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12042	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12044	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12045	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12046	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12047	T	Layer closure of wound(s)	183	11.17	\$590.61	\$286.57	\$118.12
12051	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12052	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12053	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12054	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12055	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12056	T	Layer closure of wound(s)	181	2.19	\$115.58	\$43.84	\$23.12
12057	T	Layer closure of wound(s)	183	11.17	\$590.61	\$286.57	\$118.12
13100	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13101	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13120	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13121	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13131	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13132	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13150	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13151	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13152	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
13160	T	Late closure of wound	182	4.00	\$211.56	\$84.98	\$42.31
13300	T	Repair of wound or lesion	182	4.00	\$211.56	\$84.98	\$42.31
14000	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14001	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14020	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14021	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14040	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14041	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14060	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14061	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14300	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
14350	T	Skin tissue rearrangement	183	11.17	\$590.61	\$286.57	\$118.12
15000	T	Skin graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15050	T	Skin pinch graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15100	T	Skin split graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15101	T	Skin split graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15120	T	Skin split graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15121	T	Skin split graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15200	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15201	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15220	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15221	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15240	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15241	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15260	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15261	T	Skin full graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15350	T	Skin homograft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15400	T	Skin heterograft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15570	T	Form skin pedicle flap	183	11.17	\$590.61	\$286.57	\$118.12
15572	T	Form skin pedicle flap	183	11.17	\$590.61	\$286.57	\$118.12
15574	T	Form skin pedicle flap	183	11.17	\$590.61	\$286.57	\$118.12
15576	T	Form skin pedicle flap	183	11.17	\$590.61	\$286.57	\$118.12
15580	T	Attach skin pedicle graft	183	11.17	\$590.61	\$286.57	\$118.12
15600	T	Skin graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15610	T	Skin graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15620	T	Skin graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15625	T	Skin graft procedure	183	11.17	\$590.61	\$286.57	\$118.12
15630	T	Skin graft procedure	183	11.17	\$590.61	\$286.57	\$118.12

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
15650	T	Transfer skin pedicle flap	183	11.17	\$590.61	\$286.57	\$118.12
15732	T	Muscle-skin graft, head/neck	184	15.17	\$802.17	\$396.40	\$160.43
15734	T	Muscle-skin graft, trunk	184	15.17	\$802.17	\$396.40	\$160.43
15736	T	Muscle-skin graft, arm	184	15.17	\$802.17	\$396.40	\$160.43
15738	T	Muscle-skin graft, leg	184	15.17	\$802.17	\$396.40	\$160.43
15740	T	Island pedicle flap graft	184	15.17	\$802.17	\$396.40	\$160.43
15750	T	Neurovascular pedicle graft	184	15.17	\$802.17	\$396.40	\$160.43
15756	C	Free muscle flap, microvasc					
15757	C	Free skin flap, microvasc					
15758	C	Free fascial flap, microvasc					
15760	T	Composite skin graft	184	15.17	\$802.17	\$396.40	\$160.43
15770	T	Derma-fat-fascia graft	184	15.17	\$802.17	\$396.40	\$160.43
15775	T	Hair transplant punch grafts	183	11.17	\$590.61	\$286.57	\$118.12
15776	T	Hair transplant punch grafts	183	11.17	\$590.61	\$286.57	\$118.12
15780	T	Abrasion treatment of skin	163	10.69	\$565.14	\$264.65	\$113.03
15781	T	Abrasion treatment of skin	163	10.69	\$565.14	\$264.65	\$113.03
15782	T	Abrasion treatment of skin	163	10.69	\$565.14	\$264.65	\$113.03
15783	T	Abrasion treatment of skin	151	1.74	\$92.07	\$35.71	\$18.41
15786	T	Abrasion treatment of lesion	151	1.74	\$92.07	\$35.71	\$18.41
15787	T	Abrasion, added skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
15788	T	Chemical peel, face, epiderm	151	1.74	\$92.07	\$35.71	\$18.41
15789	T	Chemical peel, face, dermal	151	1.74	\$92.07	\$35.71	\$18.41
15792	T	Chemical peel, nonfacial	151	1.74	\$92.07	\$35.71	\$18.41
15793	T	Chemical peel, nonfacial	151	1.74	\$92.07	\$35.71	\$18.41
15810	T	Salabrasion	151	1.74	\$92.07	\$35.71	\$18.41
15811	T	Salabrasion	163	10.69	\$565.14	\$264.65	\$113.03
15819	T	Plastic surgery, neck	183	11.17	\$590.61	\$286.57	\$118.12
15820	T	Revision of lower eyelid	183	11.17	\$590.61	\$286.57	\$118.12
15821	T	Revision of lower eyelid	183	11.17	\$590.61	\$286.57	\$118.12
15822	T	Revision of upper eyelid	183	11.17	\$590.61	\$286.57	\$118.12
15823	T	Revision of upper eyelid	183	11.17	\$590.61	\$286.57	\$118.12
15824	T	Removal of forehead wrinkles	184	15.17	\$802.17	\$396.40	\$160.43
15825	T	Removal of neck wrinkles	183	11.17	\$590.61	\$286.57	\$118.12
15826	T	Removal of brow wrinkles	184	15.17	\$802.17	\$396.40	\$160.43
15828	T	Removal of face wrinkles	184	15.17	\$802.17	\$396.40	\$160.43
15829	T	Removal of skin wrinkles	183	11.17	\$590.61	\$286.57	\$118.12
15831	T	Excise excessive skin tissue	184	15.17	\$802.17	\$396.40	\$160.43
15832	T	Excise excessive skin tissue	184	15.17	\$802.17	\$396.40	\$160.43
15833	T	Excise excessive skin tissue	184	15.17	\$802.17	\$396.40	\$160.43
15834	T	Excise excessive skin tissue	184	15.17	\$802.17	\$396.40	\$160.43
15835	T	Excise excessive skin tissue	183	11.17	\$590.61	\$286.57	\$118.12
15836	T	Excise excessive skin tissue	184	15.17	\$802.17	\$396.40	\$160.43
15837	T	Excise excessive skin tissue	184	15.17	\$802.17	\$396.40	\$160.43
15838	T	Excise excessive skin tissue	163	10.69	\$565.14	\$264.65	\$113.03
15839	T	Excise excessive skin tissue	184	15.17	\$802.17	\$396.40	\$160.43
15840	T	Graft for face nerve palsy	184	15.17	\$802.17	\$396.40	\$160.43
15841	T	Graft for face nerve palsy	184	15.17	\$802.17	\$396.40	\$160.43
15842	T	Graft for face nerve palsy	184	15.17	\$802.17	\$396.40	\$160.43
15845	T	Skin and muscle repair, face	184	15.17	\$802.17	\$396.40	\$160.43
15850	T	Removal of sutures	151	1.74	\$92.07	\$35.71	\$18.41
15851	T	Removal of sutures	151	1.74	\$92.07	\$35.71	\$18.41
15852	T	Dressing change, not for burn	151	1.74	\$92.07	\$35.71	\$18.41
15860	N	Test for blood flow in graft					
15876	T	Suction assisted lipectomy	184	15.17	\$802.17	\$396.40	\$160.43
15877	T	Suction assisted lipectomy	184	15.17	\$802.17	\$396.40	\$160.43
15878	T	Suction assisted lipectomy	184	15.17	\$802.17	\$396.40	\$160.43
15879	T	Suction assisted lipectomy	184	15.17	\$802.17	\$396.40	\$160.43
15920	T	Removal of tail bone ulcer	163	10.69	\$565.14	\$264.65	\$113.03
15922	T	Removal of tail bone ulcer	184	15.17	\$802.17	\$396.40	\$160.43
15931	T	Remove sacrum pressure sore	163	10.69	\$565.14	\$264.65	\$113.03
15933	T	Remove sacrum pressure sore	163	10.69	\$565.14	\$264.65	\$113.03
15934	T	Remove sacrum pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15935	T	Remove sacrum pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15936	T	Remove sacrum pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15937	T	Remove sacrum pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15940	T	Removal of pressure sore	163	10.69	\$565.14	\$264.65	\$113.03
15941	T	Removal of pressure sore	163	10.69	\$565.14	\$264.65	\$113.03
15944	T	Removal of pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15945	T	Removal of pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15946	T	Removal of pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15950	T	Remove thigh pressure sore	163	10.69	\$565.14	\$264.65	\$113.03
15951	T	Remove thigh pressure sore	163	10.69	\$565.14	\$264.65	\$113.03
15952	T	Remove thigh pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15953	T	Remove thigh pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15956	T	Remove thigh pressure sore	184	15.17	\$802.17	\$396.40	\$160.43

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
15958	T	Remove thigh pressure sore	184	15.17	\$802.17	\$396.40	\$160.43
15999	T	Removal of pressure sore	163	10.69	\$565.14	\$264.65	\$113.03
16000	T	Initial treatment of burn(s)	151	1.74	\$92.07	\$35.71	\$18.41
16010	T	Treatment of burn(s)	152	10.43	\$551.43	\$261.71	\$110.29
16015	T	Treatment of burn(s)	152	10.43	\$551.43	\$261.71	\$110.29
16020	T	Treatment of burn(s)	151	1.74	\$92.07	\$35.71	\$18.41
16025	T	Treatment of burn(s)	151	1.74	\$92.07	\$35.71	\$18.41
16030	T	Treatment of burn(s)	151	1.74	\$92.07	\$35.71	\$18.41
16035	T	Incision of burn scab	162	5.67	\$299.71	\$125.43	\$59.94
16040	T	Burn wound excision	162	5.67	\$299.71	\$125.43	\$59.94
16041	T	Burn wound excision	162	5.67	\$299.71	\$125.43	\$59.94
16042	T	Burn wound excision	162	5.67	\$299.71	\$125.43	\$59.94
17000	T	Destroy benign/premalignant lesion	141	0.59	\$31.34	\$9.49	\$6.27
17003	T	Destroy 2–14 lesions	141	0.59	\$31.34	\$9.49	\$6.27
17004	T	Destroy 15 & more lesions	142	3.78	\$199.81	\$73.00	\$39.96
17106	T	Destruction of skin lesions	141	0.59	\$31.34	\$9.49	\$6.27
17107	T	Destruction of skin lesions	142	3.78	\$199.81	\$73.00	\$39.96
17108	T	Destruction of skin lesions	142	3.78	\$199.81	\$73.00	\$39.96
17110	T	Destruct lesion, 1–14	141	0.59	\$31.34	\$9.49	\$6.27
17111	T	Destruct lesion, 15 or more	142	3.78	\$199.81	\$73.00	\$39.96
17250	T	Chemical cautery, tissue	151	1.74	\$92.07	\$35.71	\$18.41
17260	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17261	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17262	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17263	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17264	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17266	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17270	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17271	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17272	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17273	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17274	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17276	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17280	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17281	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17282	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17283	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17284	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17286	T	Destruction of skin lesions	151	1.74	\$92.07	\$35.71	\$18.41
17304	T	Chemotherapy of skin lesion	162	5.67	\$299.71	\$125.43	\$59.94
17305	T	2nd stage chemotherapy	162	5.67	\$299.71	\$125.43	\$59.94
17306	T	3rd stage chemotherapy	162	5.67	\$299.71	\$125.43	\$59.94
17307	T	Followup skin lesion therapy	162	5.67	\$299.71	\$125.43	\$59.94
17310	T	Extensive skin chemotherapy	162	5.67	\$299.71	\$125.43	\$59.94
17340	T	Cryotherapy of skin	151	1.74	\$92.07	\$35.71	\$18.41
17360	T	Skin peel therapy	151	1.74	\$92.07	\$35.71	\$18.41
17380	T	Hair removal by electrolysis	151	1.74	\$92.07	\$35.71	\$18.41
17999	T	Skin tissue procedure	121	0.67	\$35.26	\$21.02	\$7.05
19000	T	Drainage of breast lesion	121	0.67	\$35.26	\$21.02	\$7.05
19001	T	Drain added breast lesion	121	0.67	\$35.26	\$21.02	\$7.05
19020	T	Incision of breast lesion	132	6.04	\$319.30	\$134.24	\$63.86
19030	T	Injection for breast x-ray	347	2.93	\$154.75	\$62.15	\$30.95
19100	T	Biopsy of breast	122	4.87	\$257.60	\$115.03	\$51.52
19101	T	Biopsy of breast	197	12.13	\$641.54	\$310.75	\$128.31
19110	T	Nipple exploration	197	12.13	\$641.54	\$310.75	\$128.31
19112	T	Excise breast duct fistula	197	12.13	\$641.54	\$310.75	\$128.31
19120	T	Removal of breast lesion	197	12.13	\$641.54	\$310.75	\$128.31
19125	T	Excision, breast lesion	197	12.13	\$641.54	\$310.75	\$128.31
19126	T	Excision, add'l breast lesion	197	12.13	\$641.54	\$310.75	\$128.31
19140	T	Removal of breast tissue	197	12.13	\$641.54	\$310.75	\$128.31
19160	T	Removal of breast tissue	198	19.17	\$1,013.73	\$530.20	\$202.75
19162	T	Remove breast tissue, nodes	198	19.17	\$1,013.73	\$530.20	\$202.75
19180	T	Removal of breast	198	19.17	\$1,013.73	\$530.20	\$202.75
19182	T	Removal of breast	198	19.17	\$1,013.73	\$530.20	\$202.75
19200	C	Removal of breast .....	.....	.....	.....	.....	.....
19220	C	Removal of breast .....	.....	.....	.....	.....	.....
19240	C	Removal of breast .....	.....	.....	.....	.....	.....
19260	C	Removal of chest wall lesion .....	.....	.....	.....	.....	.....
19271	C	Revision of chest wall .....	.....	.....	.....	.....	.....
19272	C	Extensive chest wall surgery .....	.....	.....	.....	.....	.....
19290	T	Place needle wire, breast	197	12.13	\$641.54	\$310.75	\$128.31
19291	T	Place needle wire, breast	197	12.13	\$641.54	\$310.75	\$128.31
19316	T	Suspension of breast	198	19.17	\$1,013.73	\$530.20	\$202.75
19318	T	Reduction of large breast	198	19.17	\$1,013.73	\$530.20	\$202.75
19324	T	Enlarge breast	198	19.17	\$1,013.73	\$530.20	\$202.75

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
19325	T	Enlarge breast with implant	198	19.17	\$1,013.73	\$530.20	\$202.75
19328	T	Removal of breast implant	198	19.17	\$1,013.73	\$530.20	\$202.75
19330	T	Removal of implant material	198	19.17	\$1,013.73	\$530.20	\$202.75
19340	T	Immediate breast prosthesis	198	19.17	\$1,013.73	\$530.20	\$202.75
19342	T	Delayed breast prosthesis	198	19.17	\$1,013.73	\$530.20	\$202.75
19350	T	Breast reconstruction	198	19.17	\$1,013.73	\$530.20	\$202.75
19355	T	Correct inverted nipple(s)	198	19.17	\$1,013.73	\$530.20	\$202.75
19357	T	Breast reconstruction	198	19.17	\$1,013.73	\$530.20	\$202.75
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	198	19.17	\$1,013.73	\$530.20	\$202.75
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	198	19.17	\$1,013.73	\$530.20	\$202.75
19371	T	Removal of breast capsule	198	19.17	\$1,013.73	\$530.20	\$202.75
19380	T	Revise breast reconstruction	198	19.17	\$1,013.73	\$530.20	\$202.75
19396	T	Design custom breast implant	197	12.13	\$641.54	\$310.75	\$128.31
19499	T	Breast surgery procedure	197	12.13	\$641.54	\$310.75	\$128.31
20000	T	Incision of abscess	131	1.94	\$102.84	\$36.61	\$20.57
20005	T	Incision of deep abscess	251	14.26	\$754.18	\$366.12	\$150.84
20100	C	Explore wound, neck					
20101	C	Explore wound, chest					
20102	C	Explore wound, abdomen					
20103	C	Explore wound, extremity					
20150	C	Excise epiphyseal bar					
20200	T	Muscle biopsy	162	5.67	\$299.71	\$125.43	\$59.94
20205	T	Deep muscle biopsy	162	5.67	\$299.71	\$125.43	\$59.94
20206	T	Needle biopsy, muscle	122	4.87	\$257.6	\$115.03	\$51.52
20220	T	Bone biopsy, trocar/needle	162	5.67	\$299.71	\$125.43	\$59.94
20225	T	Bone biopsy, trocar/needle	162	5.67	\$299.71	\$125.43	\$59.94
20240	T	Bone biopsy, excisional	163	10.69	\$565.14	\$264.65	\$113.03
20245	T	Bone biopsy, excisional	163	10.69	\$565.14	\$264.65	\$113.03
20250	T	Open bone biopsy	251	14.26	\$754.18	\$366.12	\$150.84
20251	T	Open bone biopsy	251	14.26	\$754.18	\$366.12	\$150.84
20500	T	Injection of sinus tract	181	2.19	\$115.58	\$43.84	\$23.12
20501	T	Inject sinus tract for x-ray	347	2.93	\$154.75	\$62.15	\$30.95
20520	T	Removal of foreign body	161	3.50	\$185.12	\$75.48	\$37.02
20525	T	Removal of foreign body	163	10.69	\$565.14	\$264.65	\$113.03
20550	T	Inj tendon/ligament/cyst	200	1.89	\$99.90	\$39.10	\$19.98
20600	T	Drain/inject joint/bursa	200	1.89	\$99.90	\$39.10	\$19.98
20605	T	Drain/inject joint/bursa	200	1.89	\$99.90	\$39.10	\$19.98
20610	T	Drain/inject joint/bursa	200	1.89	\$99.90	\$39.10	\$19.98
20615	T	Treatment of bone cyst	121	0.67	\$35.26	\$21.02	\$7.05
20650	T	Insert and remove bone pin	251	14.26	\$754.18	\$366.12	\$150.84
20660	C	Apply,remove fixation device					
20661	C	Application of head brace					
20662	C	Application of pelvis brace					
20663	C	Application of thigh brace					
20664	C	Halo brace application					
20665	N	Removal of fixation device					
20670	T	Removal of support implant	162	5.67	\$299.71	\$125.43	\$59.94
20680	T	Removal of support implant	163	10.69	\$565.14	\$264.65	\$113.03
20690	T	Apply bone fixation device	252	19.39	\$1,025.49	\$509.18	\$205.10
20692	T	Apply bone fixation device	252	19.39	\$1,025.49	\$509.18	\$205.10
20693	T	Adjust bone fixation device	251	14.26	\$754.18	\$366.12	\$150.84
20694	T	Remove bone fixation device	251	14.26	\$754.18	\$366.12	\$150.84
20802	C	Replantation, arm, complete					
20805	C	Replant forearm, complete					
20808	C	Replantation, hand, complete					
20816	C	Replantation digit, complete					
20822	C	Replantation digit, complete					
20824	C	Replantation thumb, complete					
20827	C	Replantation thumb, complete					
20838	C	Replantation, foot, complete					
20900	T	Removal of bone for graft	252	19.39	\$1,025.49	\$509.18	\$205.10
20902	T	Removal of bone for graft	252	19.39	\$1,025.49	\$509.18	\$205.10
20910	T	Remove cartilage for graft	183	11.17	\$590.61	\$286.57	\$118.12
20912	T	Remove cartilage for graft	183	11.17	\$590.61	\$286.57	\$118.12
20920	T	Removal of fascia for graft	183	11.17	\$590.61	\$286.57	\$118.12
20922	T	Removal of fascia for graft	183	11.17	\$590.61	\$286.57	\$118.12
20924	T	Removal of tendon for graft	252	19.39	\$1,025.49	\$509.18	\$205.10
20926	T	Removal of tissue for graft	183	11.17	\$590.61	\$286.57	\$118.12
20930	C	Spinal bone allograft					
20931	C	Spinal bone allograft					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
20936	C	Spinal bone autograft .....	.....	.....	.....	.....	.....
20937	C	Spinal bone autograft .....	.....	.....	.....	.....	.....
20938	C	Spinal bone autograft .....	.....	.....	.....	.....	.....
20950	T	Record fluid pressure,muscle	132	6.04	\$319.30	\$134.24	\$63.86
20955	C	Fibula bone graft, microvasc .....	.....	.....	.....	.....	.....
20956	C	Iliac bone graft, microvasc .....	.....	.....	.....	.....	.....
20957	C	Mt bone graft, microvasc .....	.....	.....	.....	.....	.....
20962	C	Other bone graft, microvasc .....	.....	.....	.....	.....	.....
20969	C	Bone/skin graft, microvasc .....	.....	.....	.....	.....	.....
20970	C	Bone/skin graft, iliac crest .....	.....	.....	.....	.....	.....
20972	C	Bone-skin graft, metatarsal .....	.....	.....	.....	.....	.....
20973	C	Bone-skin graft, great toe .....	.....	.....	.....	.....	.....
20974	A	Electrical bone stimulation .....	.....	.....	.....	.....	.....
20975	T	Electrical bone stimulation	251	14.26	\$754.18	\$366.12	\$150.84
20999	N	Musculoskeletal surgery .....	.....	.....	.....	.....	.....
21010	T	Incision of jaw joint	232	23.93	\$1,265.45	\$639.35	\$253.09
21015	T	Resection of facial tumor	231	12.02	\$635.66	299.90	\$127.13
21025	T	Excision of bone, lower jaw	231	12.02	\$635.66	299.90	\$127.13
21026	T	Excision of facial bone(s)	231	12.02	\$635.66	299.90	\$127.13
21029	T	Contour of face bone lesion	231	12.02	\$635.66	299.90	\$127.13
21030	T	Removal of face bone lesion	231	12.02	\$635.66	299.90	\$127.13
21031	T	Remove exostosis, mandible	231	12.02	\$635.66	299.90	\$127.13
21032	T	Remove exostosis, maxilla	231	12.02	\$635.66	299.90	\$127.13
21034	T	Removal of face bone lesion	232	23.93	\$1,265.45	\$639.35	\$253.09
21040	T	Removal of jaw bone lesion	231	12.02	\$635.66	299.90	\$127.13
21041	T	Removal of jaw bone lesion	231	12.02	\$635.66	299.90	\$127.13
21044	T	Removal of jaw bone lesion	232	23.93	\$1,265.45	\$639.35	\$253.09
21045	C	Extensive jaw surgery .....	.....	.....	.....	.....	.....
21050	T	Removal of jaw joint	232	23.93	\$1,265.45	\$639.35	\$253.09
21060	T	Remove jaw joint cartilage	232	23.93	\$1,265.45	\$639.35	\$253.09
21070	T	Remove coronoid process	232	23.93	\$1,265.45	\$639.35	\$253.09
21076	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21077	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21079	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21080	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21081	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21082	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21083	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21084	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21085	N	Prepare face/oral prosthesis .....	.....	.....	.....	.....	.....
21086	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21087	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21088	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21089	T	Prepare face/oral prosthesis	226	1.59	\$84.23	\$21.92	\$16.85
21100	T	Maxillofacial fixation	231	12.02	\$635.66	299.90	\$127.13
21110	T	Interdental fixation	231	12.02	\$635.66	299.90	\$127.13
21116	T	Injection, jaw joint x-ray	347	2.93	\$154.75	\$62.15	\$30.95
21120	T	Reconstruction of chin	231	12.02	\$635.66	299.90	\$127.13
21121	T	Reconstruction of chin	232	23.93	\$1,265.45	\$639.35	\$253.09
21122	T	Reconstruction of chin	232	23.93	\$1,265.45	\$639.35	\$253.09
21123	T	Reconstruction of chin	232	23.93	\$1,265.45	\$639.35	\$253.09
21125	T	Augmentation lower jaw bone	231	12.02	\$635.66	299.90	\$127.13
21127	T	Augmentation lower jaw bone	232	23.93	\$1,265.45	\$639.35	\$253.09
21137	C	Reduction of forehead .....	.....	.....	.....	.....	.....
21138	C	Reduction of forehead .....	.....	.....	.....	.....	.....
21139	C	Reduction of forehead .....	.....	.....	.....	.....	.....
21141	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21142	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21143	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21145	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21146	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21147	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21150	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21151	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21154	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21155	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21159	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21160	C	Reconstruct midface, left .....	.....	.....	.....	.....	.....
21172	C	Reconstruct orbit/forehead .....	.....	.....	.....	.....	.....
21175	C	Reconstruct orbit/forehead .....	.....	.....	.....	.....	.....
21179	C	Reconstruct entire forehead .....	.....	.....	.....	.....	.....
21180	C	Reconstruct entire forehead .....	.....	.....	.....	.....	.....
21181	T	Contour cranial bone lesion	232	23.93	\$1,265.45	\$639.35	\$253.09
21182	C	Reconstruct cranial bone					
21183	C	Reconstruct cranial bone					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
21184	C	Reconstruct cranial bone .....	.....	.....	.....	.....	.....
21188	C	Reconstruction of midface .....	.....	.....	.....	.....	.....
21193	C	Reconstruct lower jaw bone .....	.....	.....	.....	.....	.....
21194	C	Reconstruct lower jaw bone .....	.....	.....	.....	.....	.....
21195	C	Reconstruct lower jaw bone .....	.....	.....	.....	.....	.....
21196	C	Reconstruct lower jaw bone .....	.....	.....	.....	.....	.....
21198	C	Reconstruct lower jaw bone .....	.....	.....	.....	.....	.....
21206	T	Reconstruct upper jaw bone	232	23.93	\$1,265.45	\$639.35	\$253.09
21208	T	Augmentation of facial bones	232	23.93	\$1,265.45	\$639.35	\$253.09
21209	T	Reduction of facial bones	232	23.93	\$1,265.45	\$639.35	\$253.09
21210	T	Face bone graft	232	23.93	\$1,265.45	\$639.35	\$253.09
21215	T	Lower jaw bone graft	232	23.93	\$1,265.45	\$639.35	\$253.09
21230	T	Rib cartilage graft	232	23.93	\$1,265.45	\$639.35	\$253.09
21235	T	Ear cartilage graft	232	23.93	\$1,265.45	\$639.35	\$253.09
21240	T	Reconstruction of jaw joint	232	23.93	\$1,265.45	\$639.35	\$253.09
21242	T	Reconstruction of jaw joint	232	23.93	\$1,265.45	\$639.35	\$253.09
21243	T	Reconstruction of jaw joint	218	27.50	\$1,454.49	\$715.52	\$290.90
21244	T	Reconstruction of lower jaw	232	23.93	\$1,265.45	\$639.35	\$253.09
21245	T	Reconstruction of jaw	232	23.93	\$1,265.45	\$639.35	\$253.09
21246	T	Reconstruction of jaw	232	23.93	\$1,265.45	\$639.35	\$253.09
21247	C	Reconstruct lower jaw bone .....	.....	.....	.....	.....	.....
21248	T	Reconstruction of jaw	232	23.93	\$1,265.45	\$639.35	\$253.09
21249	T	Reconstruction of jaw	232	23.93	\$1,265.45	\$639.35	\$253.09
21255	C	Reconstruct lower jaw bone .....	.....	.....	.....	.....	.....
21256	C	Reconstruction of orbit .....	.....	.....	.....	.....	.....
21260	T	Revise eye sockets	232	23.93	\$1,265.45	\$639.35	\$253.09
21261	C	Revise eye sockets .....	.....	.....	.....	.....	.....
21263	C	Revise eye sockets .....	.....	.....	.....	.....	.....
21267	T	Revise eye sockets	232	23.93	\$1,265.45	\$639.35	\$253.09
21268	C	Revise eye sockets .....	.....	.....	.....	.....	.....
21270	T	Augmentation cheek bone	232	23.93	\$1,265.45	\$639.35	\$253.09
21275	T	Revision orbitofacial bones	232	23.93	\$1,265.45	\$639.35	\$253.09
21280	T	Revision of eyelid	231	12.02	\$635.66	\$299.90	\$127.13
21282	T	Revision of eyelid	231	12.02	\$635.66	\$299.90	\$127.13
21295	T	Revision of jaw muscle/bone	231	12.02	\$635.66	\$299.90	\$127.13
21296	T	Revision of jaw muscle/bone	231	12.02	\$635.66	\$299.90	\$127.13
21299	T	Cranio/maxillofacial surgery	231	12.02	\$635.66	\$299.90	\$127.13
21300	T	Treatment of skull fracture	231	12.02	\$635.66	\$299.90	\$127.13
21310	T	Treatment of nose fracture	231	12.02	\$635.66	\$299.90	\$127.13
21315	T	Treatment of nose fracture	231	12.02	\$635.66	\$299.90	\$127.13
21320	T	Treatment of nose fracture	231	12.02	\$635.66	\$299.90	\$127.13
21325	T	Repair of nose fracture	231	12.02	\$635.66	\$299.90	\$127.13
21330	T	Repair of nose fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21335	T	Repair of nose fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21336	T	Repair nasal septal fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
21337	T	Repair nasal septal fracture	231	12.02	\$635.66	\$299.90	\$127.13
21338	T	Repair nasoethmoid fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21339	T	Repair nasoethmoid fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21340	T	Repair of nose fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21343	T	Repair of sinus fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21344	C	Repair of sinus fracture .....	.....	.....	.....	.....	.....
21345	T	Repair of nose/jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21346	C	Repair of nose/jaw fracture .....	.....	.....	.....	.....	.....
21347	C	Repair of nose/jaw fracture .....	.....	.....	.....	.....	.....
21348	C	Repair of nose/jaw fracture .....	.....	.....	.....	.....	.....
21355	T	Repair cheek bone fracture	231	12.02	\$635.66	\$299.90	\$127.13
21356	C	Repair cheek bone fracture .....	.....	.....	.....	.....	.....
21360	C	Repair cheek bone fracture .....	.....	.....	.....	.....	.....
21365	C	Repair cheek bone fracture .....	.....	.....	.....	.....	.....
21366	C	Repair cheek bone fracture .....	.....	.....	.....	.....	.....
21385	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21386	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21387	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21390	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21395	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21400	T	Treat eye socket fracture	231	12.02	\$635.66	\$299.90	\$127.13
21401	T	Repair eye socket fracture	231	12.02	\$635.66	\$299.90	\$127.13
21406	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21407	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21408	C	Repair eye socket fracture .....	.....	.....	.....	.....	.....
21421	T	Treat mouth roof fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21422	C	Repair mouth roof fracture .....	.....	.....	.....	.....	.....
21423	C	Repair mouth roof fracture .....	.....	.....	.....	.....	.....
21431	C	Treat craniofacial fracture					
21432	C	Repair craniofacial fracture					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
21433	C	Repair craniofacial fracture .....	.....	.....	.....	.....	.....
21435	C	Repair craniofacial fracture .....	.....	.....	.....	.....	.....
21436	C	Repair craniofacial fracture .....	.....	.....	.....	.....	.....
21440	T	Repair dental ridge fracture	231	12.02	\$635.66	\$299.90	\$127.13
21445	T	Repair dental ridge fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21450	T	Treat lower jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21451	T	Treat lower jaw fracture	231	12.02	\$635.66	\$299.90	\$127.13
21452	T	Treat lower jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21453	T	Treat lower jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21454	T	Treat lower jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21461	T	Repair lower jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21462	T	Repair lower jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21465	T	Repair lower jaw fracture	232	23.93	\$1,265.45	\$639.35	\$253.09
21470	C	Repair lower jaw fracture .....	.....	.....	.....	.....	.....
21480	T	Reset dislocated jaw	231	12.02	\$635.66	\$299.90	\$127.13
21485	T	Reset dislocated jaw	231	12.02	\$635.66	\$299.90	\$127.13
21490	T	Repair dislocated jaw	232	23.93	\$1,265.45	\$639.35	\$253.09
21493	T	Treat hyoid bone fracture	231	12.02	\$635.66	\$299.90	\$127.13
21494	T	Repair hyoid bone fracture	231	12.02	\$635.66	\$299.90	\$127.13
21495	C	Repair hyoid bone fracture .....	.....	.....	.....	.....	.....
21497	T	Interdental wiring	231	12.02	\$635.66	\$299.90	\$127.13
21499	T	Head surgery procedure	231	12.02	\$635.66	\$299.90	\$127.13
21501	T	Drain neck/chest lesion	132	6.04	\$319.30	\$134.24	\$63.86
21502	T	Drain chest lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
21510	C	Drainage of bone lesion .....	.....	.....	.....	.....	.....
21550	T	Biopsy of neck/chest	161	3.50	\$185.12	\$75.48	\$37.02
21555	T	Remove lesion neck/chest	163	10.69	\$565.14	\$264.65	\$113.03
21556	T	Remove lesion neck/chest	163	10.69	\$565.14	\$264.65	\$113.03
21557	C	Remove tumor, neck or chest .....	.....	.....	.....	.....	.....
21600	T	Partial removal of rib	252	19.39	\$1,025.49	\$509.18	\$205.10
21610	T	Partial removal of rib	252	19.39	\$1,025.49	\$509.18	\$205.10
21615	C	Removal of rib .....	.....	.....	.....	.....	.....
21616	C	Removal of rib and nerves .....	.....	.....	.....	.....	.....
21620	C	Partial removal of sternum .....	.....	.....	.....	.....	.....
21627	C	Sternal debridement .....	.....	.....	.....	.....	.....
21630	C	Extensive sternum surgery .....	.....	.....	.....	.....	.....
21632	C	Extensive sternum surgery .....	.....	.....	.....	.....	.....
21700	T	Revision of neck muscle	132	6.04	\$319.30	\$134.24	\$63.86
21705	C	Revision of neck muscle/rib .....	.....	.....	.....	.....	.....
21720	T	Revision of neck muscle	132	6.04	\$319.30	\$134.24	\$63.86
21725	T	Revision of neck muscle	132	6.04	\$319.30	\$134.24	\$63.86
21740	C	Reconstruction of sternum .....	.....	.....	.....	.....	.....
21750	C	Repair of sternum separation .....	.....	.....	.....	.....	.....
21800	T	Treatment of rib fracture	207	1.70	\$90.11	\$31.64	\$18.02
21805	T	Treatment of rib fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
21810	C	Treatment of rib fracture(s) .....	.....	.....	.....	.....	.....
21820	T	Treat sternum fracture	207	1.70	\$90.11	\$31.64	\$18.02
21825	C	Repair sternum fracture .....	.....	.....	.....	.....	.....
21899	T	Neck/chest surgery procedure	207	1.70	\$90.11	\$31.64	\$18.02
21920	T	Biopsy soft tissue of back	161	3.50	\$185.12	\$75.48	\$37.02
21925	T	Biopsy soft tissue of back	163	10.69	\$565.14	\$264.65	\$113.03
21930	T	Remove lesion, back or flank	163	10.69	\$565.14	\$264.65	\$113.03
21935	T	Remove tumor of back	163	10.69	\$565.14	\$264.65	\$113.03
22100	C	Remove part of neck vertebra .....	.....	.....	.....	.....	.....
22101	C	Remove part, thorax vertebra .....	.....	.....	.....	.....	.....
22102	C	Remove part, lumbar vertebra .....	.....	.....	.....	.....	.....
22103	C	Remove extra spine segment .....	.....	.....	.....	.....	.....
22110	C	Remove part of neck vertebra .....	.....	.....	.....	.....	.....
22112	C	Remove part, thorax vertebra .....	.....	.....	.....	.....	.....
22114	C	Remove part, lumbar vertebra .....	.....	.....	.....	.....	.....
22116	C	Remove extra spine segment .....	.....	.....	.....	.....	.....
22210	C	Revision of neck spine .....	.....	.....	.....	.....	.....
22212	C	Revision of thorax spine .....	.....	.....	.....	.....	.....
22214	C	Revision of lumbar spine .....	.....	.....	.....	.....	.....
22216	C	Revise, extra spine segment .....	.....	.....	.....	.....	.....
22220	C	Revision of neck spine .....	.....	.....	.....	.....	.....
22222	C	Revision of thorax spine .....	.....	.....	.....	.....	.....
22224	C	Revision of lumbar spine .....	.....	.....	.....	.....	.....
22226	C	Revise, extra spine segment .....	.....	.....	.....	.....	.....
22305	T	Treat spine process fracture	207	1.70	\$90.11	\$31.64	\$18.02
22310	T	Treat spine fracture	207	1.70	\$90.11	\$31.64	\$18.02
22315	T	Treat spine fracture	207	1.70	\$90.11	\$31.64	\$18.02
22325	C	Repair of spine fracture .....	.....	.....	.....	.....	.....
22326	C	Repair neck spine fracture					
22327	C	Repair thorax spine fracture					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
22328	C	Repair each add spine fx					
22505	T	Manipulation of spine	210	10.46	\$553.39	\$283.4	\$110.68
22548	C	Neck spine fusion					
22554	C	Neck spine fusion					
22556	C	Thorax spine fusion					
22558	C	Lumbar spine fusion					
22585	C	Additional spinal fusion					
22590	C	Spine & skull spinal fusion					
22595	C	Neck spinal fusion					
22600	C	Neck spine fusion					
22610	C	Thorax spine fusion					
22612	C	Lumbar spine fusion					
22614	C	Spine fusion, extra segment					
22630	C	Lumbar spine fusion					
22632	C	Spine fusion, extra segment					
22800	C	Fusion of spine					
22802	C	Fusion of spine					
22804	C	Fusion of spine					
22808	C	Fusion of spine					
22810	C	Fusion of spine					
22812	C	Fusion of spine					
22818	C	Kyphectomy, 1–2 segments					
22819	C	Kyphectomy, 3 & more segment					
22830	C	Exploration of spinal fusion					
22840	C	Insert spine fixation device					
22841	C	Insert spine fixation device					
22842	C	Insert spine fixation device					
22843	C	Insert spine fixation device					
22844	C	Insert spine fixation device					
22845	C	Insert spine fixation device					
22846	C	Insert spine fixation device					
22847	C	Insert spine fixation device					
22848	C	Insert pelvic fixation device					
22849	C	Reinsert spinal fixation					
22850	C	Remove spine fixation device					
22851	C	Apply spine prosth device					
22852	C	Remove spine fixation device					
22855	C	Remove spine fixation device					
22899	T	Spine surgery procedure	207	1.70	\$90.11	\$31.64	\$18.02
22900	T	Remove abdominal wall lesion	163	10.69	\$565.14	\$264.65	\$113.03
22999	T	Abdomen surgery procedure	163	10.69	\$565.14	\$264.65	\$113.03
23000	T	Removal of calcium deposits	162	5.67	\$299.71	\$125.43	\$59.94
23020	T	Release shoulder joint	253	26.33	\$1,392.78	\$699.24	\$278.56
23030	T	Drain shoulder lesion	132	6.04	\$319.30	\$134.24	\$63.86
23031	T	Drain shoulder bursa	132	6.04	\$319.30	\$134.24	\$63.86
23035	C	Drain shoulderbone lesion					
23040	T	Exploratory shoulder surgery	252	19.39	\$1,025.49	\$509.18	\$205.10
23044	T	Exploratory shoulder surgery	252	19.39	\$1,025.49	\$509.18	\$205.10
23065	T	Biopsy shoulder tissues	161	3.50	\$185.12	\$75.48	\$37.02
23066	T	Biopsy shoulder tissues	163	10.69	\$565.14	\$264.65	\$113.03
23075	T	Removal of shoulder lesion	162	5.67	\$299.71	\$125.43	\$59.94
23076	T	Removal of shoulder lesion	163	10.69	\$565.14	\$264.65	\$113.03
23077	T	Remove tumor of shoulder	163	10.69	\$565.14	\$264.65	\$113.03
23100	T	Biopsy of shoulder joint	251	14.26	\$754.18	\$366.12	\$150.84
23101	T	Shoulder joint surgery	252	19.39	\$1,025.49	\$509.18	\$205.10
23105	T	Remove shoulder joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
23106	T	Incision of collarbone joint	252	19.39	\$1,025.49	\$509.18	\$205.10
23107	T	Explore, treat shoulder joint	252	19.39	\$1,025.49	\$509.18	\$205.10
23120	T	Partial removal, collarbone	253	26.33	\$1,392.78	\$699.24	\$278.56
23125	C	Removal of collarbone					
23130	T	Partial removal, shoulderbone	253	26.33	\$1,392.78	\$699.24	\$278.56
23140	T	Removal of bone lesion	251	14.26	\$754.18	\$366.12	\$150.84
23145	T	Removal of bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23146	T	Removal of bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23150	T	Removal of humerus lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23155	T	Removal of humerus lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23156	T	Removal of humerus lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23170	T	Remove collarbone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23172	T	Remove shoulder blade lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23174	T	Remove humerus lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23180	T	Remove collarbone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23182	T	Remove shoulderblade lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23184	T	Remove humerus lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
23190	T	Partial removal of scapula	252	19.39	\$1,025.49	\$509.18	\$205.10
23195	C	Removal of head of humerus					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
23200	C	Removal of collarbone .....	.....	.....	.....	.....	.....
23210	C	Removal of shoulderblade .....	.....	.....	.....	.....	.....
23220	C	Partial removal of humerus .....	.....	.....	.....	.....	.....
23221	C	Partial removal of humerus .....	.....	.....	.....	.....	.....
23222	C	Partial removal of humerus .....	.....	.....	.....	.....	.....
23330	T	Remove shoulder foreign body	163	10.69	\$565.14	\$264.65	\$113.03
23331	T	Remove shoulder foreign body	163	10.69	\$565.14	\$264.65	\$113.03
23332	C	Remove shoulder foreign body .....	.....	.....	.....	.....	.....
23350	T	Injection for shoulder x-ray	347	2.93	\$154.75	\$62.15	\$30.95
23395	C	Muscle transfer, shoulder/arm .....	.....	.....	.....	.....	.....
23397	C	Muscle transfers .....	.....	.....	.....	.....	.....
23400	C	Fixation of shoulderblade .....	.....	.....	.....	.....	.....
23405	T	Incision of tendon & muscle	252	19.39	\$1,025.49	\$509.18	\$205.10
23406	T	Incise tendon(s) & muscle(s)	252	19.39	\$1,025.49	\$509.18	\$205.10
23410	T	Repair of tendon(s)	254	34.37	\$1,817.86	\$937.22	\$363.57
23412	T	Repair of tendon(s)	254	34.37	\$1,817.86	\$937.22	\$363.57
23415	T	Release of shoulder ligament	253	26.33	\$1,392.78	\$699.24	\$278.56
23420	T	Repair of shoulder	254	34.37	\$1,817.86	\$937.22	\$363.57
23430	T	Repair biceps tendon	254	34.37	\$1,817.86	\$937.22	\$363.57
23440	C	Removal/transplant tendon .....	.....	.....	.....	.....	.....
23450	T	Repair shoulder capsule	254	34.37	\$1,817.86	\$937.22	\$363.57
23455	T	Repair shoulder capsule	254	34.37	\$1,817.86	\$937.22	\$363.57
23460	T	Repair shoulder capsule	254	34.37	\$1,817.86	\$937.22	\$363.57
23462	T	Repair shoulder capsule	254	34.37	\$1,817.86	\$937.22	\$363.57
23465	T	Repair shoulder capsule	254	34.37	\$1,817.86	\$937.22	\$363.57
23466	T	Repair shoulder capsule	254	34.37	\$1,817.86	\$937.22	\$363.57
23470	C	Reconstruct shoulder joint .....	.....	.....	.....	.....	.....
23472	C	Reconstruct shoulder joint .....	.....	.....	.....	.....	.....
23480	T	Revision of collarbone	253	26.33	\$1,392.78	\$699.24	\$278.56
23485	T	Revision of collarbone	253	26.33	\$1,392.78	\$699.24	\$278.56
23490	T	Reinforce clavicle	253	26.33	\$1,392.78	\$699.24	\$278.56
23491	T	Reinforce shoulderbones	253	26.33	\$1,392.78	\$699.24	\$278.56
23500	T	Treat clavicle fracture	207	1.70	\$90.11	\$31.64	\$18.02
23505	T	Treat clavicle fracture	207	1.70	\$90.11	\$31.64	\$18.02
23515	T	Repair clavicle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
23520	T	Treat clavicle dislocation	207	1.70	\$90.11	\$31.64	\$18.02
23525	T	Treat clavicle dislocation	207	1.70	\$90.11	\$31.64	\$18.02
23530	T	Repair clavicle dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
23532	T	Repair clavicle dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
23540	T	Treat clavicle dislocation	207	1.70	\$90.11	\$31.64	\$18.02
23545	T	Treat clavicle dislocation	207	1.70	\$90.11	\$31.64	\$18.02
23550	T	Repair clavicle dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
23552	T	Repair clavicle dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
23570	T	Treat shoulderblade fracture	207	1.70	\$90.11	\$31.64	\$18.02
23575	T	Treat shoulderblade fracture	207	1.70	\$90.11	\$31.64	\$18.02
23585	T	Repair scapula fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
23600	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
23605	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
23615	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
23616	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
23620	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
23625	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
23630	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
23650	T	Treat shoulder dislocation	207	1.70	\$90.11	\$31.64	\$18.02
23655	T	Treat shoulder dislocation	210	10.46	\$553.39	\$283.40	\$110.68
23660	T	Repair shoulder dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
23665	T	Treat dislocation/fracture	209	1.94	\$102.84	\$37.29	\$20.57
23670	T	Repair dislocation/fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
23675	T	Treat dislocation/fracture	209	1.94	\$102.84	\$37.29	\$20.57
23680	T	Repair dislocation/fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
23700	T	Fixation of shoulder	210	10.46	\$553.39	\$283.40	\$110.68
23800	T	Fusion of shoulder joint	253	26.33	\$1,392.78	\$699.24	\$278.56
23802	T	Fusion of shoulder joint	253	26.33	\$1,392.78	\$699.24	\$278.56
23900	C	Amputation of arm & girdle .....	.....	.....	.....	.....	.....
23920	C	Amputation at shoulder joint .....	.....	.....	.....	.....	.....
23921	T	Amputation follow-up surgery	183	11.17	\$590.61	\$286.57	\$118.12
23929	T	Shoulder surgery procedure	207	1.70	\$90.11	\$31.64	\$18.02
23930	T	Drainage of arm lesion	132	6.04	\$319.30	\$134.24	\$63.86
23931	T	Drainage of arm bursa	132	6.04	\$319.30	\$134.24	\$63.86
23935	T	Drain arm/elbow bone lesion	251	14.26	\$754.18	\$366.12	\$150.84
24000	T	Exploratory elbow surgery	252	19.39	\$1,025.49	\$509.18	\$205.10
24006	T	Release elbow joint	252	19.39	\$1,025.49	\$509.18	\$205.10
24065	T	Biopsy arm/elbow soft tissue	161	3.50	\$185.12	\$75.48	\$37.02
24066	T	Biopsy arm/elbow soft tissue	163	10.69	\$565.14	\$264.65	\$113.03
24075	T	Remove arm/elbow lesion	162	5.67	\$299.71	\$125.43	\$59.94

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
24076	T	Remove arm/elbow lesion	163	10.69	\$565.14	\$264.65	\$113.03
24077	T	Remove tumor of arm/elbow	163	10.69	\$565.14	\$264.65	\$113.03
24100	T	Biopsy elbow joint lining	251	14.26	\$754.18	\$366.12	\$150.84
24101	T	Explore/treat elbow joint	252	19.39	\$1,025.49	\$509.18	\$205.10
24102	T	Remove elbow joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
24105	T	Removal of elbow bursa	251	14.26	\$754.18	\$366.12	\$150.84
24110	T	Remove humerus lesion	251	14.26	\$754.18	\$366.12	\$150.84
24115	T	Remove/graft bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
24116	T	Remove/graft bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
24120	T	Remove elbow lesion	251	14.26	\$754.18	\$366.12	\$150.84
24125	T	Remove/graft bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
24126	T	Remove/graft bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
24130	T	Removal of head of radius	252	19.39	\$1,025.49	\$509.18	\$205.10
24134	T	Removal of arm bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
24136	T	Remove radius bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
24138	T	Remove elbow bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
24140	T	Partial removal of arm bone	252	19.39	\$1,025.49	\$509.18	\$205.10
24145	T	Partial removal of radius	252	19.39	\$1,025.49	\$509.18	\$205.10
24147	T	Partial removal of elbow	252	19.39	\$1,025.49	\$509.18	\$205.10
24149	C	Radical resection of elbow					
24150	C	Extensive humerus surgery					
24151	C	Extensive humerus surgery					
24152	C	Extensive radius surgery					
24153	C	Extensive radius surgery					
24155	T	Removal of elbow joint	253	26.33	\$1,392.78	\$699.24	\$278.56
24160	T	Remove elbow joint implant	252	19.39	\$1,025.49	\$509.18	\$205.10
24164	T	Remove radius head implant	252	19.39	\$1,025.49	\$509.18	\$205.10
24200	T	Removal of arm foreign body	161	3.50	\$185.12	\$75.48	\$37.02
24201	T	Removal of arm foreign body	163	10.69	\$565.14	\$264.65	\$113.03
24220	T	Injection for elbow x-ray	347	2.93	\$154.75	\$62.15	\$30.95
24301	T	Muscle/tendon transfer	252	19.39	\$1,025.49	\$509.18	\$205.10
24305	T	Arm tendon lengthening	252	19.39	\$1,025.49	\$509.18	\$205.10
24310	T	Revision of arm tendon	251	14.26	\$754.18	\$366.12	\$150.84
24320	T	Repair of arm tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
24330	T	Revision of arm muscles	253	26.33	\$1,392.78	\$699.24	\$278.56
24331	T	Revision of arm muscles	253	26.33	\$1,392.78	\$699.24	\$278.56
24340	T	Repair of biceps tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
24341	T	Repair tendon/muscle arm	253	26.33	\$1,392.78	\$699.24	\$278.56
24342	T	Repair of ruptured tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
24350	T	Repair of tennis elbow	252	19.39	\$1,025.49	\$509.18	\$205.10
24351	T	Repair of tennis elbow	252	19.39	\$1,025.49	\$509.18	\$205.10
24352	T	Repair of tennis elbow	252	19.39	\$1,025.49	\$509.18	\$205.10
24354	T	Repair of tennis elbow	252	19.39	\$1,025.49	\$509.18	\$205.10
24356	T	Revision of tennis elbow	252	19.39	\$1,025.49	\$509.18	\$205.10
24360	T	Reconstruct elbow joint	217	20.48	\$1,083.27	\$526.81	\$216.65
24361	T	Reconstruct elbow joint	218	27.50	\$1,454.49	\$715.52	\$290.90
24362	T	Reconstruct elbow joint	218	27.50	\$1,454.49	\$715.52	\$290.90
24363	T	Replace elbow joint	218	27.50	\$1,454.49	\$715.52	\$290.90
24365	T	Reconstruct head of radius	217	20.48	\$1,083.27	\$526.81	\$216.65
24366	T	Reconstruct head of radius	218	27.50	\$1,454.49	\$715.52	\$290.90
24400	T	Revision of humerus	252	19.39	\$1,025.49	\$509.18	\$205.10
24410	T	Revision of humerus	252	19.39	\$1,025.49	\$509.18	\$205.10
24420	T	Revision of humerus	253	26.33	\$1,392.78	\$699.24	\$278.56
24430	T	Repair of humerus	253	26.33	\$1,392.78	\$699.24	\$278.56
24435	T	Repair humerus with graft	253	26.33	\$1,392.78	\$699.24	\$278.56
24470	T	Revision of elbow joint	253	26.33	\$1,392.78	\$699.24	\$278.56
24495	T	Decompression of forearm	252	19.39	\$1,025.49	\$509.18	\$205.10
24498	T	Reinforce humerus	253	26.33	\$1,392.78	\$699.24	\$278.56
24500	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24505	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24515	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24516	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24530	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24535	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24538	T	Treat humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24545	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24546	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24560	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24565	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24566	T	Treat humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24575	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24576	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24577	T	Treat humerus fracture	209	1.94	\$102.84	\$37.29	\$20.57
24579	T	Repair humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24582	T	Treat humerus fracture	216	20.13	\$1,064.67	\$520.93	\$212.93

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
24586	T	Repair elbow fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24587	T	Repair elbow fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24600	T	Treat elbow dislocation	209	1.94	\$102.84	\$37.29	\$20.57
24605	T	Treat elbow dislocation	210	10.46	\$553.39	\$283.40	\$110.68
24615	T	Repair elbow dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
24620	T	Treat elbow fracture	209	1.94	\$102.84	\$37.29	\$20.57
24635	T	Repair elbow fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24640	T	Treat elbow dislocation	209	1.94	\$102.84	\$37.29	\$20.57
24650	T	Treat radius fracture	209	1.94	\$102.84	\$37.29	\$20.57
24655	T	Treat radius fracture	209	1.94	\$102.84	\$37.29	\$20.57
24665	T	Repair radius fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24666	T	Repair radius fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24670	T	Treatment of ulna fracture	209	1.94	\$102.84	\$37.29	\$20.57
24675	T	Treatment of ulna fracture	209	1.94	\$102.84	\$37.29	\$20.57
24685	T	Repair ulna fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
24800	T	Fusion of elbow joint	253	26.33	\$1,392.78	\$699.24	\$278.56
24802	T	Fusion/graft of elbow joint	253	26.33	\$1,392.78	\$699.24	\$278.56
24900	C	Amputation of upper arm .....	.....	.....	.....	.....	.....
24920	C	Amputation of upper arm .....	.....	.....	.....	.....	.....
24925	T	Amputation follow-up surgery	251	14.26	\$754.18	\$366.12	\$150.84
24930	C	Amputation follow-up surgery .....	.....	.....	.....	.....	.....
24931	C	Amputate upper arm & implant .....	.....	.....	.....	.....	.....
24935	C	Revision of amputation .....	.....	.....	.....	.....	.....
24940	C	Revision of upper arm .....	.....	.....	.....	.....	.....
24999	T	Upper arm/elbow surgery	209	1.94	\$102.84	\$37.29	\$20.57
25000	T	Incision of tendon sheath	251	14.26	\$754.18	\$366.12	\$150.84
25020	T	Decompression of forearm	251	14.26	\$754.18	\$366.12	\$150.84
25023	T	Decompression of forearm	252	19.39	\$1,025.49	\$509.18	\$205.10
25028	T	Drainage of forearm lesion	251	14.26	\$754.18	\$366.12	\$150.84
25031	T	Drainage of forearm bursa	251	14.26	\$754.18	\$366.12	\$150.84
25035	T	Treat forearm bone lesion	251	14.26	\$754.18	\$366.12	\$150.84
25040	T	Explore/treat wrist joint	252	19.39	\$1,025.49	\$509.18	\$205.10
25065	T	Biopsy forearm soft tissues	161	3.50	\$185.12	\$75.48	\$37.02
25066	T	Biopsy forearm soft tissues	163	10.69	\$565.14	\$264.65	\$113.03
25075	T	Removal of forearm lesion	162	5.67	\$299.71	\$125.43	\$59.94
25076	T	Removal of forearm lesion	163	10.69	\$565.14	\$264.65	\$113.03
25077	T	Remove tumor, forearm/wrist	163	10.69	\$565.14	\$264.65	\$113.03
25085	T	Incision of wrist capsule	251	14.26	\$754.18	\$366.12	\$150.84
25100	T	Biopsy of wrist joint	251	14.26	\$754.18	\$366.12	\$150.84
25101	T	Explore/treat wrist joint	252	19.39	\$1,025.49	\$509.18	\$205.10
25105	T	Remove wrist joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
25107	T	Remove wrist joint cartilage	252	19.39	\$1,025.49	\$509.18	\$205.10
25110	T	Remove wrist tendon lesion	251	14.26	\$754.18	\$366.12	\$150.84
25111	T	Remove wrist tendon lesion	261	10.54	\$557.31	\$261.48	\$111.46
25112	T	Remove wrist tendon lesion	261	10.54	\$557.31	\$261.48	\$111.46
25115	T	Remove wrist/forearm lesion	251	14.26	\$754.18	\$366.12	\$150.84
25116	T	Remove wrist/forearm lesion	251	14.26	\$754.18	\$366.12	\$150.84
25118	T	Excise wrist tendon sheath	252	19.39	\$1,025.49	\$509.18	\$205.10
25119	T	Partial removal of ulna	252	19.39	\$1,025.49	\$509.18	\$205.10
25120	T	Removal of forearm lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
25125	T	Remove/graft forearm lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
25126	T	Remove/graft forearm lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
25130	T	Removal of wrist lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
25135	T	Remove & graft wrist lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
25136	T	Remove & graft wrist lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
25145	T	Remove forearm bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
25150	T	Partial removal of ulna	252	19.39	\$1,025.49	\$509.18	\$205.10
25151	T	Partial removal of radius	252	19.39	\$1,025.49	\$509.18	\$205.10
25170	C	Extensive forearm surgery .....	.....	.....	.....	.....	.....
25210	T	Removal of wrist bone	262	18.35	\$970.64	\$480.93	\$194.13
25215	T	Removal of wrist bones	262	18.35	\$970.64	\$480.93	\$194.13
25230	T	Partial removal of radius	252	19.39	\$1,025.49	\$509.18	\$205.10
25240	T	Partial removal of ulna	252	19.39	\$1,025.49	\$509.18	\$205.10
25246	T	Injection for wrist x-ray	347	2.93	\$154.75	\$62.15	\$30.95
25248	T	Remove forearm foreign body	251	14.26	\$754.18	\$366.12	\$150.84
25250	T	Removal of wrist prosthesis	252	19.39	\$1,025.49	\$509.18	\$205.10
25251	T	Removal of wrist prosthesis	252	19.39	\$1,025.49	\$509.18	\$205.10
25260	T	Repair forearm tendon/muscle	252	19.39	\$1,025.49	\$509.18	\$205.10
25263	T	Repair forearm tendon/muscle	252	19.39	\$1,025.49	\$509.18	\$205.10
25265	T	Repair forearm tendon/muscle	252	19.39	\$1,025.49	\$509.18	\$205.10
25270	T	Repair forearm tendon/muscle	252	19.39	\$1,025.49	\$509.18	\$205.10
25272	T	Repair forearm tendon/muscle	252	19.39	\$1,025.49	\$509.18	\$205.10
25274	T	Repair forearm tendon/muscle	252	19.39	\$1,025.49	\$509.18	\$205.10
25280	T	Revise wrist/forearm tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
25290	T	Incise wrist/forearm tendon	252	19.39	\$1,025.49	\$509.18	\$205.10

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
25295	T	Release wrist/forearm tendon	251	14.26	\$754.18	\$366.12	\$150.84
25300	T	Fusion of tendons at wrist	252	19.39	\$1,025.49	\$509.18	\$205.10
25301	T	Fusion of tendons at wrist	252	19.39	\$1,025.49	\$509.18	\$205.10
25310	T	Transplant forearm tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
25312	T	Transplant forearm tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
25315	T	Revise palsy hand tendon(s)	253	26.33	\$1,392.78	\$699.24	\$278.56
25316	T	Revise palsy hand tendon(s)	253	26.33	\$1,392.78	\$699.24	\$278.56
25320	T	Repair/revise wrist joint	253	26.33	\$1,392.78	\$699.24	\$278.56
25332	T	Revise wrist joint	217	20.48	\$1,083.27	\$526.81	\$216.65
25335	T	Realignment of hand	253	26.33	\$1,392.78	\$699.24	\$278.56
25337	T	Reconstruct ulna/radioulnar	253	26.33	\$1,392.78	\$699.24	\$278.56
25350	T	Revision of radius	253	26.33	\$1,392.78	\$699.24	\$278.56
25355	T	Revision of radius	253	26.33	\$1,392.78	\$699.24	\$278.56
25360	T	Revision of ulna	252	19.39	\$1,025.49	\$509.18	\$205.10
25365	T	Revise radius & ulna	252	19.39	\$1,025.49	\$509.18	\$205.10
25370	T	Revise radius or ulna	253	26.33	\$1,392.78	\$699.24	\$278.56
25375	T	Revise radius & ulna	253	26.33	\$1,392.78	\$699.24	\$278.56
25390	C	Shorten radius/ulna					
25391	C	Lengthen radius/ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
25400	T	Repair radius or ulna	252	19.39	\$1,025.49	\$509.18	\$205.10
25405	C	Repair/graft radius or ulna					
25415	T	Repair radius & ulna	252	19.39	\$1,025.49	\$509.18	\$205.10
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	253	26.33	\$1,392.78	\$699.24	\$278.56
25426	T	Repair/graft radius & ulna	253	26.33	\$1,392.78	\$699.24	\$278.56
25440	T	Repair/graft wrist bone	253	26.33	\$1,392.78	\$699.24	\$278.56
25441	T	Reconstruct wrist joint	218	27.50	\$1,454.49	\$715.52	\$290.90
25442	T	Reconstruct wrist joint	218	27.50	\$1,454.49	\$715.52	\$290.90
25443	T	Reconstruct wrist joint	218	27.50	\$1,454.49	\$715.52	\$290.90
25444	T	Reconstruct wrist joint	218	27.50	\$1,454.49	\$715.52	\$290.90
25445	T	Reconstruct wrist joint	218	27.50	\$1,454.49	\$715.52	\$290.90
25446	T	Wrist replacement	218	27.50	\$1,454.49	\$715.52	\$290.90
25447	T	Repair wrist joint(s)	217	20.48	\$1,083.27	\$526.81	\$216.65
25449	T	Remove wrist joint implant	217	20.48	\$1,083.27	\$526.81	\$216.65
25450	T	Revision of wrist joint	253	26.33	\$1,392.78	\$699.24	\$278.56
25455	T	Revision of wrist joint	253	26.33	\$1,392.78	\$699.24	\$278.56
25490	T	Reinforce radius	253	26.33	\$1,392.78	\$699.24	\$278.56
25491	T	Reinforce ulna	253	26.33	\$1,392.78	\$699.24	\$278.56
25492	T	Reinforce radius and ulna	253	26.33	\$1,392.78	\$699.24	\$278.56
25500	T	Treat fracture of radius	209	1.94	\$102.84	\$37.29	\$20.57
25505	T	Treat fracture of radius	209	1.94	\$102.84	\$37.29	\$20.57
25515	T	Repair fracture of radius	216	20.13	\$1,064.67	\$520.93	\$212.93
25520	T	Repair fracture of radius	209	1.94	\$102.84	\$37.29	\$20.57
25525	T	Repair fracture of radius	216	20.13	\$1,064.67	\$520.93	\$212.93
25526	T	Repair fracture of radius	216	20.13	\$1,064.67	\$520.93	\$212.93
25530	T	Treat fracture of ulna	209	1.94	\$102.84	\$37.29	\$20.57
25535	T	Treat fracture of ulna	209	1.94	\$102.84	\$37.29	\$20.57
25545	T	Repair fracture of ulna	216	20.13	\$1,064.67	\$520.93	\$212.93
25560	T	Treat fracture radius & ulna	209	1.94	\$102.84	\$37.29	\$20.57
25565	T	Treat fracture radius & ulna	209	1.94	\$102.84	\$37.29	\$20.57
25574	T	Treat fracture radius & ulna	216	20.13	\$1,064.67	\$520.93	\$212.93
25575	T	Repair fracture radius/ulna	216	20.13	\$1,064.67	\$520.93	\$212.93
25600	T	Treat fracture radius/ulna	209	1.94	\$102.84	\$37.29	\$20.57
25605	T	Treat fracture radius/ulna	209	1.94	\$102.84	\$37.29	\$20.57
25611	T	Repair fracture radius/ulna	216	20.13	\$1,064.67	\$520.93	\$212.93
25620	T	Repair fracture radius/ulna	216	20.13	\$1,064.67	\$520.93	\$212.93
25622	T	Treat wrist bone fracture	209	1.94	\$102.84	\$37.29	\$20.57
25624	T	Treat wrist bone fracture	209	1.94	\$102.84	\$37.29	\$20.57
25628	T	Repair wrist bone fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
25630	T	Treat wrist bone fracture	209	1.94	\$102.84	\$37.29	\$20.57
25635	T	Treat wrist bone fracture	209	1.94	\$102.84	\$37.29	\$20.57
25645	T	Repair wrist bone fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
25650	T	Repair wrist bone fracture	209	1.94	\$102.84	\$37.29	\$20.57
25660	T	Treat wrist dislocation	209	1.94	\$102.84	\$37.29	\$20.57
25670	T	Repair wrist dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
25675	T	Treat wrist dislocation	209	1.94	\$102.84	\$37.29	\$20.57
25676	T	Repair wrist dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
25680	T	Treat wrist fracture	209	1.94	\$102.84	\$37.29	\$20.57
25685	T	Repair wrist fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
25690	T	Treat wrist dislocation	209	1.94	\$102.84	\$37.29	\$20.57
25695	T	Repair wrist dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
25800	T	Fusion of wrist joint	253	26.33	\$1,392.78	\$699.24	\$278.56
25805	T	Fusion/graft of wrist joint	253	26.33	\$1,392.78	\$699.24	\$278.56

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
25810	T	Fusion/graft of wrist joint	253	26.33	\$1,392.78	\$699.24	\$278.56
25820	T	Fusion of hand bones	261	10.54	\$557.31	\$261.48	\$111.46
25825	T	Fusion hand bones with graft	262	18.35	\$970.64	\$480.93	\$194.13
25830	T	Fusion radioulnar jnt/ulna	253	26.33	\$1,392.78	\$699.24	\$278.56
25900	C	Amputation of forearm					
25905	C	Amputation of forearm					
25907	T	Amputation follow-up surgery	251	14.26	\$754.18	\$366.12	\$150.84
25909	C	Amputation follow-up surgery					
25915	C	Amputation of forearm					
25920	C	Amputate hand at wrist					
25922	T	Amputate hand at wrist	251	14.26	\$754.18	\$366.12	\$150.84
25924	C	Amputation follow-up surgery					
25927	C	Amputation of hand					
25929	T	Amputation follow-up surgery	183	11.17	\$590.61	\$286.57	\$118.12
25931	C	Amputation follow-up surgery					
25999	T	Forearm or wrist surgery	209	1.94	\$102.84	\$37.29	\$20.57
26010	T	Drainage of finger abscess	131	1.94	\$102.84	\$36.61	\$20.57
26011	T	Drainage of finger abscess	131	1.94	\$102.84	\$36.61	\$20.57
26020	T	Drain hand tendon sheath	261	10.54	\$557.31	\$261.48	\$111.46
26025	T	Drainage of palm bursa	261	10.54	\$557.31	\$261.48	\$111.46
26030	T	Drainage of palm bursa(s)	261	10.54	\$557.31	\$261.48	\$111.46
26034	T	Treat hand bone lesion	261	10.54	\$557.31	\$261.48	\$111.46
26035	T	Decompress fingers/hand	261	10.54	\$557.31	\$261.48	\$111.46
26037	T	Decompress fingers/hand	261	10.54	\$557.31	\$261.48	\$111.46
26040	T	Release palm contracture	262	18.35	\$970.64	\$480.93	\$194.13
26045	T	Release palm contracture	262	18.35	\$970.64	\$480.93	\$194.13
26055	T	Incise finger tendon sheath	261	10.54	\$557.31	\$261.48	\$111.46
26060	T	Incision of finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26070	T	Explore/treat hand joint	261	10.54	\$557.31	\$261.48	\$111.46
26075	T	Explore/treat finger joint	261	10.54	\$557.31	\$261.48	\$111.46
26080	T	Explore/treat finger joint	261	10.54	\$557.31	\$261.48	\$111.46
26100	T	Biopsy hand joint lining	261	10.54	\$557.31	\$261.48	\$111.46
26105	T	Biopsy finger joint lining	261	10.54	\$557.31	\$261.48	\$111.46
26110	T	Biopsy finger joint lining	261	10.54	\$557.31	\$261.48	\$111.46
26115	T	Removal of hand lesion	163	10.69	\$565.14	\$264.65	\$113.03
26116	T	Removal of hand lesion	163	10.69	\$565.14	\$264.65	\$113.03
26117	T	Remove tumor, hand/finger	163	10.69	\$565.14	\$264.65	\$113.03
26121	T	Release palm contracture	262	18.35	\$970.64	\$480.93	\$194.13
26123	T	Release palm contracture	262	18.35	\$970.64	\$480.93	\$194.13
26125	T	Release palm contracture	262	18.35	\$970.64	\$480.93	\$194.13
26130	T	Remove wrist joint lining	261	10.54	\$557.31	\$261.48	\$111.46
26135	T	Revise finger joint, each	262	18.35	\$970.64	\$480.93	\$194.13
26140	T	Revise finger joint, each	261	10.54	\$557.31	\$261.48	\$111.46
26145	T	Tendon excision, palm/finger	261	10.54	\$557.31	\$261.48	\$111.46
26160	T	Remove tendon sheath lesion	261	10.54	\$557.31	\$261.48	\$111.46
26170	T	Removal of palm tendon, each	261	10.54	\$557.31	\$261.48	\$111.46
26180	T	Removal of finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26185	T	Remove finger bone	261	10.54	\$557.31	\$261.48	\$111.46
26200	T	Remove hand bone lesion	261	10.54	\$557.31	\$261.48	\$111.46
26205	T	Remove/graft bone lesion	262	18.35	\$970.64	\$480.93	\$194.13
26210	T	Removal of finger lesion	261	10.54	\$557.31	\$261.48	\$111.46
26215	T	Remove/graft finger lesion	261	10.54	\$557.31	\$261.48	\$111.46
26230	T	Partial removal of hand bone	261	10.54	\$557.31	\$261.48	\$111.46
26235	T	Partial removal, finger bone	261	10.54	\$557.31	\$261.48	\$111.46
26236	T	Partial removal, finger bone	261	10.54	\$557.31	\$261.48	\$111.46
26250	T	Extensive hand surgery	261	10.54	\$557.31	\$261.48	\$111.46
26255	T	Extensive hand surgery	262	18.35	\$970.64	\$480.93	\$194.13
26260	T	Extensive finger surgery	261	10.54	\$557.31	\$261.48	\$111.46
26261	T	Extensive finger surgery	261	10.54	\$557.31	\$261.48	\$111.46
26262	T	Partial removal of finger	261	10.54	\$557.31	\$261.48	\$111.46
26320	T	Removal of implant from hand	163	10.69	\$565.14	\$264.65	\$113.03
26350	T	Repair finger/hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26352	T	Repair/graft hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26356	T	Repair finger/hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26357	T	Repair finger/hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26358	T	Repair/graft hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26370	T	Repair finger/hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26372	T	Repair/graft hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26373	T	Repair finger/hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26390	T	Revise hand/finger tendon	262	18.35	\$970.64	\$480.93	\$194.13
26392	T	Repair/graft hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26410	T	Repair hand tendon	261	10.54	\$557.31	\$261.48	\$111.46
26412	T	Repair/graft hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26415	T	Excision, hand/finger tendon	262	18.35	\$970.64	\$480.93	\$194.13
26416	T	Graft hand or finger tendon	262	18.35	\$970.64	\$480.93	\$194.13

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
26418	T	Repair finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26420	T	Repair/graft finger tendon	262	18.35	\$970.64	\$480.93	\$194.13
26426	T	Repair finger/hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26428	T	Repair/graft finger tendon	262	18.35	\$970.64	\$480.93	\$194.13
26432	T	Repair finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26433	T	Repair finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26434	T	Repair/graft finger tendon	262	18.35	\$970.64	\$480.93	\$194.13
26437	T	Realignment of tendons	261	10.54	\$557.31	\$261.48	\$111.46
26440	T	Release palm/finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26442	T	Release palm & finger tendon	262	18.35	\$970.64	\$480.93	\$194.13
26445	T	Release hand/finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26449	T	Release forearm/hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26450	T	Incision of palm tendon	261	10.54	\$557.31	\$261.48	\$111.46
26455	T	Incision of finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26460	T	Incise hand/finger tendon	261	10.54	\$557.31	\$261.48	\$111.46
26471	T	Fusion of finger tendons	261	10.54	\$557.31	\$261.48	\$111.46
26474	T	Fusion of finger tendons	261	10.54	\$557.31	\$261.48	\$111.46
26476	T	Tendon lengthening	261	10.54	\$557.31	\$261.48	\$111.46
26477	T	Tendon shortening	261	10.54	\$557.31	\$261.48	\$111.46
26478	T	Lengthening of hand tendon	261	10.54	\$557.31	\$261.48	\$111.46
26479	T	Shortening of hand tendon	261	10.54	\$557.31	\$261.48	\$111.46
26480	T	Transplant hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26483	T	Transplant/graft hand tendon	262	18.35	\$970.64	\$480.93	\$194.13
26485	T	Transplant palm tendon	262	18.35	\$970.64	\$480.93	\$194.13
26489	T	Transplant/graft palm tendon	262	18.35	\$970.64	\$480.93	\$194.13
26490	T	Revise thumb tendon	262	18.35	\$970.64	\$480.93	\$194.13
26492	T	Tendon transfer with graft	262	18.35	\$970.64	\$480.93	\$194.13
26494	T	Hand tendon/muscle transfer	262	18.35	\$970.64	\$480.93	\$194.13
26496	T	Revise thumb tendon	262	18.35	\$970.64	\$480.93	\$194.13
26497	T	Finger tendon transfer	262	18.35	\$970.64	\$480.93	\$194.13
26498	T	Finger tendon transfer	262	18.35	\$970.64	\$480.93	\$194.13
26499	T	Revision of finger	262	18.35	\$970.64	\$480.93	\$194.13
26500	T	Hand tendon reconstruction	261	10.54	\$557.31	\$261.48	\$111.46
26502	T	Hand tendon reconstruction	262	18.35	\$970.64	\$480.93	\$194.13
26504	T	Hand tendon reconstruction	262	18.35	\$970.64	\$480.93	\$194.13
26508	T	Release thumb contracture	261	10.54	\$557.31	\$261.48	\$111.46
26510	T	Thumb tendon transfer	262	18.35	\$970.64	\$480.93	\$194.13
26516	T	Fusion of knuckle joint	262	18.35	\$970.64	\$480.93	\$194.13
26517	T	Fusion of knuckle joints	262	18.35	\$970.64	\$480.93	\$194.13
26518	T	Fusion of knuckle joints	262	18.35	\$970.64	\$480.93	\$194.13
26520	T	Release knuckle contracture	261	10.54	\$557.31	\$261.48	\$111.46
26525	T	Release finger contracture	261	10.54	\$557.31	\$261.48	\$111.46
26530	T	Revise knuckle joint	217	20.48	\$1,083.27	\$526.81	\$216.65
26531	T	Revise knuckle with implant	218	27.50	\$1,454.49	\$715.52	\$290.90
26535	T	Revise finger joint	217	20.48	\$1,083.27	\$526.81	\$216.65
26536	T	Revise/implant finger joint	218	27.50	\$1,454.49	\$715.52	\$290.90
26540	T	Repair hand joint	261	10.54	\$557.31	\$261.48	\$111.46
26541	T	Repair hand joint with graft	262	18.35	\$970.64	\$480.93	\$194.13
26542	T	Repair hand joint with graft	261	10.54	\$557.31	\$261.48	\$111.46
26545	T	Reconstruct finger joint	262	18.35	\$970.64	\$480.93	\$194.13
26546	T	Repair non-union hand	262	18.35	\$970.64	\$480.93	\$194.13
26548	T	Reconstruct finger joint	262	18.35	\$970.64	\$480.93	\$194.13
26550	T	Construct thumb replacement	262	18.35	\$970.64	\$480.93	\$194.13
26551	C	Great toe-hand transfer .....	.....	.....	.....	.....	.....
26553	C	Single toe-hand transfer .....	.....	.....	.....	.....	.....
26554	C	Double toe-hand transfer .....	.....	.....	.....	.....	.....
26555	T	Positional change of finger	262	18.35	\$970.64	\$480.93	\$194.13
26556	C	Toe joint transfer .....	.....	.....	.....	.....	.....
26560	T	Repair of web finger	261	10.54	\$557.31	\$261.48	\$111.46
26561	T	Repair of web finger	262	18.35	\$970.64	\$480.93	\$194.13
26562	T	Repair of web finger	262	18.35	\$970.64	\$480.93	\$194.13
26565	T	Correct metacarpal flaw	262	18.35	\$970.64	\$480.93	\$194.13
26567	T	Correct finger deformity	262	18.35	\$970.64	\$480.93	\$194.13
26568	T	Lengthen metacarpal/finger	262	18.35	\$970.64	\$480.93	\$194.13
26580	T	Repair hand deformity	262	18.35	\$970.64	\$480.93	\$194.13
26585	T	Repair finger deformity	262	18.35	\$970.64	\$480.93	\$194.13
26587	T	Reconstruct extra finger	261	10.54	\$557.31	\$261.48	\$111.46
26590	T	Repair finger deformity	262	18.35	\$970.64	\$480.93	\$194.13
26591	T	Repair muscles of hand	262	18.35	\$970.64	\$480.93	\$194.13
26593	T	Release muscles of hand	261	10.54	\$557.31	\$261.48	\$111.46
26596	T	Excision constricting tissue	262	18.35	\$970.64	\$480.93	\$194.13
26597	T	Release of scar contracture	262	18.35	\$970.64	\$480.93	\$194.13
26600	T	Treat metacarpal fracture	209	1.94	\$102.84	\$37.29	\$20.57
26605	T	Treat metacarpal fracture	209	1.94	\$102.84	\$37.29	\$20.57
26607	T	Treat metacarpal fracture	209	1.94	\$102.84	\$37.29	\$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
26608	T	Treat metacarpal fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
26615	T	Repair metacarpal fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
26641	T	Treat thumb dislocation	209	1.94	\$102.84	\$37.29	\$20.57
26645	T	Treat thumb fracture	209	1.94	\$102.84	\$37.29	\$20.57
26650	T	Repair thumb fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
26665	T	Repair thumb fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
26670	T	Treat hand dislocation	209	1.94	\$102.84	\$37.29	\$20.57
26675	T	Treat hand dislocation	210	10.46	\$553.39	\$283.4	\$110.68
26676	T	Pin hand dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
26685	T	Repair hand dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
26686	T	Repair hand dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
26700	T	Treat knuckle dislocation	207	1.70	\$90.11	\$31.64	\$18.02
26705	T	Treat knuckle dislocation	210	10.46	\$553.39	\$283.4	\$110.68
26706	T	Pin knuckle dislocation	209	1.94	\$102.84	\$37.29	\$20.57
26715	T	Repair knuckle dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
26720	T	Treat finger fracture, each	207	1.70	\$90.11	\$31.64	\$18.02
26725	T	Treat finger fracture, each	207	1.70	\$90.11	\$31.64	\$18.02
26727	T	Treat finger fracture, each	216	20.13	\$1,064.67	\$520.93	\$212.93
26735	T	Repair finger fracture, each	216	20.13	\$1,064.67	\$520.93	\$212.93
26740	T	Treat finger fracture, each	207	1.70	\$90.11	\$31.64	\$18.02
26742	T	Treat finger fracture, each	209	1.94	\$102.84	\$37.29	\$20.57
26746	T	Repair finger fracture, each	216	20.13	\$1,064.67	\$520.93	\$212.93
26750	T	Treat finger fracture, each	207	1.70	\$90.11	\$31.64	\$18.02
26755	T	Treat finger fracture, each	207	1.70	\$90.11	\$31.64	\$18.02
26756	T	Pin finger fracture, each	216	20.13	\$1,064.67	\$520.93	\$212.93
26765	T	Repair finger fracture, each	216	20.13	\$1,064.67	\$520.93	\$212.93
26770	T	Treat finger dislocation	207	1.70	\$90.11	\$31.64	\$18.02
26775	T	Treat finger dislocation	210	10.46	\$553.39	\$283.4	\$110.68
26776	T	Pin finger dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
26785	T	Repair finger dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
26820	T	Thumb fusion with graft	262	18.35	\$970.64	\$480.93	\$194.13
26841	T	Fusion of thumb	262	18.35	\$970.64	\$480.93	\$194.13
26842	T	Thumb fusion with graft	262	18.35	\$970.64	\$480.93	\$194.13
26843	T	Fusion of hand joint	262	18.35	\$970.64	\$480.93	\$194.13
26844	T	Fusion/graft of hand joint	262	18.35	\$970.64	\$480.93	\$194.13
26850	T	Fusion of knuckle	262	18.35	\$970.64	\$480.93	\$194.13
26852	T	Fusion of knuckle with graft	262	18.35	\$970.64	\$480.93	\$194.13
26860	T	Fusion of finger joint	262	18.35	\$970.64	\$480.93	\$194.13
26861	T	Fusion of finger joint, added	262	18.35	\$970.64	\$480.93	\$194.13
26862	T	Fusion/graft of finger joint	262	18.35	\$970.64	\$480.93	\$194.13
26863	T	Fuse/graft added joint	262	18.35	\$970.64	\$480.93	\$194.13
26910	T	Amputate metacarpal bone	262	18.35	\$970.64	\$480.93	\$194.13
26951	T	Amputation of finger/thumb	261	10.54	\$557.31	\$261.48	\$111.46
26952	T	Amputation of finger/thumb	261	10.54	\$557.31	\$261.48	\$111.46
26989	T	Hand/finger surgery	207	1.70	\$90.11	\$31.64	\$18.02
26990	T	Drainage of pelvis lesion	251	14.26	\$754.18	\$366.12	\$150.84
26991	T	Drainage of pelvis bursa	251	14.26	\$754.18	\$366.12	\$150.84
26992	C	Drainage of bone lesion .....	.....	.....	.....	.....	.....
27000	T	Incision of hip tendon	251	14.26	\$754.18	\$366.12	\$150.84
27001	T	Incision of hip tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27003	T	Incision of hip tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27005	C	Incision of hip tendon .....	.....	.....	.....	.....	.....
27006	C	Incision of hip tendons .....	.....	.....	.....	.....	.....
27025	C	Incision of hip/thigh fascia .....	.....	.....	.....	.....	.....
27030	C	Drainage of hip joint .....	.....	.....	.....	.....	.....
27033	T	Exploration of hip joint	253	26.33	\$1,392.78	\$699.24	\$278.56
27035	C	Denervation of hip joint .....	.....	.....	.....	.....	.....
27036	C	Excision of hip joint/muscle .....	.....	.....	.....	.....	.....
27040	T	Biopsy of soft tissues	162	5.67	\$299.71	\$125.43	\$59.94
27041	T	Biopsy of soft tissues	163	10.69	\$565.14	\$264.65	\$113.03
27047	T	Remove hip/pelvis lesion	163	10.69	\$565.14	\$264.65	\$113.03
27048	T	Remove hip/pelvis lesion	163	10.69	\$565.14	\$264.65	\$113.03
27049	T	Remove tumor, hip/pelvis	163	10.69	\$565.14	\$264.65	\$113.03
27050	T	Biopsy of sacroiliac joint	251	14.26	\$754.18	\$366.12	\$150.84
27052	T	Biopsy of hip joint	251	14.26	\$754.18	\$366.12	\$150.84
27054	C	Removal of hip joint lining .....	.....	.....	.....	.....	.....
27060	T	Removal of ischial bursa	251	14.26	\$754.18	\$366.12	\$150.84
27062	T	Remove femur lesion/bursa	251	14.26	\$754.18	\$366.12	\$150.84
27065	T	Removal of hip bone lesion	251	14.26	\$754.18	\$366.12	\$150.84
27066	T	Removal of hip bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
27067	T	Remove/graft hip bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
27070	C	Partial removal of hip bone .....	.....	.....	.....	.....	.....
27071	C	Partial removal of hip bone					
27075	C	Extensive hip surgery					
27076	C	Extensive hip surgery					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27077	C	Extensive hip surgery .....	.....	.....	.....	.....	.....
27078	C	Extensive hip surgery .....	.....	.....	.....	.....	.....
27079	C	Extensive hip surgery .....	.....	.....	.....	.....	.....
27080	T	Removal of tail bone	252	19.39	\$1,025.49	\$509.18	\$205.10
27086	T	Remove hip foreign body	251	14.26	\$754.18	\$366.12	\$150.84
27087	T	Remove hip foreign body	251	14.26	\$754.18	\$366.12	\$150.84
27090	C	Removal of hip prosthesis .....	.....	.....	.....	.....	.....
27091	C	Removal of hip prosthesis .....	.....	.....	.....	.....	.....
27093	T	Injection for hip x-ray	347	2.93	\$154.75	\$62.15	\$30.95
27095	T	Injection for hip x-ray	347	2.93	\$154.75	\$62.15	\$30.95
27097	T	Revision of hip tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27098	T	Transfer tendon to pelvis	252	19.39	\$1,025.49	\$509.18	\$205.10
27100	T	Transfer of abdominal muscle	253	26.33	\$1,392.78	\$699.24	\$278.56
27105	T	Transfer of spinal muscle	253	26.33	\$1,392.78	\$699.24	\$278.56
27110	T	Transfer of iliopsoas muscle	253	26.33	\$1,392.78	\$699.24	\$278.56
27111	T	Transfer of iliopsoas muscle	253	26.33	\$1,392.78	\$699.24	\$278.56
27120	C	Reconstruction of hip socket .....	.....	.....	.....	.....	.....
27122	C	Reconstruction of hip socket .....	.....	.....	.....	.....	.....
27125	C	Partial hip replacement .....	.....	.....	.....	.....	.....
27130	C	Total hip replacement .....	.....	.....	.....	.....	.....
27132	C	Total hip replacement .....	.....	.....	.....	.....	.....
27134	C	Revise hip joint replacement .....	.....	.....	.....	.....	.....
27137	C	Revise hip joint replacement .....	.....	.....	.....	.....	.....
27138	C	Revise hip joint replacement .....	.....	.....	.....	.....	.....
27140	C	Transplant of femur ridge .....	.....	.....	.....	.....	.....
27146	C	Incision of hip bone .....	.....	.....	.....	.....	.....
27147	C	Revision of hip bone .....	.....	.....	.....	.....	.....
27151	C	Incision of hip bones .....	.....	.....	.....	.....	.....
27156	C	Revision of hip bones .....	.....	.....	.....	.....	.....
27158	C	Revision of pelvis .....	.....	.....	.....	.....	.....
27161	C	Incision of neck of femur .....	.....	.....	.....	.....	.....
27165	C	Incision/fixation of femur .....	.....	.....	.....	.....	.....
27170	C	Repair/graft femur head/neck .....	.....	.....	.....	.....	.....
27175	C	Treat slipped epiphysis .....	.....	.....	.....	.....	.....
27176	C	Treat slipped epiphysis .....	.....	.....	.....	.....	.....
27177	C	Repair slipped epiphysis .....	.....	.....	.....	.....	.....
27178	C	Repair slipped epiphysis .....	.....	.....	.....	.....	.....
27179	C	Revise head/neck of femur .....	.....	.....	.....	.....	.....
27181	C	Repair slipped epiphysis .....	.....	.....	.....	.....	.....
27185	C	Revision of femur epiphysis .....	.....	.....	.....	.....	.....
27187	C	Reinforce hip bones .....	.....	.....	.....	.....	.....
27193	T	Treat pelvic ring fracture	209	1.94	\$102.84	\$37.29	\$20.57
27194	T	Treat pelvic ring fracture	210	10.46	\$553.39	\$283.4	\$110.68
27200	T	Treat tail bone fracture	207	1.70	\$90.11	\$31.64	\$18.02
27202	T	Repair tail bone fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27215	C	Pelvic fracture(s) treatment .....	.....	.....	.....	.....	.....
27216	C	Treat pelvic ring fracture .....	.....	.....	.....	.....	.....
27217	C	Treat pelvic ring fracture .....	.....	.....	.....	.....	.....
27218	C	Treat pelvic ring fracture .....	.....	.....	.....	.....	.....
27220	T	Treat hip socket fracture	209	1.94	\$102.84	\$37.29	\$20.57
27222	C	Treat hip socket fracture .....	.....	.....	.....	.....	.....
27226	C	Treat hip wall fracture .....	.....	.....	.....	.....	.....
27227	C	Treat hip fracture(s) .....	.....	.....	.....	.....	.....
27228	C	Treat hip fracture(s) .....	.....	.....	.....	.....	.....
27230	T	Treat fracture of thigh	209	1.94	\$102.84	\$37.29	\$20.57
27232	C	Treat fracture of thigh .....	.....	.....	.....	.....	.....
27235	C	Repair of thigh fracture .....	.....	.....	.....	.....	.....
27236	C	Repair of thigh fracture .....	.....	.....	.....	.....	.....
27238	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27240	C	Treatment of thigh fracture .....	.....	.....	.....	.....	.....
27244	C	Repair of thigh fracture .....	.....	.....	.....	.....	.....
27245	C	Repair of thigh fracture .....	.....	.....	.....	.....	.....
27246	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27248	C	Repair of thigh fracture .....	.....	.....	.....	.....	.....
27250	T	Treat hip dislocation	209	1.94	\$102.84	\$37.29	\$20.57
27252	T	Treat hip dislocation	210	10.46	\$553.39	\$283.4	\$110.68
27253	C	Repair of hip dislocation .....	.....	.....	.....	.....	.....
27254	C	Repair of hip dislocation .....	.....	.....	.....	.....	.....
27256	T	Treatment of hip dislocation	209	1.94	\$102.84	\$37.29	\$20.57
27257	T	Treatment of hip dislocation	210	10.46	\$553.39	\$283.4	\$110.68
27258	C	Repair of hip dislocation .....	.....	.....	.....	.....	.....
27259	C	Repair of hip dislocation .....	.....	.....	.....	.....	.....
27265	T	Treatment of hip dislocation	209	1.94	\$102.84	\$37.29	\$20.57
27266	T	Treatment of hip dislocation	217	20.48	\$1,083.27	\$526.81	\$216.65
27275	T	Manipulation of hip joint	210	10.46	\$553.39	\$283.4	\$110.68

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27280	C	Fusion of sacroiliac joint .....	.....	.....	.....	.....	.....
27282	C	Fusion of pubic bones .....	.....	.....	.....	.....	.....
27284	C	Fusion of hip joint .....	.....	.....	.....	.....	.....
27286	C	Fusion of hip joint .....	.....	.....	.....	.....	.....
27290	C	Amputation of leg at hip .....	.....	.....	.....	.....	.....
27295	C	Amputation of leg at hip .....	.....	.....	.....	.....	.....
27299	T	Pelvis/hip joint surgery	207	1.70	\$90.11	\$31.64	\$18.02
27301	T	Drain thigh/knee lesion	132	6.04	\$319.3	\$134.24	\$63.86
27303	C	Drainage of bone lesion .....	.....	.....	.....	.....	.....
27305	T	Incise thigh tendon & fascia	251	14.26	\$754.18	\$366.12	\$150.84
27306	T	Incision of thigh tendon	251	14.26	\$754.18	\$366.12	\$150.84
27307	T	Incision of thigh tendons	251	14.26	\$754.18	\$366.12	\$150.84
27310	T	Exploration of knee joint	252	19.39	\$1,025.49	\$509.18	\$205.10
27315	T	Partial removal, thigh nerve	631	12.98	\$686.6	\$333.8	\$137.32
27320	T	Partial removal, thigh nerve	631	12.98	\$686.6	\$333.8	\$137.32
27323	T	Biopsy thigh soft tissues	162	5.67	\$299.71	\$125.43	\$59.94
27324	T	Biopsy thigh soft tissues	163	10.69	\$565.14	\$264.65	\$113.03
27327	T	Removal of thigh lesion	163	10.69	\$565.14	\$264.65	\$113.03
27328	T	Removal of thigh lesion	163	10.69	\$565.14	\$264.65	\$113.03
27329	T	Remove tumor, thigh/knee	163	10.69	\$565.14	\$264.65	\$113.03
27330	T	Biopsy knee joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
27331	T	Explore/treat knee joint	252	19.39	\$1,025.49	\$509.18	\$205.10
27332	T	Removal of knee cartilage	252	19.39	\$1,025.49	\$509.18	\$205.10
27333	T	Removal of knee cartilage	252	19.39	\$1,025.49	\$509.18	\$205.10
27334	T	Remove knee joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
27335	T	Remove knee joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
27340	T	Removal of kneecap bursa	251	14.26	\$754.18	\$366.12	\$150.84
27345	T	Removal of knee cyst	251	14.26	\$754.18	\$366.12	\$150.84
27350	T	Removal of kneecap	252	19.39	\$1,025.49	\$509.18	\$205.10
27355	T	Remove femur lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
27356	T	Remove femur lesion/graft	252	19.39	\$1,025.49	\$509.18	\$205.10
27357	T	Remove femur lesion/graft	252	19.39	\$1,025.49	\$509.18	\$205.10
27358	T	Remove femur lesion/fixation	252	19.39	\$1,025.49	\$509.18	\$205.10
27360	T	Partial removal leg bone(s)	252	19.39	\$1,025.49	\$509.18	\$205.10
27365	C	Extensive leg surgery .....	.....	.....	.....	.....	.....
27370	T	Injection for knee x-ray	347	2.93	\$154.75	\$62.15	\$30.95
27372	T	Removal of foreign body	163	10.69	\$565.14	\$264.65	\$113.03
27380	T	Repair of kneecap tendon	251	14.26	\$754.18	\$366.12	\$150.84
27381	T	Repair/graft kneecap tendon	251	14.26	\$754.18	\$366.12	\$150.84
27385	T	Repair of thigh muscle	251	14.26	\$754.18	\$366.12	\$150.84
27386	T	Repair/graft of thigh muscle	251	14.26	\$754.18	\$366.12	\$150.84
27390	T	Incision of thigh tendon	251	14.26	\$754.18	\$366.12	\$150.84
27391	T	Incision of thigh tendons	251	14.26	\$754.18	\$366.12	\$150.84
27392	T	Incision of thigh tendons	251	14.26	\$754.18	\$366.12	\$150.84
27393	T	Lengthening of thigh tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27394	T	Lengthening of thigh tendons	252	19.39	\$1,025.49	\$509.18	\$205.10
27395	T	Lengthening of thigh tendons	253	26.33	\$1,392.78	\$699.24	\$278.56
27396	T	Transplant of thigh tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27397	T	Transplants of thigh tendons	253	26.33	\$1,392.78	\$699.24	\$278.56
27400	T	Revise thigh muscles/tendons	253	26.33	\$1,392.78	\$699.24	\$278.56
27403	T	Repair of knee cartilage	252	19.39	\$1,025.49	\$509.18	\$205.10
27405	T	Repair of knee ligament	253	26.33	\$1,392.78	\$699.24	\$278.56
27407	T	Repair of knee ligament	253	26.33	\$1,392.78	\$699.24	\$278.56
27409	T	Repair of knee ligaments	253	26.33	\$1,392.78	\$699.24	\$278.56
27418	T	Repair degenerated kneecap	253	26.33	\$1,392.78	\$699.24	\$278.56
27420	T	Revision of unstable kneecap	253	26.33	\$1,392.78	\$699.24	\$278.56
27422	T	Revision of unstable kneecap	253	26.33	\$1,392.78	\$699.24	\$278.56
27424	T	Revision/removal of kneecap	253	26.33	\$1,392.78	\$699.24	\$278.56
27425	T	Lateral retinacular release	252	19.39	\$1,025.49	\$509.18	\$205.10
27427	T	Reconstruction, knee	254	34.37	\$1,817.86	\$937.22	\$363.57
27428	T	Reconstruction, knee	254	34.37	\$1,817.86	\$937.22	\$363.57
27429	T	Reconstruction, knee	254	34.37	\$1,817.86	\$937.22	\$363.57
27430	T	Revision of thigh muscles	253	26.33	\$1,392.78	\$699.24	\$278.56
27435	T	Incision of knee joint	253	26.33	\$1,392.78	\$699.24	\$278.56
27437	T	Revise kneecap	217	20.48	\$1,083.27	\$526.81	\$216.65
27438	T	Revise kneecap with implant	218	27.50	\$1,454.49	\$715.52	\$290.90
27440	T	Revision of knee joint	217	20.48	\$1,083.27	\$526.81	\$216.65
27441	T	Revision of knee joint	217	20.48	\$1,083.27	\$526.81	\$216.65
27442	T	Revision of knee joint	217	20.48	\$1,083.27	\$526.81	\$216.65
27443	T	Revision of knee joint	217	20.48	\$1,083.27	\$526.81	\$216.65
27445	C	Revision of knee joint .....	.....	.....	.....	.....	.....
27446	C	Revision of knee joint .....	.....	.....	.....	.....	.....
27447	C	Total knee replacement					
27448	C	Incision of thigh					
27450	C	Incision of thigh					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27454	C	Realignment of thigh bone .....	.....	.....	.....	.....	.....
27455	C	Realignment of knee .....	.....	.....	.....	.....	.....
27457	C	Realignment of knee .....	.....	.....	.....	.....	.....
27465	C	Shortening of thigh bone .....	.....	.....	.....	.....	.....
27466	C	Lengthening of thigh bone .....	.....	.....	.....	.....	.....
27468	C	Shorten/lengthen thighs .....	.....	.....	.....	.....	.....
27470	C	Repair of thigh .....	.....	.....	.....	.....	.....
27472	C	Repair/graft of thigh .....	.....	.....	.....	.....	.....
27475	C	Surgery to stop leg growth .....	.....	.....	.....	.....	.....
27477	C	Surgery to stop leg growth .....	.....	.....	.....	.....	.....
27479	C	Surgery to stop leg growth .....	.....	.....	.....	.....	.....
27485	C	Surgery to stop leg growth .....	.....	.....	.....	.....	.....
27486	C	Revise knee joint replace .....	.....	.....	.....	.....	.....
27487	C	Revise knee joint replace .....	.....	.....	.....	.....	.....
27488	C	Removal of knee prosthesis .....	.....	.....	.....	.....	.....
27495	C	Reinforce thigh .....	.....	.....	.....	.....	.....
27496	T	Decompression of thigh/knee	251	14.26	\$754.18	\$366.12	\$150.84
27497	T	Decompression of thigh/knee	251	14.26	\$754.18	\$366.12	\$150.84
27498	T	Decompression of thigh/knee	251	14.26	\$754.18	\$366.12	\$150.84
27499	T	Decompression of thigh/knee	251	14.26	\$754.18	\$366.12	\$150.84
27500	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27501	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27502	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27503	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27506	C	Repair of thigh fracture .....	.....	.....	.....	.....	.....
27507	C	Treatment of thigh fracture .....	.....	.....	.....	.....	.....
27508	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27509	T	Treatment of thigh fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27510	T	Treatment of thigh fracture	209	1.94	\$102.84	\$37.29	\$20.57
27511	C	Treatment of thigh fracture .....	.....	.....	.....	.....	.....
27513	C	Treatment of thigh fracture .....	.....	.....	.....	.....	.....
27514	C	Repair of thigh fracture .....	.....	.....	.....	.....	.....
27516	T	Repair of thigh growth plate	209	1.94	\$102.84	\$37.29	\$20.57
27517	T	Repair of thigh growth plate	209	1.94	\$102.84	\$37.29	\$20.57
27519	C	Repair of thigh growth plate .....	.....	.....	.....	.....	.....
27520	T	Treat kneecap fracture	209	1.94	\$102.84	\$37.29	\$20.57
27524	C	Repair of kneecap fracture .....	.....	.....	.....	.....	.....
27530	T	Treatment of knee fracture	209	1.94	\$102.84	\$37.29	\$20.57
27532	T	Treatment of knee fracture	209	1.94	\$102.84	\$37.29	\$20.57
27535	C	Treatment of knee fracture .....	.....	.....	.....	.....	.....
27536	C	Repair of knee fracture .....	.....	.....	.....	.....	.....
27538	C	Treat knee fracture(s)	209	1.94	\$102.84	\$37.29	\$20.57
27540	C	Repair of knee fracture .....	.....	.....	.....	.....	.....
27550	T	Treat knee dislocation	209	1.94	\$102.84	\$37.29	\$20.57
27552	T	Treat knee dislocation	210	10.46	\$553.39	\$283.40	\$110.68
27556	T	Repair of knee dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
27557	C	Repair of knee dislocation .....	.....	.....	.....	.....	.....
27558	C	Repair of knee dislocation .....	.....	.....	.....	.....	.....
27560	T	Treat kneecap dislocation	209	1.94	\$102.84	\$37.29	\$20.57
27562	T	Treat kneecap dislocation	210	10.46	\$553.39	\$283.40	\$110.68
27566	T	Repair kneecap dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
27570	T	Fixation of knee joint	210	10.46	\$553.39	\$283.40	\$110.68
27580	C	Fusion of knee .....	.....	.....	.....	.....	.....
27590	C	Amputate leg at thigh .....	.....	.....	.....	.....	.....
27591	C	Amputate leg at thigh .....	.....	.....	.....	.....	.....
27592	C	Amputate leg at thigh .....	.....	.....	.....	.....	.....
27594	T	Amputation follow-up surgery	251	14.26	\$754.18	\$366.12	\$150.84
27596	C	Amputation follow-up surgery .....	.....	.....	.....	.....	.....
27598	C	Amputate lower leg at knee .....	.....	.....	.....	.....	.....
27599	T	Leg surgery procedure	209	1.94	\$102.84	\$37.29	\$20.57
27600	T	Decompression of lower leg	251	14.26	\$754.18	\$366.12	\$150.84
27601	T	Decompression of lower leg	251	14.26	\$754.18	\$366.12	\$150.84
27602	T	Decompression of lower leg	251	14.26	\$754.18	\$366.12	\$150.84
27603	T	Drain lower leg lesion	132	6.04	\$319.3	\$134.24	\$63.86
27604	T	Drain lower leg bursa	251	14.26	\$754.18	\$366.12	\$150.84
27605	T	Incision of achilles tendon	271	14.41	\$762.01	\$368.38	\$152.40
27606	T	Incision of achilles tendon	251	14.26	\$754.18	\$366.12	\$150.84
27607	T	Treat lower leg bone lesion	251	14.26	\$754.18	\$366.12	\$150.84
27610	T	Explore/treat ankle joint	252	19.39	\$1,025.49	\$509.18	\$205.10
27612	T	Exploration of ankle joint	252	19.39	\$1,025.49	\$509.18	\$205.10
27613	T	Biopsy lower leg soft tissue	161	3.50	\$185.12	\$75.48	\$37.02
27614	T	Biopsy lower leg soft tissue	163	10.69	\$565.14	\$264.65	\$113.03
27615	T	Remove tumor, lower leg	216	20.13	\$1,064.67	\$520.93	\$212.93
27618	T	Remove lower leg lesion	163	10.69	\$565.14	\$264.65	\$113.03
27619	T	Remove lower leg lesion	163	10.69	\$565.14	\$264.65	\$113.03

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27620	T	Explore, treat ankle joint	252	19.39	\$1,025.49	\$509.18	\$205.10
27625	T	Remove ankle joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
27626	T	Remove ankle joint lining	252	19.39	\$1,025.49	\$509.18	\$205.10
27630	T	Removal of tendon lesion	251	14.26	\$754.18	\$366.12	\$150.84
27635	T	Remove lower leg bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
27637	T	Remove/graft leg bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
27638	T	Remove/graft leg bone lesion	252	19.39	\$1,025.49	\$509.18	\$205.10
27640	T	Partial removal of tibia	253	26.33	\$1,392.78	\$699.24	\$278.56
27641	T	Partial removal of fibula	252	19.39	\$1,025.49	\$509.18	\$205.10
27645	C	Extensive lower leg surgery .....	.....	.....	.....	.....	.....
27646	C	Extensive lower leg surgery .....	.....	.....	.....	.....	.....
27647	T	Extensive ankle/heel surgery	253	26.33	\$1,392.78	\$699.24	\$278.56
27648	T	Injection for ankle x-ray	347	2.93	\$154.75	\$62.15	\$30.95
27650	T	Repair achilles tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
27652	T	Repair/graft achilles tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
27654	T	Repair of achilles tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
27656	T	Repair leg fascia defect	251	14.26	\$754.18	\$366.12	\$150.84
27658	T	Repair of leg tendon, each	251	14.26	\$754.18	\$366.12	\$150.84
27659	T	Repair of leg tendon, each	251	14.26	\$754.18	\$366.12	\$150.84
27664	T	Repair of leg tendon, each	251	14.26	\$754.18	\$366.12	\$150.84
27665	T	Repair of leg tendon, each	252	19.39	\$1,025.49	\$509.18	\$205.10
27675	T	Repair lower leg tendons	251	14.26	\$754.18	\$366.12	\$150.84
27676	T	Repair lower leg tendons	252	19.39	\$1,025.49	\$509.18	\$205.10
27680	T	Release of lower leg tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27681	T	Release of lower leg tendons	252	19.39	\$1,025.49	\$509.18	\$205.10
27685	T	Revision of lower leg tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27686	T	Revise lower leg tendons	252	19.39	\$1,025.49	\$509.18	\$205.10
27687	T	Revision of calf tendon	252	19.39	\$1,025.49	\$509.18	\$205.10
27690	T	Revise lower leg tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
27691	T	Revise lower leg tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
27692	T	Revise additional leg tendon	253	26.33	\$1,392.78	\$699.24	\$278.56
27695	T	Repair of ankle ligament	252	19.39	\$1,025.49	\$509.18	\$205.10
27696	T	Repair of ankle ligaments	252	19.39	\$1,025.49	\$509.18	\$205.10
27698	T	Repair of ankle ligament	252	19.39	\$1,025.49	\$509.18	\$205.10
27700	T	Revision of ankle joint	217	20.48	\$1,083.27	\$526.81	\$216.65
27702	C	Reconstruct ankle joint .....	.....	.....	.....	.....	.....
27703	C	Reconstruction, ankle joint .....	.....	.....	.....	.....	.....
27704	T	Removal of ankle implant	251	14.26	\$754.18	\$366.12	\$150.84
27705	T	Incision of tibia	253	26.33	\$1,392.78	\$699.24	\$278.56
27707	T	Incision of fibula	251	14.26	\$754.18	\$366.12	\$150.84
27709	T	Incision of tibia & fibula	252	19.39	\$1,025.49	\$509.18	\$205.10
27712	C	Realignment of lower leg .....	.....	.....	.....	.....	.....
27715	C	Revision of lower leg .....	.....	.....	.....	.....	.....
27720	C	Repair of tibia .....	.....	.....	.....	.....	.....
27722	C	Repair/graft of tibia .....	.....	.....	.....	.....	.....
27724	C	Repair/graft of tibia .....	.....	.....	.....	.....	.....
27725	C	Repair of lower leg .....	.....	.....	.....	.....	.....
27727	C	Repair of lower leg .....	.....	.....	.....	.....	.....
27730	T	Repair of tibia epiphysis	252	19.39	\$1,025.49	\$509.18	\$205.10
27732	T	Repair of fibula epiphysis	252	19.39	\$1,025.49	\$509.18	\$205.10
27734	T	Repair lower leg epiphyses	252	19.39	\$1,025.49	\$509.18	\$205.10
27740	T	Repair of leg epiphyses	252	19.39	\$1,025.49	\$509.18	\$205.10
27742	T	Repair of leg epiphyses	253	26.33	\$1,392.78	\$699.24	\$278.56
27745	T	Reinforce tibia	253	26.33	\$1,392.78	\$699.24	\$278.56
27750	T	Treatment of tibia fracture	209	1.94	\$102.84	\$37.29	\$20.57
27752	T	Treatment of tibia fracture	209	1.94	\$102.84	\$37.29	\$20.57
27756	T	Repair of tibia fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27758	T	Repair of tibia fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27759	T	Repair of tibia fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27760	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27762	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27766	T	Repair of ankle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27780	T	Treatment of fibula fracture	209	1.94	\$102.84	\$37.29	\$20.57
27781	T	Treatment of fibula fracture	209	1.94	\$102.84	\$37.29	\$20.57
27784	T	Repair of fibula fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27786	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27788	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27792	T	Repair of ankle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27808	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27810	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27814	T	Repair of ankle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27816	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27818	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
27822	T	Repair of ankle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27823	T	Repair of ankle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27824	T	Treat lower leg fracture	209	1.94	\$102.84	\$37.29	\$20.57
27825	T	Treat lower leg fracture	209	1.94	\$102.84	\$37.29	\$20.57
27826	T	Treat lower leg fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27827	T	Treat lower leg fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27828	T	Treat lower leg fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
27829	T	Treat lower leg joint	216	20.13	\$1,064.67	\$520.93	\$212.93
27830	T	Treat lower leg dislocation	209	1.94	\$102.84	\$37.29	\$20.57
27831	T	Treat lower leg dislocation	210	10.46	\$553.39	\$283.40	\$110.68
27832	T	Repair lower leg dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
27840	T	Treat ankle dislocation	209	1.94	\$102.84	\$37.29	\$20.57
27842	T	Treat ankle dislocation	210	10.46	\$553.39	\$283.40	\$110.68
27846	T	Repair ankle dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
27848	T	Repair ankle dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
27860	T	Fixation of ankle joint	210	10.46	\$553.39	\$283.40	\$110.68
27870	T	Fusion of ankle joint	253	26.33	\$1,392.78	\$699.24	\$278.56
27871	T	Fusion of tibiofibular joint	253	26.33	\$1,392.78	\$699.24	\$278.56
27880	C	Amputation of lower leg					
27881	C	Amputation of lower leg					
27882	C	Amputation of lower leg					
27884	T	Amputation follow-up surgery	251	14.26	\$754.18	\$366.12	\$150.84
27886	C	Amputation follow-up surgery					
27888	C	Amputation of foot at ankle					
27889	T	Amputation of foot at ankle	252	19.39	\$1,025.49	\$509.18	\$205.10
27892	T	Decompression of leg	251	14.26	\$754.18	\$366.12	\$150.84
27893	T	Decompression of leg	251	14.26	\$754.18	\$366.12	\$150.84
27894	T	Decompression of leg	251	14.26	\$754.18	\$366.12	\$150.84
27899	T	Leg/ankle surgery procedure	209	1.94	\$102.84	\$37.29	\$20.57
28001	T	Drainage of bursa of foot	132	6.04	\$319.3	\$134.24	\$63.86
28002	T	Treatment of foot infection	251	14.26	\$754.18	\$366.12	\$150.84
28003	T	Treatment of foot infection	251	14.26	\$754.18	\$366.12	\$150.84
28005	T	Treat foot bone lesion	271	14.41	\$762.01	\$368.38	\$152.40
28008	T	Incision of foot fascia	271	14.41	\$762.01	\$368.38	\$152.40
28010	T	Incision of toe tendon	271	14.41	\$762.01	\$368.38	\$152.40
28011	T	Incision of toe tendons	271	14.41	\$762.01	\$368.38	\$152.40
28020	T	Exploration of a foot joint	271	14.41	\$762.01	\$368.38	\$152.40
28022	T	Exploration of a foot joint	271	14.41	\$762.01	\$368.38	\$152.40
28024	T	Exploration of a toe joint	271	14.41	\$762.01	\$368.38	\$152.40
28030	T	Removal of foot nerve	631	12.98	\$686.60	\$333.80	\$137.32
28035	T	Decompression of tibia nerve	631	12.98	\$686.60	\$333.80	\$137.32
28043	T	Excision of foot lesion	162	5.67	\$299.71	\$125.43	\$59.94
28045	T	Excision of foot lesion	271	14.41	\$762.01	\$368.38	\$152.40
28046	T	Resection of tumor, foot	271	14.41	\$762.01	\$368.38	\$152.40
28050	T	Biopsy of foot joint lining	271	14.41	\$762.01	\$368.38	\$152.40
28052	T	Biopsy of foot joint lining	271	14.41	\$762.01	\$368.38	\$152.40
28054	T	Biopsy of toe joint lining	271	14.41	\$762.01	\$368.38	\$152.40
28060	T	Partial removal foot fascia	272	16.56	\$875.63	\$409.74	\$175.13
28062	T	Removal of foot fascia	272	16.56	\$875.63	\$409.74	\$175.13
28070	T	Removal of foot joint lining	272	16.56	\$875.63	\$409.74	\$175.13
28072	T	Removal of foot joint lining	272	16.56	\$875.63	\$409.74	\$175.13
28080	T	Removal of foot lesion	271	14.41	\$762.01	\$368.38	\$152.40
28086	T	Excise foot tendon sheath	271	14.41	\$762.01	\$368.38	\$152.40
28088	T	Excise foot tendon sheath	271	14.41	\$762.01	\$368.38	\$152.40
28090	T	Removal of foot lesion	271	14.41	\$762.01	\$368.38	\$152.40
28092	T	Removal of toe lesions	271	14.41	\$762.01	\$368.38	\$152.40
28100	T	Removal of ankle/heel lesion	271	14.41	\$762.01	\$368.38	\$152.40
28102	T	Remove/graft foot lesion	272	16.56	\$875.63	\$409.74	\$175.13
28103	T	Remove/graft foot lesion	272	16.56	\$875.63	\$409.74	\$175.13
28104	T	Removal of foot lesion	271	14.41	\$762.01	\$368.38	\$152.40
28106	T	Remove/graft foot lesion	272	16.56	\$875.63	\$409.74	\$175.13
28107	T	Remove/graft foot lesion	272	16.56	\$875.63	\$409.74	\$175.13
28108	T	Removal of toe lesions	271	14.41	\$762.01	\$368.38	\$152.40
28110	T	Part removal of metatarsal	276	19.19	\$1,014.71	\$500.14	\$202.94
28111	T	Part removal of metatarsal	271	14.41	\$762.01	\$368.38	\$152.40
28112	T	Part removal of metatarsal	271	14.41	\$762.01	\$368.38	\$152.40
28113	T	Part removal of metatarsal	271	14.41	\$762.01	\$368.38	\$152.40
28114	T	Removal of metatarsal heads	271	14.41	\$762.01	\$368.38	\$152.40
28116	T	Revision of foot	271	14.41	\$762.01	\$368.38	\$152.40
28118	T	Removal of heel bone	271	14.41	\$762.01	\$368.38	\$152.40
28119	T	Removal of heel spur	271	14.41	\$762.01	\$368.38	\$152.40
28120	T	Part removal of ankle/heel	271	14.41	\$762.01	\$368.38	\$152.40
28122	T	Partial removal of foot bone	271	14.41	\$762.01	\$368.38	\$152.40
28124	T	Partial removal of toe	271	14.41	\$762.01	\$368.38	\$152.40
28126	T	Partial removal of toe	271	14.41	\$762.01	\$368.38	\$152.40
28130	T	Removal of ankle bone	271	14.41	\$762.01	\$368.38	\$152.40
28140	T	Removal of metatarsal	271	14.41	\$762.01	\$368.38	\$152.40

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
28150	T	Removal of toe	271	14.41	\$762.01	\$368.38	\$152.40
28153	T	Partial removal of toe	271	14.41	\$762.01	\$368.38	\$152.40
28160	T	Partial removal of toe	271	14.41	\$762.01	\$368.38	\$152.40
28171	T	Extensive foot surgery	271	14.41	\$762.01	\$368.38	\$152.40
28173	T	Extensive foot surgery	271	14.41	\$762.01	\$368.38	\$152.40
28175	T	Extensive foot surgery	271	14.41	\$762.01	\$368.38	\$152.40
28190	T	Removal of foot foreign body	161	3.50	\$185.12	\$75.48	\$37.02
28192	T	Removal of foot foreign body	163	10.69	\$565.14	\$264.65	\$113.03
28193	T	Removal of foot foreign body	163	10.69	\$565.14	\$264.65	\$113.03
28200	T	Repair of foot tendon	271	14.41	\$762.01	\$368.38	\$152.40
28202	T	Repair/graft of foot tendon	272	16.56	\$875.63	\$409.74	\$175.13
28208	T	Repair of foot tendon	271	14.41	\$762.01	\$368.38	\$152.40
28210	T	Repair/graft of foot tendon	271	14.41	\$762.01	\$368.38	\$152.40
28220	T	Release of foot tendon	271	14.41	\$762.01	\$368.38	\$152.40
28222	T	Release of foot tendons	271	14.41	\$762.01	\$368.38	\$152.40
28225	T	Release of foot tendon	271	14.41	\$762.01	\$368.38	\$152.40
28226	T	Release of foot tendons	271	14.41	\$762.01	\$368.38	\$152.40
28230	T	Incision of foot tendon(s)	271	14.41	\$762.01	\$368.38	\$152.40
28232	T	Incision of toe tendon	271	14.41	\$762.01	\$368.38	\$152.40
28234	T	Incision of foot tendon	271	14.41	\$762.01	\$368.38	\$152.40
28238	T	Revision of foot tendon	272	16.56	\$875.63	\$409.74	\$175.13
28240	T	Release of big toe	271	14.41	\$762.01	\$368.38	\$152.40
28250	T	Revision of foot fascia	272	16.56	\$875.63	\$409.74	\$175.13
28260	T	Release of midfoot joint	272	16.56	\$875.63	\$409.74	\$175.13
28261	T	Revision of foot tendon	272	16.56	\$875.63	\$409.74	\$175.13
28262	T	Revision of foot and ankle	272	16.56	\$875.63	\$409.74	\$175.13
28264	T	Release of midfoot joint	272	16.56	\$875.63	\$409.74	\$175.13
28270	T	Release of foot contracture	271	14.41	\$762.01	\$368.38	\$152.40
28272	T	Release of toe joint, each	271	14.41	\$762.01	\$368.38	\$152.40
28280	T	Fusion of toes	271	14.41	\$762.01	\$368.38	\$152.40
28285	T	Repair of hammertoe	271	14.41	\$762.01	\$368.38	\$152.40
28286	T	Repair of hammertoe	271	14.41	\$762.01	\$368.38	\$152.40
28288	T	Partial removal of foot bone	272	16.56	\$875.63	\$409.74	\$175.13
28290	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28292	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28293	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28294	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28296	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28297	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28298	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28299	T	Correction of bunion	276	19.19	\$1,014.71	\$500.14	\$202.94
28300	T	Incision of heel bone	272	16.56	\$875.63	\$409.74	\$175.13
28302	T	Incision of ankle bone	272	16.56	\$875.63	\$409.74	\$175.13
28304	T	Incision of midfoot bones	272	16.56	\$875.63	\$409.74	\$175.13
28305	T	Incise/graft midfoot bones	272	16.56	\$875.63	\$409.74	\$175.13
28306	T	Incision of metatarsal	272	16.56	\$875.63	\$409.74	\$175.13
28307	T	Incision of metatarsal	272	16.56	\$875.63	\$409.74	\$175.13
28308	T	Incision of metatarsal	272	16.56	\$875.63	\$409.74	\$175.13
28309	T	Incision of metatarsals	272	16.56	\$875.63	\$409.74	\$175.13
28310	T	Revision of big toe	271	14.41	\$762.01	\$368.38	\$152.40
28312	T	Revision of toe	271	14.41	\$762.01	\$368.38	\$152.40
28313	T	Repair deformity of toe	271	14.41	\$762.01	\$368.38	\$152.40
28315	T	Removal of sesamoid bone	271	14.41	\$762.01	\$368.38	\$152.40
28320	T	Repair of foot bones	272	16.56	\$875.63	\$409.74	\$175.13
28322	T	Repair of metatarsals	272	16.56	\$875.63	\$409.74	\$175.13
28340	T	Resect enlarged toe tissue	271	14.41	\$762.01	\$368.38	\$152.40
28341	T	Resect enlarged toe	271	14.41	\$762.01	\$368.38	\$152.40
28344	T	Repair extra toe(s)	272	16.56	\$875.63	\$409.74	\$175.13
28345	T	Repair webbed toe(s)	272	16.56	\$875.63	\$409.74	\$175.13
28360	T	Reconstruct cleft foot	272	16.56	\$875.63	\$409.74	\$175.13
28400	T	Treatment of heel fracture	209	1.94	\$102.84	\$37.29	\$20.57
28405	T	Treatment of heel fracture	209	1.94	\$102.84	\$37.29	\$20.57
28406	T	Treatment of heel fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28415	T	Repair of heel fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28420	T	Repair/graft heel fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28430	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
28435	T	Treatment of ankle fracture	209	1.94	\$102.84	\$37.29	\$20.57
28436	T	Treatment of ankle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28445	T	Repair of ankle fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28450	T	Treat midfoot fracture, each	209	1.94	\$102.84	\$37.29	\$20.57
28455	T	Treat midfoot fracture, each	209	1.94	\$102.84	\$37.29	\$20.57
28456	T	Repair midfoot fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28465	T	Repair midfoot fracture, each	216	20.13	\$1,064.67	\$520.93	\$212.93
28470	T	Treat metatarsal fracture	209	1.94	\$102.84	\$37.29	\$20.57
28475	T	Treat metatarsal fracture	209	1.94	\$102.84	\$37.29	\$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
28476	T	Repair metatarsal fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28485	T	Repair metatarsal fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28490	T	Treat big toe fracture	207	1.70	\$90.11	\$31.64	\$18.02
28495	T	Treat big toe fracture	207	1.70	\$90.11	\$31.64	\$18.02
28496	T	Repair big toe fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28505	T	Repair big toe fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28510	T	Treatment of toe fracture	207	1.70	\$90.11	\$31.64	\$18.02
28515	T	Treatment of toe fracture	207	1.70	\$90.11	\$31.64	\$18.02
28525	T	Repair of toe fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28530	T	Treat sesamoid bone fracture	209	1.94	\$102.84	\$37.29	\$20.57
28531	T	Treat sesamoid bone fracture	216	20.13	\$1,064.67	\$520.93	\$212.93
28540	T	Treat foot dislocation	209	1.94	\$102.84	\$37.29	\$20.57
28545	T	Treat foot dislocation	210	10.46	\$553.39	\$283.40	\$110.68
28546	T	Treat foot dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28555	T	Repair foot dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28570	T	Treat foot dislocation	209	1.94	\$102.84	\$37.29	\$20.57
28575	T	Treat foot dislocation	210	10.46	\$553.39	\$283.40	\$110.68
28576	T	Treat foot dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28585	T	Repair foot dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28600	T	Treat foot dislocation	209	1.94	\$102.84	\$37.29	\$20.57
28605	T	Treat foot dislocation	210	10.46	\$553.39	\$283.40	\$110.68
28606	T	Treat foot dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28615	T	Repair foot dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28630	T	Treat toe dislocation	207	1.70	\$90.11	\$31.64	\$18.02
28635	T	Treat toe dislocation	210	10.46	\$553.39	\$283.40	\$110.68
28636	T	Treat toe dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28645	T	Repair toe dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28660	T	Treat toe dislocation	207	1.70	\$90.11	\$31.64	\$18.02
28665	T	Treat toe dislocation	210	10.46	\$553.39	\$283.40	\$110.68
28666	T	Treat toe dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28675	T	Repair of toe dislocation	216	20.13	\$1,064.67	\$520.93	\$212.93
28705	T	Fusion of foot bones	272	16.56	\$875.63	\$409.74	\$175.13
28715	T	Fusion of foot bones	272	16.56	\$875.63	\$409.74	\$175.13
28725	T	Fusion of foot bones	272	16.56	\$875.63	\$409.74	\$175.13
28730	T	Fusion of foot bones	272	16.56	\$875.63	\$409.74	\$175.13
28735	T	Fusion of foot bones	272	16.56	\$875.63	\$409.74	\$175.13
28737	T	Revision of foot bones	271	14.41	\$762.01	\$368.38	\$152.40
28740	T	Fusion of foot bones	272	16.56	\$875.63	\$409.74	\$175.13
28750	T	Fusion of big toe joint	271	14.41	\$762.01	\$368.38	\$152.40
28755	T	Fusion of big toe joint	271	14.41	\$762.01	\$368.38	\$152.40
28760	T	Fusion of big toe joint	272	16.56	\$875.63	\$409.74	\$175.13
28800	C	Amputation of midfoot .....	.....	.....	.....	.....	.....
28805	C	Amputation thru metatarsal .....	.....	.....	.....	.....	.....
28810	T	Amputation toe & metatarsal	271	14.41	\$762.01	\$368.38	\$152.40
28820	T	Amputation of toe	271	14.41	\$762.01	\$368.38	\$152.40
28825	T	Partial amputation of toe	271	14.41	\$762.01	\$368.38	\$152.40
28899	T	Foot/toes surgery procedure	207	1.70	\$90.11	\$31.64	\$18.02
29000	N	Application of body cast .....	.....	.....	.....	.....	.....
29010	N	Application of body cast .....	.....	.....	.....	.....	.....
29015	N	Application of body cast .....	.....	.....	.....	.....	.....
29020	N	Application of body cast .....	.....	.....	.....	.....	.....
29025	N	Application of body cast .....	.....	.....	.....	.....	.....
29035	N	Application of body cast .....	.....	.....	.....	.....	.....
29040	N	Application of body cast .....	.....	.....	.....	.....	.....
29044	N	Application of body cast .....	.....	.....	.....	.....	.....
29046	N	Application of body cast .....	.....	.....	.....	.....	.....
29049	N	Application of figure eight .....	.....	.....	.....	.....	.....
29055	N	Application of shoulder cast .....	.....	.....	.....	.....	.....
29058	N	Application of shoulder cast .....	.....	.....	.....	.....	.....
29065	N	Application of long arm cast .....	.....	.....	.....	.....	.....
29075	N	Application of forearm cast .....	.....	.....	.....	.....	.....
29085	N	Apply hand/wrist cast .....	.....	.....	.....	.....	.....
29105	N	Apply long arm splint .....	.....	.....	.....	.....	.....
29125	N	Apply forearm splint .....	.....	.....	.....	.....	.....
29126	N	Apply forearm splint .....	.....	.....	.....	.....	.....
29130	N	Application of finger splint .....	.....	.....	.....	.....	.....
29131	N	Application of finger splint .....	.....	.....	.....	.....	.....
29200	N	Strapping of chest .....	.....	.....	.....	.....	.....
29220	N	Strapping of low back .....	.....	.....	.....	.....	.....
29240	N	Strapping of shoulder .....	.....	.....	.....	.....	.....
29260	N	Strapping of elbow or wrist .....	.....	.....	.....	.....	.....
29280	N	Strapping of hand or finger .....	.....	.....	.....	.....	.....
29305	N	Application of hip cast					
29325	N	Application of hip casts					
29345	N	Application of long leg cast					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
29355	N	Application of long leg cast .....	.....	.....	.....	.....	.....
29358	N	Apply long leg cast brace .....	.....	.....	.....	.....	.....
29365	N	Application of long leg cast .....	.....	.....	.....	.....	.....
29405	N	Apply short leg cast .....	.....	.....	.....	.....	.....
29425	N	Apply short leg cast .....	.....	.....	.....	.....	.....
29435	N	Apply short leg cast .....	.....	.....	.....	.....	.....
29440	N	Addition of walker to cast .....	.....	.....	.....	.....	.....
29445	N	Apply rigid leg cast .....	.....	.....	.....	.....	.....
29450	N	Application of leg cast .....	.....	.....	.....	.....	.....
29505	N	Application long leg splint .....	.....	.....	.....	.....	.....
29515	N	Application lower leg splint .....	.....	.....	.....	.....	.....
29520	N	Strapping of hip .....	.....	.....	.....	.....	.....
29530	N	Strapping of knee .....	.....	.....	.....	.....	.....
29540	N	Strapping of ankle .....	.....	.....	.....	.....	.....
29550	N	Strapping of toes .....	.....	.....	.....	.....	.....
29580	N	Application of paste boot .....	.....	.....	.....	.....	.....
29590	N	Application of foot splint .....	.....	.....	.....	.....	.....
29700	N	Removal/revision of cast .....	.....	.....	.....	.....	.....
29705	N	Removal/revision of cast .....	.....	.....	.....	.....	.....
29710	N	Removal/revision of cast .....	.....	.....	.....	.....	.....
29715	N	Removal/revision of cast .....	.....	.....	.....	.....	.....
29720	N	Repair of body cast .....	.....	.....	.....	.....	.....
29730	N	Windowing of cast .....	.....	.....	.....	.....	.....
29740	N	Wedging of cast .....	.....	.....	.....	.....	.....
29750	N	Wedging of clubfoot cast .....	.....	.....	.....	.....	.....
29799	N	Casting/strapping procedure .....	.....	.....	.....	.....	.....
29800	T	Jaw arthroscopy/surgery	280	22.20	\$1,174.36	\$581.72	\$234.87
29804	T	Jaw arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29815	T	Shoulder arthroscopy	280	22.20	\$1,174.36	\$581.72	\$234.87
29819	T	Shoulder arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29820	T	Shoulder arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29821	T	Shoulder arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29822	T	Shoulder arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29823	T	Shoulder arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29825	T	Shoulder arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29826	T	Shoulder arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29830	T	Elbow arthroscopy	280	22.20	\$1,174.36	\$581.72	\$234.87
29834	T	Elbow arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29835	T	Elbow arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29836	T	Elbow arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29837	T	Elbow arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29838	T	Elbow arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29840	T	Wrist arthroscopy	280	22.20	\$1,174.36	\$581.72	\$234.87
29843	T	Wrist arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29844	T	Wrist arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29845	T	Wrist arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29846	T	Wrist arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29847	T	Wrist arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29848	T	Wrist arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29850	T	Knee arthroscopy/surgery	286	26.76	\$1,415.31	\$802.53	\$283.06
29851	T	Knee arthroscopy/surgery	286	26.76	\$1,415.31	\$802.53	\$283.06
29855	T	Tibial arthroscopy/surgery	286	26.76	\$1,415.31	\$802.53	\$283.06
29856	T	Tibial arthroscopy/surgery	286	26.76	\$1,415.31	\$802.53	\$283.06
29860	T	Hip arthroscopy, dx	281	22.65	\$1,197.87	\$590.31	\$239.57
29861	T	Hip arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29862	T	Hip arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29863	T	Hip arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29870	T	Knee arthroscopy, diagnostic	280	22.20	\$1,174.36	\$581.72	\$234.87
29871	T	Knee arthroscopy/drainage	282	23.94	\$1,266.43	\$614.04	\$253.29
29874	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29875	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29876	T	Knee arthroscopy/surgery	282	23.94	\$1,266.43	\$614.04	\$253.29
29877	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29879	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29880	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29881	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29882	T	Knee arthroscopy/surgery	282	23.94	\$1,266.43	\$614.04	\$253.29
29883	T	Knee arthroscopy/surgery	282	23.94	\$1,266.43	\$614.04	\$253.29
29884	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29885	T	Knee arthroscopy/surgery	282	23.94	\$1,266.43	\$614.04	\$253.29
29886	T	Knee arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29887	T	Knee arthroscopy/surgery	282	23.94	\$1,266.43	\$614.04	\$253.29
29888	T	Knee arthroscopy/surgery	286	26.76	\$1,415.31	\$802.53	\$283.06
29889	T	Knee arthroscopy/surgery	286	26.76	\$1,415.31	\$802.53	\$283.06
29891	T	Ankle arthroscopy/surgery	282	23.94	\$1,266.43	\$614.04	\$253.29

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
29892	T	Ankle arthroscopy/surgery	286	26.76	\$1,415.31	\$802.53	\$283.06
29893	T	Scope, plantar fasciotomy	271	14.41	\$762.01	\$368.38	\$152.40
29894	T	Ankle arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29895	T	Ankle arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29897	T	Ankle arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29898	T	Ankle arthroscopy/surgery	281	22.65	\$1,197.87	\$590.31	\$239.57
29909	T	Arthroscopy of joint	280	22.20	\$1,174.36	\$581.72	\$234.87
30000	T	Drainage of nose lesion	311	1.43	\$75.42	\$20.57	\$15.08
30020	T	Drainage of nose lesion	311	1.43	\$75.42	\$20.57	\$15.08
30100	T	Intranasal biopsy	311	1.43	\$75.42	\$20.57	\$15.08
30110	T	Removal of nose polyp(s)	311	1.43	\$75.42	\$20.57	\$15.08
30115	T	Removal of nose polyp(s)	313	15.81	\$836.45	\$411.09	\$167.29
30117	T	Removal of intranasal lesion	311	1.43	\$75.42	\$20.57	\$15.08
30118	T	Removal of intranasal lesion	313	15.81	\$836.45	\$411.09	\$167.29
30120	T	Revision of nose	313	15.81	\$836.45	\$411.09	\$167.29
30124	T	Removal of nose lesion	311	1.43	\$75.42	\$20.57	\$15.08
30125	T	Removal of nose lesion	313	15.81	\$836.45	\$411.09	\$167.29
30130	T	Removal of turbinate bones	313	15.81	\$836.45	\$411.09	\$167.29
30140	T	Removal of turbinate bones	313	15.81	\$836.45	\$411.09	\$167.29
30150	T	Partial removal of nose	313	15.81	\$836.45	\$411.09	\$167.29
30160	T	Removal of nose	313	15.81	\$836.45	\$411.09	\$167.29
30200	T	Injection treatment of nose	347	2.93	\$154.75	\$62.15	\$30.95
30210	T	Nasal sinus therapy	311	1.43	\$75.42	\$20.57	\$15.08
30220	T	Insert nasal septal button	311	1.43	\$75.42	\$20.57	\$15.08
30300	T	Remove nasal foreign body	311	1.43	\$75.42	\$20.57	\$15.08
30310	T	Remove nasal foreign body	313	15.81	\$836.45	\$411.09	\$167.29
30320	T	Remove nasal foreign body	313	15.81	\$836.45	\$411.09	\$167.29
30400	T	Reconstruction of nose	314	25.65	\$1,356.54	\$693.37	\$271.31
30410	T	Reconstruction of nose	314	25.65	\$1,356.54	\$693.37	\$271.31
30420	T	Reconstruction of nose	314	25.65	\$1,356.54	\$693.37	\$271.31
30430	T	Revision of nose	313	15.81	\$836.45	\$411.09	\$167.29
30435	T	Revision of nose	314	25.65	\$1,356.54	\$693.37	\$271.31
30450	T	Revision of nose	314	25.65	\$1,356.54	\$693.37	\$271.31
30460	T	Revision of nose	314	25.65	\$1,356.54	\$693.37	\$271.31
30462	T	Revision of nose	314	25.65	\$1,356.54	\$693.37	\$271.31
30520	T	Repair of nasal septum	313	15.81	\$836.45	\$411.09	\$167.29
30540	T	Repair nasal defect	313	15.81	\$836.45	\$411.09	\$167.29
30545	T	Repair nasal defect	314	25.65	\$1,356.54	\$693.37	\$271.31
30560	T	Release of nasal adhesions	311	1.43	\$75.42	\$20.57	\$15.08
30580	T	Repair upper jaw fistula	313	15.81	\$836.45	\$411.09	\$167.29
30600	T	Repair mouth/nose fistula	313	15.81	\$836.45	\$411.09	\$167.29
30620	T	Intranasal reconstruction	313	15.81	\$836.45	\$411.09	\$167.29
30630	T	Repair nasal septum defect	313	15.81	\$836.45	\$411.09	\$167.29
30801	T	Cauterization inner nose	312	7.26	\$383.95	\$178.31	\$76.79
30802	T	Cauterization inner nose	312	7.26	\$383.95	\$178.31	\$76.79
30901	T	Control of nosebleed	318	2.07	\$109.70	\$38.65	\$21.94
30903	T	Control of nosebleed	318	2.07	109.70	\$38.65	\$21.94
30905	T	Control of nosebleed	318	2.07	\$109.70	\$38.65	\$21.94
30906	T	Repeat control of nosebleed	318	2.07	\$109.70	\$38.65	\$21.94
30915	T	Ligation nasal sinus artery	367	17.59	\$930.48	\$449.06	\$186.10
30920	T	Ligation upper jaw artery	367	17.59	\$930.48	\$449.06	\$186.10
30930	T	Therapy fracture of nose	312	7.26	\$383.95	\$178.31	\$76.79
30999	T	Nasal surgery procedure	318	2.07	\$109.70	\$38.65	\$21.94
31000	T	Irrigation maxillary sinus	311	1.43	\$75.42	\$20.57	\$15.08
31002	T	Irrigation sphenoid sinus	311	1.43	\$75.42	\$20.57	\$15.08
31020	T	Exploration maxillary sinus	313	15.81	\$836.45	\$411.09	\$167.29
31030	T	Exploration maxillary sinus	313	15.81	\$836.45	\$411.09	\$167.29
31032	T	Explore sinus, remove polyps	313	15.81	\$836.45	\$411.09	\$167.29
31040	T	Exploration behind upper jaw	314	25.65	\$1,356.54	\$693.37	\$271.31
31050	T	Exploration sphenoid sinus	313	15.81	\$836.45	\$411.09	\$167.29
31051	T	Sphenoid sinus surgery	313	15.81	\$836.45	\$411.09	\$167.29
31070	T	Exploration of frontal sinus	313	15.81	\$836.45	\$411.09	\$167.29
31075	T	Exploration of frontal sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31080	T	Removal of frontal sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31081	T	Removal of frontal sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31084	T	Removal of frontal sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31085	T	Removal of frontal sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31086	T	Removal of frontal sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31087	T	Removal of frontal sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31090	T	Exploration of sinuses	314	25.65	\$1,356.54	\$693.37	\$271.31
31200	T	Removal of ethmoid sinus	313	15.81	\$836.45	\$411.09	\$167.29
31201	T	Removal of ethmoid sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31205	T	Removal of ethmoid sinus	314	25.65	\$1,356.54	\$693.37	\$271.31
31225	C	Removal of upper jaw					
31230	C	Removal of upper jaw					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
31231	T	Nasal endoscopy, dx	331	0.69	\$36.24	\$14.01	\$7.25
31233	T	Nasal/sinus endoscopy, dx	332	9.74	\$515.19	\$244.98	\$103.04
31235	T	Nasal/sinus endoscopy, dx	332	9.74	\$515.19	\$244.98	\$103.04
31237	T	Nasal/sinus endoscopy, surg	332	9.74	\$515.19	\$244.98	\$103.04
31238	T	Nasal/sinus endoscopy, surg	332	9.74	\$515.19	\$244.98	\$103.04
31239	T	Nasal/sinus endoscopy, surg	333	17.24	\$911.87	\$464.20	\$182.37
31240	T	Nasal/sinus endoscopy, surg	332	9.74	\$515.19	\$244.98	\$103.04
31254	T	Revision of ethmoid sinus	333	17.24	\$911.87	\$464.20	\$182.37
31255	T	Removal of ethmoid sinus	333	17.24	\$911.87	\$464.20	\$182.37
31256	T	Exploration maxillary sinus	333	17.24	\$911.87	\$464.20	\$182.37
31267	T	Endoscopy, maxillary sinus	333	17.24	\$911.87	\$464.20	\$182.37
31276	T	Sinus surgical endoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31287	T	Nasal/sinus endoscopy, surg	333	17.24	\$911.87	\$464.20	\$182.37
31288	T	Nasal/sinus endoscopy, surg	333	17.24	\$911.87	\$464.20	\$182.37
31290	C	Nasal/sinus endoscopy, surg .....	.....	.....	.....	.....	.....
31291	C	Nasal/sinus endoscopy, surg .....	.....	.....	.....	.....	.....
31292	C	Nasal/sinus endoscopy, surg .....	.....	.....	.....	.....	.....
31293	C	Nasal/sinus endoscopy, surg .....	.....	.....	.....	.....	.....
31294	C	Nasal/sinus endoscopy, surg .....	.....	.....	.....	.....	.....
31299	T	Sinus surgery procedure	331	0.69	\$36.24	\$14.01	\$7.25
31300	T	Removal of larynx lesion	314	25.65	\$1,356.54	\$693.37	\$271.31
31320	T	Diagnostic incision larynx	313	15.81	\$836.45	\$411.09	\$167.29
31360	C	Removal of larynx .....	.....	.....	.....	.....	.....
31365	C	Removal of larynx .....	.....	.....	.....	.....	.....
31367	C	Partial removal of larynx .....	.....	.....	.....	.....	.....
31368	C	Partial removal of larynx .....	.....	.....	.....	.....	.....
31370	C	Partial removal of larynx .....	.....	.....	.....	.....	.....
31375	C	Partial removal of larynx .....	.....	.....	.....	.....	.....
31380	C	Partial removal of larynx .....	.....	.....	.....	.....	.....
31382	C	Partial removal of larynx .....	.....	.....	.....	.....	.....
31390	C	Removal of larynx & pharynx .....	.....	.....	.....	.....	.....
31395	C	Reconstruct larynx & pharynx .....	.....	.....	.....	.....	.....
31400	T	Revision of larynx	314	25.65	\$1,356.54	\$693.37	\$271.31
31420	T	Removal of epiglottis	314	25.65	\$1,356.54	\$693.37	\$271.31
31500	S	Insert emergency airway	947	4.07	\$215.48	\$109.61	\$43.10
31502	T	Change of windpipe airway	470	2.22	\$117.53	\$54.92	\$23.51
31505	T	Diagnostic laryngoscopy	331	0.69	\$36.24	\$14.01	\$7.25
31510	T	Laryngoscopy with biopsy	332	9.74	\$515.19	\$244.98	\$103.04
31511	T	Remove foreign body, larynx	332	9.74	\$515.19	\$244.98	\$103.04
31512	T	Removal of larynx lesion	332	9.74	\$515.19	\$244.98	\$103.04
31513	T	Injection into vocal cord	332	9.74	\$515.19	\$244.98	\$103.04
31515	T	Laryngoscopy for aspiration	332	9.74	\$515.19	\$244.98	\$103.04
31520	T	Diagnostic laryngoscopy	332	9.74	\$515.19	\$244.98	\$103.04
31525	T	Diagnostic laryngoscopy	332	9.74	\$515.19	\$244.98	\$103.04
31526	T	Diagnostic laryngoscopy	332	9.74	\$515.19	\$244.98	\$103.04
31527	T	Laryngoscopy for treatment	333	17.24	\$911.87	\$464.20	\$182.37
31528	T	Laryngoscopy and dilatation	332	9.74	\$515.19	\$244.98	\$103.04
31529	T	Laryngoscopy and dilatation	332	9.74	\$515.19	\$244.98	\$103.04
31530	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31531	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31535	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31536	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31540	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31541	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31560	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31561	T	Operative laryngoscopy	333	17.24	\$911.87	\$464.20	\$182.37
31570	T	Laryngoscopy with injection	333	17.24	\$911.87	\$464.20	\$182.37
31571	T	Laryngoscopy with injection	333	17.24	\$911.87	\$464.20	\$182.37
31575	T	Diagnostic laryngoscopy	331	0.69	\$36.24	\$14.01	\$7.25
31576	T	Laryngoscopy with biopsy	332	9.74	\$515.19	\$244.98	\$103.04
31577	T	Remove foreign body, larynx	332	9.74	\$515.19	\$244.98	\$103.04
31578	T	Removal of larynx lesion	332	9.74	\$515.19	\$244.98	\$103.04
31579	T	Diagnostic laryngoscopy	331	0.69	\$36.24	\$14.01	\$7.25
31580	C	Revision of larynx .....	.....	.....	.....	.....	.....
31582	C	Revision of larynx .....	.....	.....	.....	.....	.....
31584	C	Repair of larynx fracture .....	.....	.....	.....	.....	.....
31585	T	Repair of larynx fracture	207	1.70	\$90.11	\$31.64	\$18.02
31586	T	Repair of larynx fracture	209	1.94	\$102.84	\$37.29	\$20.57
31587	C	Revision of larynx .....	.....	.....	.....	.....	.....
31588	T	Revision of larynx	314	25.65	\$1,356.54	\$693.37	\$271.31
31590	T	Reinnervate larynx	314	25.65	\$1,356.54	\$693.37	\$271.31
31595	T	Larynx nerve surgery	313	15.81	\$836.45	\$411.09	\$167.29
31599	T	Larynx surgery procedure	207	1.70	\$90.11	\$31.64	\$18.02
31600	C	Incision of windpipe					
31601	C	Incision of windpipe					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
31603	T	Incision of windpipe	311	1.43	\$75.42	\$20.57	\$15.08
31605	T	Incision of windpipe	311	1.43	\$75.42	\$20.57	\$15.08
31610	C	Incision of windpipe					
31611	T	Surgery/speech prosthesis	313	15.81	\$836.45	\$411.09	\$167.29
31612	T	Puncture/clear windpipe	312	7.26	\$383.95	\$178.31	\$76.79
31613	T	Repair windpipe opening	313	15.81	\$836.45	\$411.09	\$167.29
31614	T	Repair windpipe opening	313	15.81	\$836.45	\$411.09	\$167.29
31615	T	Visualization of windpipe	336	7.44	\$393.74	\$197.98	\$78.75
31622	T	Diagnostic bronchoscopy	336	7.44	\$393.74	\$197.98	\$78.75
31625	T	Bronchoscopy with biopsy	336	7.44	\$393.74	\$197.98	\$78.75
31628	T	Bronchoscopy with biopsy	336	7.44	\$393.74	\$197.98	\$78.75
31629	T	Bronchoscopy with biopsy	336	7.44	\$393.74	\$197.98	\$78.75
31630	T	Bronchoscopy with repair	336	7.44	\$393.74	\$197.98	\$78.75
31631	T	Bronchoscopy with dilation	336	7.44	\$393.74	\$197.98	\$78.75
31635	T	Remove foreign body, airway	336	7.44	\$393.74	\$197.98	\$78.75
31640	T	Bronchoscopy & remove lesion	336	7.44	\$393.74	\$197.98	\$78.75
31641	T	Bronchoscopy, treat blockage	336	7.44	\$393.74	\$197.98	\$78.75
31645	T	Bronchoscopy, clear airways	336	7.44	\$393.74	\$197.98	\$78.75
31646	T	Bronchoscopy, reclear airways	336	7.44	\$393.74	\$197.98	\$78.75
31656	T	Bronchoscopy, inject for xray	336	7.44	\$393.74	\$197.98	\$78.75
31700	T	Insertion of airway catheter	332	9.74	\$515.19	\$244.98	\$103.04
31708	T	Instill airway contrast dye	347	2.93	\$154.75	\$62.15	\$30.95
31710	T	Insertion of airway catheter	347	2.93	\$154.75	\$62.15	\$30.95
31715	T	Injection for bronchus x-ray	347	2.93	\$154.75	\$62.15	\$30.95
31717	T	Bronchial brush biopsy	332	9.74	\$515.19	\$244.98	\$103.04
31720	T	Clearance of airways	332	9.74	\$515.19	\$244.98	\$103.04
31725	C	Clearance of airways					
31730	T	Intro windpipe wire/tube	332	9.74	\$515.19	\$244.98	\$103.04
31750	T	Repair of windpipe	314	25.65	\$1,356.54	\$693.37	\$271.31
31755	T	Repair of windpipe	314	25.65	\$1,356.54	\$693.37	\$271.31
31760	C	Repair of windpipe					
31766	C	Reconstruction of windpipe					
31770	C	Repair/graft of bronchus					
31775	C	Reconstruct bronchus					
31780	C	Reconstruct windpipe					
31781	C	Reconstruct windpipe					
31785	C	Remove windpipe lesion					
31786	C	Remove windpipe lesion					
31800	C	Repair of windpipe injury					
31805	C	Repair of windpipe injury					
31820	T	Closure of windpipe lesion	313	15.81	\$836.45	\$411.09	\$167.29
31825	T	Repair of windpipe defect	313	15.81	\$836.45	\$411.09	\$167.29
31830	T	Revise windpipe scar	313	15.81	\$836.45	\$411.09	\$167.29
31899	T	Airways surgical procedure	336	7.44	\$393.74	\$197.98	\$78.75
32000	T	Drainage of chest	320	3.17	\$167.49	\$79.33	\$33.50
32002	T	Treatment of collapsed lung	320	3.17	\$167.49	\$79.33	\$33.50
32005	C	Treat lung lining chemically					
32020	T	Insertion of chest tube	320	3.17	\$167.49	\$79.33	\$33.50
32035	C	Exploration of chest					
32036	C	Exploration of chest					
32095	C	Biopsy through chest wall					
32100	C	Exploration/biopsy of chest					
32110	C	Explore/repair chest					
32120	C	Re-exploration of chest					
32124	C	Explore chest, free adhesions					
32140	C	Removal of lung lesion(s)					
32141	C	Remove/treat lung lesions					
32150	C	Removal of lung lesion(s)					
32151	C	Remove lung foreign body					
32160	C	Open chest heart massage					
32200	C	Open drainage, lung lesion					
32201	C	Percut drainage, lung lesion					
32215	C	Treat chest lining					
32220	C	Release of lung					
32225	C	Partial release of lung					
32310	C	Removal of chest lining					
32320	C	Free/remove chest lining					
32400	T	Needle biopsy chest lining	122	4.87	\$257.60	\$115.03	\$51.52
32402	C	Open biopsy chest lining					
32405	T	Biopsy, lung or mediastinum	122	4.87	\$257.60	\$115.03	\$51.52
32420	T	Puncture/clear lung	320	3.17	\$167.49	\$79.33	\$33.50
32440	C	Removal of lung					
32442	C	Sleeve pneumonectomy					
32445	C	Removal of lung					
32480	C	Partial removal of lung					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
32482	C	Bilobectomy .....	.....	.....	.....	.....	.....
32484	C	Segmentectomy .....	.....	.....	.....	.....	.....
32486	C	Sleeve lobectomy .....	.....	.....	.....	.....	.....
32488	C	Completion pneumonectomy .....	.....	.....	.....	.....	.....
32491	C	Lung volume reduction .....	.....	.....	.....	.....	.....
32500	C	Partial removal of lung .....	.....	.....	.....	.....	.....
32501	C	Repair bronchus (add-on) .....	.....	.....	.....	.....	.....
32520	C	Remove lung & revise chest .....	.....	.....	.....	.....	.....
32522	C	Remove lung & revise chest .....	.....	.....	.....	.....	.....
32525	C	Remove lung & revise chest .....	.....	.....	.....	.....	.....
32540	C	Removal of lung lesion .....	.....	.....	.....	.....	.....
32601	C	Thoracoscopy, diagnostic .....	.....	.....	.....	.....	.....
32602	C	Thoracoscopy, diagnostic .....	.....	.....	.....	.....	.....
32603	C	Thoracoscopy, diagnostic .....	.....	.....	.....	.....	.....
32604	C	Thoracoscopy, diagnostic .....	.....	.....	.....	.....	.....
32605	C	Thoracoscopy, diagnostic .....	.....	.....	.....	.....	.....
32606	C	Thoracoscopy, diagnostic .....	.....	.....	.....	.....	.....
32650	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32651	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32652	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32653	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32654	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32655	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32656	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32657	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32658	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32659	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32660	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32661	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32662	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32663	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32664	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32665	C	Thoracoscopy, surgical .....	.....	.....	.....	.....	.....
32800	C	Repair lung hernia .....	.....	.....	.....	.....	.....
32810	C	Close chest after drainage .....	.....	.....	.....	.....	.....
32815	C	Close bronchial fistula .....	.....	.....	.....	.....	.....
32820	C	Reconstruct injured chest .....	.....	.....	.....	.....	.....
32850	C	Donor pneumonectomy .....	.....	.....	.....	.....	.....
32851	C	Lung transplant, single .....	.....	.....	.....	.....	.....
32852	C	Lung transplant w/bypass .....	.....	.....	.....	.....	.....
32853	C	Lung transplant, double .....	.....	.....	.....	.....	.....
32854	C	Lung transplant w/bypass .....	.....	.....	.....	.....	.....
32900	C	Removal of rib(s) .....	.....	.....	.....	.....	.....
32905	C	Revise & repair chest wall .....	.....	.....	.....	.....	.....
32906	C	Revise & repair chest wall .....	.....	.....	.....	.....	.....
32940	C	Revision of lung .....	.....	.....	.....	.....	.....
32960	T	Therapeutic pneumothorax	320	3.17	\$167.49	\$79.33	\$33.50
32999	T	Chest surgery procedure	320	3.17	\$167.49	\$79.33	\$33.50
33010	T	Drainage of heart sac	320	3.17	\$167.49	\$79.33	\$33.50
33011	T	Repeat drainage of heart sac	320	3.17	\$167.49	\$79.33	\$33.50
33015	C	Incision of heart sac .....	.....	.....	.....	.....	.....
33020	C	Incision of heart sac .....	.....	.....	.....	.....	.....
33025	C	Incision of heart sac .....	.....	.....	.....	.....	.....
33030	C	Partial removal of heart sac .....	.....	.....	.....	.....	.....
33031	C	Partial removal of heart sac .....	.....	.....	.....	.....	.....
33050	C	Removal of heart sac lesion .....	.....	.....	.....	.....	.....
33120	C	Removal of heart lesion .....	.....	.....	.....	.....	.....
33130	C	Removal of heart lesion .....	.....	.....	.....	.....	.....
33200	C	Insertion of heart pacemaker .....	.....	.....	.....	.....	.....
33201	C	Insertion of heart pacemaker .....	.....	.....	.....	.....	.....
33206	C	Insertion of heart pacemaker .....	.....	.....	.....	.....	.....
33207	C	Insertion of heart pacemaker .....	.....	.....	.....	.....	.....
33208	C	Insertion of heart pacemaker .....	.....	.....	.....	.....	.....
33210	C	Insertion of heart electrode .....	.....	.....	.....	.....	.....
33211	C	Insertion of heart electrode .....	.....	.....	.....	.....	.....
33212	C	Insertion of pulse generator .....	.....	.....	.....	.....	.....
33213	C	Insertion of pulse generator .....	.....	.....	.....	.....	.....
33214	C	Upgrade of pacemaker system .....	.....	.....	.....	.....	.....
33216	C	Revision implanted electrode .....	.....	.....	.....	.....	.....
33217	C	Insert/revise electrode .....	.....	.....	.....	.....	.....
33218	C	Repair pacemaker electrodes .....	.....	.....	.....	.....	.....
33220	C	Repair pacemaker electrode .....	.....	.....	.....	.....	.....
33222	T	Pacemaker AICD pocket	360	6.09	\$322.24	\$140.12	\$64.45
33223	T	Pacemaker AICD pocket	360	6.09	\$322.24	\$140.12	\$64.45
33233	C	Removal of pacemaker system					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
33234	C	Removal of pacemaker system .....	.....	.....	.....	.....	.....
33235	C	Removal pacemaker electrode .....	.....	.....	.....	.....	.....
33236	C	Remove electrode/thoracotomy .....	.....	.....	.....	.....	.....
33237	C	Remove electrode/thoracotomy .....	.....	.....	.....	.....	.....
33238	C	Remove electrode/thoracotomy .....	.....	.....	.....	.....	.....
33240	C	Insert/replace pulse gener .....	.....	.....	.....	.....	.....
33241	C	Remove pulse generator only .....	.....	.....	.....	.....	.....
33242	C	Repair pulse generator/leads .....	.....	.....	.....	.....	.....
33243	C	Remove generator/thoracotomy .....	.....	.....	.....	.....	.....
33244	C	Remove generator .....	.....	.....	.....	.....	.....
33245	C	Implant heart defibrillator .....	.....	.....	.....	.....	.....
33246	C	Implant heart defibrillator .....	.....	.....	.....	.....	.....
33247	C	Insert/replace leads .....	.....	.....	.....	.....	.....
33249	C	Insert/replace leads/gener .....	.....	.....	.....	.....	.....
33250	C	Ablate heart dysrhythm focus .....	.....	.....	.....	.....	.....
33251	C	Ablate heart dysrhythm focus .....	.....	.....	.....	.....	.....
33253	C	Reconstruct atria .....	.....	.....	.....	.....	.....
33261	C	Ablate heart dysrhythm focus .....	.....	.....	.....	.....	.....
33300	C	Repair of heart wound .....	.....	.....	.....	.....	.....
33305	C	Repair of heart wound .....	.....	.....	.....	.....	.....
33310	C	Exploratory heart surgery .....	.....	.....	.....	.....	.....
33315	C	Exploratory heart surgery .....	.....	.....	.....	.....	.....
33320	C	Repair major blood vessel(s) .....	.....	.....	.....	.....	.....
33321	C	Repair major vessel .....	.....	.....	.....	.....	.....
33322	C	Repair major blood vessel(s) .....	.....	.....	.....	.....	.....
33330	C	Insert major vessel graft .....	.....	.....	.....	.....	.....
33332	C	Insert major vessel graft .....	.....	.....	.....	.....	.....
33335	C	Insert major vessel graft .....	.....	.....	.....	.....	.....
33400	C	Repair of aortic valve .....	.....	.....	.....	.....	.....
33401	C	Valvuloplasty, open .....	.....	.....	.....	.....	.....
33403	C	Valvuloplasty, w/cp bypass .....	.....	.....	.....	.....	.....
33404	C	Prepare heart-aorta conduit .....	.....	.....	.....	.....	.....
33405	C	Replacement of aortic valve .....	.....	.....	.....	.....	.....
33406	C	Replacement, aortic valve .....	.....	.....	.....	.....	.....
33411	C	Replacement of aortic valve .....	.....	.....	.....	.....	.....
33412	C	Replacement of aortic valve .....	.....	.....	.....	.....	.....
33413	C	Replacement, aortic valve .....	.....	.....	.....	.....	.....
33414	C	Repair, aortic valve .....	.....	.....	.....	.....	.....
33415	C	Revision, subvalvular tissue .....	.....	.....	.....	.....	.....
33416	C	Revise ventricle muscle .....	.....	.....	.....	.....	.....
33417	C	Repair of aortic valve .....	.....	.....	.....	.....	.....
33420	C	Revision of mitral valve .....	.....	.....	.....	.....	.....
33422	C	Revision of mitral valve .....	.....	.....	.....	.....	.....
33425	C	Repair of mitral valve .....	.....	.....	.....	.....	.....
33426	C	Repair of mitral valve .....	.....	.....	.....	.....	.....
33427	C	Repair of mitral valve .....	.....	.....	.....	.....	.....
33430	C	Replacement of mitral valve .....	.....	.....	.....	.....	.....
33460	C	Revision of tricuspid valve .....	.....	.....	.....	.....	.....
33463	C	Valvuloplasty, tricuspid .....	.....	.....	.....	.....	.....
33464	C	Valvuloplasty, tricuspid .....	.....	.....	.....	.....	.....
33465	C	Replace tricuspid valve .....	.....	.....	.....	.....	.....
33468	C	Revision of tricuspid valve .....	.....	.....	.....	.....	.....
33470	C	Revision of pulmonary valve .....	.....	.....	.....	.....	.....
33471	C	Valvotomy, pulmonary valve .....	.....	.....	.....	.....	.....
33472	C	Revision of pulmonary valve .....	.....	.....	.....	.....	.....
33474	C	Revision of pulmonary valve .....	.....	.....	.....	.....	.....
33475	C	Replacement, pulmonary valve .....	.....	.....	.....	.....	.....
33476	C	Revision of heart chamber .....	.....	.....	.....	.....	.....
33478	C	Revision of heart chamber .....	.....	.....	.....	.....	.....
33496	C	Repair, prosth valve clot .....	.....	.....	.....	.....	.....
33500	C	Repair heart vessel fistula .....	.....	.....	.....	.....	.....
33501	C	Repair heart vessel fistula .....	.....	.....	.....	.....	.....
33502	C	Coronary artery correction .....	.....	.....	.....	.....	.....
33503	C	Coronary artery graft .....	.....	.....	.....	.....	.....
33504	C	Coronary artery graft .....	.....	.....	.....	.....	.....
33505	C	Repair artery w/tunnel .....	.....	.....	.....	.....	.....
33506	C	Repair artery, translocation .....	.....	.....	.....	.....	.....
33510	C	CABG, vein, single .....	.....	.....	.....	.....	.....
33511	C	CABG, vein, two .....	.....	.....	.....	.....	.....
33512	C	CABG, vein, three .....	.....	.....	.....	.....	.....
33513	C	CABG, vein, four .....	.....	.....	.....	.....	.....
33514	C	CABG, vein, five .....	.....	.....	.....	.....	.....
33516	C	CABG, vein, six+					
33517	C	CABG, artery-vein, single					
33518	C	CABG, artery-vein, two					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
33519	C	CABG, artery-vein, three .....	.....	.....	.....	.....	.....
33521	C	CABG, artery-vein, four .....	.....	.....	.....	.....	.....
33522	C	CABG, artery-vein, five .....	.....	.....	.....	.....	.....
33523	C	CABG, artery-vein, six+ .....	.....	.....	.....	.....	.....
33530	C	Coronary artery, bypass/reop .....	.....	.....	.....	.....	.....
33533	C	CABG, arterial, single .....	.....	.....	.....	.....	.....
33534	C	CABG, arterial, two .....	.....	.....	.....	.....	.....
33535	C	CABG, arterial, three .....	.....	.....	.....	.....	.....
33536	C	CABG, arterial, four+ .....	.....	.....	.....	.....	.....
33542	C	Removal of heart lesion .....	.....	.....	.....	.....	.....
33545	C	Repair of heart damage .....	.....	.....	.....	.....	.....
33572	C	Open coronary endarterectomy .....	.....	.....	.....	.....	.....
33600	C	Closure of valve .....	.....	.....	.....	.....	.....
33602	C	Closure of valve .....	.....	.....	.....	.....	.....
33606	C	Anastomosis/artery-aorta .....	.....	.....	.....	.....	.....
33608	C	Repair anomaly w/conduit .....	.....	.....	.....	.....	.....
33610	C	Repair by enlargement .....	.....	.....	.....	.....	.....
33611	C	Repair double ventricle .....	.....	.....	.....	.....	.....
33612	C	Repair double ventricle .....	.....	.....	.....	.....	.....
33615	C	Repair (simple fontan) .....	.....	.....	.....	.....	.....
33617	C	Repair by modified fontan .....	.....	.....	.....	.....	.....
33619	C	Repair single ventricle .....	.....	.....	.....	.....	.....
33641	C	Repair heart septum defect .....	.....	.....	.....	.....	.....
33645	C	Revision of heart veins .....	.....	.....	.....	.....	.....
33647	C	Repair heart septum defects .....	.....	.....	.....	.....	.....
33660	C	Repair of heart defects .....	.....	.....	.....	.....	.....
33665	C	Repair of heart defects .....	.....	.....	.....	.....	.....
33670	C	Repair of heart chambers .....	.....	.....	.....	.....	.....
33681	C	Repair heart septum defect .....	.....	.....	.....	.....	.....
33684	C	Repair heart septum defect .....	.....	.....	.....	.....	.....
33688	C	Repair heart septum defect .....	.....	.....	.....	.....	.....
33690	C	Reinforce pulmonary artery .....	.....	.....	.....	.....	.....
33692	C	Repair of heart defects .....	.....	.....	.....	.....	.....
33694	C	Repair of heart defects .....	.....	.....	.....	.....	.....
33697	C	Repair of heart defects .....	.....	.....	.....	.....	.....
33702	C	Repair of heart defects .....	.....	.....	.....	.....	.....
33710	C	Repair of heart defects .....	.....	.....	.....	.....	.....
33720	C	Repair of heart defect .....	.....	.....	.....	.....	.....
33722	C	Repair of heart defect .....	.....	.....	.....	.....	.....
33730	C	Repair heart-vein defect(s) .....	.....	.....	.....	.....	.....
33732	C	Repair heart-vein defect .....	.....	.....	.....	.....	.....
33735	C	Revision of heart chamber .....	.....	.....	.....	.....	.....
33736	C	Revision of heart chamber .....	.....	.....	.....	.....	.....
33737	C	Revision of heart chamber .....	.....	.....	.....	.....	.....
33750	C	Major vessel shunt .....	.....	.....	.....	.....	.....
33755	C	Major vessel shunt .....	.....	.....	.....	.....	.....
33762	C	Major vessel shunt .....	.....	.....	.....	.....	.....
33764	C	Major vessel shunt & graft .....	.....	.....	.....	.....	.....
33766	C	Major vessel shunt .....	.....	.....	.....	.....	.....
33767	C	Atrial septectomy/septostomy .....	.....	.....	.....	.....	.....
33770	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33771	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33774	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33775	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33776	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33777	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33778	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33779	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33780	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33781	C	Repair great vessels defect .....	.....	.....	.....	.....	.....
33786	C	Repair arterial trunk .....	.....	.....	.....	.....	.....
33788	C	Revision of pulmonary artery .....	.....	.....	.....	.....	.....
33800	C	Aortic suspension .....	.....	.....	.....	.....	.....
33802	C	Repair vessel defect .....	.....	.....	.....	.....	.....
33803	C	Repair vessel defect .....	.....	.....	.....	.....	.....
33813	C	Repair septal defect .....	.....	.....	.....	.....	.....
33814	C	Repair septal defect .....	.....	.....	.....	.....	.....
33820	C	Revise major vessel .....	.....	.....	.....	.....	.....
33822	C	Revise major vessel .....	.....	.....	.....	.....	.....
33824	C	Revise major vessel .....	.....	.....	.....	.....	.....
33840	C	Remove aorta constriction .....	.....	.....	.....	.....	.....
33845	C	Remove aorta constriction .....	.....	.....	.....	.....	.....
33851	C	Remove aorta constriction					
33852	C	Repair septal defect					
33853	C	Repair septal defect					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
33860	C	Ascending aorta graft .....	.....	.....	.....	.....	.....
33861	C	Ascending aorta graft .....	.....	.....	.....	.....	.....
33863	C	Ascending aorta graft .....	.....	.....	.....	.....	.....
33870	C	Transverse aortic arch graft .....	.....	.....	.....	.....	.....
33875	C	Thoracic aorta graft .....	.....	.....	.....	.....	.....
33877	C	Thoracoabdominal graft .....	.....	.....	.....	.....	.....
33910	C	Remove lung artery emboli .....	.....	.....	.....	.....	.....
33915	C	Remove lung artery emboli .....	.....	.....	.....	.....	.....
33916	C	Surgery of great vessel .....	.....	.....	.....	.....	.....
33917	C	Repair pulmonary artery .....	.....	.....	.....	.....	.....
33918	C	Repair pulmonary atresia .....	.....	.....	.....	.....	.....
33919	C	Repair pulmonary atresia .....	.....	.....	.....	.....	.....
33920	C	Repair pulmonary atresia .....	.....	.....	.....	.....	.....
33922	C	Transect pulmonary artery .....	.....	.....	.....	.....	.....
33924	C	Remove pulmonary shunt .....	.....	.....	.....	.....	.....
33930	C	Removal of donor heart/lung .....	.....	.....	.....	.....	.....
33935	C	Transplantation, heart/lung .....	.....	.....	.....	.....	.....
33940	C	Removal of donor heart .....	.....	.....	.....	.....	.....
33945	C	Transplantation of heart .....	.....	.....	.....	.....	.....
33960	C	External circulation assist .....	.....	.....	.....	.....	.....
33961	C	External circulation assist .....	.....	.....	.....	.....	.....
33970	C	Aortic circulation assist .....	.....	.....	.....	.....	.....
33971	C	Aortic circulation assist .....	.....	.....	.....	.....	.....
33973	C	Insert balloon device .....	.....	.....	.....	.....	.....
33974	C	Remove intra-aortic balloon .....	.....	.....	.....	.....	.....
33975	C	Implant ventricular device .....	.....	.....	.....	.....	.....
33976	C	Implant ventricular device .....	.....	.....	.....	.....	.....
33977	C	Remove ventricular device .....	.....	.....	.....	.....	.....
33978	C	Remove ventricular device .....	.....	.....	.....	.....	.....
33999	T	Cardiac surgery procedure	320	3.17	\$167.49	\$79.33	\$33.50
34001	C	Removal of artery clot .....	.....	.....	.....	.....	.....
34051	C	Removal of artery clot .....	.....	.....	.....	.....	.....
34101	C	Removal of artery clot .....	.....	.....	.....	.....	.....
34111	C	Removal of arm artery clot .....	.....	.....	.....	.....	.....
34151	C	Removal of artery clot .....	.....	.....	.....	.....	.....
34201	C	Removal of artery clot .....	.....	.....	.....	.....	.....
34203	C	Removal of leg artery clot .....	.....	.....	.....	.....	.....
34401	C	Removal of vein clot .....	.....	.....	.....	.....	.....
34421	C	Removal of vein clot .....	.....	.....	.....	.....	.....
34451	C	Removal of vein clot .....	.....	.....	.....	.....	.....
34471	C	Removal of vein clot .....	.....	.....	.....	.....	.....
34490	C	Removal of vein clot .....	.....	.....	.....	.....	.....
34501	C	Repair valve, femoral vein .....	.....	.....	.....	.....	.....
34502	C	Reconstruct, vena cava .....	.....	.....	.....	.....	.....
34510	C	Transposition of vein valve .....	.....	.....	.....	.....	.....
34520	C	Cross-over vein graft .....	.....	.....	.....	.....	.....
34530	C	Leg vein fusion .....	.....	.....	.....	.....	.....
35001	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35002	C	Repair artery rupture, neck .....	.....	.....	.....	.....	.....
35005	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35011	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35013	C	Repair artery rupture, arm .....	.....	.....	.....	.....	.....
35021	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35022	C	Repair artery rupture, chest .....	.....	.....	.....	.....	.....
35045	C	Repair defect of arm artery .....	.....	.....	.....	.....	.....
35081	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35082	C	Repair artery rupture, aorta .....	.....	.....	.....	.....	.....
35091	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35092	C	Repair artery rupture, aorta .....	.....	.....	.....	.....	.....
35102	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35103	C	Repair artery rupture, groin .....	.....	.....	.....	.....	.....
35111	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35112	C	Repair artery rupture, spleen .....	.....	.....	.....	.....	.....
35121	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35122	C	Repair artery rupture, belly .....	.....	.....	.....	.....	.....
35131	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35132	C	Repair artery rupture, groin .....	.....	.....	.....	.....	.....
35141	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35142	C	Repair artery rupture, thigh .....	.....	.....	.....	.....	.....
35151	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35152	C	Repair artery rupture, knee .....	.....	.....	.....	.....	.....
35161	C	Repair defect of artery .....	.....	.....	.....	.....	.....
35162	C	Repair artery rupture					
35180	C	Repair blood vessel lesion					
35182	C	Repair blood vessel lesion					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
35184	C	Repair blood vessel lesion					
35188	T	Repair blood vessel lesion	368	22.83	\$1,207.67	\$648.85	\$241.53
35189	C	Repair blood vessel lesion					
35190	C	Repair blood vessel lesion					
35201	C	Repair blood vessel lesion					
35206	C	Repair blood vessel lesion					
35207	T	Repair blood vessel lesion	368	22.83	\$1,207.67	\$648.85	\$241.53
35211	C	Repair blood vessel lesion					
35216	C	Repair blood vessel lesion					
35221	C	Repair blood vessel lesion					
35226	C	Repair blood vessel lesion					
35231	C	Repair blood vessel lesion					
35236	C	Repair blood vessel lesion					
35241	C	Repair blood vessel lesion					
35246	C	Repair blood vessel lesion					
35251	C	Repair blood vessel lesion					
35256	C	Repair blood vessel lesion					
35261	C	Repair blood vessel lesion					
35266	C	Repair blood vessel lesion					
35271	C	Repair blood vessel lesion					
35276	C	Repair blood vessel lesion					
35281	C	Repair blood vessel lesion					
35286	C	Repair blood vessel lesion					
35301	C	Rechanneling of artery					
35311	C	Rechanneling of artery					
35321	C	Rechanneling of artery					
35331	C	Rechanneling of artery					
35341	C	Rechanneling of artery					
35351	C	Rechanneling of artery					
35355	C	Rechanneling of artery					
35361	C	Rechanneling of artery					
35363	C	Rechanneling of artery					
35371	C	Rechanneling of artery					
35372	C	Rechanneling of artery					
35381	C	Rechanneling of artery					
35390	C	Reoperation, carotid					
35400	C	Angioscopy					
35450	C	Repair arterial blockage					
35452	C	Repair arterial blockage					
35454	C	Repair arterial blockage					
35456	C	Repair arterial blockage					
35458	C	Repair arterial blockage					
35459	C	Repair arterial blockage					
35460	C	Repair venous blockage					
35470	C	Repair arterial blockage					
35471	C	Repair arterial blockage					
35472	C	Repair arterial blockage					
35473	C	Repair arterial blockage					
35474	C	Repair arterial blockage					
35475	C	Repair arterial blockage					
35476	C	Repair venous blockage					
35480	C	Atherectomy, open					
35481	C	Atherectomy, open					
35482	C	Atherectomy, open					
35483	C	Atherectomy, open					
35484	C	Atherectomy, open					
35485	C	Atherectomy, open					
35490	C	Atherectomy, percutaneous					
35491	C	Atherectomy, percutaneous					
35492	C	Atherectomy, percutaneous					
35493	C	Atherectomy, percutaneous					
35494	C	Atherectomy, percutaneous					
35495	C	Atherectomy, percutaneous					
35501	C	Artery bypass graft					
35506	C	Artery bypass graft					
35507	C	Artery bypass graft					
35508	C	Artery bypass graft					
35509	C	Artery bypass graft					
35511	C	Artery bypass graft					
35515	C	Artery bypass graft					
35516	C	Artery bypass graft					
35518	C	Artery bypass graft					
35521	C	Artery bypass graft					
35526	C	Artery bypass graft					
35531	C	Artery bypass graft					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
35533	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35536	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35541	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35546	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35548	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35549	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35551	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35556	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35558	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35560	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35563	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35565	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35566	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35571	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35582	C	Vein bypass graft .....	.....	.....	.....	.....	.....
35583	C	Vein bypass graft .....	.....	.....	.....	.....	.....
35585	C	Vein bypass graft .....	.....	.....	.....	.....	.....
35587	C	Vein bypass graft .....	.....	.....	.....	.....	.....
35601	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35606	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35612	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35616	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35621	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35623	C	Bypass graft, not vein .....	.....	.....	.....	.....	.....
35626	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35631	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35636	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35641	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35642	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35645	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35646	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35650	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35651	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35654	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35656	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35661	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35663	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35665	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35666	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35671	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35681	C	Artery bypass graft .....	.....	.....	.....	.....	.....
35691	C	Arterial transposition .....	.....	.....	.....	.....	.....
35693	C	Arterial transposition .....	.....	.....	.....	.....	.....
35694	C	Arterial transposition .....	.....	.....	.....	.....	.....
35695	C	Arterial transposition .....	.....	.....	.....	.....	.....
35700	C	Reoperation, bypass graft .....	.....	.....	.....	.....	.....
35701	C	Exploration, carotid artery .....	.....	.....	.....	.....	.....
35721	C	Exploration, femoral artery .....	.....	.....	.....	.....	.....
35741	C	Exploration popliteal artery .....	.....	.....	.....	.....	.....
35761	C	Exploration of artery/vein .....	.....	.....	.....	.....	.....
35800	C	Explore neck vessels .....	.....	.....	.....	.....	.....
35820	C	Explore chest vessels .....	.....	.....	.....	.....	.....
35840	C	Explore abdominal vessels .....	.....	.....	.....	.....	.....
35860	C	Explore limb vessels .....	.....	.....	.....	.....	.....
35870	C	Repair vessel graft defect .....	.....	.....	.....	.....	.....
35875	T	Removal of clot in graft	368	22.83	\$1,207.67	\$648.85	\$241.53
35876	T	Removal of clot in graft	368	22.83	\$1,207.67	\$648.85	\$241.53
35901	C	Excision, graft, neck .....	.....	.....	.....	.....	.....
35903	C	Excision, graft, extremity .....	.....	.....	.....	.....	.....
35905	C	Excision, graft, thorax .....	.....	.....	.....	.....	.....
35907	C	Excision, graft, abdomen .....	.....	.....	.....	.....	.....
36000	N	Place needle in vein .....	.....	.....	.....	.....	.....
36005	T	Injection, venography	347	2.93	\$154.75	\$62.15	\$30.95
36010	T	Place catheter in vein	342	3.20	\$169.45	\$80.23	\$33.89
36011	T	Place catheter in vein	342	3.20	\$169.45	\$80.23	\$33.89
36012	T	Place catheter in vein	342	3.20	\$169.45	\$80.23	\$33.89
36013	T	Place catheter in artery	342	3.20	\$169.45	\$80.23	\$33.89
36014	T	Place catheter in artery	342	3.20	\$169.45	\$80.23	\$33.89
36015	T	Place catheter in artery	342	3.20	\$169.45	\$80.23	\$33.89
36100	T	Establish access to artery	342	3.20	\$169.45	\$80.23	\$33.89
36120	T	Establish access to artery	342	3.20	\$169.45	\$80.23	\$33.89
36140	T	Establish access to artery	342	3.20	\$169.45	\$80.23	\$33.89
36145	N	Artery to vein shunt .....	.....	.....	.....	.....	.....
36160	T	Establish access to aorta	342	3.20	\$169.45	\$80.23	\$33.89
36200	T	Place catheter in aorta	342	3.20	\$169.45	\$80.23	\$33.89

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
36215	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36216	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36217	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36218	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36245	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36246	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36247	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36248	T	Place catheter in artery	343	9.52	\$503.44	\$224.87	\$100.69
36260	T	Insertion of infusion pump	368	22.83	\$1,207.67	\$648.85	\$241.53
36261	T	Revision of infusion pump	360	6.09	\$322.24	\$140.12	\$64.45
36262	T	Removal of infusion pump	360	6.09	\$322.24	\$140.12	\$64.45
36299	T	Vessel injection procedure	360	6.09	\$322.24	\$140.12	\$64.45
36400	N	Drawing blood .....	.....	.....	.....	.....	.....
36405	N	Drawing blood .....	.....	.....	.....	.....	.....
36406	N	Drawing blood .....	.....	.....	.....	.....	.....
36410	T	Drawing blood	341	0.13	\$6.86	\$2.94	\$1.37
36415	E	Drawing blood .....	.....	.....	.....	.....	.....
36420	T	Establish access to vein	341	0.13	\$6.86	\$2.94	\$1.37
36425	T	Establish access to vein	341	0.13	\$6.86	\$2.94	\$1.37
36430	T	Blood transfusion service	369	4.33	\$229.19	\$97.18	\$45.84
36440	T	Blood transfusion service	369	4.33	\$229.19	\$97.18	\$45.84
36450	T	Exchange transfusion service	369	4.33	\$229.19	\$97.18	\$45.84
36455	T	Exchange transfusion service	369	4.33	\$229.19	\$97.18	\$45.84
36460	T	Transfusion service, fetal	369	4.33	\$229.19	\$97.18	\$45.84
36468	T	Injection(s); spider veins	339	1.02	\$53.87	\$19.66	\$10.77
36469	T	Injection(s); spider veins	339	1.02	\$53.87	\$19.66	\$10.77
36470	T	Injection therapy of vein	339	1.02	\$53.87	\$19.66	\$10.77
36471	T	Injection therapy of veins	339	1.02	\$53.87	\$19.66	\$10.77
36481	T	Insertion of catheter, vein	343	9.52	\$503.44	\$224.87	\$100.69
36488	S	Insertion of catheter, vein	346	4.83	\$255.64	\$120.23	\$51.13
36489	S	Insertion of catheter, vein	346	4.83	\$255.64	\$120.23	\$51.13
36490	S	Insertion of catheter, vein	346	4.83	\$255.64	\$120.23	\$51.13
36491	S	Insertion of catheter, vein	346	4.83	\$255.64	\$120.23	\$51.13
36493	S	Repositioning of cvc	346	4.83	\$255.64	\$120.23	\$51.13
36500	T	Insertion of catheter, vein	342	3.20	\$169.45	\$80.23	\$33.89
36510	C	Insertion of catheter, vein .....	.....	.....	.....	.....	.....
36520	T	Plasma and/or cell exchange	369	4.33	\$229.19	\$97.18	\$45.84
36522	T	Photopheresis	369	4.33	\$229.19	\$97.18	\$45.84
36530	T	Insertion of infusion pump	368	22.83	\$1,207.67	\$648.85	\$241.53
36531	T	Revision of infusion pump	360	6.09	\$322.24	\$140.12	\$64.45
36532	T	Removal of infusion pump	360	6.09	\$322.24	\$140.12	\$64.45
36533	T	Insertion of access port	368	22.83	\$1,207.67	\$648.85	\$241.53
36534	T	Revision of access port	360	6.09	\$322.24	\$140.12	\$64.45
36535	T	Removal of access port	360	6.09	\$322.24	\$140.12	\$64.45
36600	N	Withdrawal of arterial blood .....	.....	.....	.....	.....	.....
36620	T	Insertion catheter, artery	342	3.20	\$169.45	\$80.23	\$33.89
36625	T	Insertion catheter, artery	342	3.20	\$169.45	\$80.23	\$33.89
36640	S	Insertion catheter, artery	346	4.83	\$255.64	\$120.23	\$51.13
36660	C	Insertion catheter, artery .....	.....	.....	.....	.....	.....
36680	X	Insert needle, bone cavity	906	1.46	\$77.38	\$42.49	\$15.48
36800	T	Insertion of cannula	368	22.83	\$1,207.67	\$648.85	\$241.53
36810	T	Insertion of cannula	368	22.83	\$1,207.67	\$648.85	\$241.53
36815	T	Insertion of cannula	368	22.83	\$1,207.67	\$648.85	\$241.53
36821	T	Artery-vein fusion	368	22.83	\$1,207.67	\$648.85	\$241.53
36822	C	Insertion of cannula(s) .....	.....	.....	.....	.....	.....
36825	T	Artery-vein graft	368	22.83	\$1,207.67	\$648.85	\$241.53
36830	T	Artery-vein graft	368	22.83	\$1,207.67	\$648.85	\$241.53
36832	T	Revise artery-vein fistula	368	22.83	\$1,207.67	\$648.85	\$241.53
36834	C	Repair A-V aneurysm .....	.....	.....	.....	.....	.....
36835	T	Artery to vein shunt	368	22.83	\$1,207.67	\$648.85	\$241.53
36860	T	Cannula declotting	368	22.83	\$1,207.67	\$648.85	\$241.53
36861	T	Cannula declotting	368	22.83	\$1,207.67	\$648.85	\$241.53
37140	C	Revision of circulation .....	.....	.....	.....	.....	.....
37145	C	Revision of circulation .....	.....	.....	.....	.....	.....
37160	C	Revision of circulation .....	.....	.....	.....	.....	.....
37180	C	Revision of circulation .....	.....	.....	.....	.....	.....
37181	C	Splice spleen/kidney veins .....	.....	.....	.....	.....	.....
37195	C	Thrombolytic therapy, stroke .....	.....	.....	.....	.....	.....
37200	C	Transcatheter biopsy .....	.....	.....	.....	.....	.....
37201	C	Transcatheter therapy infuse .....	.....	.....	.....	.....	.....
37202	C	Transcatheter therapy infuse .....	.....	.....	.....	.....	.....
37203	T	Transcatheter retrieval	360	6.09	\$322.24	\$140.12	\$64.45
37204	C	Transcatheter occlusion					
37205	C	Transcatheter stent					
37206	C	Transcatheter stent					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
37207	C	Transcatheter stent .....	.....	.....	.....	.....	.....
37208	C	Transcatheter stent .....	.....	.....	.....	.....	.....
37209	C	Exchange arterial catheter .....	.....	.....	.....	.....	.....
37250	C	Intravascular us .....	.....	.....	.....	.....	.....
37251	C	Intravascular us .....	.....	.....	.....	.....	.....
37565	C	Ligation of neck vein .....	.....	.....	.....	.....	.....
37600	C	Ligation of neck artery .....	.....	.....	.....	.....	.....
37605	C	Ligation of neck artery .....	.....	.....	.....	.....	.....
37606	C	Ligation of neck artery .....	.....	.....	.....	.....	.....
37607	T	Ligation of fistula	368	22.83	\$1,207.67	\$648.85	\$241.53
37609	T	Temporal artery procedure	162	5.67	\$299.71	\$125.43	\$59.94
37615	C	Ligation of neck artery .....	.....	.....	.....	.....	.....
37616	C	Ligation of chest artery .....	.....	.....	.....	.....	.....
37617	C	Ligation of abdomen artery .....	.....	.....	.....	.....	.....
37618	T	Ligation of extremity artery	367	17.59	\$930.48	\$449.06	\$186.10
37620	C	Revision of major vein .....	.....	.....	.....	.....	.....
37650	T	Revision of major vein	367	17.59	\$930.48	\$449.06	\$186.10
37660	C	Revision of major vein .....	.....	.....	.....	.....	.....
37700	T	Revise leg vein	367	17.59	\$930.48	\$449.06	\$186.10
37720	T	Removal of leg vein	367	17.59	\$930.48	\$449.06	\$186.10
37730	T	Removal of leg veins	367	17.59	\$930.48	\$449.06	\$186.10
37735	T	Removal of leg veins/lesion	367	17.59	\$930.48	\$449.06	\$186.10
37760	T	Revision of leg veins	367	17.59	\$930.48	\$449.06	\$186.10
37780	T	Revision of leg vein	367	17.59	\$930.48	\$449.06	\$186.10
37785	T	Revise secondary varicosity	367	17.59	\$930.48	\$449.06	\$186.10
37788	C	Revascularization, penis .....	.....	.....	.....	.....	.....
37790	T	Penile venous occlusion	537	28.72	\$1,519.13	\$864.45	\$303.83
37799	T	Vascular surgery procedure	162	5.67	\$299.71	\$125.43	\$59.94
38100	C	Removal of spleen, total .....	.....	.....	.....	.....	.....
38101	C	Removal of spleen, partial .....	.....	.....	.....	.....	.....
38102	C	Removal of spleen, total .....	.....	.....	.....	.....	.....
38115	C	Repair of ruptured spleen .....	.....	.....	.....	.....	.....
38200	T	Injection for spleen x-ray	347	2.93	\$154.75	\$62.15	\$30.95
38230	T	Bone marrow collection	369	4.33	\$229.19	\$97.18	\$45.84
38231	T	Stem cell collection	369	4.33	\$229.19	\$97.18	\$45.84
38240	C	Bone marrow/stem transplant .....	.....	.....	.....	.....	.....
38241	C	Bone marrow/stem transplant .....	.....	.....	.....	.....	.....
38300	T	Drainage lymph node lesion	132	6.04	\$319.3	\$134.24	\$63.86
38305	T	Drainage lymph node lesion	132	6.04	\$319.3	\$134.24	\$63.86
38308	T	Incision of lymph channels	396	13.28	\$702.27	\$338.77	\$140.45
38380	C	Thoracic duct procedure .....	.....	.....	.....	.....	.....
38381	C	Thoracic duct procedure .....	.....	.....	.....	.....	.....
38382	C	Thoracic duct procedure .....	.....	.....	.....	.....	.....
38500	T	Biopsy/removal, lymph node(s)	396	13.28	\$702.27	\$338.77	\$140.45
38505	T	Needle biopsy, lymph node(s)	122	4.87	\$257.6	\$115.03	\$51.52
38510	T	Biopsy/removal, lymph node(s)	396	13.28	\$702.27	\$338.77	\$140.45
38520	T	Biopsy/removal, lymph node(s)	396	13.28	\$702.27	\$338.77	\$140.45
38525	T	Biopsy/removal, lymph node(s)	396	13.28	\$702.27	\$338.77	\$140.45
38530	T	Biopsy/removal, lymph node(s)	396	13.28	\$702.27	\$338.77	\$140.45
38542	T	Explore deep node(s), neck	397	18.37	\$971.62	\$496.97	\$194.32
38550	T	Removal neck/armpit lesion	396	13.28	\$702.27	\$338.77	\$140.45
38555	T	Removal neck/armpit lesion	397	18.37	\$971.62	\$496.97	\$194.32
38562	C	Removal, pelvic lymph nodes .....	.....	.....	.....	.....	.....
38564	C	Removal, abdomen lymph nodes .....	.....	.....	.....	.....	.....
38700	C	Removal of lymph nodes, neck .....	.....	.....	.....	.....	.....
38720	C	Removal of lymph nodes, neck .....	.....	.....	.....	.....	.....
38724	C	Removal of lymph nodes, neck .....	.....	.....	.....	.....	.....
38740	T	Remove armpit lymph nodes	397	18.37	\$971.62	\$496.97	\$194.32
38745	T	Remove armpits lymph nodes	397	18.37	\$971.62	\$496.97	\$194.32
38746	C	Remove thoracic lymph nodes .....	.....	.....	.....	.....	.....
38747	C	Remove abdominal lymph nodes .....	.....	.....	.....	.....	.....
38760	T	Remove groin lymph nodes	397	18.37	\$971.62	\$496.97	\$194.32
38765	C	Remove groin lymph nodes .....	.....	.....	.....	.....	.....
38770	C	Remove pelvis lymph nodes .....	.....	.....	.....	.....	.....
38780	C	Remove abdomen lymph nodes .....	.....	.....	.....	.....	.....
38790	T	Injection for lymphatic xray	347	2.93	\$154.75	\$62.15	\$30.95
38794	T	Access thoracic lymph duct	342	3.20	\$169.45	\$80.23	\$33.89
38999	T	Blood/lymph system procedure	132	6.04	\$319.30	\$134.24	\$63.86
39000	C	Exploration of chest .....	.....	.....	.....	.....	.....
39010	C	Exploration of chest .....	.....	.....	.....	.....	.....
39200	C	Removal chest lesion .....	.....	.....	.....	.....	.....
39220	C	Removal chest lesion .....	.....	.....	.....	.....	.....
39400	C	Visualization of chest					
39499	C	Chest procedure					
39501	C	Repair diaphragm laceration					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
39502	C	Repair paraesophageal hernia .....	.....	.....	.....	.....	.....
39503	C	Repair of diaphragm hernia .....	.....	.....	.....	.....	.....
39520	C	Repair of diaphragm hernia .....	.....	.....	.....	.....	.....
39530	C	Repair of diaphragm hernia .....	.....	.....	.....	.....	.....
39531	C	Repair of diaphragm hernia .....	.....	.....	.....	.....	.....
39540	C	Repair of diaphragm hernia .....	.....	.....	.....	.....	.....
39541	C	Repair of diaphragm hernia .....	.....	.....	.....	.....	.....
39545	C	Revision of diaphragm .....	.....	.....	.....	.....	.....
39599	C	Diaphragm surgery procedure .....	.....	.....	.....	.....	.....
40490	T	Biopsy of lip	311	1.43	\$75.42	\$20.57	\$15.08
40500	T	Partial excision of lip	313	15.81	\$836.45	\$411.09	\$167.29
40510	T	Partial excision of lip	313	15.81	\$836.45	\$411.09	\$167.29
40520	T	Partial excision of lip	313	15.81	\$836.45	\$411.09	\$167.29
40525	T	Reconstruct lip with flap	313	15.81	\$836.45	\$411.09	\$167.29
40527	T	Reconstruct lip with flap	313	15.81	\$836.45	\$411.09	\$167.29
40530	T	Partial removal of lip	313	15.81	\$836.45	\$411.09	\$167.29
40650	T	Repair lip	313	15.81	\$836.45	\$411.09	\$167.29
40652	T	Repair lip	313	15.81	\$836.45	\$411.09	\$167.29
40654	T	Repair lip	313	15.81	\$836.45	\$411.09	\$167.29
40700	T	Repair cleft lip/nasal	314	25.65	\$1,356.54	\$693.37	\$271.31
40701	T	Repair cleft lip/nasal	314	25.65	\$1,356.54	\$693.37	\$271.31
40702	T	Repair cleft lip/nasal	314	25.65	\$1,356.54	\$693.37	\$271.31
40720	T	Repair cleft lip/nasal	314	25.65	\$1,356.54	\$693.37	\$271.31
40761	T	Repair cleft lip/nasal	314	25.65	\$1,356.54	\$693.37	\$271.31
40799	T	Lip surgery procedure	311	1.43	\$75.42	\$20.57	\$15.08
40800	T	Drainage of mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
40801	T	Drainage of mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
40804	T	Removal foreign body, mouth	311	1.43	\$75.42	\$20.57	\$15.08
40805	T	Removal foreign body, mouth	311	1.43	\$75.42	\$20.57	\$15.08
40806	T	Incision of lip fold	311	1.43	\$75.42	\$20.57	\$15.08
40808	T	Biopsy of mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
40810	T	Excision of mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
40812	T	Excise/repair mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
40814	T	Excise/repair mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
40816	T	Excision of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
40818	T	Excise oral mucosa for graft	313	15.81	\$836.45	\$411.09	\$167.29
40819	T	Excise lip or cheek fold	313	15.81	\$836.45	\$411.09	\$167.29
40820	T	Treatment of mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
40830	T	Repair mouth laceration	312	7.26	\$383.95	\$178.31	\$76.79
40831	T	Repair mouth laceration	312	7.26	\$383.95	\$178.31	\$76.79
40840	T	Reconstruction of mouth	313	15.81	\$836.45	\$411.09	\$167.29
40842	T	Reconstruction of mouth	313	15.81	\$836.45	\$411.09	\$167.29
40843	T	Reconstruction of mouth	314	25.65	\$1,356.54	\$693.37	\$271.31
40844	T	Reconstruction of mouth	314	25.65	\$1,356.54	\$693.37	\$271.31
40845	T	Reconstruction of mouth	314	25.65	\$1,356.54	\$693.37	\$271.31
40899	T	Mouth surgery procedure	311	1.43	\$75.42	\$20.57	\$15.08
41000	T	Drainage of mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
41005	T	Drainage of mouth lesion	311	1.43	\$75.42	\$20.57	\$15.08
41006	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41007	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41008	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41009	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41010	T	Incision of tongue fold	313	15.81	\$836.45	\$411.09	\$167.29
41015	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41016	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41017	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41018	T	Drainage of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41100	T	Biopsy of tongue	311	1.43	\$75.42	\$20.57	\$15.08
41105	T	Biopsy of tongue	311	1.43	\$75.42	\$20.57	\$15.08
41108	T	Biopsy of floor of mouth	311	1.43	\$75.42	\$20.57	\$15.08
41110	T	Excision of tongue lesion	311	1.43	\$75.42	\$20.57	\$15.08
41112	T	Excision of tongue lesion	313	15.81	\$836.45	\$411.09	\$167.29
41113	T	Excision of tongue lesion	313	15.81	\$836.45	\$411.09	\$167.29
41114	T	Excision of tongue lesion	313	15.81	\$836.45	\$411.09	\$167.29
41115	T	Excision of tongue fold	311	1.43	\$75.42	\$20.57	\$15.08
41116	T	Excision of mouth lesion	313	15.81	\$836.45	\$411.09	\$167.29
41120	T	Partial removal of tongue	313	15.81	\$836.45	\$411.09	\$167.29
41130	C	Partial removal of tongue .....	.....	.....	.....	.....	.....
41135	C	Tongue and neck surgery .....	.....	.....	.....	.....	.....
41140	C	Removal of tongue .....	.....	.....	.....	.....	.....
41145	C	Tongue removal; neck surgery .....	.....	.....	.....	.....	.....
41150	C	Tongue, mouth, jaw surgery .....	.....	.....	.....	.....	.....
41153	C	Tongue, mouth, neck surgery .....	.....	.....	.....	.....	.....
41155	C	Tongue, jaw, & neck surgery					
41250	T	Repair tongue laceration	312	7.26	\$383.95	\$178.31	\$76.79

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
41251	T	Repair tongue laceration	312	7.26	\$383.95	\$178.31	\$76.79
41252	T	Repair tongue laceration	312	7.26	\$383.95	\$178.31	\$76.79
41500	T	Fixation of tongue	312	7.26	\$383.95	\$178.31	\$76.79
41510	T	Tongue to lip surgery	312	7.26	\$383.95	\$178.31	\$76.79
41520	T	Reconstruction, tongue fold	313	15.81	\$836.45	\$411.09	\$167.29
41599	T	Tongue and mouth surgery	311	1.43	\$75.42	\$20.57	\$15.08
41800	T	Drainage of gum lesion	312	7.26	\$383.95	\$178.31	\$76.79
41805	T	Removal foreign body, gum	311	1.43	\$75.42	\$20.57	\$15.08
41806	T	Removal foreign body, jawbone	311	1.43	\$75.42	\$20.57	\$15.08
41820	T	Excision, gum, each quadrant	311	1.43	\$75.42	\$20.57	\$15.08
41821	T	Excision of gum flap	311	1.43	\$75.42	\$20.57	\$15.08
41822	T	Excision of gum lesion	231	12.02	\$635.66	\$299.9	\$127.13
41823	T	Excision of gum lesion	231	12.02	\$635.66	\$299.9	\$127.13
41825	T	Excision of gum lesion	311	1.43	\$75.42	\$20.57	\$15.08
41826	T	Excision of gum lesion	311	1.43	\$75.42	\$20.57	\$15.08
41827	T	Excision of gum lesion	313	15.81	\$836.45	\$411.09	\$167.29
41828	T	Excision of gum lesion	311	1.43	\$75.42	\$20.57	\$15.08
41830	T	Removal of gum tissue	311	1.43	\$75.42	\$20.57	\$15.08
41850	T	Treatment of gum lesion	311	1.43	\$75.42	\$20.57	\$15.08
41870	T	Gum graft	311	1.43	\$75.42	\$20.57	\$15.08
41872	T	Repair gum	311	1.43	\$75.42	\$20.57	\$15.08
41874	T	Repair tooth socket	311	1.43	\$75.42	\$20.57	\$15.08
41899	T	Dental surgery procedure	311	1.43	\$75.42	\$20.57	\$15.08
42000	T	Drainage mouth roof lesion	311	1.43	\$75.42	\$20.57	\$15.08
42100	T	Biopsy roof of mouth	311	1.43	\$75.42	\$20.57	\$15.08
42104	T	Excision lesion, mouth roof	311	1.43	\$75.42	\$20.57	\$15.08
42106	T	Excision lesion, mouth roof	311	1.43	\$75.42	\$20.57	\$15.08
42107	T	Excision lesion, mouth roof	313	15.81	\$836.45	\$411.09	\$167.29
42120	T	Remove palate/lesion	313	15.81	\$836.45	\$411.09	\$167.29
42140	T	Excision of uvula	311	1.43	\$75.42	\$20.57	\$15.08
42145	C	Repair, palate,pharynx/uvula					
42160	T	Treatment mouth roof lesion	311	1.43	\$75.42	\$20.57	\$15.08
42180	T	Repair palate	313	15.81	\$836.45	\$411.09	\$167.29
42182	T	Repair palate	313	15.81	\$836.45	\$411.09	\$167.29
42200	T	Reconstruct cleft palate	313	15.81	\$836.45	\$411.09	\$167.29
42205	T	Reconstruct cleft palate	313	15.81	\$836.45	\$411.09	\$167.29
42210	T	Reconstruct cleft palate	314	25.65	\$1,356.54	\$693.37	\$271.31
42215	T	Reconstruct cleft palate	313	15.81	\$836.45	\$411.09	\$167.29
42220	T	Reconstruct cleft palate	313	15.81	\$836.45	\$411.09	\$167.29
42225	T	Reconstruct cleft palate	314	25.65	\$1,356.54	\$693.37	\$271.31
42226	T	Lengthening of palate	314	25.65	\$1,356.54	\$693.37	\$271.31
42227	T	Lengthening of palate	314	25.65	\$1,356.54	\$693.37	\$271.31
42235	T	Repair palate	313	15.81	\$836.45	\$411.09	\$167.29
42260	T	Repair nose to lip fistula	313	15.81	\$836.45	\$411.09	\$167.29
42280	T	Preparation, palate mold	311	1.43	\$75.42	\$20.57	\$15.08
42281	T	Insertion, palate prosthesis	311	1.43	\$75.42	\$20.57	\$15.08
42299	T	Palate/uvula surgery	311	1.43	\$75.42	\$20.57	\$15.08
42300	T	Drainage of salivary gland	312	7.26	\$383.95	\$178.31	\$76.79
42305	T	Drainage of salivary gland	312	7.26	\$383.95	\$178.31	\$76.79
42310	T	Drainage of salivary gland	312	7.26	\$383.95	\$178.31	\$76.79
42320	T	Drainage of salivary gland	312	7.26	\$383.95	\$178.31	\$76.79
42325	T	Create salivary cyst drain	313	15.81	\$836.45	\$411.09	\$167.29
42326	T	Create salivary cyst drain	313	15.81	\$836.45	\$411.09	\$167.29
42330	T	Removal of salivary stone	311	1.43	\$75.42	\$20.57	\$15.08
42335	T	Removal of salivary stone	311	1.43	\$75.42	\$20.57	\$15.08
42340	T	Removal of salivary stone	313	15.81	\$836.45	\$411.09	\$167.29
42400	T	Biopsy of salivary gland	122	4.87	\$257.6	\$115.03	\$51.52
42405	T	Biopsy of salivary gland	312	7.26	\$383.95	\$178.31	\$76.79
42408	T	Excision of salivary cyst	313	15.81	\$836.45	\$411.09	\$167.29
42409	T	Drainage of salivary cyst	313	15.81	\$836.45	\$411.09	\$167.29
42410	T	Excise parotid gland/lesion	313	15.81	\$836.45	\$411.09	\$167.29
42415	T	Excise parotid gland/lesion	314	25.65	\$1,356.54	\$693.37	\$271.31
42420	T	Excise parotid gland/lesion	314	25.65	\$1,356.54	\$693.37	\$271.31
42425	T	Excise parotid gland/lesion	314	25.65	\$1,356.54	\$693.37	\$271.31
42426	C	Excise parotid gland/lesion					
42440	T	Excision submaxillary gland	313	15.81	\$836.45	\$411.09	\$167.29
42450	T	Excision sublingual gland	313	15.81	\$836.45	\$411.09	\$167.29
42500	T	Repair salivary duct	313	15.81	\$836.45	\$411.09	\$167.29
42505	T	Repair salivary duct	313	15.81	\$836.45	\$411.09	\$167.29
42507	T	Parotid duct diversion	313	15.81	\$836.45	\$411.09	\$167.29
42508	T	Parotid duct diversion	313	15.81	\$836.45	\$411.09	\$167.29
42509	T	Parotid duct diversion	314	25.65	\$1,356.54	\$693.37	\$271.31
42510	T	Parotid duct diversion	313	15.81	\$836.45	\$411.09	\$167.29
42550	T	Injection for salivary x-ray	347	2.93	\$154.75	\$62.15	\$30.95
42600	T	Closure of salivary fistula	313	15.81	\$836.45	\$411.09	\$167.29

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
42650	T	Dilation of salivary duct	311	1.43	\$75.42	\$20.57	\$15.08
42660	T	Dilation of salivary duct	311	1.43	\$75.42	\$20.57	\$15.08
42665	T	Ligation of salivary duct	311	1.43	\$75.42	\$20.57	\$15.08
42699	T	Salivary surgery procedure	311	1.43	\$75.42	\$20.57	\$15.08
42700	T	Drainage of tonsil abscess	312	7.26	\$383.95	\$178.31	\$76.79
42720	T	Drainage of throat abscess	312	7.26	\$383.95	\$178.31	\$76.79
42725	T	Drainage of throat abscess	313	15.81	\$836.45	\$411.09	\$167.29
42800	T	Biopsy of throat	312	7.26	\$383.95	\$178.31	\$76.79
42802	T	Biopsy of throat	312	7.26	\$383.95	\$178.31	\$76.79
42804	T	Biopsy of upper nose/throat	312	7.26	\$383.95	\$178.31	\$76.79
42806	T	Biopsy of upper nose/throat	312	7.26	\$383.95	\$178.31	\$76.79
42808	T	Excise pharynx lesion	312	7.26	\$383.95	\$178.31	\$76.79
42809	T	Remove pharynx foreign body	151	1.74	\$92.07	\$35.71	\$18.41
42810	T	Excision of neck cyst	313	15.81	\$836.45	\$411.09	\$167.29
42815	T	Excision of neck cyst	313	15.81	\$836.45	\$411.09	\$167.29
42820	T	Remove tonsils and adenoids	319	17.30	\$914.81	\$480.02	\$182.96
42821	T	Remove tonsils and adenoids	319	17.30	\$914.81	\$480.02	\$182.96
42825	T	Removal of tonsils	319	17.30	\$914.81	\$480.02	\$182.96
42826	T	Removal of tonsils	319	17.30	\$914.81	\$480.02	\$182.96
42830	T	Removal of adenoids	319	17.30	\$914.81	\$480.02	\$182.96
42831	T	Removal of adenoids	319	17.30	\$914.81	\$480.02	\$182.96
42835	T	Removal of adenoids	319	17.30	\$914.81	\$480.02	\$182.96
42836	T	Removal of adenoids	319	17.30	\$914.81	\$480.02	\$182.96
42842	T	Extensive surgery of throat	314	25.65	\$1,356.54	\$693.37	\$271.31
42844	T	Extensive surgery of throat	314	25.65	\$1,356.54	\$693.37	\$271.31
42845	C	Extensive surgery of throat					
42860	T	Excision of tonsil tags	319	17.30	\$914.81	\$480.02	\$182.96
42870	T	Excision of lingual tonsil	319	17.30	\$914.81	\$480.02	\$182.96
42890	T	Partial removal of pharynx	314	25.65	\$1,356.54	\$693.37	\$271.31
42892	T	Revision of pharyngeal walls	314	25.65	\$1,356.54	\$693.37	\$271.31
42894	C	Revision of pharyngeal walls					
42900	T	Repair throat wound	313	15.81	\$836.45	\$411.09	\$167.29
42950	T	Reconstruction of throat	313	15.81	\$836.45	\$411.09	\$167.29
42953	C	Repair throat, esophagus					
42955	T	Surgical opening of throat	313	15.81	\$836.45	\$411.09	\$167.29
42960	T	Control throat bleeding	318	2.07	\$109.7	\$38.65	\$21.94
42961	C	Control throat bleeding					
42962	T	Control throat bleeding	313	15.81	\$836.45	\$411.09	\$167.29
42970	T	Control nose/throat bleeding	318	2.07	\$109.7	\$38.65	\$21.94
42971	C	Control nose/throat bleeding					
42972	T	Control nose/throat bleeding	313	15.81	\$836.45	\$411.09	\$167.29
42999	T	Throat surgery procedure	318	2.07	\$109.7	\$38.65	\$21.94
43020	T	Incision of esophagus	313	15.81	\$836.45	\$411.09	\$167.29
43030	T	Throat muscle surgery	313	15.81	\$836.45	\$411.09	\$167.29
43045	C	Incision of esophagus					
43100	C	Excision of esophagus lesion					
43101	C	Excision of esophagus lesion					
43107	C	Removal of esophagus					
43108	C	Removal of esophagus					
43112	C	Removal of esophagus					
43113	C	Removal of esophagus					
43116	C	Partial removal of esophagus					
43117	C	Partial removal of esophagus					
43118	C	Partial removal of esophagus					
43121	C	Partial removal of esophagus					
43122	C	Partial removal of esophagus					
43123	C	Partial removal of esophagus					
43124	C	Removal of esophagus					
43130	C	Removal of esophagus pouch					
43135	C	Removal of esophagus pouch					
43200	T	Esophagus endoscopy	417	6.44	\$340.85	\$181.70	\$68.17
43202	T	Esophagus endoscopy, biopsy	417	6.44	\$340.85	\$181.70	\$68.17
43204	T	Esophagus endoscopy & inject	407	7.06	\$373.17	\$189.84	\$74.63
43205	T	Esophagus endoscopy/ligation	407	7.06	\$373.17	\$189.84	\$74.63
43215	T	Esophagus endoscopy	407	7.06	\$373.17	\$189.84	\$74.63
43216	T	Esophagus endoscopy/lesion	407	7.06	\$373.17	\$189.84	\$74.63
43217	T	Esophagus endoscopy	407	7.06	\$373.17	\$189.84	\$74.63
43219	T	Esophagus endoscopy	449	7.80	\$412.35	\$215.38	\$82.47
43220	T	Esophagus endoscopy,dilation	407	7.06	\$373.17	\$189.84	\$74.63
43226	T	Esophagus endoscopy,dilation	407	7.06	\$373.17	\$189.84	\$74.63
43227	T	Esophagus endoscopy, repair	407	7.06	\$373.17	\$189.84	\$74.63
43228	T	Esophagus endoscopy,ablation	449	7.80	\$412.35	\$215.38	\$82.47
43234	T	Upper GI endoscopy, exam	417	6.44	\$340.85	\$181.70	\$68.17
43235	T	Upper gi endoscopy,diagnosis	417	6.44	\$340.85	\$181.70	\$68.17
43239	T	Upper GI endoscopy, biopsy	417	6.44	\$340.85	\$181.70	\$68.17

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
43241	T	Upper GI endoscopy with tube	418	7.59	\$401.58	\$214.25	\$80.32
43243	T	Upper GI endoscopy & inject.	418	7.59	\$401.58	\$214.25	\$80.32
43244	T	Upper GI endoscopy/ligation	418	7.59	\$401.58	\$214.25	\$80.32
43245	T	Operative upper GI endoscopy	418	7.59	\$401.58	\$214.25	\$80.32
43246	T	Place gastrostomy tube	418	7.59	\$401.58	\$214.25	\$80.32
43247	T	Operative upper GI endoscopy	418	7.59	\$401.58	\$214.25	\$80.32
43248	T	Upper GI endoscopy/guidewire	418	7.59	\$401.58	\$214.25	\$80.32
43249	T	Esophagus endoscopy,dilation	418	7.59	\$401.58	\$214.25	\$80.32
43250	T	Upper GI endoscopy/tumor	418	7.59	\$401.58	\$214.25	\$80.32
43251	T	Operative upper GI endoscopy	418	7.59	\$401.58	\$214.25	\$80.32
43255	T	Operative upper GI endoscopy	418	7.59	\$401.58	\$214.25	\$80.32
43258	T	Operative upper GI endoscopy	449	7.80	\$412.35	\$215.38	\$82.47
43259	T	Endoscopic ultrasound exam	449	7.80	\$412.35	\$215.38	\$82.47
43260	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43261	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43262	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43263	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43264	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43265	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43267	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43268	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43269	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43271	T	Endoscopy,bile duct/pancreas	456	9.78	\$517.15	\$257.19	\$103.43
43272	T	Endoscopy,bile duct/pancreas	449	7.80	\$412.35	\$215.38	\$82.47
43300	C	Repair of esophagus .....	.....	.....	.....	.....	.....
43305	C	Repair esophagus and fistula .....	.....	.....	.....	.....	.....
43310	C	Repair of esophagus .....	.....	.....	.....	.....	.....
43312	C	Repair esophagus and fistula .....	.....	.....	.....	.....	.....
43320	C	Fuse esophagus & stomach .....	.....	.....	.....	.....	.....
43324	C	Revise esophagus & stomach .....	.....	.....	.....	.....	.....
43325	C	Revise esophagus & stomach .....	.....	.....	.....	.....	.....
43326	C	Revise esophagus & stomach .....	.....	.....	.....	.....	.....
43330	C	Repair of esophagus .....	.....	.....	.....	.....	.....
43331	C	Repair of esophagus .....	.....	.....	.....	.....	.....
43340	C	Fuse esophagus & intestine .....	.....	.....	.....	.....	.....
43341	C	Fuse esophagus & intestine .....	.....	.....	.....	.....	.....
43350	C	Surgical opening, esophagus .....	.....	.....	.....	.....	.....
43351	C	Surgical opening, esophagus .....	.....	.....	.....	.....	.....
43352	C	Surgical opening, esophagus .....	.....	.....	.....	.....	.....
43360	C	Gastrointestinal repair .....	.....	.....	.....	.....	.....
43361	C	Gastrointestinal repair .....	.....	.....	.....	.....	.....
43400	C	Ligate esophagus veins .....	.....	.....	.....	.....	.....
43401	C	Esophagus surgery for veins .....	.....	.....	.....	.....	.....
43405	C	Ligate/staple esophagus .....	.....	.....	.....	.....	.....
43410	C	Repair esophagus wound .....	.....	.....	.....	.....	.....
43415	C	Repair esophagus wound .....	.....	.....	.....	.....	.....
43420	C	Repair esophagus opening .....	.....	.....	.....	.....	.....
43425	C	Repair esophagus opening .....	.....	.....	.....	.....	.....
43450	T	Dilate esophagus	406	4.31	\$228.21	\$108.48	\$45.64
43453	T	Dilate esophagus	406	4.31	\$228.21	\$108.48	\$45.64
43456	T	Dilate esophagus	406	4.31	\$228.21	\$108.48	\$45.64
43458	T	Dilation of esophagus	406	4.31	\$228.21	\$108.48	\$45.64
43460	C	Pressure treatment esophagus .....	.....	.....	.....	.....	.....
43496	C	Free jejunum flap, microvasc .....	.....	.....	.....	.....	.....
43499	T	Esophagus surgery procedure	406	4.31	\$228.21	\$108.48	\$45.64
43500	C	Surgical opening of stomach .....	.....	.....	.....	.....	.....
43501	C	Surgical repair of stomach .....	.....	.....	.....	.....	.....
43502	C	Surgical repair of stomach .....	.....	.....	.....	.....	.....
43510	C	Surgical opening of stomach .....	.....	.....	.....	.....	.....
43520	C	Incision of pyloric muscle .....	.....	.....	.....	.....	.....
43600	T	Biopsy of stomach	417	6.44	\$340.85	\$181.70	\$68.17
43605	C	Biopsy of stomach .....	.....	.....	.....	.....	.....
43610	C	Excision of stomach lesion .....	.....	.....	.....	.....	.....
43611	C	Excision of stomach lesion .....	.....	.....	.....	.....	.....
43620	C	Removal of stomach .....	.....	.....	.....	.....	.....
43621	C	Removal of stomach .....	.....	.....	.....	.....	.....
43622	C	Removal of stomach .....	.....	.....	.....	.....	.....
43631	C	Removal of stomach, partial .....	.....	.....	.....	.....	.....
43632	C	Removal stomach, partial .....	.....	.....	.....	.....	.....
43633	C	Removal stomach, partial .....	.....	.....	.....	.....	.....
43634	C	Removal stomach, partial .....	.....	.....	.....	.....	.....
43635	C	Partial removal of stomach .....	.....	.....	.....	.....	.....
43638	C	Partial removal of stomach					
43639	C	Removal stomach, partial					
43640	C	Vagotomy & pylorus repair					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
43641	C	Vagotomy & pylorus repair					
43750	T	Place gastrostomy tube	418	7.59	\$401.58	\$214.25	\$80.32
43760	T	Change gastrostomy tube	470	2.22	\$117.53	\$54.92	\$23.51
43761	T	Reposition gastrostomy tube	470	2.22	\$117.53	\$54.92	\$23.51
43800	C	Reconstruction of pylorus					
43810	C	Fusion of stomach and bowel					
43820	C	Fusion of stomach and bowel					
43825	C	Fusion of stomach and bowel					
43830	C	Place gastrostomy tube					
43831	C	Place gastrostomy tube					
43832	C	Place gastrostomy tube					
43840	C	Repair of stomach lesion					
43842	C	Gastroplasty for obesity					
43843	C	Gastroplasty for obesity					
43846	C	Gastric bypass for obesity					
43847	C	Gastric bypass for obesity					
43848	C	Revision gastroplasty					
43850	C	Revise stomach-bowel fusion					
43855	C	Revise stomach-bowel fusion					
43860	C	Revise stomach-bowel fusion					
43865	C	Revise stomach-bowel fusion					
43870	T	Repair stomach opening	182	4.00	\$211.56	\$84.98	\$42.31
43880	C	Repair stomach-bowel fistula					
43999	T	Stomach surgery procedure	470	2.22	\$117.53	\$54.92	\$23.51
44005	C	Freeing of bowel adhesion					
44010	C	Incision of small bowel					
44015	C	Insert needle catheter, bowel					
44020	C	Exploration of small bowel					
44021	C	Decompress small bowel					
44025	C	Incision of large bowel					
44050	C	Reduce bowel obstruction					
44055	C	Correct malrotation of bowel					
44100	T	Biopsy of bowel	417	6.44	\$340.85	\$181.70	\$68.17
44110	C	Excision of bowel lesion(s)					
44111	C	Excision of bowel lesion(s)					
44120	C	Removal of small intestine					
44121	C	Removal of small intestine					
44125	C	Removal of small intestine					
44130	C	Bowel to bowel fusion					
44139	C	Mobilization of colon					
44140	C	Partial removal of colon					
44141	C	Partial removal of colon					
44143	C	Partial removal of colon					
44144	C	Partial removal of colon					
44145	C	Partial removal of colon					
44146	C	Partial removal of colon					
44147	C	Partial removal of colon					
44150	C	Removal of colon					
44151	C	Removal of colon/ileostomy					
44152	C	Removal of colon/ileostomy					
44153	C	Removal of colon/ileostomy					
44155	C	Removal of colon					
44156	C	Removal of colon/ileostomy					
44160	C	Removal of colon					
44300	C	Open bowel to skin					
44310	C	Ileostomy/jejunostomy					
44312	T	Revision of ileostomy	183	11.17	\$590.61	\$286.57	\$118.12
44314	C	Revision of ileostomy					
44316	C	Devise bowel pouch					
44320	C	Colostomy					
44322	C	Colostomy with biopsies					
44340	T	Revision of colostomy	183	11.17	\$590.61	\$286.57	\$118.12
44345	C	Revision of colostomy					
44346	C	Revision of colostomy					
44360	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44361	T	Small bowel endoscopy, biopsy	419	7.13	\$377.09	\$164.08	\$75.42
44363	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44364	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44365	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44366	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44369	T	Small bowel endoscopy	449	7.80	\$412.35	\$215.38	\$82.47
44372	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44373	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44376	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44377	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
44378	T	Small bowel endoscopy	419	7.13	\$377.09	\$164.08	\$75.42
44380	T	Small bowel endoscopy	426	6.85	\$362.40	\$187.81	\$72.48
44382	T	Small bowel endoscopy	426	6.85	\$362.40	\$187.81	\$72.48
44385	T	Endoscopy of bowel pouch	426	6.85	\$362.40	\$187.81	\$72.48
44386	T	Endoscopy, bowel pouch, biopsy	426	6.85	\$362.40	\$187.81	\$72.48
44388	T	Colon endoscopy	426	6.85	\$362.40	\$187.81	\$72.48
44389	T	Colonoscopy with biopsy	426	6.85	\$362.40	\$187.81	\$72.48
44390	T	Colonoscopy for foreign body	427	8.22	\$434.88	\$224.19	\$86.98
44391	T	Colonoscopy for bleeding	427	8.22	\$434.88	\$224.19	\$86.98
44392	T	Colonoscopy & polypectomy	427	8.22	\$434.88	\$224.19	\$86.98
44393	T	Colonoscopy, lesion removal	449	7.80	\$412.35	\$215.38	\$82.47
44394	T	Colonoscopy w/snare	427	8.22	\$434.88	\$224.19	\$86.98
44500	C	Intro, gastrointestinal tube					
44602	C	Suture, small intestine					
44603	C	Suture, small intestine					
44604	C	Suture, large intestine					
44605	C	Repair of bowel lesion					
44615	C	Intestinal stricturoplasty					
44620	C	Repair bowel opening					
44625	C	Repair bowel opening					
44626	C	Repair bowel opening					
44640	C	Repair bowel-skin fistula					
44650	C	Repair bowel fistula					
44660	C	Repair bowel-bladder fistula					
44661	C	Repair bowel-bladder fistula					
44680	C	Surgical revision, intestine					
44700	C	Suspend bowel w/prosthesis					
44799	T	Intestine surgery procedure	419	7.13	\$377.09	\$164.08	\$75.42
44800	C	Excision of bowel pouch					
44820	C	Excision of mesentery lesion					
44850	C	Repair of mesentery					
44899	C	Bowel surgery procedure					
44900	C	Drain, app abscess, open					
44901	C	Drain, app abscess, perc					
44950	C	Appendectomy					
44955	C	Appendectomy					
44960	C	Appendectomy					
45000	T	Drainage of pelvic abscess	452	4.83	\$255.64	\$109.61	\$51.13
45005	T	Drainage of rectal abscess	452	4.83	\$255.64	\$109.61	\$51.13
45020	T	Drainage of rectal abscess	452	4.83	\$255.64	\$109.61	\$51.13
45100	T	Biopsy of rectum	452	4.83	\$255.64	\$109.61	\$51.13
45108	T	Removal of anorectal lesion	453	16.87	\$892.28	\$445.22	\$178.46
45110	C	Removal of rectum					
45111	C	Partial removal of rectum					
45112	C	Removal of rectum					
45113	C	Partial proctectomy					
45114	C	Partial removal of rectum					
45116	C	Partial removal of rectum					
45119	C	Remove, rectum w/reservoir					
45120	C	Removal of rectum					
45121	C	Removal of rectum and colon					
45123	C	Partial proctectomy					
45130	C	Excision of rectal prolapse					
45135	C	Excision of rectal prolapse					
45150	T	Excision of rectal stricture	453	16.87	\$892.28	\$445.22	\$178.46
45160	T	Excision of rectal lesion	453	16.87	\$892.28	\$445.22	\$178.46
45170	T	Excision of rectal lesion	453	16.87	\$892.28	\$445.22	\$178.46
45190	T	Destruction, rectal tumor	453	16.87	\$892.28	\$445.22	\$178.46
45300	T	Proctosigmoidoscopy	446	2.59	\$137.12	\$65.09	\$27.42
45303	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45305	T	Proctosigmoidoscopy; biopsy	446	2.59	\$137.12	\$65.09	\$27.42
45307	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45308	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45309	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45315	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45317	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45320	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45321	T	Proctosigmoidoscopy	447	6.87	\$363.38	\$184.87	\$72.68
45330	T	Sigmoidoscopy, diagnostic	446	2.59	\$137.12	\$65.09	\$27.42
45331	T	Sigmoidoscopy and biopsy	446	2.59	\$137.12	\$65.09	\$27.42
45332	T	Sigmoidoscopy	448	5.37	\$284.04	\$141.25	\$56.81
45333	T	Sigmoidoscopy & polypectomy	448	5.37	\$284.04	\$141.25	\$56.81
45334	T	Sigmoidoscopy for bleeding	448	5.37	\$284.04	\$141.25	\$56.81
45337	T	Sigmoidoscopy, decompression	448	5.37	\$284.04	\$141.25	\$56.81
45338	T	Sigmoidoscopy	448	5.37	\$284.04	\$141.25	\$56.81

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
45339	T	Sigmoidoscopy	449	7.80	\$412.35	\$215.38	\$82.47
45355	T	Surgical colonoscopy	427	8.22	\$434.88	\$224.19	\$86.98
45378	T	Diagnostic colonoscopy	426	6.85	\$362.40	\$187.81	\$72.48
45379	T	Colonoscopy	427	8.22	\$434.88	\$224.19	\$86.98
45380	T	Colonoscopy and biopsy	426	6.85	\$362.40	\$187.81	\$72.48
45382	T	Colonoscopy, control bleeding	427	8.22	\$434.88	\$224.19	\$86.98
45383	T	Colonoscopy, lesion removal	449	7.80	\$412.35	\$215.38	\$82.47
45384	T	Colonoscopy	427	8.22	\$434.88	\$224.19	\$86.98
45385	T	Colonoscopy, lesion removal	427	8.22	\$434.88	\$224.19	\$86.98
45500	T	Repair of rectum	453	16.87	\$892.28	\$445.22	\$178.46
45505	T	Repair of rectum	453	16.87	\$892.28	\$445.22	\$178.46
45520	T	Treatment of rectal prolapse	339	1.02	\$53.87	\$19.66	\$10.77
45540	C	Correct rectal prolapse					
45541	C	Correct rectal prolapse					
45550	C	Repair rectum; remove sigmoid					
45560	T	Repair of rectocele	453	16.87	\$892.28	\$445.22	\$178.46
45562	C	Exploration/repair of rectum					
45563	C	Exploration/repair of rectum					
45800	C	Repair rectumbladder fistula					
45805	C	Repair fistula; colostomy					
45820	C	Repair rectourethral fistula					
45825	C	Repair fistula; colostomy					
45900	T	Reduction of rectal prolapse	452	4.83	\$255.64	\$109.61	\$51.13
45905	T	Dilation of anal sphincter	452	4.83	\$255.64	\$109.61	\$51.13
45910	T	Dilation of rectal narrowing	452	4.83	\$255.64	\$109.61	\$51.13
45915	T	Remove rectal obstruction	452	4.83	\$255.64	\$109.61	\$51.13
45999	T	Rectum surgery procedure	452	4.83	\$255.64	\$109.61	\$51.13
46030	T	Removal of rectal marker	452	4.83	\$255.64	\$109.61	\$51.13
46040	T	Incision of rectal abscess	452	4.83	\$255.64	\$109.61	\$51.13
46045	T	Incision of rectal abscess	453	16.87	\$892.28	\$445.22	\$178.46
46050	T	Incision of anal abscess	452	4.83	\$255.64	\$109.61	\$51.13
46060	T	Incision of rectal abscess	453	16.87	\$892.28	\$445.22	\$178.46
46070	T	Incision of anal septum	451	2.56	\$135.16	\$54.24	\$27.03
46080	T	Incision of anal sphincter	452	4.83	\$255.64	\$109.61	\$51.13
46083	T	Incise external hemorrhoid	451	2.56	\$135.16	\$54.24	\$27.03
46200	T	Removal of anal fissure	453	16.87	\$892.28	\$445.22	\$178.46
46210	T	Removal of anal crypt	452	4.83	\$255.64	\$109.61	\$51.13
46211	T	Removal of anal crypts	453	16.87	\$892.28	\$445.22	\$178.46
46220	T	Removal of anal tab	451	2.56	\$135.16	\$54.24	\$27.03
46221	T	Ligation of hemorrhoid(s)	451	2.56	\$135.16	\$54.24	\$27.03
46230	T	Removal of anal tabs	451	2.56	\$135.16	\$54.24	\$27.03
46250	T	Hemorrhoidectomy	453	16.87	\$892.28	\$445.22	\$178.46
46255	T	Hemorrhoidectomy	453	16.87	\$892.28	\$445.22	\$178.46
46257	T	Remove hemorrhoids & fissure	453	16.87	\$892.28	\$445.22	\$178.46
46258	T	Remove hemorrhoids & fistula	453	16.87	\$892.28	\$445.22	\$178.46
46260	T	Hemorrhoidectomy	453	16.87	\$892.28	\$445.22	\$178.46
46261	T	Remove hemorrhoids & fissure	453	16.87	\$892.28	\$445.22	\$178.46
46262	T	Remove hemorrhoids & fistula	453	16.87	\$892.28	\$445.22	\$178.46
46270	T	Removal of anal fistula	453	16.87	\$892.28	\$445.22	\$178.46
46275	T	Removal of anal fistula	453	16.87	\$892.28	\$445.22	\$178.46
46280	T	Removal of anal fistula	453	16.87	\$892.28	\$445.22	\$178.46
46285	T	Removal of anal fistula	453	16.87	\$892.28	\$445.22	\$178.46
46288	T	Repair anal fistula	453	16.87	\$892.28	\$445.22	\$178.46
46320	T	Removal of hemorrhoid clot	451	2.56	\$135.16	\$54.24	\$27.03
46500	T	Injection into hemorrhoids	451	2.56	\$135.16	\$54.24	\$27.03
46600	N	Diagnostic anoscopy					
46604	N	Anoscopy and dilation					
46606	T	Anoscopy and biopsy	436	1.43	\$75.42	\$24.86	\$15.08
46608	T	Anoscopy; remove foreign body	437	2.91	\$153.77	\$76.61	\$30.75
46610	T	Anoscopy; remove lesion	437	2.91	\$153.77	\$76.61	\$30.75
46611	T	Anoscopy	437	2.91	\$153.77	\$76.61	\$30.75
46612	T	Anoscopy; remove lesions	437	2.91	\$153.77	\$76.61	\$30.75
46614	T	Anoscopy; control bleeding	437	2.91	\$153.77	\$76.61	\$30.75
46615	T	Anoscopy	437	2.91	\$153.77	\$76.61	\$30.75
46700	T	Repair of anal stricture	453	16.87	\$892.28	\$445.22	\$178.46
46705	C	Repair of anal stricture					
46715	C	Repair of anovaginal fistula					
46716	C	Repair of anovaginal fistula					
46730	C	Construction of absent anus					
46735	C	Construction of absent anus					
46740	C	Construction of absent anus					
46742	C	Repair, imperforated anus					
46744	C	Repair, cloacal anomaly					
46746	C	Repair, cloacal anomaly					
46748	C	Repair, cloacal anomaly					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
46750	T	Repair of anal sphincter	453	16.87	\$892.28	\$445.22	\$178.46
46751	C	Repair of anal sphincter .....	.....	.....	.....	.....	.....
46753	T	Reconstruction of anus	453	16.87	\$892.28	\$445.22	\$178.46
46754	T	Removal of suture from anus	452	4.83	\$255.64	\$109.61	\$51.13
46760	T	Repair of anal sphincter	453	16.87	\$892.28	\$445.22	\$178.46
46761	T	Repair of anal sphincter	453	16.87	\$892.28	\$445.22	\$178.46
46762	T	Implant artificial sphincter	453	16.87	\$892.28	\$445.22	\$178.46
46900	T	Destruction, anal lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
46910	T	Destruction, anal lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
46916	T	Cryosurgery, anal lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
46917	T	Laser surgery, anal lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
46922	T	Excision of anal lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
46924	T	Destruction, anal lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
46934	T	Destruction of hemorrhoids	451	2.56	\$135.16	\$54.24	\$27.03
46935	T	Destruction of hemorrhoids	451	2.56	\$135.16	\$54.24	\$27.03
46936	T	Destruction of hemorrhoids	451	2.56	\$135.16	\$54.24	\$27.03
46937	T	Cryotherapy of rectal lesion	453	16.87	\$892.28	\$445.22	\$178.46
46938	T	Cryotherapy of rectal lesion	453	16.87	\$892.28	\$445.22	\$178.46
46940	T	Treatment of anal fissure	451	2.56	\$135.16	\$54.24	\$27.03
46942	T	Treatment of anal fissure	451	2.56	\$135.16	\$54.24	\$27.03
46945	T	Ligation of hemorrhoids	451	2.56	\$135.16	\$54.24	\$27.03
46946	T	Ligation of hemorrhoids	451	2.56	\$135.16	\$54.24	\$27.03
46999	T	Anus surgery procedure	452	4.83	\$255.64	\$109.61	\$51.13
47000	T	Needle biopsy of liver	122	4.87	\$257.60	\$115.03	\$51.52
47001	C	Needle biopsy, liver .....	.....	.....	.....	.....	.....
47010	C	Open drainage, liver lesion .....	.....	.....	.....	.....	.....
47011	C	Percut drain, liver lesion .....	.....	.....	.....	.....	.....
47015	C	Inject/aspirate liver cyst .....	.....	.....	.....	.....	.....
47100	C	Wedge biopsy of liver .....	.....	.....	.....	.....	.....
47120	C	Partial removal of liver .....	.....	.....	.....	.....	.....
47122	C	Extensive removal of liver .....	.....	.....	.....	.....	.....
47125	C	Partial removal of liver .....	.....	.....	.....	.....	.....
47130	C	Partial removal of liver .....	.....	.....	.....	.....	.....
47133	C	Removal of donor liver .....	.....	.....	.....	.....	.....
47134	C	Partial removal, donor liver .....	.....	.....	.....	.....	.....
47135	C	Transplantation of liver .....	.....	.....	.....	.....	.....
47136	C	Transplantation of liver .....	.....	.....	.....	.....	.....
47300	C	Surgery for liver lesion .....	.....	.....	.....	.....	.....
47350	C	Repair liver wound .....	.....	.....	.....	.....	.....
47360	C	Repair liver wound .....	.....	.....	.....	.....	.....
47361	C	Repair liver wound .....	.....	.....	.....	.....	.....
47362	C	Repair liver wound .....	.....	.....	.....	.....	.....
47399	T	Liver surgery procedure	122	4.87	\$257.60	\$115.03	\$51.52
47400	C	Incision of liver duct .....	.....	.....	.....	.....	.....
47420	C	Incision of bile duct .....	.....	.....	.....	.....	.....
47425	C	Incision of bile duct .....	.....	.....	.....	.....	.....
47460	C	Incise bile duct sphincter .....	.....	.....	.....	.....	.....
47480	C	Incision of gallbladder .....	.....	.....	.....	.....	.....
47490	C	Incision of gallbladder .....	.....	.....	.....	.....	.....
47500	T	Injection for liver x-rays	347	2.93	\$154.75	\$62.15	\$30.95
47505	T	Injection for liver x-rays	347	2.93	\$154.75	\$62.15	\$30.95
47510	T	Insert catheter, bile duct	458	7.24	\$382.97	\$181.70	\$76.59
47511	T	Insert bile duct drain	458	7.24	\$382.97	\$181.70	\$76.59
47525	T	Change bile duct catheter	470	2.22	\$117.53	\$54.92	\$23.51
47530	T	Revise, reinsert bile tube	470	2.22	\$117.53	\$54.92	\$23.51
47550	C	Bile duct endoscopy .....	.....	.....	.....	.....	.....
47552	T	Biliary endoscopy, thru skin	458	7.24	\$382.97	\$181.70	\$76.59
47553	T	Biliary endoscopy, thru skin	458	7.24	\$382.97	\$181.70	\$76.59
47554	T	Biliary endoscopy, thru skin	458	7.24	\$382.97	\$181.70	\$76.59
47555	T	Biliary endoscopy, thru skin	458	7.24	\$382.97	\$181.70	\$76.59
47556	T	Biliary endoscopy, thru skin	458	7.24	\$382.97	\$181.70	\$76.59
47600	C	Removal of gallbladder .....	.....	.....	.....	.....	.....
47605	C	Removal of gallbladder .....	.....	.....	.....	.....	.....
47610	C	Removal of gallbladder .....	.....	.....	.....	.....	.....
47612	C	Removal of gallbladder .....	.....	.....	.....	.....	.....
47620	C	Removal of gallbladder .....	.....	.....	.....	.....	.....
47630	T	Remove bile duct stone	458	7.24	\$382.97	\$181.70	\$76.59
47700	C	Exploration of bile ducts .....	.....	.....	.....	.....	.....
47701	C	Bile duct revision .....	.....	.....	.....	.....	.....
47711	C	Excision of bile duct tumor .....	.....	.....	.....	.....	.....
47712	C	Excision of bile duct tumor .....	.....	.....	.....	.....	.....
47715	C	Excision of bile duct cyst .....	.....	.....	.....	.....	.....
47716	C	Fusion of bile duct cyst					
47720	C	Fuse gallbladder & bowel					
47721	C	Fuse upper gi structures					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
47740	C	Fuse gallbladder & bowel .....	.....	.....	.....	.....	.....
47741	C	Fuse gallbladder & bowel .....	.....	.....	.....	.....	.....
47760	C	Fuse bile ducts and bowel .....	.....	.....	.....	.....	.....
47765	C	Fuse liver ducts & bowel .....	.....	.....	.....	.....	.....
47780	C	Fuse bile ducts and bowel .....	.....	.....	.....	.....	.....
47785	C	Fuse bile ducts and bowel .....	.....	.....	.....	.....	.....
47800	C	Reconstruction of bile ducts .....	.....	.....	.....	.....	.....
47801	C	Placement, bile duct support .....	.....	.....	.....	.....	.....
47802	C	Fuse liver duct & intestine .....	.....	.....	.....	.....	.....
47900	C	Suture bile duct injury .....	.....	.....	.....	.....	.....
47999	T	Bile tract surgery procedure	470	2.22	\$117.53	\$54.92	\$23.51
48000	C	Drainage of abdomen .....	.....	.....	.....	.....	.....
48001	C	Placement of drain, pancreas .....	.....	.....	.....	.....	.....
48005	C	Resect/debride pancreas .....	.....	.....	.....	.....	.....
48020	C	Removal of pancreatic stone .....	.....	.....	.....	.....	.....
48100	C	Biopsy of pancreas .....	.....	.....	.....	.....	.....
48102	T	Needle biopsy, pancreas	122	4.87	\$257.60	\$115.03	\$51.52
48120	C	Removal of pancreas lesion .....	.....	.....	.....	.....	.....
48140	C	Partial removal of pancreas .....	.....	.....	.....	.....	.....
48145	C	Partial removal of pancreas .....	.....	.....	.....	.....	.....
48146	C	Pancreatectomy .....	.....	.....	.....	.....	.....
48148	C	Removal of pancreatic duct .....	.....	.....	.....	.....	.....
48150	C	Partial removal of pancreas .....	.....	.....	.....	.....	.....
48152	C	Pancreatectomy .....	.....	.....	.....	.....	.....
48153	C	Pancreatectomy .....	.....	.....	.....	.....	.....
48154	C	Pancreatectomy .....	.....	.....	.....	.....	.....
48155	C	Removal of pancreas .....	.....	.....	.....	.....	.....
48160	E	Pancreas removal, transplant .....	.....	.....	.....	.....	.....
48180	C	Fuse pancreas and bowel .....	.....	.....	.....	.....	.....
48400	C	Injection, intraoperative .....	.....	.....	.....	.....	.....
48500	C	Surgery of pancreas cyst .....	.....	.....	.....	.....	.....
48510	C	Drain pancreatic pseudocyst .....	.....	.....	.....	.....	.....
48511	C	Drain pancreatic pseudocyst .....	.....	.....	.....	.....	.....
48520	C	Fuse pancreas cyst and bowel .....	.....	.....	.....	.....	.....
48540	C	Fuse pancreas cyst and bowel .....	.....	.....	.....	.....	.....
48545	C	Pancreatorrhaphy .....	.....	.....	.....	.....	.....
48547	C	Duodenal exclusion .....	.....	.....	.....	.....	.....
48550	E	Donor pancreatectomy .....	.....	.....	.....	.....	.....
48554	E	Transplantallograft pancreas .....	.....	.....	.....	.....	.....
48556	C	Removal, allograft pancreas .....	.....	.....	.....	.....	.....
48999	T	Pancreas surgery procedure	122	4.87	\$257.60	\$115.03	\$51.52
49000	C	Exploration of abdomen .....	.....	.....	.....	.....	.....
49002	C	Reopening of abdomen .....	.....	.....	.....	.....	.....
49010	C	Exploration behind abdomen .....	.....	.....	.....	.....	.....
49020	C	Drain abdominal abscess .....	.....	.....	.....	.....	.....
49021	C	Drain abdominal abscess .....	.....	.....	.....	.....	.....
49040	C	Open drainage abdom abscess .....	.....	.....	.....	.....	.....
49041	C	Percut drain abdom abscess .....	.....	.....	.....	.....	.....
49060	C	Open drain retroper abscess .....	.....	.....	.....	.....	.....
49061	C	Percutdrain retroper abscess .....	.....	.....	.....	.....	.....
49062	C	Drain to peritoneal cavity .....	.....	.....	.....	.....	.....
49080	T	Puncture, peritoneal cavity	320	3.17	\$167.49	\$79.33	\$33.50
49081	T	Removal of abdominal fluid	320	3.17	\$167.49	\$79.33	\$33.50
49085	T	Remove abdomen foreign body	459	18.06	\$954.97	\$496.52	\$190.99
49180	T	Biopsy, abdominal mass	122	4.87	\$257.60	\$115.03	\$51.52
49200	C	Removal of abdominal lesion .....	.....	.....	.....	.....	.....
49201	C	Removal of abdominal lesion .....	.....	.....	.....	.....	.....
49215	C	Excise sacral spine tumor .....	.....	.....	.....	.....	.....
49220	C	Multiple surgery, abdomen .....	.....	.....	.....	.....	.....
49250	T	Excision of umbilicus	459	18.06	\$954.97	\$496.52	\$190.99
49255	C	Removal of omentum .....	.....	.....	.....	.....	.....
49400	T	Air injection into abdomen	347	2.93	\$154.75	\$62.15	\$30.95
49420	T	Insert abdominal drain	459	18.06	\$954.97	\$496.52	\$190.99
49421	T	Insert abdominal drain	459	18.06	\$954.97	\$496.52	\$190.99
49422	T	Remove perm cannula/catheter	470	2.22	\$117.53	\$54.92	\$23.51
49423	T	Exchange drainage cath	459	18.06	\$954.97	\$496.52	\$190.99
49424	T	Assess cyst, contrast inj	347	2.93	\$154.75	\$62.15	\$30.95
49425	C	Insert abdomen-venous drain .....	.....	.....	.....	.....	.....
49426	T	Revise abdomen-venous shunt	459	18.06	\$954.97	\$496.52	\$190.99
49427	T	Injection, abdominal shunt	347	2.93	\$154.75	\$62.15	\$30.95
49428	C	Ligation of shunt .....	.....	.....	.....	.....	.....
49429	T	Removal of shunt	470	2.22	\$117.53	\$54.92	\$23.51
49495	T	Repair inguinal hernia, init	466	21.43	\$1,133.23	\$562.97	\$226.65
49496	T	Repair inguinal hernia, init	466	21.43	\$1,133.23	\$562.97	\$226.65
49500	T	Repair inguinal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
49501	T	Repair inguinal hernia, init	466	21.43	\$1,133.23	\$562.97	\$226.65
49505	T	Repair inguinal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49507	T	Repair, inguinal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49520	T	Rerepair inguinal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49521	T	Repair inguinal hernia, rec	466	21.43	\$1,133.23	\$562.97	\$226.65
49525	T	Repair inguinal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49540	T	Repair lumbar hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49550	T	Repair femoral hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49553	T	Repair femoral hernia, init	466	21.43	\$1,133.23	\$562.97	\$226.65
49555	T	Repair femoral hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49557	T	Repair femoral hernia, recur	466	21.43	\$1,133.23	\$562.97	\$226.65
49560	T	Repair abdominal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49561	T	Repair incisional hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49565	T	Rerepair abdominal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49566	T	Repair incisional hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49568	T	Hernia repair w/mesh	466	21.43	\$1,133.23	\$562.97	\$226.65
49570	T	Repair epigastric hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49572	T	Repair, epigastric hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49580	T	Repair umbilical hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49582	T	Repair umbilical hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49585	T	Repair umbilical hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49587	T	Repair umbilical hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49590	T	Repair abdominal hernia	466	21.43	\$1,133.23	\$562.97	\$226.65
49600	T	Repair umbilical lesion	466	21.43	\$1,133.23	\$562.97	\$226.65
49605	C	Repair umbilical lesion					
49606	C	Repair umbilical lesion					
49610	C	Repair umbilical lesion					
49611	C	Repair umbilical lesion					
49900	C	Repair of abdominal wall					
49905	C	Omental flap					
49906	C	Free omental flap, microvasc					
49999	T	Abdomen surgery procedure	470	2.22	\$117.53	\$54.92	\$23.51
50010	C	Exploration of kidney					
50020	C	Open drain renal abscess					
50021	C	Percut drain renal abscess					
50040	C	Drainage of kidney					
50045	C	Exploration of kidney					
50060	C	Removal of kidney stone					
50065	C	Incision of kidney					
50070	C	Incision of kidney					
50075	C	Removal of kidney stone					
50080	C	Removal of kidney stone					
50081	C	Removal of kidney stone					
50100	C	Revise kidney blood vessels					
50120	C	Exploration of kidney					
50125	C	Explore and drain kidney					
50130	C	Removal of kidney stone					
50135	C	Exploration of kidney					
50200	T	Biopsy of kidney	122	4.87	\$257.60	\$115.03	\$51.52
50205	C	Biopsy of kidney					
50220	C	Removal of kidney					
50225	C	Removal of kidney					
50230	C	Removal of kidney					
50234	C	Removal of kidney & ureter					
50236	C	Removal of kidney & ureter					
50240	C	Partial removal of kidney					
50280	C	Removal of kidney lesion					
50290	C	Removal of kidney lesion					
50300	C	Removal of donor kidney					
50320	C	Removal of donor kidney					
50340	C	Removal of kidney					
50360	C	Transplantation of kidney					
50365	C	Transplantation of kidney					
50370	C	Remove transplanted kidney					
50380	C	Reimplantation of kidney					
50390	T	Drainage of kidney lesion	122	4.87	\$257.60	\$115.03	\$51.52
50392	T	Insert kidney drain	347	2.93	\$154.75	\$62.15	\$30.95
50393	T	Insert ureteral tube	347	2.93	\$154.75	\$62.15	\$30.95
50394	T	Injection for kidney x-ray	347	2.93	\$154.75	\$62.15	\$30.95
50395	T	Create passage to kidney	347	2.93	\$154.75	\$62.15	\$30.95
50396	T	Measure kidney pressure	529	2.50	\$132.23	\$63.05	\$26.45
50398	T	Change kidney tube	521	5.06	\$267.39	\$112.10	\$53.48
50400	C	Revision of kidney/ureter					
50405	C	Revision of kidney/ureter					
50500	C	Repair of kidney wound					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
50520	C	Close kidney-skin fistula .....	.....	.....	.....	.....	.....
50525	C	Repair renal-abdomen fistula .....	.....	.....	.....	.....	.....
50526	C	Repair renal-abdomen fistula .....	.....	.....	.....	.....	.....
50540	C	Revision of horseshoe kidney .....	.....	.....	.....	.....	.....
50551	T	Kidney endoscopy	522	10.46	\$553.39	\$262.39	\$110.68
50553	T	Kidney endoscopy	522	10.46	\$553.39	\$262.39	\$110.68
50555	T	Kidney endoscopy & biopsy	522	10.46	\$553.39	\$262.39	\$110.68
50557	T	Kidney endoscopy & treatment	522	10.46	\$553.39	\$262.39	\$110.68
50559	T	Renal endoscopy; radiotracer	522	10.46	\$553.39	\$262.39	\$110.68
50561	T	Kidney endoscopy & treatment	522	10.46	\$553.39	\$262.39	\$110.68
50570	C	Kidney endoscopy .....	.....	.....	.....	.....	.....
50572	C	Kidney endoscopy .....	.....	.....	.....	.....	.....
50574	C	Kidney endoscopy & biopsy .....	.....	.....	.....	.....	.....
50575	C	Kidney endoscopy .....	.....	.....	.....	.....	.....
50576	C	Kidney endoscopy & treatment .....	.....	.....	.....	.....	.....
50578	C	Renal endoscopy; radiotracer .....	.....	.....	.....	.....	.....
50580	C	Kidney endoscopy & treatment .....	.....	.....	.....	.....	.....
50590	T	Fragmenting of kidney stone	527	51.56	\$2,726.80	\$1,372.95	\$545.36
50600	C	Exploration of ureter .....	.....	.....	.....	.....	.....
50605	C	Insert ureteral support .....	.....	.....	.....	.....	.....
50610	C	Removal of ureter stone .....	.....	.....	.....	.....	.....
50620	C	Removal of ureter stone .....	.....	.....	.....	.....	.....
50630	C	Removal of ureter stone .....	.....	.....	.....	.....	.....
50650	C	Removal of ureter .....	.....	.....	.....	.....	.....
50660	C	Removal of ureter .....	.....	.....	.....	.....	.....
50684	T	Injection for ureter x-ray	347	2.93	\$154.75	\$62.15	\$30.95
50686	T	Measure ureter pressure	529	2.50	\$132.23	\$63.05	\$26.45
50688	T	Change of ureter tube	470	2.22	\$117.53	\$54.92	\$23.51
50690	T	Injection for ureter x-ray	347	2.93	\$154.75	\$62.15	\$30.95
50700	C	Revision of ureter .....	.....	.....	.....	.....	.....
50715	C	Release of ureter .....	.....	.....	.....	.....	.....
50722	C	Release of ureter .....	.....	.....	.....	.....	.....
50725	C	Release/revise ureter .....	.....	.....	.....	.....	.....
50727	C	Revise ureter .....	.....	.....	.....	.....	.....
50728	C	Revise ureter .....	.....	.....	.....	.....	.....
50740	C	Fusion of ureter & kidney .....	.....	.....	.....	.....	.....
50750	C	Fusion of ureter & kidney .....	.....	.....	.....	.....	.....
50760	C	Fusion of ureters .....	.....	.....	.....	.....	.....
50770	C	Splicing of ureters .....	.....	.....	.....	.....	.....
50780	C	Reimplant ureter in bladder .....	.....	.....	.....	.....	.....
50782	C	Reimplant ureter in bladder .....	.....	.....	.....	.....	.....
50783	C	Reimplant ureter in bladder .....	.....	.....	.....	.....	.....
50785	C	Reimplant ureter in bladder .....	.....	.....	.....	.....	.....
50800	C	Implant ureter in bowel .....	.....	.....	.....	.....	.....
50810	C	Fusion of ureter & bowel .....	.....	.....	.....	.....	.....
50815	C	Urine shunt to bowel .....	.....	.....	.....	.....	.....
50820	C	Construct bowel bladder .....	.....	.....	.....	.....	.....
50825	C	Construct bowel bladder .....	.....	.....	.....	.....	.....
50830	C	Revise urine flow .....	.....	.....	.....	.....	.....
50840	C	Replace ureter by bowel .....	.....	.....	.....	.....	.....
50845	C	Appendico-vesicostomy .....	.....	.....	.....	.....	.....
50860	C	Transplant ureter to skin .....	.....	.....	.....	.....	.....
50900	C	Repair of ureter .....	.....	.....	.....	.....	.....
50920	C	Closure ureter/skin fistula .....	.....	.....	.....	.....	.....
50930	C	Closure ureter/bowel fistula .....	.....	.....	.....	.....	.....
50940	C	Release of ureter .....	.....	.....	.....	.....	.....
50951	T	Endoscopy of ureter	523	16.87	\$892.28	\$447.03	\$178.46
50953	T	Endoscopy of ureter	523	16.87	\$892.28	\$447.03	\$178.46
50955	T	Ureter endoscopy & biopsy	523	16.87	\$892.28	\$447.03	\$178.46
50957	T	Ureter endoscopy & treatment	523	16.87	\$892.28	\$447.03	\$178.46
50959	T	Ureter endoscopy & tracer	523	16.87	\$892.28	\$447.03	\$178.46
50961	T	Ureter endoscopy & treatment	523	16.87	\$892.28	\$447.03	\$178.46
50970	C	Ureter endoscopy .....	.....	.....	.....	.....	.....
50972	C	Ureter endoscopy & catheter .....	.....	.....	.....	.....	.....
50974	C	Ureter endoscopy & biopsy .....	.....	.....	.....	.....	.....
50976	C	Ureter endoscopy & treatment .....	.....	.....	.....	.....	.....
50978	C	Ureter endoscopy & tracer .....	.....	.....	.....	.....	.....
50980	C	Ureter endoscopy & treatment .....	.....	.....	.....	.....	.....
51000	T	Drainage of bladder	530	2.52	\$133.21	\$54.69	\$26.64
51005	T	Drainage of bladder	530	2.52	\$133.21	\$54.69	\$26.64
51010	T	Drainage of bladder	530	2.52	\$133.21	\$54.69	\$26.64
51020	T	Incise & treat bladder	523	16.87	\$892.28	\$447.03	\$178.46
51030	T	Incise & treat bladder	523	16.87	\$892.28	\$447.03	\$178.46
51040	T	Incise & drain bladder	523	16.87	\$892.28	\$447.03	\$178.46
51045	T	Incise bladder, drain ureter	523	16.87	\$892.28	\$447.03	\$178.46

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
51050	T	Removal of bladder stone	523	16.87	\$892.28	\$447.03	\$178.46
51060	C	Removal of ureter stone					
51065	T	Removal of ureter stone	523	16.87	\$892.28	\$447.03	\$178.46
51080	T	Drainage of bladder abscess	132	6.04	\$319.30	\$134.24	\$63.86
51500	T	Removal of bladder cyst	466	21.43	\$1,133.23	\$562.97	\$226.65
51520	T	Removal of bladder lesion	523	16.87	\$892.28	\$447.03	\$178.46
51525	C	Removal of bladder lesion					
51530	C	Removal of bladder lesion					
51535	C	Repair of ureter lesion					
51550	C	Partial removal of bladder					
51555	C	Partial removal of bladder					
51565	C	Revise bladder & ureter(s)					
51570	C	Removal of bladder					
51575	C	Removal of bladder & nodes					
51580	C	Remove bladder; revise tract					
51585	C	Removal of bladder & nodes					
51590	C	Remove bladder; revise tract					
51595	C	Remove bladder; revise tract					
51596	C	Remove bladder, create pouch					
51597	C	Removal of pelvic structures					
51600	T	Injection for bladder x-ray	347	2.93	\$154.75	\$62.15	\$30.95
51605	T	Preparation for bladder xray	347	2.93	\$154.75	\$62.15	\$30.95
51610	T	Injection for bladder x-ray	347	2.93	\$154.75	\$62.15	\$30.95
51700	T	Irrigation of bladder	530	2.52	\$133.21	\$54.69	\$26.64
51705	T	Change of bladder tube	470	2.22	\$117.53	\$54.92	\$23.51
51710	T	Change of bladder tube	470	2.22	\$117.53	\$54.92	\$23.51
51715	T	Endoscopic injection/implant	531	18.94	\$1,001.98	\$527.26	\$200.40
51720	T	Treatment of bladder lesion	530	2.52	\$133.21	\$54.69	\$26.64
51725	T	Simple cystometrogram	529	2.50	\$132.23	\$63.05	\$26.45
51726	T	Complex cystometrogram	529	2.50	\$132.23	\$63.05	\$26.45
51736	T	Urine flow measurement	529	2.50	\$132.23	\$63.05	\$26.45
51741	T	Electro-uroflowmetry, first	529	2.50	\$132.23	\$63.05	\$26.45
51772	T	Urethra pressure profile	529	2.50	\$132.23	\$63.05	\$26.45
51784	T	Anal/urinary muscle study	529	2.50	\$132.23	\$63.05	\$26.45
51785	T	Anal/urinary muscle study	529	2.50	\$132.23	\$63.05	\$26.45
51792	T	Urinary reflex study	529	2.50	\$132.23	\$63.05	\$26.45
51795	T	Urine voiding pressure study	529	2.50	\$132.23	\$63.05	\$26.45
51797	T	Intraabdominal pressure test	529	2.50	\$132.23	\$63.05	\$26.45
51800	C	Revision of bladder/urethra					
51820	C	Revision of urinary tract					
51840	C	Attach bladder/urethra					
51841	C	Attach bladder/urethra					
51845	C	Repair bladder neck					
51860	C	Repair of bladder wound					
51865	C	Repair of bladder wound					
51880	T	Repair of bladder opening	523	16.87	\$892.28	\$447.03	\$178.46
51900	C	Repair bladder/vagina lesion					
51920	C	Close bladder-uterus fistula					
51925	C	Hysterectomy/bladder repair					
51940	C	Correction of bladder defect					
51960	C	Revision of bladder & bowel					
51980	C	Construct bladder opening					
52000	T	Cystoscopy	521	5.06	\$267.39	\$112.10	\$53.48
52005	T	Cystoscopy & ureter catheter	522	10.46	\$553.39	\$262.39	\$110.68
52007	T	Cystoscopy and biopsy	522	10.46	\$553.39	\$262.39	\$110.68
52010	T	Cystoscopy & duct catheter	522	10.46	\$553.39	\$262.39	\$110.68
52204	T	Cystoscopy	522	10.46	\$553.39	\$262.39	\$110.68
52214	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52224	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52234	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52235	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52240	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52250	T	Cystoscopy & radiotracer	523	16.87	\$892.28	\$447.03	\$178.46
52260	T	Cystoscopy & treatment	522	10.46	\$553.39	\$262.39	\$110.68
52265	T	Cystoscopy & treatment	521	5.06	\$267.39	\$112.10	\$53.48
52270	T	Cystoscopy & revise urethra	522	10.46	\$553.39	\$262.39	\$110.68
52275	T	Cystoscopy & revise urethra	522	10.46	\$553.39	\$262.39	\$110.68
52276	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52277	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52281	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52282	T	Cystoscopy, implant stent	523	16.87	\$892.28	\$447.03	\$178.46
52283	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52285	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52290	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52300	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
52301	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52305	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52310	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52315	T	Cystoscopy and treatment	522	10.46	\$553.39	\$262.39	\$110.68
52317	T	Remove bladder stone	523	16.87	\$892.28	\$447.03	\$178.46
52318	T	Remove bladder stone	523	16.87	\$892.28	\$447.03	\$178.46
52320	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52325	T	Cystoscopy, stone removal	523	16.87	\$892.28	\$447.03	\$178.46
52327	T	Cystoscopy, inject material	522	10.46	\$553.39	\$262.39	\$110.68
52330	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52332	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52334	T	Create passage to kidney	523	16.87	\$892.28	\$447.03	\$178.46
52335	T	Endoscopy of urinary tract	523	16.87	\$892.28	\$447.03	\$178.46
52336	T	Cystoscopy, stone removal	523	16.87	\$892.28	\$447.03	\$178.46
52337	T	Cystoscopy, stone removal	524	28.89	\$1,527.95	\$833.49	\$305.59
52338	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52339	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52340	T	Cystoscopy and treatment	523	16.87	\$892.28	\$447.03	\$178.46
52450	T	Incision of prostate	523	16.87	\$892.28	\$447.03	\$178.46
52500	T	Revision of bladder neck	523	16.87	\$892.28	\$447.03	\$178.46
52510	T	Dilation prostatic urethra	522	10.46	\$553.39	\$262.39	\$110.68
52601	T	Prostatectomy (TURP)	524	28.89	\$1,527.95	\$833.49	\$305.59
52606	T	Control postop bleeding	523	16.87	\$892.28	\$447.03	\$178.46
52612	T	Prostatectomy, first stage	524	28.89	\$1,527.95	\$833.49	\$305.59
52614	T	Prostatectomy, second stage	524	28.89	\$1,527.95	\$833.49	\$305.59
52620	T	Remove residual prostate	524	28.89	\$1,527.95	\$833.49	\$305.59
52630	T	Remove prostate regrowth	524	28.89	\$1,527.95	\$833.49	\$305.59
52640	T	Relieve bladder contracture	523	16.87	\$892.28	\$447.03	\$178.46
52647	T	Laser surgery of prostate	524	28.89	\$1,527.95	\$833.49	\$305.59
52648	T	Laser surgery of prostate	524	28.89	\$1,527.95	\$833.49	\$305.59
52700	T	Drainage of prostate abscess	523	16.87	\$892.28	\$447.03	\$178.46
53000	T	Incision of urethra	531	18.94	\$1,001.98	\$527.26	\$200.40
53010	T	Incision of urethra	531	18.94	\$1,001.98	\$527.26	\$200.40
53020	T	Incision of urethra	531	18.94	\$1,001.98	\$527.26	\$200.40
53025	T	Incision of urethra	531	18.94	\$1,001.98	\$527.26	\$200.40
53040	T	Drainage of urethra abscess	531	18.94	\$1,001.98	\$527.26	\$200.40
53060	T	Drainage of urethra abscess	531	18.94	\$1,001.98	\$527.26	\$200.40
53080	T	Drainage of urinary leakage	531	18.94	\$1,001.98	\$527.26	\$200.40
53085	C	Drainage of urinary leakage .....	.....	.....	.....	.....	.....
53200	T	Biopsy of urethra	531	18.94	\$1,001.98	\$527.26	\$200.40
53210	T	Removal of urethra	532	25.50	\$1,348.71	\$602.29	\$269.74
53215	T	Removal of urethra	532	25.50	\$1,348.71	\$602.29	\$269.74
53220	T	Treatment of urethra lesion	532	25.50	\$1,348.71	\$602.29	\$269.74
53230	T	Removal of urethra lesion	532	25.50	\$1,348.71	\$602.29	\$269.74
53235	T	Removal of urethra lesion	532	25.50	\$1,348.71	\$602.29	\$269.74
53240	T	Surgery for urethra pouch	532	25.50	\$1,348.71	\$602.29	\$269.74
53250	T	Removal of urethra gland	531	18.94	\$1,001.98	\$527.26	\$200.40
53260	T	Treatment of urethra lesion	531	18.94	\$1,001.98	\$527.26	\$200.40
53265	T	Treatment of urethra lesion	531	18.94	\$1,001.98	\$527.26	\$200.40
53270	T	Removal of urethra gland	531	18.94	\$1,001.98	\$527.26	\$200.40
53275	T	Repair of urethra defect	531	18.94	\$1,001.98	\$527.26	\$200.40
53400	T	Revise urethra, 1st stage	532	25.50	\$1,348.71	\$602.29	\$269.74
53405	T	Revise urethra, 2nd stage	532	25.50	\$1,348.71	\$602.29	\$269.74
53410	T	Reconstruction of urethra	532	25.50	\$1,348.71	\$602.29	\$269.74
53415	C	Reconstruction of urethra .....	.....	.....	.....	.....	.....
53420	T	Reconstruct urethra, stage 1	532	25.50	\$1,348.71	\$602.29	\$269.74
53425	T	Reconstruct urethra, stage 2	532	25.50	\$1,348.71	\$602.29	\$269.74
53430	T	Reconstruction of urethra	532	25.50	\$1,348.71	\$602.29	\$269.74
53440	T	Correct bladder function	538	45.59	\$2,411.41	\$1,540.64	\$482.28
53442	T	Remove perineal prosthesis	531	18.94	\$1,001.98	\$527.26	\$200.40
53443	C	Reconstruction of urethra .....	.....	.....	.....	.....	.....
53445	T	Correct urine flow control	538	45.59	\$2,411.41	\$1,540.64	\$482.28
53447	T	Remove artificial sphincter	532	25.50	\$1,348.71	\$602.29	\$269.74
53449	T	Correct artificial sphincter	532	25.50	\$1,348.71	\$602.29	\$269.74
53450	T	Revision of urethra	532	25.50	\$1,348.71	\$602.29	\$269.74
53460	T	Revision of urethra	532	25.50	\$1,348.71	\$602.29	\$269.74
53502	T	Repair of urethra injury	531	18.94	\$1,001.98	\$527.26	\$200.40
53505	T	Repair of urethra injury	531	18.94	\$1,001.98	\$527.26	\$200.40
53510	T	Repair of urethra injury	531	18.94	\$1,001.98	\$527.26	\$200.40
53515	T	Repair of urethra injury	532	25.50	\$1,348.71	\$602.29	\$269.74
53520	T	Repair of urethra defect	532	25.50	\$1,348.71	\$602.29	\$269.74
53600	T	Dilate urethra stricture	530	2.52	\$133.21	\$54.69	\$26.64
53601	T	Dilate urethra stricture	530	2.52	\$133.21	\$54.69	\$26.64
53605	T	Dilate urethra stricture	522	10.46	\$553.39	\$262.39	\$110.68
53620	T	Dilate urethra stricture	530	2.52	\$133.21	\$54.69	\$26.64

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
53621	T	Dilate urethra stricture	530	2.52	\$133.21	\$54.69	\$26.64
53660	T	Dilation of urethra	530	2.52	\$133.21	\$54.69	\$26.64
53661	T	Dilation of urethra	530	2.52	\$133.21	\$54.69	\$26.64
53665	T	Dilation of urethra	531	18.94	\$1,001.98	\$527.26	\$200.4
53670	N	Insert urinary catheter .....	.....	.....	.....	.....	.....
53675	T	Insert urinary catheter	530	2.52	\$133.21	\$54.69	\$26.64
53850	T	Prostatic microwave thermotx	524	28.89	\$1,527.95	\$833.49	\$305.59
53852	T	Prostatic rf thermotx	524	28.89	\$1,527.95	\$833.49	\$305.59
53899	T	Urology surgery procedure	530	2.52	\$133.21	\$54.69	\$26.64
54000	T	Slitting of prepuce	531	18.94	\$1,001.98	\$527.26	\$200.4
54001	T	Slitting of prepuce	531	18.94	\$1,001.98	\$527.26	\$200.4
54015	T	Drain penis lesion	132	6.04	\$319.3	\$134.24	\$63.86
54050	T	Destruction, penis lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
54055	T	Destruction, penis lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
54056	T	Cryosurgery, penis lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
54057	T	Laser surg, penis lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
54060	T	Excision of penis lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
54065	T	Destruction, penis lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
54100	T	Biopsy of penis	162	5.67	\$299.71	\$125.43	\$59.94
54105	T	Biopsy of penis	162	5.67	\$299.71	\$125.43	\$59.94
54110	T	Treatment of penis lesion	537	28.72	\$1,519.13	\$864.45	\$303.83
54111	T	Treat penis lesion, graft	537	28.72	\$1,519.13	\$864.45	\$303.83
54112	T	Treat penis lesion, graft	537	28.72	\$1,519.13	\$864.45	\$303.83
54115	T	Treatment of penis lesion	132	6.04	\$319.3	\$134.24	\$63.86
54120	T	Partial removal of penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54125	C	Removal of penis .....	.....	.....	.....	.....	.....
54130	C	Remove penis & nodes .....	.....	.....	.....	.....	.....
54135	C	Remove penis & nodes .....	.....	.....	.....	.....	.....
54150	T	Circumcision	536	13.17	\$696.39	\$326.57	\$139.28
54152	T	Circumcision	536	13.17	\$696.39	\$326.57	\$139.28
54160	T	Circumcision	536	13.17	\$696.39	\$326.57	\$139.28
54161	T	Circumcision	536	13.17	\$696.39	\$326.57	\$139.28
54200	T	Treatment of penis lesion	530	2.52	\$133.21	\$54.69	\$26.64
54205	T	Treatment of penis lesion	537	28.72	\$1,519.13	\$864.45	\$303.83
54220	T	Treatment of penis lesion	530	2.52	\$133.21	\$54.69	\$26.64
54230	T	Prepare penis study	347	2.93	\$154.75	\$62.15	\$30.95
54231	T	Dynamic cavernosometry	530	2.52	\$133.21	\$54.69	\$26.64
54235	T	Penile injection	530	2.52	\$133.21	\$54.69	\$26.64
54240	T	Penis study	529	2.50	\$132.23	\$63.05	\$26.45
54250	T	Penis study	529	2.50	\$132.23	\$63.05	\$26.45
54300	T	Revision of penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54304	T	Revision of penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54308	T	Reconstruction of urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54312	T	Reconstruction of urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54316	T	Reconstruction of urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54318	T	Reconstruction of urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54322	T	Reconstruction of urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54324	T	Reconstruction of urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54326	T	Reconstruction of urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54328	T	Revise penis, urethra	537	28.72	\$1,519.13	\$864.45	\$303.83
54332	C	Revise penis, urethra .....	.....	.....	.....	.....	.....
54336	C	Revise penis, urethra .....	.....	.....	.....	.....	.....
54340	T	Secondary urethral surgery	537	28.72	\$1,519.13	\$864.45	\$303.83
54344	T	Secondary urethral surgery	537	28.72	\$1,519.13	\$864.45	\$303.83
54348	T	Secondary urethral surgery	537	28.72	\$1,519.13	\$864.45	\$303.83
54352	T	Reconstruct urethra, penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54360	T	Penis plastic surgery	537	28.72	\$1,519.13	\$864.45	\$303.83
54380	T	Repair penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54385	T	Repair penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54390	C	Repair penis and bladder .....	.....	.....	.....	.....	.....
54400	T	Insert semi-rigid prosthesis	538	45.59	\$2,411.41	\$1,540.64	\$482.28
54401	T	Insert self-contd prosthesis	538	45.59	\$2,411.41	\$1,540.64	\$482.28
54402	T	Remove penis prosthesis	537	28.72	\$1,519.13	\$864.45	\$303.83
54405	T	Insert multi-comp prosthesis	538	45.59	\$2,411.41	\$1,540.64	\$482.28
54407	T	Remove multi-comp prosthesis	537	28.72	\$1,519.13	\$864.45	\$303.83
54409	T	Revise penis prosthesis	537	28.72	\$1,519.13	\$864.45	\$303.83
54420	T	Revision of penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54430	C	Revision of penis .....	.....	.....	.....	.....	.....
54435	T	Revision of penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54440	T	Repair of penis	537	28.72	\$1,519.13	\$864.45	\$303.83
54450	T	Preputial stretching	530	2.52	\$133.21	\$54.69	\$26.64
54500	T	Biopsy of testis	122	4.87	\$257.6	\$115.03	\$51.52
54505	T	Biopsy of testis	546	17.15	\$906.97	\$453.81	\$181.39
54510	T	Removal of testis lesion	546	17.15	\$906.97	\$453.81	\$181.39
54520	T	Removal of testis	546	17.15	\$906.97	\$453.81	\$181.39

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
54530	T	Removal of testis	546	17.15	\$906.97	\$453.81	\$181.39
54535	C	Extensive testis surgery					
54550	T	Exploration for testis	546	17.15	\$906.97	\$453.81	\$181.39
54560	C	Exploration for testis					
54600	T	Reduce testis torsion	546	17.15	\$906.97	\$453.81	\$181.39
54620	T	Suspension of testis	546	17.15	\$906.97	\$453.81	\$181.39
54640	T	Suspension of testis	546	17.15	\$906.97	\$453.81	\$181.39
54650	C	Orchiopexy (Fowler-Stephens)					
54660	T	Revision of testis	546	17.15	\$906.97	\$453.81	\$181.39
54670	T	Repair testis injury	546	17.15	\$906.97	\$453.81	\$181.39
54680	T	Relocation of testis(es)	546	17.15	\$906.97	\$453.81	\$181.39
54700	T	Drainage of scrotum	546	17.15	\$906.97	\$453.81	\$181.39
54800	T	Biopsy of epididymis	122	4.87	\$257.6	\$115.03	\$51.52
54820	T	Exploration of epididymis	546	17.15	\$906.97	\$453.81	\$181.39
54830	T	Remove epididymis lesion	546	17.15	\$906.97	\$453.81	\$181.39
54840	T	Remove epididymis lesion	546	17.15	\$906.97	\$453.81	\$181.39
54860	T	Removal of epididymis	546	17.15	\$906.97	\$453.81	\$181.39
54861	T	Removal of epididymis	546	17.15	\$906.97	\$453.81	\$181.39
54900	T	Fusion of spermatic ducts	546	17.15	\$906.97	\$453.81	\$181.39
54901	T	Fusion of spermatic ducts	546	17.15	\$906.97	\$453.81	\$181.39
55000	T	Drainage of hydrocele	121	0.67	\$35.26	\$21.02	\$7.05
55040	T	Removal of hydrocele	466	21.43	\$1,133.23	\$562.97	\$226.65
55041	T	Removal of hydroceles	466	21.43	\$1,133.23	\$562.97	\$226.65
55060	T	Repair of hydrocele	546	17.15	\$906.97	\$453.81	\$181.39
55100	T	Drainage of scrotum abscess	132	6.04	\$319.3	\$134.24	\$63.86
55110	T	Explore scrotum	546	17.15	\$906.97	\$453.81	\$181.39
55120	T	Removal of scrotum lesion	546	17.15	\$906.97	\$453.81	\$181.39
55150	T	Removal of scrotum	546	17.15	\$906.97	\$453.81	\$181.39
55175	T	Revision of scrotum	546	17.15	\$906.97	\$453.81	\$181.39
55180	T	Revision of scrotum	546	17.15	\$906.97	\$453.81	\$181.39
55200	T	Incision of sperm duct	546	17.15	\$906.97	\$453.81	\$181.39
55250	T	Removal of sperm duct(s)	546	17.15	\$906.97	\$453.81	\$181.39
55300	T	Preparation, sperm duct x-ray	347	2.93	\$154.75	\$62.15	\$30.95
55400	T	Repair of sperm duct	546	17.15	\$906.97	\$453.81	\$181.39
55450	T	Ligation of sperm duct	546	17.15	\$906.97	\$453.81	\$181.39
55500	T	Removal of hydrocele	546	17.15	\$906.97	\$453.81	\$181.39
55520	T	Removal of sperm cord lesion	546	17.15	\$906.97	\$453.81	\$181.39
55530	T	Revise spermatic cord veins	546	17.15	\$906.97	\$453.81	\$181.39
55535	T	Revise spermatic cord veins	546	17.15	\$906.97	\$453.81	\$181.39
55540	T	Revise hernia & sperm veins	546	17.15	\$906.97	\$453.81	\$181.39
55600	C	Incise sperm duct pouch					
55605	C	Incise sperm duct pouch					
55650	C	Remove sperm duct pouch					
55680	T	Remove sperm pouch lesion	546	17.15	\$906.97	\$453.81	\$181.39
55700	T	Biopsy of prostate	547	4.39	\$232.13	\$125.2	\$46.43
55705	T	Biopsy of prostate	547	4.39	\$232.13	\$125.2	\$46.43
55720	T	Drainage of prostate abscess	523	16.87	\$892.28	\$447.03	\$178.46
55725	T	Drainage of prostate abscess	523	16.87	\$892.28	\$447.03	\$178.46
55801	C	Removal of prostate					
55810	C	Extensive prostate surgery					
55812	C	Extensive prostate surgery					
55815	C	Extensive prostate surgery					
55821	C	Removal of prostate					
55831	C	Removal of prostate					
55840	C	Extensive prostate surgery					
55842	C	Extensive prostate surgery					
55845	C	Extensive prostate surgery					
55859	T	Percut/needle insert, pros	523	16.87	\$892.28	\$447.03	\$178.46
55860	C	Surgical exposure, prostate					
55862	C	Extensive prostate surgery					
55865	C	Extensive prostate surgery					
55870	T	Electroejaculation	568	2.50	\$132.23	\$49.49	\$26.45
55899	T	Genital surgery procedure	530	2.52	\$133.21	\$54.69	\$26.64
55970	E	Sex transformation, M to F					
55980	E	Sex transformation, F to M					
56300	T	Laparoscopy; diagnostic	551	24.78	\$1,310.51	\$711.67	\$262.1
56301	T	Laparoscopy; tubal cautery	551	24.78	\$1,310.51	\$711.67	\$262.1
56302	T	Laparoscopy; tubal block	551	24.78	\$1,310.51	\$711.67	\$262.1
56303	T	Laparoscopy; excise lesions	551	24.78	\$1,310.51	\$711.67	\$262.1
56304	T	Laparoscopy; lysis	551	24.78	\$1,310.51	\$711.67	\$262.1
56305	T	Laparoscopy; biopsy	551	24.78	\$1,310.51	\$711.67	\$262.1
56306	T	Laparoscopy; aspiration	551	24.78	\$1,310.51	\$711.67	\$262.1
56307	T	Laparoscopy; remove adnexa	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56308	C	Laparoscopy; hysterectomy					
56309	T	Laparoscopy; remove myoma	552	37.72	\$1,995.15	\$1,053.16	\$399.03

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
56310	C	Laparoscopic enterolysis					
56311	T	Laparoscopic lymph node biop	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56312	T	Laparoscopic lymphadenectomy	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56313	T	Laparoscopic lymphadenectomy	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56314	C	Lapar; drain lymphocele					
56315	C	Laparoscopic appendectomy					
56316	T	Laparoscopic hernia repair	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56317	T	Laparoscopic hernia repair	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56318	T	Laparoscopic orchiectomy	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56320	T	Laparoscopy, spermatic veins	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56322	C	Laparoscopy, vagus nerves					
56323	C	Laparoscopy, vagus nerves					
56324	C	Laparoscopy, cholecystoenter					
56340	C	Laparoscopic cholecystectomy					
56341	C	Laparoscopic cholecystectomy					
56342	C	Laparoscopic cholecystectomy					
56343	T	Laparoscopic salpingostomy	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56344	T	Laparoscopic fimbrioplasty	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56345	C	Laparoscopic splenectomy					
56346	T	Laparoscopic gastrostomy	551	24.78	\$1,310.51	\$711.67	\$262.1
56347	C	Laparoscopic jejunostomy					
56348	C	Laparo; resect intestine					
56349	C	Laparoscopy; fundoplasty					
56350	T	Hysteroscopy; diagnostic	562	12.76	\$674.84	\$330.86	\$134.97
56351	T	Hysteroscopy; biopsy	550	16.89	\$893.26	\$447.93	\$178.65
56352	T	Hysteroscopy; lysis	550	16.89	\$893.26	\$447.93	\$178.65
56353	T	Hysteroscopy; resect septum	550	16.89	\$893.26	\$447.93	\$178.65
56354	T	Hysteroscopy; remove myoma	550	16.89	\$893.26	\$447.93	\$178.65
56355	T	Hysteroscopy; remove impact	550	16.89	\$893.26	\$447.93	\$178.65
56356	T	Hysteroscopy; ablation	550	16.89	\$893.26	\$447.93	\$178.65
56362	T	Laparoscopy w/choleangio	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56363	T	Laparoscopy w/biopsy	552	37.72	\$1,995.15	\$1,053.16	\$399.03
56399	T	Laparoscopy procedure	562	12.76	\$674.84	\$330.86	\$134.97
56405	T	I & D of vulva/perineum	561	1.52	\$80.32	\$24.63	\$16.06
56420	T	Drainage of gland abscess	561	1.52	\$80.32	\$24.63	\$16.06
56440	T	Surgery for vulva lesion	562	12.76	\$674.84	\$330.86	\$134.97
56441	T	Lysis of labial lesion(s)	561	1.52	\$80.32	\$24.63	\$16.06
56501	T	Destruction, vulva lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
56515	T	Destruction, vulva lesion(s)	152	10.43	\$551.43	\$261.71	\$110.29
56605	T	Biopsy of vulva/perineum	161	3.50	\$385.12	\$75.48	\$37.02
56606	T	Biopsy of vulva/perineum	161	3.50	\$185.12	\$75.48	\$37.02
56620	T	Partial removal of vulva	563	16.91	\$894.24	\$464.88	\$178.85
56625	T	Complete removal of vulva	563	16.91	\$894.24	\$464.88	\$178.85
56630	C	Extensive vulva surgery					
56631	C	Extensive vulva surgery					
56632	C	Extensive vulva surgery					
56633	C	Extensive vulva surgery					
56634	C	Extensive vulva surgery					
56637	C	Extensive vulva surgery					
56640	C	Extensive vulva surgery					
56700	T	Partial removal of hymen	562	12.76	\$674.84	\$330.86	\$134.97
56720	T	Incision of hymen	562	12.76	\$674.84	\$330.86	\$134.97
56740	T	Remove vagina gland lesion	562	12.76	\$674.84	\$330.86	\$134.97
56800	T	Repair of vagina	562	12.76	\$674.84	\$330.86	\$134.97
56805	C	Repair clitoris					
56810	T	Repair of perineum	562	12.76	\$674.84	\$330.86	\$134.97
57000	T	Exploration of vagina	562	12.76	\$674.84	\$330.86	\$134.97
57010	T	Drainage of pelvic abscess	562	12.76	\$674.84	\$330.86	\$134.97
57020	T	Drainage of pelvic fluid	562	12.76	\$674.84	\$330.86	\$134.97
57061	T	Destruction vagina lesion(s)	561	1.52	\$80.32	\$24.63	\$16.06
57065	T	Destruction vagina lesion(s)	562	12.76	\$674.84	\$330.86	\$134.97
57100	T	Biopsy of vagina	561	1.52	\$80.32	\$24.63	\$16.06
57105	T	Biopsy of vagina	562	12.76	\$674.84	\$330.86	\$134.97
57108	C	Partial removal of vagina					
57110	C	Removal of vagina					
57120	C	Closure of vagina					
57130	T	Remove vagina lesion	562	12.76	\$674.84	\$330.86	\$134.97
57135	T	Remove vagina lesion	562	12.76	\$674.84	\$330.86	\$134.97
57150	T	Treat vagina infection	561	1.52	\$80.32	\$24.63	\$16.06
57160	T	Insertion of pessary/device	561	1.52	\$80.32	\$24.63	\$16.06
57170	T	Fitting of diaphragm/cap	561	1.52	\$80.32	\$24.63	\$16.06
57180	T	Treat vaginal bleeding	561	1.52	\$80.32	\$24.63	\$16.06
57200	T	Repair of vagina	562	12.76	\$674.84	\$330.86	\$134.97
57210	T	Repair vagina/perineum	562	12.76	\$674.84	\$330.86	\$134.97
57220	T	Revision of urethra	563	16.91	\$894.24	\$464.88	\$178.85

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
57230	T	Repair of urethral lesion	562	12.76	\$674.84	\$330.86	\$134.97
57240	T	Repair bladder & vagina	563	16.91	\$894.24	\$464.88	\$178.85
57250	T	Repair rectum & vagina	563	16.91	\$894.24	\$464.88	\$178.85
57260	T	Repair of vagina	563	16.91	\$894.24	\$464.88	\$178.85
57265	T	Extensive repair of vagina	563	16.91	\$894.24	\$464.88	\$178.85
57268	T	Repair of bowel bulge	563	16.91	\$894.24	\$464.88	\$178.85
57270	C	Repair of bowel pouch					
57280	C	Suspension of vagina					
57282	C	Repair of vaginal prolapse					
57284	T	Repair paravaginal defect	563	16.91	\$894.24	\$464.88	\$178.85
57288	T	Repair bladder defect	563	16.91	\$894.24	\$464.88	\$178.85
57289	T	Repair bladder & vagina	563	16.91	\$894.24	\$464.88	\$178.85
57291	T	Construction of vagina	563	16.91	\$894.24	\$464.88	\$178.85
57292	C	Construct vagina with graft					
57300	T	Repair rectum-vagina fistula	563	16.91	\$894.24	\$464.88	\$178.85
57305	C	Repair rectum-vagina fistula					
57307	C	Fistula repair & colostomy					
57308	C	Fistula repair, transperine					
57310	C	Repair urethrovaginal lesion					
57311	C	Repair urethrovaginal lesion					
57320	C	Repair bladder-vagina lesion					
57330	C	Repair bladder-vagina lesion					
57335	C	Repair vagina					
57400	T	Dilation of vagina	562	12.76	\$674.84	\$330.86	\$134.97
57410	T	Pelvic examination	562	12.76	\$674.84	\$330.86	\$134.97
57415	T	Removal vaginal foreign body	562	12.76	\$674.84	\$330.86	\$134.97
57452	T	Examination of vagina	561	1.52	\$80.32	\$24.63	\$16.06
57454	T	Vagina examination & biopsy	561	1.52	\$80.32	\$24.63	\$16.06
57460	T	Cervix excision	562	12.76	\$674.84	\$330.86	\$134.97
57500	T	Biopsy of cervix	561	1.52	\$80.32	\$24.63	\$16.06
57505	T	Endocervical curettage	561	1.52	\$80.32	\$24.63	\$16.06
57510	T	Cauterization of cervix	561	1.52	\$80.32	\$24.63	\$16.06
57511	T	Cryocautery of cervix	561	1.52	\$80.32	\$24.63	\$16.06
57513	T	Laser surgery of cervix	561	1.52	\$80.32	\$24.63	\$16.06
57520	T	Conization of cervix	563	16.91	\$894.24	\$464.88	\$178.85
57522	T	Conization of cervix	563	16.91	\$894.24	\$464.88	\$178.85
57530	T	Removal of cervix	563	16.91	\$894.24	\$464.88	\$178.85
57531	C	Removal of cervix, radical					
57540	C	Removal of residual cervix					
57545	C	Remove cervix, repair pelvis					
57550	T	Removal of residual cervix	563	16.91	\$894.24	\$464.88	\$178.85
57555	T	Remove cervix, repair vagina	563	16.91	\$894.24	\$464.88	\$178.85
57556	T	Remove cervix, repair bowel	563	16.91	\$894.24	\$464.88	\$178.85
57700	T	Revision of cervix	562	12.76	\$674.84	\$330.86	\$134.97
57720	T	Revision of cervix	562	12.76	\$674.84	\$330.86	\$134.97
57800	T	Dilation of cervical canal	561	1.52	\$80.32	\$24.63	\$16.06
57820	T	D&C of residual cervix	567	13.61	\$719.9	\$364.09	\$143.98
58100	T	Biopsy of uterus lining	561	1.52	\$80.32	\$24.63	\$16.06
58120	T	Dilation and curettage (D&C)	567	13.61	\$719.9	\$364.09	\$143.98
58140	C	Removal of uterus lesion					
58145	T	Removal of uterus lesion	563	16.91	\$894.24	\$464.88	\$178.85
58150	C	Total hysterectomy					
58152	C	Total hysterectomy					
58180	C	Partial hysterectomy					
58200	C	Extensive hysterectomy					
58210	C	Extensive hysterectomy					
58240	C	Removal of pelvis contents					
58260	C	Vaginal hysterectomy					
58262	C	Vaginal hysterectomy					
58263	C	Vaginal hysterectomy					
58267	C	Hysterectomy & vagina repair					
58270	C	Hysterectomy & vagina repair					
58275	C	Hysterectomy, revise vagina					
58280	C	Hysterectomy, revise vagina					
58285	C	Extensive hysterectomy					
58300	E	Insert intrauterine device					
58301	T	Remove intrauterine device	561	1.52	\$80.32	\$24.63	\$16.06
58321	T	Artificial insemination	568	2.50	\$132.23	\$49.49	\$26.45
58322	T	Artificial insemination	568	2.50	\$132.23	\$49.49	\$26.45
58323	T	Sperm washing	568	2.50	\$132.23	\$49.49	\$26.45
58340	T	Catheter for hystero-graphy	347	2.93	\$154.75	\$62.15	\$30.95
58345	T	Reopen fallopian tube	562	12.76	\$674.84	\$330.86	\$134.97
58350	T	Reopen fallopian tube	562	12.76	\$674.84	\$330.86	\$134.97
58400	C	Suspension of uterus					
58410	C	Suspension of uterus					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
58520	C	Repair of ruptured uterus .....	.....	.....	.....	.....	.....
58540	C	Revision of uterus .....	.....	.....	.....	.....	.....
58600	C	Division of fallopian tube .....	.....	.....	.....	.....	.....
58605	C	Division of fallopian tube .....	.....	.....	.....	.....	.....
58611	C	Ligate oviduct(s) .....	.....	.....	.....	.....	.....
58615	C	Occlude fallopian tube(s) .....	.....	.....	.....	.....	.....
58700	C	Removal of fallopian tube .....	.....	.....	.....	.....	.....
58720	C	Removal of ovary/tube(s) .....	.....	.....	.....	.....	.....
58740	C	Revise fallopian tube(s) .....	.....	.....	.....	.....	.....
58750	C	Repair oviduct .....	.....	.....	.....	.....	.....
58752	C	Revise ovarian tube(s) .....	.....	.....	.....	.....	.....
58760	C	Remove tubal obstruction .....	.....	.....	.....	.....	.....
58770	C	Create new tubal opening .....	.....	.....	.....	.....	.....
58800	T	Drainage of ovarian cyst(s)	563	16.91	\$894.24	\$464.88	\$178.85
58805	C	Drainage of ovarian cyst(s) .....	.....	.....	.....	.....	.....
58820	T	Open drain ovary abscess	563	16.91	\$894.24	\$464.88	\$178.85
58822	C	Percut drain ovary abscess .....	.....	.....	.....	.....	.....
58823	C	Percut drain pelvic abscess .....	.....	.....	.....	.....	.....
58825	C	Transposition, ovary(s) .....	.....	.....	.....	.....	.....
58900	C	Biopsy of ovary(s) .....	.....	.....	.....	.....	.....
58920	C	Partial removal of ovary(s) .....	.....	.....	.....	.....	.....
58925	C	Removal of ovarian cyst(s) .....	.....	.....	.....	.....	.....
58940	C	Removal of ovary(s) .....	.....	.....	.....	.....	.....
58943	C	Removal of ovary(s) .....	.....	.....	.....	.....	.....
58950	C	Resect ovarian malignancy .....	.....	.....	.....	.....	.....
58951	C	Resect ovarian malignancy .....	.....	.....	.....	.....	.....
58952	C	Resect ovarian malignancy .....	.....	.....	.....	.....	.....
58960	C	Exploration of abdomen .....	.....	.....	.....	.....	.....
58970	T	Retrieval of oocyte	562	12.76	\$674.84	\$330.86	\$134.97
58974	T	Transfer of embryo	568	2.50	\$132.23	\$49.49	\$26.45
58976	T	Transfer of embryo	568	2.50	\$132.23	\$49.49	\$26.45
58999	T	Genital surgery procedure	161	3.50	\$185.12	\$75.48	\$37.02
59000	T	Amniocentesis	578	1.26	\$66.60	\$33.90	\$13.32
59012	T	Fetal cord puncture, prenatal	578	1.26	\$66.60	\$33.90	\$13.32
59015	T	Chorion biopsy	578	1.26	\$66.60	\$33.90	\$13.32
59020	T	Fetal contract stress test	578	1.26	\$66.60	\$33.90	\$13.32
59025	T	Fetal non-stress test	578	1.26	\$66.60	\$33.90	\$13.32
59030	T	Fetal scalp blood sample	578	1.26	\$66.60	\$33.90	\$13.32
59050	T	Fetal monitor w/report	578	1.26	\$66.60	\$33.90	\$13.32
59051	N	Fetal monitor/interpret only .....	.....	.....	.....	.....	.....
59100	C	Remove uterus lesion .....	.....	.....	.....	.....	.....
59120	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59121	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59130	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59135	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59136	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59140	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59150	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59151	C	Treat ectopic pregnancy .....	.....	.....	.....	.....	.....
59160	T	D&C after delivery	567	13.61	\$719.90	\$364.09	\$143.98
59200	T	Insert cervical dilator	561	1.52	\$80.32	\$24.63	\$16.06
59300	T	Episiotomy or vaginal repair	562	12.76	\$674.84	\$330.86	\$134.97
59320	T	Revision of cervix	562	12.76	\$674.84	\$330.86	\$134.97
59325	C	Revision of cervix .....	.....	.....	.....	.....	.....
59350	C	Repair of uterus .....	.....	.....	.....	.....	.....
59400	E	Obstetrical care .....	.....	.....	.....	.....	.....
59409	T	Obstetrical care	580	4.59	\$242.90	\$146.45	\$48.58
59410	E	Obstetrical care .....	.....	.....	.....	.....	.....
59412	T	Antepartum manipulation	580	4.59	\$242.90	\$146.45	\$48.58
59414	T	Deliver placenta	580	4.59	\$242.90	\$146.45	\$48.58
59425	E	Antepartum care only .....	.....	.....	.....	.....	.....
59426	E	Antepartum care only .....	.....	.....	.....	.....	.....
59430	E	Care after delivery .....	.....	.....	.....	.....	.....
59510	E	Cesarean delivery .....	.....	.....	.....	.....	.....
59514	C	Cesarean delivery only .....	.....	.....	.....	.....	.....
59515	E	Cesarean delivery .....	.....	.....	.....	.....	.....
59525	C	Remove uterus after cesarean .....	.....	.....	.....	.....	.....
59610	E	Vbac delivery .....	.....	.....	.....	.....	.....
59612	T	Vbac delivery only	580	4.59	\$242.90	\$146.45	\$48.58
59614	E	Vbac care after delivery .....	.....	.....	.....	.....	.....
59618	E	Attempted vbac delivery .....	.....	.....	.....	.....	.....
59620	C	Attempted vbac delivery only .....	.....	.....	.....	.....	.....
59622	E	Attempted vbac after care .....	.....	.....	.....	.....	.....
59812	T	Treatment of miscarriage	587	13.26	\$701.29	\$347.14	\$140.26
59820	T	Care of miscarriage	587	13.26	\$701.29	\$347.14	\$140.26

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
59821	T	Treatment of miscarriage	587	13.26	\$701.29	\$347.14	\$140.26
59830	C	Treat uterus infection					
59840	T	Abortion	586	12.50	\$661.13	\$431.89	\$132.23
59841	T	Abortion	586	12.50	\$661.13	\$431.89	\$132.23
59850	C	Abortion					
59851	C	Abortion					
59852	C	Abortion					
59855	C	Abortion					
59856	C	Abortion					
59857	C	Abortion					
59866	C	Abortion					
59870	T	Evacuate mole of uterus	587	13.26	\$701.29	\$347.14	\$140.26
59871	T	Remove cerclage suture	562	12.76	\$674.84	\$330.86	\$134.97
59899	T	Maternity care procedure	578	1.26	\$66.60	\$33.90	\$13.32
60000	T	Drain thyroid/tongue cyst	312	7.26	\$383.95	\$178.31	\$76.79
60001	T	Aspirate/inject thyroid cyst	121	0.67	\$35.26	\$21.02	\$7.05
60100	T	Biopsy of thyroid	122	4.87	\$257.60	\$115.03	\$51.52
60200	T	Remove thyroid lesion	397	18.37	\$971.62	\$496.97	\$194.32
60210	T	Partial excision thyroid	397	18.37	\$971.62	\$496.97	\$194.32
60212	C	Partial thyroid excision					
60220	T	Partial removal of thyroid	397	18.37	\$971.62	\$496.97	\$194.32
60225	T	Partial removal of thyroid	397	18.37	\$971.62	\$496.97	\$194.32
60240	T	Removal of thyroid	397	18.37	\$971.62	\$496.97	\$194.32
60252	C	Removal of thyroid					
60254	C	Extensive thyroid surgery					
60260	C	Repeat thyroid surgery					
60270	C	Removal of thyroid					
60271	C	Removal of thyroid					
60280	T	Remove thyroid duct lesion	397	18.37	\$971.62	\$496.97	\$194.32
60281	T	Remove thyroid duct lesion	397	18.37	\$971.62	\$496.97	\$194.32
60500	C	Explore parathyroid glands					
60502	C	Re-explore parathyroids					
60505	C	Explore parathyroid glands					
60512	C	Autotransplant, parathyroid					
60520	C	Removal of thymus gland					
60521	C	Removal thymus gland					
60522	C	Removal of thymus gland					
60540	C	Explore adrenal gland					
60545	C	Explore adrenal gland					
60600	C	Remove carotid body lesion					
60605	C	Remove carotid body lesion					
60699	T	Endocrine surgery procedure	121	0.67	\$35.26	\$21.02	\$7.05
61000	T	Remove cranial cavity fluid	602	3.33	\$176.30	\$87.69	\$35.26
61001	T	Remove cranial cavity fluid	602	3.33	\$176.30	\$87.69	\$35.26
61020	T	Remove brain cavity fluid	602	3.33	\$176.30	\$87.69	\$35.26
61026	T	Injection into brain canal	602	3.33	\$176.30	\$87.69	\$35.26
61050	T	Remove brain canal fluid	602	3.33	\$176.30	\$87.69	\$35.26
61055	T	Injection into brain canal	602	3.33	\$176.30	\$87.69	\$35.26
61070	T	Brain canal shunt procedure	602	3.33	\$176.30	\$87.69	\$35.26
61105	C	Drill skull for examination					
61106	C	Drill skull for exam/surgery					
61107	C	Drill skull for implantation					
61108	C	Drill skull for drainage					
61120	C	Pierce skull for examination					
61130	C	Pierce skull, exam/surgery					
61140	C	Pierce skull for biopsy					
61150	C	Pierce skull for drainage					
61151	C	Pierce skull for drainage					
61154	C	Pierce skull, remove clot					
61156	C	Pierce skull for drainage					
61210	C	Pierce skull; implant device					
61215	T	Insert brain-fluid device	618	25.56	\$1,351.64	\$780.60	\$270.33
61250	C	Pierce skull & explore					
61253	C	Pierce skull & explore					
61304	C	Open skull for exploration					
61305	C	Open skull for exploration					
61312	C	Open skull for drainage					
61313	C	Open skull for drainage					
61314	C	Open skull for drainage					
61315	C	Open skull for drainage					
61320	C	Open skull for drainage					
61321	C	Open skull for drainage					
61330	C	Decompress eye socket					
61332	C	Explore/biopsy eye socket					
61333	C	Explore orbit; remove lesion					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
61334	C	Explore orbit; remove object .....	.....	.....	.....	.....	.....
61340	C	Relieve cranial pressure .....	.....	.....	.....	.....	.....
61343	C	Incise skull, pressure relief .....	.....	.....	.....	.....	.....
61345	C	Relieve cranial pressure .....	.....	.....	.....	.....	.....
61440	C	Incise skull for surgery .....	.....	.....	.....	.....	.....
61450	C	Incise skull for surgery .....	.....	.....	.....	.....	.....
61458	C	Incise skull for brain wound .....	.....	.....	.....	.....	.....
61460	C	Incise skull for surgery .....	.....	.....	.....	.....	.....
61470	C	Incise skull for surgery .....	.....	.....	.....	.....	.....
61480	C	Incise skull for surgery .....	.....	.....	.....	.....	.....
61490	C	Incise skull for surgery .....	.....	.....	.....	.....	.....
61500	C	Removal of skull lesion .....	.....	.....	.....	.....	.....
61501	C	Remove infected skull bone .....	.....	.....	.....	.....	.....
61510	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61512	C	Remove brain lining lesion .....	.....	.....	.....	.....	.....
61514	C	Removal of brain abscess .....	.....	.....	.....	.....	.....
61516	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61518	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61519	C	Remove brain lining lesion .....	.....	.....	.....	.....	.....
61520	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61521	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61522	C	Removal of brain abscess .....	.....	.....	.....	.....	.....
61524	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61526	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61530	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61531	C	Implant brain electrodes .....	.....	.....	.....	.....	.....
61533	C	Implant brain electrodes .....	.....	.....	.....	.....	.....
61534	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61535	C	Remove brain electrodes .....	.....	.....	.....	.....	.....
61536	C	Removal of brain lesion .....	.....	.....	.....	.....	.....
61538	C	Removal of brain tissue .....	.....	.....	.....	.....	.....
61539	C	Removal of brain tissue .....	.....	.....	.....	.....	.....
61541	C	Incision of brain tissue .....	.....	.....	.....	.....	.....
61542	C	Removal of brain tissue .....	.....	.....	.....	.....	.....
61543	C	Removal of brain tissue .....	.....	.....	.....	.....	.....
61544	C	Remove and treat brain lesion .....	.....	.....	.....	.....	.....
61545	C	Excision of brain tumor .....	.....	.....	.....	.....	.....
61546	C	Removal of pituitary gland .....	.....	.....	.....	.....	.....
61548	C	Removal of pituitary gland .....	.....	.....	.....	.....	.....
61550	C	Release of skull seams .....	.....	.....	.....	.....	.....
61552	C	Release of skull seams .....	.....	.....	.....	.....	.....
61556	C	Incise skull/sutures .....	.....	.....	.....	.....	.....
61557	C	Incise skull/sutures .....	.....	.....	.....	.....	.....
61558	C	Excision of skull/sutures .....	.....	.....	.....	.....	.....
61559	C	Excision of skull/sutures .....	.....	.....	.....	.....	.....
61563	C	Excision of skull tumor .....	.....	.....	.....	.....	.....
61564	C	Excision of skull tumor .....	.....	.....	.....	.....	.....
61570	C	Remove brain foreign body .....	.....	.....	.....	.....	.....
61571	C	Incise skull for brain wound .....	.....	.....	.....	.....	.....
61575	C	Skull base/brainstem surgery .....	.....	.....	.....	.....	.....
61576	C	Skull base/brainstem surgery .....	.....	.....	.....	.....	.....
61580	C	Craniofacial approach, skull .....	.....	.....	.....	.....	.....
61581	C	Craniofacial approach, skull .....	.....	.....	.....	.....	.....
61582	C	Craniofacial approach, skull .....	.....	.....	.....	.....	.....
61583	C	Craniofacial approach, skull .....	.....	.....	.....	.....	.....
61584	C	Orbitocranial approach/skull .....	.....	.....	.....	.....	.....
61585	C	Orbitocranial approach/skull .....	.....	.....	.....	.....	.....
61586	C	Resect nasopharynx, skull .....	.....	.....	.....	.....	.....
61590	C	Infratemporal approach/skull .....	.....	.....	.....	.....	.....
61591	C	Infratemporal approach/skull .....	.....	.....	.....	.....	.....
61592	C	Orbitocranial approach/skull .....	.....	.....	.....	.....	.....
61595	C	Transstemporal approach/skull .....	.....	.....	.....	.....	.....
61596	C	Transcochlear approach/skull .....	.....	.....	.....	.....	.....
61597	C	Transcondylar approach/skull .....	.....	.....	.....	.....	.....
61598	C	Transpetrosal approach/skull .....	.....	.....	.....	.....	.....
61600	C	Resect/excise cranial lesion .....	.....	.....	.....	.....	.....
61601	C	Resect/excise cranial lesion .....	.....	.....	.....	.....	.....
61605	C	Resect/excise cranial lesion .....	.....	.....	.....	.....	.....
61606	C	Resect/excise cranial lesion .....	.....	.....	.....	.....	.....
61607	C	Resect/excise cranial lesion .....	.....	.....	.....	.....	.....
61608	C	Resect/excise cranial lesion .....	.....	.....	.....	.....	.....
61609	C	Transect, artery, sinus .....	.....	.....	.....	.....	.....
61610	C	Transect, artery, sinus					
61611	C	Transect, artery, sinus					
61612	C	Transect, artery, sinus					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
61613	C	Remove aneurysm, sinus .....	.....	.....	.....	.....	.....
61615	C	Resect/excise lesion, skull .....	.....	.....	.....	.....	.....
61616	C	Resect/excise lesion, skull .....	.....	.....	.....	.....	.....
61618	C	Repair dura .....	.....	.....	.....	.....	.....
61619	C	Repair dura .....	.....	.....	.....	.....	.....
61624	C	Occlusion/embolization cath .....	.....	.....	.....	.....	.....
61626	C	Occlusion/embolization cath .....	.....	.....	.....	.....	.....
61680	C	Intracranial vessel surgery .....	.....	.....	.....	.....	.....
61682	C	Intracranial vessel surgery .....	.....	.....	.....	.....	.....
61684	C	Intracranial vessel surgery .....	.....	.....	.....	.....	.....
61686	C	Intracranial vessel surgery .....	.....	.....	.....	.....	.....
61690	C	Intracranial vessel surgery .....	.....	.....	.....	.....	.....
61692	C	Intracranial vessel surgery .....	.....	.....	.....	.....	.....
61700	C	Inner skull vessel surgery .....	.....	.....	.....	.....	.....
61702	C	Inner skull vessel surgery .....	.....	.....	.....	.....	.....
61703	C	Clamp neck artery .....	.....	.....	.....	.....	.....
61705	C	Revise circulation to head .....	.....	.....	.....	.....	.....
61708	C	Revise circulation to head .....	.....	.....	.....	.....	.....
61710	C	Revise circulation to head .....	.....	.....	.....	.....	.....
61711	C	Fusion of skull arteries .....	.....	.....	.....	.....	.....
61712	C	Skull or spine microsurgery .....	.....	.....	.....	.....	.....
61720	C	Incise skull/brain surgery .....	.....	.....	.....	.....	.....
61735	C	Incise skull/brain surgery .....	.....	.....	.....	.....	.....
61750	C	Incise skull; brain biopsy .....	.....	.....	.....	.....	.....
61751	C	Brain biopsy with cat scan .....	.....	.....	.....	.....	.....
61760	C	Implant brain electrodes .....	.....	.....	.....	.....	.....
61770	C	Incise skull for treatment .....	.....	.....	.....	.....	.....
61790	T	Treat trigeminal nerve	631	12.98	\$686.60	\$333.80	\$137.32
61791	C	Treat trigeminal tract .....	.....	.....	.....	.....	.....
61793	S	Focus radiation beam	757	2.20	\$116.55	\$52.43	\$23.31
61795	C	Brain surgery using computer .....	.....	.....	.....	.....	.....
61850	C	Implant neuroelectrodes .....	.....	.....	.....	.....	.....
61855	C	Implant neuroelectrodes .....	.....	.....	.....	.....	.....
61860	C	Implant neuroelectrodes .....	.....	.....	.....	.....	.....
61865	C	Implant neuroelectrodes .....	.....	.....	.....	.....	.....
61870	C	Implant neuroelectrodes .....	.....	.....	.....	.....	.....
61875	C	Implant neuroelectrodes .....	.....	.....	.....	.....	.....
61880	C	Revise/remove neuroelectrode .....	.....	.....	.....	.....	.....
61885	T	Implant neuroreceiver	618	25.56	\$1,351.64	\$780.60	\$270.33
61888	C	Revise/remove neuroreceiver .....	.....	.....	.....	.....	.....
62000	C	Repair of skull fracture .....	.....	.....	.....	.....	.....
62005	C	Repair of skull fracture .....	.....	.....	.....	.....	.....
62010	C	Treatment of head injury .....	.....	.....	.....	.....	.....
62100	C	Repair brain fluid leakage .....	.....	.....	.....	.....	.....
62115	C	Reduction of skull defect .....	.....	.....	.....	.....	.....
62116	C	Reduction of skull defect .....	.....	.....	.....	.....	.....
62117	C	Reduction of skull defect .....	.....	.....	.....	.....	.....
62120	C	Repair skull cavity lesion .....	.....	.....	.....	.....	.....
62121	C	Incise skull repair .....	.....	.....	.....	.....	.....
62140	C	Repair of skull defect .....	.....	.....	.....	.....	.....
62141	C	Repair of skull defect .....	.....	.....	.....	.....	.....
62142	C	Remove skull plate/flap .....	.....	.....	.....	.....	.....
62143	C	Replace skull plate/flap .....	.....	.....	.....	.....	.....
62145	C	Repair of skull and brain .....	.....	.....	.....	.....	.....
62146	C	Repair of skull with graft .....	.....	.....	.....	.....	.....
62147	C	Repair of skull with graft .....	.....	.....	.....	.....	.....
62180	C	Establish brain cavity shunt .....	.....	.....	.....	.....	.....
62190	C	Establish brain cavity shunt .....	.....	.....	.....	.....	.....
62192	C	Establish brain cavity shunt .....	.....	.....	.....	.....	.....
62194	T	Replace/irrigate catheter	602	3.33	\$176.30	\$87.69	\$35.26
62200	C	Establish brain cavity shunt .....	.....	.....	.....	.....	.....
62201	C	Establish brain cavity shunt .....	.....	.....	.....	.....	.....
62220	C	Establish brain cavity shunt .....	.....	.....	.....	.....	.....
62223	C	Establish brain cavity shunt .....	.....	.....	.....	.....	.....
62225	T	Replace/irrigate catheter	602	3.33	\$176.30	\$87.69	\$35.26
62230	T	Replace/revise brain shunt	617	11.56	\$611.18	\$287.70	\$122.24
62256	C	Remove brain cavity shunt .....	.....	.....	.....	.....	.....
62258	C	Replace brain cavity shunt .....	.....	.....	.....	.....	.....
62268	T	Drain spinal cord cyst	602	3.33	\$176.30	\$87.69	\$35.26
62269	T	Needle biopsy spinal cord	122	4.87	\$257.60	\$115.03	\$51.52
62270	T	Spinal fluid tap, diagnostic	600	2.63	\$139.08	\$61.47	\$27.82
62272	T	Drain spinal fluid	600	2.63	\$139.08	\$61.47	\$27.82
62273	T	Treat lumbar spine lesion	602	3.33	\$176.30	\$87.69	\$35.26
62274	T	Inject spinal anesthetic	602	3.33	\$176.30	\$87.69	\$35.26
62275	T	Inject spinal anesthetic	602	3.33	\$176.30	\$87.69	\$35.26

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
62276	T	Inject spinal anesthetic	602	3.33	\$176.30	\$87.69	\$35.26
62277	T	Inject spinal anesthetic	602	3.33	176.30	\$87.69	\$35.26
62278	T	Inject spinal anesthetic	602	3.33	\$176.30	\$87.69	\$35.26
62279	T	Inject spinal anesthetic	602	3.33	\$176.30	\$87.69	\$35.26
62280	T	Treat spinal cord lesion	602	3.33	\$176.30	\$87.69	\$35.26
62281	T	Treat spinal cord lesion	602	3.33	\$176.30	\$87.69	\$35.26
62282	T	Treat spinal canal lesion	602	3.33	\$176.30	\$87.69	\$35.26
62284	T	Injection for myelogram	347	2.93	\$154.75	\$62.15	\$30.95
62287	T	Percutaneous discectomy	631	12.98	\$686.60	\$333.80	\$137.32
62288	T	Injection into spinal canal	602	3.33	\$176.30	\$87.69	\$35.26
62289	T	Injection into spinal canal	602	3.33	\$176.30	\$87.69	\$35.26
62290	T	Inject for spine disk x-ray	347	2.93	\$154.75	\$62.15	\$30.95
62291	T	Inject for spine disk x-ray	347	2.93	\$154.75	\$62.15	\$30.95
62292	T	Injection into disk lesion	602	3.33	\$176.30	\$87.69	\$35.26
62294	T	Injection into spinal artery	602	3.33	\$176.30	\$87.69	\$35.26
62298	T	Injection into spinal canal	602	3.33	\$176.30	\$87.69	\$35.26
62350	T	Implant spinal catheter	617	11.56	\$611.18	\$287.70	\$122.24
62351	C	Implant spinal catheter					
62355	T	Remove spinal canal catheter	617	11.56	\$611.18	\$287.70	\$122.24
62360	T	Insert spine infusion device	618	25.56	\$1,351.64	\$780.60	\$270.33
62361	T	Implant spine infusion pump	618	25.56	\$1,351.64	\$780.60	\$270.33
62362	T	Implant spine infusion pump	618	25.56	\$1,351.64	\$780.60	\$270.33
62365	T	Remove spine infusion device	617	11.56	\$611.18	\$287.70	\$122.24
62367	X	Analyze spine infusion pump	966	0.39	\$20.57	\$12.43	\$4.11
62368	X	Analyze spine infusion pump	966	0.39	\$20.57	\$12.43	\$4.11
63001	C	Removal of spinal lamina					
63003	C	Removal of spinal lamina					
63005	C	Removal of spinal lamina					
63011	C	Removal of spinal lamina					
63012	C	Removal of spinal lamina					
63015	C	Removal of spinal lamina					
63016	C	Removal of spinal lamina					
63017	C	Removal of spinal lamina					
63020	C	Neck spine disk surgery					
63030	C	Low back disk surgery					
63035	C	Added spinal disk surgery					
63040	C	Neck spine disk surgery					
63042	C	Low back disk surgery					
63045	C	Removal of spinal lamina					
63046	C	Removal of spinal lamina					
63047	C	Removal of spinal lamina					
63048	C	Removal of spinal lamina					
63055	C	Decompress spinal cord					
63056	C	Decompress spinal cord					
63057	C	Decompress spinal cord					
63064	C	Decompress spinal cord					
63066	C	Decompress spinal cord					
63075	C	Neck spine disk surgery					
63076	C	Neck spine disk surgery					
63077	C	Spine disk surgery, thorax					
63078	C	Spine disk surgery, thorax					
63081	C	Removal of vertebral body					
63082	C	Removal of vertebral body					
63085	C	Removal of vertebral body					
63086	C	Removal of vertebral body					
63087	C	Removal of vertebral body					
63088	C	Removal of vertebral body					
63090	C	Removal of vertebral body					
63091	C	Removal of vertebral body					
63170	C	Incise spinal cord tract(s)					
63172	C	Drainage of spinal cyst					
63173	C	Drainage of spinal cyst					
63180	C	Revise spinal cord ligaments					
63182	C	Revise spinal cord ligaments					
63185	C	Incise spinal column/nerves					
63190	C	Incise spinal column/nerves					
63191	C	Incise spinal column/nerves					
63194	C	Incise spinal column & cord					
63195	C	Incise spinal column & cord					
63196	C	Incise spinal column & cord					
63197	C	Incise spinal column & cord					
63198	C	Incise spinal column & cord					
63199	C	Incise spinal column & cord					
63200	C	Release of spinal cord					
63250	C	Revise spinal cord vessels					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
63251	C	Revise spinal cord vessels .....	.....	.....	.....	.....	.....
63252	C	Revise spinal cord vessels .....	.....	.....	.....	.....	.....
63265	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63266	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63267	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63268	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63270	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63271	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63272	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63273	C	Excise intraspinal lesion .....	.....	.....	.....	.....	.....
63275	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63276	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63277	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63278	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63280	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63281	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63282	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63283	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63285	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63286	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63287	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63290	C	Biopsy/excise spinal tumor .....	.....	.....	.....	.....	.....
63300	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63301	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63302	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63303	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63304	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63305	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63306	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63307	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63308	C	Removal of vertebral body .....	.....	.....	.....	.....	.....
63600	T	Remove spinal cord lesion	631	12.98	\$686.60	\$333.80	\$137.32
63610	T	Stimulation of spinal cord	631	12.98	\$686.60	\$333.80	\$137.32
63615	T	Remove lesion of spinal cord	631	12.98	\$686.60	\$333.80	\$137.32
63650	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
63655	C	Implant neuroelectrodes .....	.....	.....	.....	.....	.....
63660	T	Revise/remove neuroelectrode	617	11.56	\$611.18	\$287.70	\$122.24
63685	T	Implant neuroreceiver	618	25.56	\$1,351.64	\$780.60	\$270.33
63688	T	Revise/remove neuroreceiver	617	11.56	\$611.18	\$287.70	\$122.24
63690	X	Analysis of neuroreceiver	966	0.39	\$20.57	\$12.43	\$4.11
63691	X	Analysis of neuroreceiver	966	0.39	\$20.57	\$12.43	\$4.11
63700	C	Repair of spinal herniation .....	.....	.....	.....	.....	.....
63702	C	Repair of spinal herniation .....	.....	.....	.....	.....	.....
63704	C	Repair of spinal herniation .....	.....	.....	.....	.....	.....
63706	C	Repair of spinal herniation .....	.....	.....	.....	.....	.....
63707	C	Repair spinal fluid leakage .....	.....	.....	.....	.....	.....
63709	C	Repair spinal fluid leakage .....	.....	.....	.....	.....	.....
63710	C	Graft repair of spine defect .....	.....	.....	.....	.....	.....
63740	C	Install spinal shunt .....	.....	.....	.....	.....	.....
63741	C	Install spinal shunt .....	.....	.....	.....	.....	.....
63744	T	Revision of spinal shunt	617	11.56	\$611.18	\$287.70	\$122.24
63746	T	Removal of spinal shunt	617	11.56	\$611.18	\$287.70	\$122.24
64400	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64402	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64405	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64408	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64410	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64412	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64413	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64415	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64417	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64418	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64420	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64421	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64425	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64430	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64435	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64440	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64441	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64442	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64443	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64445	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64450	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64505	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64508	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
64510	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64520	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64530	T	Injection for nerve block	601	3.11	\$164.55	\$74.13	\$32.91
64550	A	Apply neurostimulator .....	.....	.....	.....	.....	.....
64553	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64555	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64560	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64565	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64573	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64575	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64577	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64580	T	Implant neuroelectrodes	616	14.43	\$762.99	\$366.57	\$152.60
64585	T	Revise/remove neuroelectrode	617	11.56	\$611.18	\$287.70	\$122.24
64590	T	Implant neuroreceiver	618	25.56	\$1,351.64	\$780.60	\$270.33
64595	T	Revise/remove neuroreceiver	617	11.56	\$611.18	\$287.70	\$122.24
64600	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64605	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64610	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64612	T	Destroy nerve, face muscle	601	3.11	\$164.55	\$74.13	\$32.91
64613	T	Destroy nerve, spine muscle	601	3.11	\$164.55	\$74.13	\$32.91
64620	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64622	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64623	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64630	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64640	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64680	T	Injection treatment of nerve	601	3.11	\$164.55	\$74.13	\$32.91
64702	T	Revise finger/toe nerve	631	12.98	\$686.60	\$333.80	\$137.32
64704	T	Revise hand/foot nerve	631	12.98	\$686.60	\$333.80	\$137.32
64708	T	Revise arm/leg nerve	631	12.98	\$686.60	\$333.80	\$137.32
64712	T	Revision of sciatic nerve	631	12.98	\$686.60	\$333.80	\$137.32
64713	T	Revision of arm nerve(s)	631	12.98	\$686.60	\$333.80	\$137.32
64714	T	Revise low back nerve(s)	631	12.98	\$686.60	\$333.80	\$137.32
64716	T	Revision of cranial nerve	631	12.98	\$686.60	\$333.80	\$137.32
64718	T	Revise ulnar nerve at elbow	631	12.98	\$686.60	\$333.80	\$137.32
64719	T	Revise ulnar nerve at wrist	631	12.98	\$686.60	\$333.80	\$137.32
64721	T	Carpal tunnel surgery	631	12.98	\$686.60	\$333.80	\$137.32
64722	T	Relieve pressure on nerve(s)	631	12.98	\$686.60	\$333.80	\$137.32
64726	T	Release foot/toe nerve	631	12.98	\$686.60	\$333.80	\$137.32
64727	T	Internal nerve revision	631	12.98	\$686.60	\$333.80	\$137.32
64732	T	Incision of brow nerve	631	12.98	\$686.60	\$333.80	\$137.32
64734	T	Incision of cheek nerve	631	12.98	\$686.60	\$333.80	\$137.32
64736	T	Incision of chin nerve	631	12.98	\$686.60	\$333.80	\$137.32
64738	T	Incision of jaw nerve	631	12.98	\$686.60	\$333.80	\$137.32
64740	T	Incision of tongue nerve	631	12.98	\$686.60	\$333.80	\$137.32
64742	T	Incision of facial nerve	631	12.98	\$686.60	\$333.80	\$137.32
64744	T	Incise nerve, back of head	631	12.98	\$686.60	\$333.80	\$137.32
64746	T	Incise diaphragm nerve	631	12.98	\$686.60	\$333.80	\$137.32
64752	C	Incision of vagus nerve .....	.....	.....	.....	.....	.....
64755	C	Incision of stomach nerves .....	.....	.....	.....	.....	.....
64760	C	Incision of vagus nerve .....	.....	.....	.....	.....	.....
64761	C	Incision of pelvis nerve	631	12.98	\$686.60	\$333.80	\$137.32
64763	C	Incise hip/thigh nerve .....	.....	.....	.....	.....	.....
64766	C	Incise hip/thigh nerve .....	.....	.....	.....	.....	.....
64771	T	Sever cranial nerve	631	12.98	\$686.60	\$333.80	\$137.32
64772	T	Incision of spinal nerve	631	12.98	\$686.60	\$333.80	\$137.32
64774	T	Remove skin nerve lesion	631	12.98	\$686.60	\$333.80	\$137.32
64776	T	Remove digit nerve lesion	631	12.98	\$686.60	\$333.80	\$137.32
64778	T	Added digit nerve surgery	631	12.98	\$686.60	\$333.80	\$137.32
64782	T	Remove limb nerve lesion	631	12.98	\$686.60	\$333.80	\$137.32
64783	T	Added limb nerve surgery	631	12.98	\$686.60	\$333.80	\$137.32
64784	T	Remove nerve lesion	631	12.98	\$686.60	\$333.80	\$137.32
64786	T	Remove sciatic nerve lesion	632	18.13	\$958.88	\$461.04	\$191.78
64787	T	Implant nerve end	631	12.98	\$686.60	\$333.80	\$137.32
64788	T	Remove skin nerve lesion	631	12.98	\$686.60	\$333.80	\$137.32
64790	T	Removal of nerve lesion	631	12.98	\$686.60	\$333.80	\$137.32
64792	T	Removal of nerve lesion	632	18.13	\$958.88	\$461.04	\$191.78
64795	T	Biopsy of nerve	631	12.98	\$686.60	\$333.80	\$137.32
64802	C	Remove sympathetic nerves .....	.....	.....	.....	.....	.....
64804	C	Remove sympathetic nerves .....	.....	.....	.....	.....	.....
64809	C	Remove sympathetic nerves .....	.....	.....	.....	.....	.....
64818	C	Remove sympathetic nerves .....	.....	.....	.....	.....	.....
64820	C	Remove sympathetic nerves .....	.....	.....	.....	.....	.....
64830	T	Microrepair of nerve	631	12.98	\$686.60	\$333.80	\$137.32
64831	T	Repair of digit nerve	632	18.13	\$958.88	\$461.04	\$191.78
64832	T	Repair additional nerve	632	18.13	\$958.88	\$461.04	\$191.78

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
64834	T	Repair of hand or foot nerve	632	18.13	\$958.88	\$461.04	\$191.78
64835	T	Repair of hand or foot nerve	632	18.13	\$958.88	\$461.04	\$191.78
64836	T	Repair of hand or foot nerve	632	18.13	\$958.88	\$461.04	\$191.78
64837	T	Repair additional nerve	632	18.13	\$958.88	\$461.04	\$191.78
64840	T	Repair of leg nerve	632	18.13	\$958.88	\$461.04	\$191.78
64856	T	Repair/transpose nerve	632	18.13	\$958.88	\$461.04	\$191.78
64857	T	Repair arm/leg nerve	632	18.13	\$958.88	\$461.04	\$191.78
64858	T	Repair sciatic nerve	632	18.13	\$958.88	\$461.04	\$191.78
64859	T	Additional nerve surgery	632	18.13	\$958.88	\$461.04	\$191.78
64861	T	Repair of arm nerves	632	18.13	\$958.88	\$461.04	\$191.78
64862	T	Repair of low back nerves	632	18.13	\$958.88	\$461.04	\$191.78
64864	T	Repair of facial nerve	632	18.13	\$958.88	\$461.04	\$191.78
64865	T	Repair of facial nerve	632	18.13	\$958.88	\$461.04	\$191.78
64866	C	Fusion of facial/other nerve .....	.....	.....	.....	.....	.....
64868	C	Fusion of facial/other nerve .....	.....	.....	.....	.....	.....
64870	T	Fusion of facial/other nerve	632	18.13	\$958.88	\$461.04	\$191.78
64872	T	Subsequent repair of nerve	632	18.13	\$958.88	\$461.04	\$191.78
64874	T	Repair & revise nerve	632	18.13	\$958.88	\$461.04	\$191.78
64876	T	Repair nerve; shorten bone	632	18.13	\$958.88	\$461.04	\$191.78
64885	T	Nerve graft, head or neck	632	18.13	\$958.88	\$461.04	\$191.78
64886	T	Nerve graft, head or neck	632	18.13	\$958.88	\$461.04	\$191.78
64890	T	Nerve graft, hand or foot	632	18.13	\$958.88	\$461.04	\$191.78
64891	T	Nerve graft, hand or foot	632	18.13	\$958.88	\$461.04	\$191.78
64892	T	Nerve graft, arm or leg	632	18.13	\$958.88	\$461.04	\$191.78
64893	T	Nerve graft, arm or leg	632	18.13	\$958.88	\$461.04	\$191.78
64895	T	Nerve graft, hand or foot	632	18.13	\$958.88	\$461.04	\$191.78
64896	T	Nerve graft, hand or foot	632	18.13	\$958.88	\$461.04	\$191.78
64897	T	Nerve graft, arm or leg	632	18.13	\$958.88	\$461.04	\$191.78
64898	T	Nerve graft, arm or leg	632	18.13	\$958.88	\$461.04	\$191.78
64901	T	Additional nerve graft	632	18.13	\$958.88	\$461.04	\$191.78
64902	T	Additional nerve graft	632	18.13	\$958.88	\$461.04	\$191.78
64905	T	Nerve pedicle transfer	632	18.13	\$958.88	\$461.04	\$191.78
64907	T	Nerve pedicle transfer	632	18.13	\$958.88	\$461.04	\$191.78
64999	T	Nervous system surgery	601	3.11	\$164.55	\$74.13	\$32.91
65091	T	Revise eye	684	13.48	\$713.04	\$348.94	\$142.61
65093	T	Revise eye with implant	684	13.48	\$713.04	\$348.94	\$142.61
65101	T	Removal of eye	684	13.48	\$713.04	\$348.94	\$142.61
65103	T	Remove eye/insert implant	684	13.48	\$713.04	\$348.94	\$142.61
65105	T	Remove eye/attach implant	684	13.48	\$713.04	\$348.94	\$142.61
65110	C	Removal of eye .....	.....	.....	.....	.....	.....
65112	C	Remove eye, revise socket .....	.....	.....	.....	.....	.....
65114	C	Remove eye, revise socket .....	.....	.....	.....	.....	.....
65125	T	Revise ocular implant	681	1.67	\$88.15	\$30.51	\$17.63
65130	T	Insert ocular implant	684	13.48	\$713.04	\$348.94	\$142.61
65135	T	Insert ocular implant	684	13.48	\$713.04	\$348.94	\$142.61
65140	T	Attach ocular implant	684	13.48	\$713.04	\$348.94	\$142.61
65150	T	Revise ocular implant	684	13.48	\$713.04	\$348.94	\$142.61
65155	T	Reinsert ocular implant	684	13.48	\$713.04	\$348.94	\$142.61
65175	T	Removal of ocular implant	683	10.19	\$538.7	\$257.87	\$107.74
65205	T	Remove foreign body from eye	681	1.67	\$88.15	\$30.51	\$17.63
65210	T	Remove foreign body from eye	681	1.67	\$88.15	\$30.51	\$17.63
65220	T	Remove foreign body from eye	681	1.67	\$88.15	\$30.51	\$17.63
65222	T	Remove foreign body from eye	681	1.67	\$88.15	\$30.51	\$17.63
65235	T	Remove foreign body from eye	652	16.48	\$871.71	\$433.69	\$174.34
65260	T	Remove foreign body from eye	676	6.30	\$333.01	\$140.35	\$66.60
65265	T	Remove foreign body from eye	676	6.30	\$333.01	\$140.35	\$66.60
65270	T	Repair of eye wound	183	11.17	\$590.61	\$286.57	\$118.12
65272	T	Repair of eye wound	651	7.24	\$382.97	\$174.70	\$76.59
65273	C	Repair of eye wound .....	.....	.....	.....	.....	.....
65275	T	Repair of eye wound	651	7.24	\$382.97	\$174.70	\$76.59
65280	T	Repair of eye wound	652	16.48	\$871.71	\$433.69	\$174.34
65285	T	Repair of eye wound	652	16.48	\$871.71	\$433.69	\$174.34
65286	T	Repair of eye wound	651	7.24	\$382.97	\$174.70	\$76.59
65290	T	Repair of eye socket wound	677	16.26	\$859.96	\$436.63	\$171.99
65400	T	Removal of eye lesion	652	16.48	\$871.71	\$433.69	\$174.34
65410	T	Biopsy of cornea	683	10.19	\$538.70	\$257.87	\$107.74
65420	T	Removal of eye lesion	651	7.24	\$382.97	\$174.70	\$76.59
65426	T	Removal of eye lesion	652	16.48	\$871.71	\$433.69	\$174.34
65430	T	Corneal smear	681	1.67	\$88.15	\$30.51	\$17.63
65435	T	Curette/treat cornea	681	1.67	\$88.15	\$30.51	\$17.63
65436	T	Curette/treat cornea	651	7.24	\$382.97	\$174.70	\$76.59
65450	T	Treatment of corneal lesion	651	7.24	\$382.97	\$174.70	\$76.59
65600	T	Revision of cornea	681	1.67	\$88.15	\$30.51	\$17.63
65710	T	Corneal transplant	670	29.24	\$1,546.56	\$847.50	\$309.31
65730	T	Corneal transplant	670	29.24	\$1,546.56	\$847.50	\$309.31

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
65750	T	Corneal transplant	670	29.24	\$1,546.56	\$847.50	\$309.31
65755	T	Corneal transplant	670	29.24	\$1,546.56	\$847.50	\$309.31
65760	E	Revision of cornea .....	.....	.....	.....	.....	.....
65765	E	Revision of cornea .....	.....	.....	.....	.....	.....
65767	E	Corneal tissue transplant .....	.....	.....	.....	.....	.....
65770	T	Revise cornea with implant	652	16.48	\$871.71	\$433.69	\$174.34
65771	E	Radial keratotomy .....	.....	.....	.....	.....	.....
65772	T	Correction of astigmatism	651	7.24	\$382.97	\$174.70	\$76.59
65775	T	Correction of astigmatism	652	16.48	\$871.71	\$433.69	\$174.34
65800	T	Drainage of eye	683	10.19	\$538.70	\$257.87	\$107.74
65805	T	Drainage of eye	683	10.19	\$538.70	\$257.87	\$107.74
65810	T	Drainage of eye	651	7.24	\$382.97	\$174.70	\$76.59
65815	T	Drainage of eye	651	7.24	\$382.97	\$174.70	\$76.59
65820	T	Relieve inner eye pressure	651	7.24	\$382.97	\$174.70	\$76.59
65850	T	Incision of eye	652	16.48	\$871.71	\$433.69	\$174.34
65855	T	Laser surgery of eye	649	4.44	\$235.07	\$111.64	\$47.01
65860	T	Incise inner eye adhesions	649	4.44	\$235.07	\$111.64	\$47.01
65865	T	Incise inner eye adhesions	652	16.48	\$871.71	\$433.69	\$174.34
65870	T	Incise inner eye adhesions	652	16.48	\$871.71	\$433.69	\$174.34
65875	T	Incise inner eye adhesions	652	16.48	\$871.71	\$433.69	\$174.34
65880	T	Incise inner eye adhesions	652	16.48	\$871.71	\$433.69	\$174.34
65900	T	Remove eye lesion	652	16.48	\$871.71	\$433.69	\$174.34
65920	T	Remove implant from eye	652	16.48	\$871.71	\$433.69	\$174.34
65930	T	Remove blood clot from eye	652	16.48	\$871.71	\$433.69	\$174.34
66020	T	Injection treatment of eye	683	10.19	\$538.70	\$257.87	\$107.74
66030	T	Injection treatment of eye	683	10.19	\$538.70	\$257.87	\$107.74
66130	T	Remove eye lesion	651	7.24	\$382.97	\$174.70	\$76.59
66150	T	Glaucoma surgery	652	16.48	\$871.71	\$433.69	\$174.34
66155	T	Glaucoma surgery	652	16.48	\$871.71	\$433.69	\$174.34
66160	T	Glaucoma surgery	652	16.48	\$871.71	\$433.69	\$174.34
66165	T	Glaucoma surgery	652	16.48	\$871.71	\$433.69	\$174.34
66170	T	Glaucoma surgery	652	16.48	\$871.71	\$433.69	\$174.34
66172	T	Incision of eye	652	16.48	\$871.71	\$433.69	\$174.34
66180	T	Implant eye shunt	652	16.48	\$871.71	\$433.69	\$174.34
66185	T	Revise eye shunt	652	16.48	\$871.71	\$433.69	\$174.34
66220	T	Repair eye lesion	676	6.30	\$333.01	\$140.35	\$66.60
66225	T	Repair/graft eye lesion	652	16.48	\$871.71	\$433.69	\$174.34
66250	T	Follow-up surgery of eye	652	16.48	\$871.71	\$433.69	\$174.34
66500	T	Incision of iris	651	7.24	\$382.97	\$174.70	\$76.59
66505	T	Incision of iris	651	7.24	\$382.97	\$174.70	\$76.59
66600	T	Remove iris and lesion	651	7.24	\$382.97	\$174.70	\$76.59
66605	T	Removal of iris	652	16.48	\$871.71	\$433.69	\$174.34
66625	T	Removal of iris	651	7.24	\$382.97	\$174.70	\$76.59
66630	T	Removal of iris	651	7.24	\$382.97	\$174.70	\$76.59
66635	T	Removal of iris	652	16.48	\$871.71	\$433.69	\$174.34
66680	T	Repair iris & ciliary body	652	16.48	\$871.71	\$433.69	\$174.34
66682	T	Repair iris and ciliary body	652	16.48	\$871.71	\$433.69	\$174.34
66700	T	Destruction, ciliary body	651	7.24	\$382.97	\$174.70	\$76.59
66710	T	Destruction, ciliary body	651	7.24	\$382.97	\$174.70	\$76.59
66720	T	Destruction, ciliary body	651	7.24	\$382.97	\$174.70	\$76.59
66740	T	Destruction, ciliary body	652	16.48	\$871.71	\$433.69	\$174.34
66761	T	Revision of iris	649	4.44	\$235.07	\$111.64	\$47.01
66762	T	Revision of iris	649	4.44	\$235.07	\$111.64	\$47.01
66770	T	Removal of inner eye lesion	649	4.44	\$235.07	\$111.64	\$47.01
66820	T	Incision, secondary cataract	651	7.24	\$382.97	\$174.70	\$76.59
66821	T	After cataract laser surgery	649	4.44	\$235.07	\$111.64	\$47.01
66825	T	Reposition intraocular lens	651	7.24	\$382.97	\$174.70	\$76.59
66830	T	Removal of lens lesion	652	16.48	\$871.71	\$433.69	\$174.34
66840	T	Removal of lens material	667	19.28	\$1,019.61	\$521.83	\$203.92
66850	T	Removal of lens material	667	19.28	\$1,019.61	\$521.83	\$203.92
66852	T	Removal of lens material	667	19.28	\$1,019.61	\$521.83	\$203.92
66920	T	Extraction of lens	667	19.28	\$1,019.61	\$521.83	\$203.92
66930	T	Extraction of lens	667	19.28	\$1,019.61	\$521.83	\$203.92
66940	T	Extraction of lens	667	19.28	\$1,019.61	\$521.83	\$203.92
66983	T	Remove cataract, insert lens	668	19.28	\$1,019.61	\$530.87	\$203.92
66984	T	Remove cataract, insert lens	668	19.28	\$1,019.61	\$530.87	\$203.92
66985	T	Insert lens prosthesis	668	19.28	\$1,019.61	\$530.87	\$203.92
66986	T	Exchange lens prosthesis	668	19.28	\$1,019.61	\$530.87	\$203.92
66999	T	Eye surgery procedure	649	4.44	\$235.07	\$111.64	\$47.01
67005	T	Partial removal of eye fluid	676	6.30	\$333.01	\$140.35	\$66.60
67010	T	Partial removal of eye fluid	676	6.30	\$333.01	\$140.35	\$66.60
67015	T	Release of eye fluid	676	6.30	\$333.01	\$140.35	\$66.60
67025	T	Replace eye fluid	683	10.19	\$538.70	\$257.87	\$107.74
67027	T	Implant eye drug system	690	30.54	\$1,615.12	\$852.02	\$323.02
67028	T	Injection eye drug	682	3.54	\$187.08	\$81.36	\$37.42

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
67030	T	Incise inner eye strands	676	6.30	\$333.01	\$140.35	\$66.60
67031	T	Laser surgery, eye strands	649	4.44	\$235.07	\$111.64	\$47.01
67036	T	Removal of inner eye fluid	690	30.54	\$1,615.12	\$852.02	\$323.02
67038	T	Strip retinal membrane	690	30.54	\$1,615.12	\$852.02	\$323.02
67039	T	Laser treatment of retina	690	30.54	\$1,615.12	\$852.02	\$323.02
67040	T	Laser treatment of retina	690	30.54	\$1,615.12	\$852.02	\$323.02
67101	T	Repair, detached retina	676	6.30	\$333.01	\$140.35	\$66.60
67105	T	Repair, detached retina	648	3.94	\$208.62	\$95.15	\$41.72
67107	T	Repair detached retina	690	30.54	\$1,615.12	\$852.02	\$323.02
67108	T	Repair detached retina	690	30.54	\$1,615.12	\$852.02	\$323.02
67110	T	Repair detached retina	676	6.30	\$333.01	\$140.35	\$66.60
67112	T	Re-repair detached retina	690	30.54	\$1,615.12	\$852.02	\$323.02
67115	T	Release, encircling material	676	6.30	\$333.01	\$140.35	\$66.60
67120	T	Remove eye implant material	676	6.30	\$333.01	\$140.35	\$66.60
67121	T	Remove eye implant material	676	6.30	\$333.01	\$140.35	\$66.60
67141	T	Treatment of retina	676	6.30	\$333.01	\$140.35	\$66.60
67145	T	Treatment of retina	648	3.94	\$208.62	\$95.15	\$41.72
67208	T	Treatment of retinal lesion	676	6.30	\$333.01	\$140.35	\$66.60
67210	T	Treatment of retinal lesion	648	3.94	\$208.62	\$95.15	\$41.72
67218	T	Treatment of retinal lesion	676	6.30	\$333.01	\$140.35	\$66.60
67227	T	Treatment of retinal lesion	676	6.30	\$333.01	\$140.35	\$66.60
67228	T	Treatment of retinal lesion	648	3.94	\$208.62	\$95.15	\$41.72
67250	T	Reinforce eye wall	684	13.48	\$713.04	\$348.94	\$142.61
67255	T	Reinforce/graft eye wall	684	13.48	\$713.04	\$348.94	\$142.61
67299	T	Eye surgery procedure	649	4.44	\$235.07	\$111.64	\$47.01
67311	T	Revise eye muscle	677	16.26	\$859.96	\$436.63	\$171.99
67312	T	Revise two eye muscles	677	16.26	\$859.96	\$436.63	\$171.99
67314	T	Revise eye muscle	677	16.26	\$859.96	\$436.63	\$171.99
67316	T	Revise two eye muscles	677	16.26	\$859.96	\$436.63	\$171.99
67318	T	Revise eye muscle(s)	677	16.26	\$859.96	\$436.63	\$171.99
67320	T	Revise eye muscle(s)	677	16.26	\$859.96	\$436.63	\$171.99
67331	T	Eye surgery follow-up	677	16.26	\$859.96	\$436.63	\$171.99
67332	T	Rerevise eye muscles	677	16.26	\$859.96	\$436.63	\$171.99
67334	T	Revise eye muscle w/suture	677	16.26	\$859.96	\$436.63	\$171.99
67335	T	Eye suture during surgery	677	16.26	\$859.96	\$436.63	\$171.99
67340	T	Revise eye muscle	677	16.26	\$859.96	\$436.63	\$171.99
67343	T	Release eye tissue	677	16.26	\$859.96	\$436.63	\$171.99
67345	T	Destroy nerve of eye muscle	681	1.67	\$88.15	\$30.51	\$17.63
67350	T	Biopsy eye muscle	162	5.67	\$299.71	\$125.43	\$59.94
67399	T	Eye muscle surgery procedure	162	5.67	\$299.71	\$125.43	\$59.94
67400	T	Explore/biopsy eye socket	684	13.48	\$713.04	\$348.94	\$142.61
67405	T	Explore/drain eye socket	684	13.48	\$713.04	\$348.94	\$142.61
67412	T	Explore/treat eye socket	684	13.48	\$713.04	\$348.94	\$142.61
67413	T	Explore/treat eye socket	684	13.48	\$713.04	\$348.94	\$142.61
67414	C	Explore/decompress eye socke .....	.....	.....	.....	.....	.....
67415	T	Aspiration orbital contents	122	\$4.87	\$257.60	\$115.03	\$51.52
67420	T	Explore/treat eye socket	232	23.93	\$1,265.45	\$639.35	\$253.09
67430	T	Explore/treat eye socket	232	23.93	\$1,265.45	\$639.35	\$253.09
67440	T	Explore/drain eye socket	232	23.93	\$1,265.45	\$639.35	\$253.09
67445	C	Explore/decompress eye socke .....	.....	.....	.....	.....	.....
67450	T	Explore/biopsy eye socket	232	23.93	\$1,265.45	\$639.35	\$253.09
67500	T	Inject/treat eye socket	681	1.67	\$88.15	\$30.51	\$17.63
67505	T	Inject/treat eye socket	681	1.67	\$88.15	\$30.51	\$17.63
67515	T	Inject/treat eye socket	681	1.67	\$88.15	\$30.51	\$17.63
67550	T	Insert eye socket implant	684	13.48	\$713.04	\$348.94	\$142.61
67560	T	Revise eye socket implant	684	13.48	\$713.04	\$348.94	\$142.61
67570	C	Decompress optic nerve .....	.....	.....	.....	.....	.....
67599	T	Orbit surgery procedure	681	1.67	\$88.15	\$30.51	\$17.63
67700	T	Drainage of eyelid abscess	682	3.54	\$187.08	\$81.36	\$37.42
67710	T	Incision of eyelid	682	3.54	\$187.08	\$81.36	\$37.42
67715	T	Incision of eyelid fold	683	10.19	\$538.76	\$257.87	\$107.74
67800	T	Remove eyelid lesion	682	3.54	\$187.08	\$81.36	\$37.42
67801	T	Remove eyelid lesions	682	3.54	\$187.08	\$81.36	\$37.42
67805	T	Remove eyelid lesions	682	3.54	\$187.08	\$81.36	\$37.42
67808	T	Remove eyelid lesion(s)	684	13.48	\$713.04	\$348.94	\$142.61
67810	T	Biopsy of eyelid	682	3.54	\$187.08	\$81.36	\$37.42
67820	T	Revise eyelashes	682	3.54	\$187.08	\$81.36	\$37.42
67825	T	Revise eyelashes	682	3.54	\$187.08	\$81.36	\$37.42
67830	T	Revise eyelashes	683	10.19	\$538.7	\$257.87	\$107.74
67835	T	Revise eyelashes	684	13.48	\$713.04	\$348.94	\$142.61
67840	T	Remove eyelid lesion	682	3.54	\$187.08	\$81.36	\$37.42
67850	T	Treat eyelid lesion	682	3.54	\$187.08	\$81.36	\$37.42
67875	T	Closure of eyelid by suture	682	3.54	\$187.08	\$81.36	\$37.42
67880	T	Revision of eyelid	683	10.19	\$538.70	\$257.87	\$107.74
67882	T	Revision of eyelid	684	13.48	\$713.04	\$348.94	\$142.61

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
67900	T	Repair brow defect	684	13.48	\$713.04	\$348.94	\$142.61
67901	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67902	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67903	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67904	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67906	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67908	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67909	T	Revise eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67911	T	Revise eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67914	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67915	T	Repair eyelid defect	682	3.54	\$187.08	\$81.36	\$37.42
67916	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67917	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67921	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67922	T	Repair eyelid defect	682	3.54	\$187.08	\$81.36	\$37.42
67923	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67924	T	Repair eyelid defect	684	13.48	\$713.04	\$348.94	\$142.61
67930	T	Repair eyelid wound	682	3.54	\$187.08	\$81.36	\$37.42
67935	T	Repair eyelid wound	683	10.19	\$538.70	\$257.87	\$107.74
67938	T	Remove eyelid foreign body	682	3.54	\$187.08	\$81.36	\$37.42
67950	T	Revision of eyelid	684	13.48	\$713.04	\$348.94	\$142.61
67961	T	Revision of eyelid	684	13.48	\$713.04	\$348.94	\$142.61
67966	T	Revision of eyelid	684	13.48	\$713.04	\$348.94	\$142.61
67971	T	Reconstruction of eyelid	684	13.48	\$713.04	\$348.94	\$142.61
67973	T	Reconstruction of eyelid	684	13.48	\$713.04	\$348.94	\$142.61
67974	T	Reconstruction of eyelid	684	13.48	\$713.04	\$348.94	\$142.61
67975	T	Reconstruction of eyelid	684	13.48	\$713.04	\$348.94	\$142.61
67999	T	Revision of eyelid	682	3.54	\$187.08	\$81.36	\$37.42
68020	T	Incise/drain eyelid lining	682	3.54	\$187.08	\$81.36	\$37.42
68040	T	Treatment of eyelid lesions	682	3.54	\$187.08	\$81.36	\$37.42
68100	T	Biopsy of eyelid lining	162	5.67	\$299.71	\$125.43	\$59.94
68110	T	Remove eyelid lining lesion	162	5.67	\$299.71	\$125.43	\$59.94
68115	T	Remove eyelid lining lesion	162	5.67	\$299.71	\$125.43	\$59.94
68130	T	Remove eyelid lining lesion	652	16.48	\$871.71	\$433.69	\$174.34
68135	T	Remove eyelid lining lesion	162	5.67	\$299.71	\$125.43	\$59.94
68200	T	Treat eyelid by injection	681	1.67	\$88.15	\$30.51	\$17.63
68320	T	Revise/graft eyelid lining	684	13.48	\$713.04	\$348.94	\$142.61
68325	T	Revise/graft eyelid lining	684	13.48	\$713.04	\$348.94	\$142.61
68326	T	Revise/graft eyelid lining	684	13.48	\$713.04	\$348.94	\$142.61
68328	T	Revise/graft eyelid lining	684	13.48	\$713.04	\$348.94	\$142.61
68330	T	Revise eyelid lining	652	16.48	\$871.71	\$433.69	\$174.34
68335	T	Revise/graft eyelid lining	684	13.48	\$713.04	\$348.94	\$142.61
68340	T	Separate eyelid adhesions	684	13.48	\$713.04	\$348.94	\$142.61
68360	T	Revise eyelid lining	652	16.48	\$871.71	\$433.69	\$174.34
68362	T	Revise eyelid lining	652	16.48	\$871.71	\$433.69	\$174.34
68399	T	Eyelid lining surgery	162	5.67	\$299.71	\$125.43	\$59.94
68400	T	Incise/drain tear gland	682	3.54	\$187.08	\$81.36	\$37.42
68420	T	Incise/drain tear sac	682	3.54	\$187.08	\$81.36	\$37.42
68440	T	Incise tear duct opening	682	3.54	\$187.08	\$81.36	\$37.42
68500	T	Removal of tear gland	684	13.48	\$713.04	\$348.94	\$142.61
68505	T	Partial removal tear gland	684	13.48	\$713.04	\$348.94	\$142.61
68510	T	Biopsy of tear gland	683	10.19	\$538.70	\$257.87	\$107.74
68520	T	Removal of tear sac	684	13.48	\$713.04	\$348.94	\$142.61
68525	T	Biopsy of tear sac	683	10.19	\$538.70	\$257.87	\$107.74
68530	T	Clearance of tear duct	682	3.54	\$187.08	\$81.36	\$37.42
68540	T	Remove tear gland lesion	684	13.48	\$713.04	\$348.94	\$142.61
68550	T	Remove tear gland lesion	684	13.48	\$713.04	\$348.94	\$142.61
68700	T	Repair tear ducts	684	13.48	\$713.04	\$348.94	\$142.61
68705	T	Revise tear duct opening	682	3.54	\$187.08	\$81.36	\$37.42
68720	T	Create tear sac drain	684	13.48	\$713.04	\$348.94	\$142.61
68745	T	Create tear duct drain	684	13.48	\$713.04	\$348.94	\$142.61
68750	T	Create tear duct drain	684	13.48	\$713.04	\$348.94	\$142.61
68760	T	Close tear duct opening	682	3.54	\$187.08	\$81.36	\$37.42
68761	T	Close tear duct opening	681	1.67	\$88.15	\$30.51	\$17.63
68770	T	Close tear system fistula	684	13.48	\$713.04	\$348.94	\$142.61
68801	T	Dilate tear duct opening	682	3.54	\$187.08	\$81.36	\$37.42
68810	T	Probe nasolacrimal duct	683	10.19	\$538.70	\$257.87	\$107.74
68811	T	Probe nasolacrimal duct	684	13.48	\$713.04	\$348.94	\$142.61
68815	T	Probe nasolacrimal duct	684	13.48	\$713.04	\$348.94	\$142.61
68840	T	Explore/irrigate tear ducts	682	3.54	\$187.08	\$81.36	\$37.42
68850	T	Injection for tear sac x-ray	347	2.93	\$154.75	\$62.15	\$30.95
68899	T	Tear duct system surgery	681	1.67	\$88.15	\$30.51	\$17.63
69000	T	Drain external ear lesion	131	1.94	\$102.84	\$36.61	\$20.57
69005	T	Drain external ear lesion	131	1.94	\$102.84	\$36.61	\$20.57
69020	T	Drain outer ear canal lesion	131	1.94	\$102.84	\$36.61	\$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
69090	E	Pierce earlobes					
69100	T	Biopsy of external ear	161	3.50	\$185.12	\$75.48	\$37.02
69105	T	Biopsy of external ear canal	161	3.50	\$185.12	\$75.48	\$37.02
69110	T	Partial removal external ear	163	10.69	\$565.14	\$264.65	\$113.03
69120	T	Removal of external ear	313	15.81	\$836.45	\$411.09	\$167.29
69140	T	Remove ear canal lesion(s)	313	15.81	\$836.45	\$411.09	\$167.29
69145	T	Remove ear canal lesion(s)	163	10.69	\$565.14	\$264.65	\$113.03
69150	T	Extensive ear canal surgery	314	25.65	\$1,356.54	\$693.37	\$271.31
69155	C	Extensive ear/neck surgery					
69200	T	Clear outer ear canal	311	1.43	\$75.42	\$20.57	\$15.08
69205	T	Clear outer ear canal	163	10.69	\$565.14	\$264.65	\$113.03
69210	T	Remove impacted ear wax	311	1.43	\$75.42	\$20.57	\$15.08
69220	T	Clean out mastoid cavity	151	1.74	\$92.07	\$35.71	\$18.41
69222	T	Clean out mastoid cavity	311	1.43	\$75.42	\$20.57	\$15.08
69300	T	Revise external ear	313	15.81	\$836.45	\$411.09	\$167.29
69310	T	Rebuild outer ear canal	314	25.65	\$1,356.54	\$693.37	\$271.31
69320	T	Rebuild outer ear canal	314	25.65	\$1,356.54	\$693.37	\$271.31
69399	T	Outer ear surgery procedure	311	1.43	\$75.42	\$20.57	\$15.08
69400	T	Inflate middle ear canal	311	1.43	\$75.42	\$20.57	\$15.08
69401	N	Inflate middle ear canal					
69405	T	Catheterize middle ear canal	311	1.43	\$75.42	\$20.57	\$15.08
69410	T	Inset middle ear baffle	311	1.43	\$75.42	\$20.57	\$15.08
69420	T	Incision of eardrum	311	1.43	\$75.42	\$20.57	\$15.08
69421	T	Incision of eardrum	312	7.26	\$383.95	\$178.31	\$76.79
69424	T	Remove ventilating tube	311	1.43	\$75.42	\$20.57	\$15.08
69433	T	Create eardrum opening	312	7.26	\$383.95	\$178.31	\$76.79
69436	T	Create eardrum opening	312	7.26	\$383.95	\$178.31	\$76.79
69440	T	Exploration of middle ear	313	15.81	\$836.45	\$411.09	\$167.29
69450	T	Eardrum revision	313	15.81	\$836.45	\$411.09	\$167.29
69501	T	Mastoidectomy	314	25.65	\$1,356.54	\$693.37	\$271.31
69502	T	Mastoidectomy	314	25.65	\$1,356.54	\$693.37	\$271.31
69505	T	Remove mastoid structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69511	T	Extensive mastoid surgery	314	25.65	\$1,356.54	\$693.37	\$271.31
69530	T	Extensive mastoid surgery	314	25.65	\$1,356.54	\$693.37	\$271.31
69535	C	Remove part of temporal bone					
69540	T	Remove ear lesion	311	1.43	\$75.42	\$20.57	\$15.08
69550	T	Remove ear lesion	314	25.65	\$1,356.54	\$693.37	\$271.31
69552	T	Remove ear lesion	314	25.65	\$1,356.54	\$693.37	\$271.31
69554	C	Remove ear lesion					
69601	T	Mastoid surgery revision	314	25.65	\$1,356.54	\$693.37	\$271.31
69602	T	Mastoid surgery revision	314	25.65	\$1,356.54	\$693.37	\$271.31
69603	T	Mastoid surgery revision	314	25.65	\$1,356.54	\$693.37	\$271.31
69604	T	Mastoid surgery revision	314	25.65	\$1,356.54	\$693.37	\$271.31
69605	T	Mastoid surgery revision	314	25.65	\$1,356.54	\$693.37	\$271.31
69610	T	Repair of eardrum	311	1.43	\$75.42	\$20.57	\$15.08
69620	T	Repair of eardrum	313	15.81	\$836.45	\$411.09	\$167.29
69631	T	Repair eardrum structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69632	T	Rebuild eardrum structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69633	T	Rebuild eardrum structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69635	T	Repair eardrum structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69636	T	Rebuild eardrum structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69637	T	Rebuild eardrum structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69641	T	Revise middle ear & mastoid	314	25.65	\$1,356.54	\$693.37	\$271.31
69642	T	Revise middle ear & mastoid	314	25.65	\$1,356.54	\$693.37	\$271.31
69643	T	Revise middle ear & mastoid	314	25.65	\$1,356.54	\$693.37	\$271.31
69644	T	Revise middle ear & mastoid	314	25.65	\$1,356.54	\$693.37	\$271.31
69645	T	Revise middle ear & mastoid	314	25.65	\$1,356.54	\$693.37	\$271.31
69646	T	Revise middle ear & mastoid	314	25.65	\$1,356.54	\$693.37	\$271.31
69650	T	Release middle ear bone	314	25.65	\$1,356.54	\$693.37	\$271.31
69660	T	Revise middle ear bone	314	25.65	\$1,356.54	\$693.37	\$271.31
69661	T	Revise middle ear bone	314	25.65	\$1,356.54	\$693.37	\$271.31
69662	T	Revise middle ear bone	314	25.65	\$1,356.54	\$693.37	\$271.31
69666	T	Repair middle ear structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69667	T	Repair middle ear structures	314	25.65	\$1,356.54	\$693.37	\$271.31
69670	T	Remove mastoid air cells	314	25.65	\$1,356.54	\$693.37	\$271.31
69676	T	Remove middle ear nerve	314	25.65	\$1,356.54	\$693.37	\$271.31
69700	T	Close mastoid fistula	314	25.65	\$1,356.54	\$693.37	\$271.31
69710	E	Implant/replace hearing aid					
69711	T	Remove/repair hearing aid	314	25.65	\$1,356.54	\$693.37	\$271.31
69720	T	Release facial nerve	314	25.65	\$1,356.54	\$693.37	\$271.31
69725	T	Release facial nerve	314	25.65	\$1,356.54	\$693.37	\$271.31
69740	T	Repair facial nerve	314	25.65	\$1,356.54	\$693.37	\$271.31
69745	T	Repair facial nerve	314	25.65	\$1,356.54	\$693.37	\$271.31
69799	T	Middle ear surgery procedure	311	1.43	\$75.42	\$20.57	\$15.08
69801	T	Incise inner ear	314	25.65	\$1,356.54	\$693.37	\$271.31

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
69802	T	Incise inner ear	314	25.65	\$1,356.54	\$693.37	\$271.31
69805	T	Explore inner ear	314	25.65	\$1,356.54	\$693.37	\$271.31
69806	T	Explore inner ear	314	25.65	\$1,356.54	\$693.37	\$271.31
69820	T	Establish inner ear window	314	25.65	\$1,356.54	\$693.37	\$271.31
69840	T	Revise inner ear window	314	25.65	\$1,356.54	\$693.37	\$271.31
69905	T	Remove inner ear	314	25.65	\$1,356.54	\$693.37	\$271.31
69910	T	Remove inner ear & mastoid	314	25.65	\$1,356.54	\$693.37	\$271.31
69915	T	Incise inner ear nerve	314	25.65	\$1,356.54	\$693.37	\$271.31
69930	T	Implant cochlear device	317				
69949	T	Inner ear surgery procedure	314	25.65	\$1,356.54	\$693.37	\$271.31
69950	C	Incise inner ear nerve					
69955	C	Release facial nerve					
69960	C	Release inner ear canal					
69970	C	Remove inner ear lesion					
69979	C	Temporal bone surgery					
70010	S	Contrast x-ray of brain	728	4.07	\$215.48	\$113.23	\$43.10
70015	S	Contrast x-ray of brain	728	4.07	\$215.48	\$113.23	\$43.10
70030	X	X-ray eye for foreign body	700	0.78	\$41.14	\$22.37	\$8.23
70100	X	X-ray exam of jaw	700	0.78	\$41.14	\$22.37	\$8.23
70110	X	X-ray exam of jaw	700	0.78	\$41.14	\$22.37	\$8.23
70120	X	X-ray exam of mastoids	700	0.78	\$41.14	\$22.37	\$8.23
70130	X	X-ray exam of mastoids	700	0.78	\$41.14	\$22.37	\$8.23
70134	X	X-ray exam of middle ear	700	0.78	\$41.14	\$22.37	\$8.23
70140	X	X-ray exam of facial bones	700	0.78	\$41.14	\$22.37	\$8.23
70150	X	X-ray exam of facial bones	700	0.78	\$41.14	\$22.37	\$8.23
70160	X	X-ray exam of nasal bones	700	0.78	\$41.14	\$22.37	\$8.23
70170	X	X-ray exam of tear duct	706	1.96	\$103.82	\$57.63	\$20.76
70190	X	X-ray exam of eye sockets	700	0.78	\$41.14	\$22.37	\$8.23
70200	X	X-ray exam of eye sockets	700	0.78	\$41.14	\$22.37	\$8.23
70210	X	X-ray exam of sinuses	700	0.78	\$41.14	\$22.37	\$8.23
70220	X	X-ray exam of sinuses	700	0.78	\$41.14	\$22.37	\$8.23
70240	X	X-ray exam pituitary saddle	700	0.78	\$41.14	\$22.37	\$8.23
70250	X	X-ray exam of skull	700	0.78	\$41.14	\$22.37	\$8.23
70260	X	X-ray exam of skull	700	0.78	\$41.14	\$22.37	\$8.23
70300	X	X-ray exam of teeth	700	0.78	\$41.14	\$22.37	\$8.23
70310	X	X-ray exam of teeth	700	0.78	\$41.14	\$22.37	\$8.23
70320	X	Full mouth x-ray of teeth	700	0.78	\$41.14	\$22.37	\$8.23
70328	X	X-ray exam of jaw joint	700	0.78	\$41.14	\$22.37	\$8.23
70330	X	X-ray exam of jaw joints	700	0.78	\$41.14	\$22.37	\$8.23
70332	S	X-ray exam of jaw joint	730	2.48	\$131.25	\$72.09	\$26.25
70336	S	Magnetic image jaw joint	726	7.96	\$421.16	\$258.09	\$84.23
70350	X	X-ray head for orthodontia	700	0.78	\$41.14	\$22.37	\$8.23
70355	X	Panoramic x-ray of jaws	700	0.78	\$41.14	\$22.37	\$8.23
70360	X	X-ray exam of neck	700	0.78	\$41.14	\$22.37	\$8.23
70370	X	Throat x-ray & fluoroscopy	716	1.59	\$84.23	\$47.91	\$16.85
70371	X	Speech evaluation, complex	716	1.59	\$84.23	\$47.91	\$16.85
70373	X	Contrast x-ray of larynx	706	1.96	\$103.82	\$57.63	\$20.76
70380	X	X-ray exam of salivary gland	700	0.78	\$41.14	\$22.37	\$8.23
70390	X	X-ray exam of salivary duct	706	1.96	\$103.82	\$57.63	\$20.76
70450	S	CAT scan of head or brain	710	5.06	\$267.39	\$176.28	\$53.48
70460	S	Contrast CAT scan of head	710	5.06	\$267.39	\$176.28	\$53.48
70470	S	Contrast CAT scans of head	710	5.06	\$267.39	\$176.28	\$53.48
70480	S	CAT scan of skull	710	5.06	\$267.39	\$176.28	\$53.48
70481	S	Contrast CAT scan of skull	710	5.06	\$267.39	\$176.28	\$53.48
70482	S	Contrast CAT scans of skull	710	5.06	\$267.39	\$176.28	\$53.48
70486	S	CAT scan of face, jaw	710	5.06	\$267.39	\$176.28	\$53.48
70487	S	Contrast CAT scan, face/jaw	710	5.06	\$267.39	\$176.28	\$53.48
70488	S	Contrast CAT scans face/jaw	710	5.06	\$267.39	\$176.28	\$53.48
70490	S	CAT scan of neck tissue	710	5.06	\$267.39	\$176.28	\$53.48
70491	S	Contrast CAT of neck tissue	710	5.06	\$267.39	\$176.28	\$53.48
70492	S	Contrast CAT of neck tissue	710	5.06	\$267.39	\$176.28	\$53.48
70540	S	Magnetic image, face, neck	726	7.96	\$421.16	\$258.09	\$84.23
70541	S	Magnetic image, head (MRA)	720	6.35	\$335.95	\$206.11	\$67.19
70551	S	Magnetic image, brain (MRI)	726	7.96	\$421.16	\$258.09	\$84.23
70552	S	Magnetic image, brain (MRI)	726	7.96	\$421.16	\$258.09	\$84.23
70553	S	Magnetic image, brain	726	7.96	\$421.16	\$258.09	\$84.23
71010	X	Chest x-ray	700	0.78	\$41.14	\$22.37	\$8.23
71015	X	X-ray exam of chest	700	0.78	\$41.14	\$22.37	\$8.23
71020	X	Chest x-ray	700	0.78	\$41.14	\$22.37	\$8.23
71021	X	Chest x-ray	700	0.78	\$41.14	\$22.37	\$8.23
71022	X	Chest x-ray	700	0.78	\$41.14	\$22.37	\$8.23
71023	X	Chest x-ray and fluoroscopy	716	1.59	\$84.23	\$47.91	\$16.85
71030	X	Chest x-ray	700	0.78	\$41.14	\$22.37	\$8.23
71034	X	Chest x-ray & fluoroscopy	716	1.59	\$84.23	\$47.91	\$16.85
71035	X	Chest x-ray	700	0.78	\$41.14	\$22.37	\$8.23

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
71036	X	X-ray guidance for biopsy	716	1.59	\$84.23	\$47.91	\$16.85
71038	X	X-ray guidance for biopsy	716	1.59	\$84.23	\$47.91	\$16.85
71040	X	Contrast x-ray of bronchi	706	1.96	\$103.82	\$57.63	\$20.76
71060	X	Contrast x-ray of bronchi	706	1.96	\$103.82	\$57.63	\$20.76
71090	X	X-ray & pacemaker insertion	716	1.59	\$84.23	\$47.91	\$16.85
71100	X	X-ray exam of ribs	700	0.78	\$41.14	\$22.37	\$8.23
71101	X	X-ray exam of ribs, chest	700	0.78	\$41.14	\$22.37	\$8.23
71110	X	X-ray exam of ribs	700	0.78	\$41.14	\$22.37	\$8.23
71111	X	X-ray exam of ribs, chest	700	0.78	\$41.14	\$22.37	\$8.23
71120	X	X-ray exam of breastbone	700	0.78	\$41.14	\$22.37	\$8.23
71130	X	X-ray exam of breastbone	700	0.78	\$41.14	\$22.37	\$8.23
71250	S	Cat scan of chest	710	5.06	\$267.39	\$176.28	\$53.48
71260	S	Contrast CAT scan of chest	710	5.06	\$267.39	\$176.28	\$53.48
71270	S	Contrast CAT scans of chest	710	5.06	\$267.39	\$176.28	\$53.48
71550	S	Magnetic image, chest	726	7.96	\$421.16	\$258.09	\$84.23
71555	E	Magnetic imaging/chest (MRA)					
72010	X	X-ray exam of spine	700	0.78	\$41.14	\$22.37	\$8.23
72020	X	X-ray exam of spine	700	0.78	\$41.14	\$22.37	\$8.23
72040	X	X-ray exam of neck spine	700	0.78	\$41.14	\$22.37	\$8.23
72050	X	X-ray exam of neck spine	700	0.78	\$41.14	\$22.37	\$8.23
72052	X	X-ray exam of neck spine	700	0.78	\$41.14	\$22.37	\$8.23
72069	X	X-ray exam of trunk spine	700	0.78	\$41.14	\$22.37	\$8.23
72070	X	X-ray exam of thorax spine	700	0.78	\$41.14	\$22.37	\$8.23
72072	X	X-ray exam of thoracic spine	700	0.78	\$41.14	\$22.37	\$8.23
72074	X	X-ray exam of thoracic spine	700	0.78	\$41.14	\$22.37	\$8.23
72080	X	X-ray exam of trunk spine	700	0.78	\$41.14	\$22.37	\$8.23
72090	X	X-ray exam of trunk spine	700	0.78	\$41.14	\$22.37	\$8.23
72100	X	X-ray exam of lower spine	700	0.78	\$41.14	\$22.37	\$8.23
72110	X	X-ray exam of lower spine	700	0.78	\$41.14	\$22.37	\$8.23
72114	X	X-ray exam of lower spine	700	0.78	\$41.14	\$22.37	\$8.23
72120	X	X-ray exam of lower spine	700	0.78	\$41.14	\$22.37	\$8.23
72125	S	CAT scan of neck spine	710	5.06	\$267.39	\$176.28	\$53.48
72126	S	Contrast CAT scan of neck	710	5.06	\$267.39	\$176.28	\$53.48
72127	S	Contrast CAT scans of neck	710	5.06	\$267.39	\$176.28	\$53.48
72128	S	CAT scan of thorax spine	710	5.06	\$267.39	\$176.28	\$53.48
72129	S	Contrast CAT scan of thorax	710	5.06	\$267.39	\$176.28	\$53.48
72130	S	Contrast CAT scans of thorax	710	5.06	\$267.39	\$176.28	\$53.48
72131	S	CAT scan of lower spine	710	5.06	\$267.39	\$176.28	\$53.48
72132	S	Contrast CAT of lower spine	710	5.06	\$267.39	\$176.28	\$53.48
72133	S	Contrast CAT scans, low spine	710	5.06	\$267.39	\$176.28	\$53.48
72141	S	Magnetic image, neck spine	726	7.96	\$421.16	\$258.09	\$84.23
72142	S	Magnetic image, neck spine	726	7.96	\$421.16	\$258.09	\$84.23
72146	S	Magnetic image, chest spine	726	7.96	\$421.16	\$258.09	\$84.23
72147	S	Magnetic image, chest spine	726	7.96	\$421.16	\$258.09	\$84.23
72148	S	Magnetic image, lumbar spine	726	7.96	\$421.16	\$258.09	\$84.23
72149	S	Magnetic image, lumbar spine	726	7.96	\$421.16	\$258.09	\$84.23
72156	S	Magnetic image, neck spine	726	7.96	\$421.16	\$258.09	\$84.23
72157	S	Magnetic image, chest spine	726	7.96	\$421.16	\$258.09	\$84.23
72158	S	Magnetic image, lumbar spine	726	7.96	\$421.16	\$258.09	\$84.23
72159	E	Magnetic imaging/spine (MRA)					
72170	X	X-ray exam of pelvis	700	0.78	\$41.14	\$22.37	\$8.23
72190	X	X-ray exam of pelvis	700	0.78	\$41.14	\$22.37	\$8.23
72192	S	CAT scan of pelvis	710	5.06	\$267.39	\$176.28	\$53.48
72193	S	Contrast CAT scan of pelvis	710	5.06	\$267.39	\$176.28	\$53.48
72194	S	Contrast CAT scans of pelvis	710	5.06	\$267.39	\$176.28	\$53.48
72196	S	Magnetic image, pelvis	726	7.96	\$421.16	\$258.09	\$84.23
72198	E	Magnetic imaging/pelvis(MRA)					
72200	X	X-ray exam sacroiliac joints	700	0.78	\$41.14	\$22.37	\$8.23
72202	X	X-ray exam sacroiliac joints	700	0.78	\$41.14	\$22.37	\$8.23
72220	X	X-ray exam of tailbone	700	0.78	\$41.14	\$22.37	\$8.23
72240	S	Contrast x-ray of neck spine	728	4.07	\$215.48	\$113.23	\$43.10
72255	S	Contrast x-ray thorax spine	728	4.07	\$215.48	\$113.23	\$43.10
72265	S	Contrast x-ray lower spine	728	4.07	\$215.48	\$113.23	\$43.10
72270	S	Contrast x-ray of spine	728	4.07	\$215.48	\$113.23	\$43.10
72285	S	X-ray of neck spine disk	728	4.07	\$215.48	\$113.23	\$43.10
72295	S	X-ray of lower spine disk	728	4.07	\$215.48	\$113.23	\$43.10
73000	X	X-ray exam of collarbone	700	0.78	\$41.14	\$22.37	\$8.23
73010	X	X-ray exam of shoulderblade	700	0.78	\$41.14	\$22.37	\$8.23
73020	X	X-ray exam of shoulder	700	0.78	\$41.14	\$22.37	\$8.23
73030	X	X-ray exam of shoulder	700	0.78	\$41.14	\$22.37	\$8.23
73040	S	Contrast x-ray of shoulder	730	2.48	\$131.25	\$72.09	\$26.25
73050	X	X-ray exam of shoulders	700	0.78	\$41.14	\$22.37	\$8.23
73060	X	X-ray exam of humerus	700	0.78	\$41.14	\$22.37	\$8.23
73070	X	X-ray exam of elbow	700	0.78	\$41.14	\$22.37	\$8.23
73080	X	X-ray exam of elbow	700	0.78	\$41.14	\$22.37	\$8.23

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
73085	S	Contrast x-ray of elbow	730	2.48	\$131.25	\$72.09	\$26.25
73090	X	X-ray exam of forearm	700	0.78	\$41.14	\$22.37	\$8.23
73092	X	X-ray exam of arm, infant	700	0.78	\$41.14	\$22.37	\$8.23
73100	X	X-ray exam of wrist	700	0.78	\$41.14	\$22.37	\$8.23
73110	X	X-ray exam of wrist	700	0.78	\$41.14	\$22.37	\$8.23
73115	S	Contrast x-ray of wrist	730	2.48	\$131.25	\$72.09	\$26.25
73120	X	X-ray exam of hand	700	0.78	\$41.14	\$22.37	\$8.23
73130	X	X-ray exam of hand	700	0.78	\$41.14	\$22.37	\$8.23
73140	X	X-ray exam of finger(s)	700	0.78	\$41.14	\$22.37	\$8.23
73200	S	CAT scan of arm	710	5.06	\$267.39	\$176.28	\$53.48
73201	S	Contrast CAT scan of arm	710	5.06	\$267.39	\$176.28	\$53.48
73202	S	Contrast CAT scans of arm	710	5.06	\$267.39	\$176.28	\$53.48
73220	S	Magnetic image, arm, hand	726	7.96	\$421.16	\$258.09	\$84.23
73221	S	Magnetic image, joint of arm	726	7.96	\$421.16	\$258.09	\$84.23
73225	E	Magnetic imaging/upper (MRA)					
73500	X	X-ray exam of hip	700	0.78	\$41.14	\$22.37	\$8.23
73510	X	X-ray exam of hip	700	0.78	\$41.14	\$22.37	\$8.23
73520	X	X-ray exam of hips	700	0.78	\$41.14	\$22.37	\$8.23
73525	S	Contrast x-ray of hip	730	2.48	\$131.25	\$72.09	\$26.25
73530	X	X-ray exam of hip	700	0.78	\$41.14	\$22.37	\$8.23
73540	X	X-ray exam of pelvis & hips	700	0.78	\$41.14	\$22.37	\$8.23
73550	X	X-ray exam of thigh	700	0.78	\$41.14	\$22.37	\$8.23
73560	X	X-ray exam of knee	700	0.78	\$41.14	\$22.37	\$8.23
73562	X	X-ray exam of knee	700	0.78	\$41.14	\$22.37	\$8.23
73564	X	X-ray exam of knee	700	0.78	\$41.14	\$22.37	\$8.23
73565	X	X-ray exam of knee	700	0.78	\$41.14	\$22.37	\$8.23
73580	S	Contrast x-ray of knee joint	730	2.48	\$131.25	\$72.09	\$26.25
73590	X	X-ray exam of lower leg	700	0.78	\$41.14	\$22.37	\$8.23
73592	X	X-ray exam of leg, infant	700	0.78	\$41.14	\$22.37	\$8.23
73600	X	X-ray exam of ankle	700	0.78	\$41.14	\$22.37	\$8.23
73610	X	X-ray exam of ankle	700	0.78	\$41.14	\$22.37	\$8.23
73615	S	Contrast x-ray of ankle	730	2.48	\$131.25	\$72.09	\$26.25
73620	X	X-ray exam of foot	700	0.78	\$41.14	\$22.37	\$8.23
73630	X	X-ray exam of foot	700	0.78	\$41.14	\$22.37	\$8.23
73650	X	X-ray exam of heel	700	0.78	\$41.14	\$22.37	\$8.23
73660	X	X-ray exam of toe(s)	700	0.78	\$41.14	\$22.37	\$8.23
73700	S	CAT scan of leg	710	5.06	\$267.39	\$176.28	\$53.48
73701	S	Contrast CAT scan of leg	710	5.06	\$267.39	\$176.28	\$53.48
73702	S	Contrast CAT scans of leg	710	5.06	\$267.39	\$176.28	\$53.48
73720	S	Magnetic image, leg, foot	726	7.96	\$421.16	\$258.09	\$84.23
73721	S	Magnetic image, joint of leg	726	7.96	\$421.16	\$258.09	\$84.23
73725	E	Magnetic imaging/lower (MRA)					
74000	X	X-ray exam of abdomen	700	0.78	\$41.14	\$22.37	\$8.23
74010	X	X-ray exam of abdomen	700	0.78	\$41.14	\$22.37	\$8.23
74020	X	X-ray exam of abdomen	700	0.78	\$41.14	\$22.37	\$8.23
74022	X	X-ray exam series, abdomen	700	0.78	\$41.14	\$22.37	\$8.23
74150	S	CAT scan of abdomen	710	5.06	\$267.39	\$176.28	\$53.48
74160	S	Contrast CAT scan of abdomen	710	5.06	\$267.39	\$176.28	\$53.48
74170	S	Contrast CAT scans, abdomen	710	5.06	\$267.39	\$176.28	\$53.48
74181	S	Magnetic image, abdomen (MRI)	726	7.96	\$421.16	\$258.09	\$84.23
74185	E	Magnetic image/abdomen (MRA)					
74190	X	X-ray exam of peritoneum	706	1.96	\$103.82	\$57.63	\$20.76
74210	S	Contrast x-ray exam of throat	736	1.85	\$97.95	\$54.24	\$19.59
74220	S	Contrast x-ray exam, esophagus	736	1.85	\$97.95	\$54.24	\$19.59
74230	S	Cinema x-ray throat/esophagus	736	1.85	\$97.95	\$54.24	\$19.59
74235	S	Remove esophagus obstruction	738	4.48	\$237.03	\$133.34	\$47.41
74240	S	X-ray exam upper GI tract	736	1.85	\$97.95	\$54.24	\$19.59
74241	S	X-ray exam upper GI tract	736	1.85	\$97.95	\$54.24	\$19.59
74245	S	X-ray exam upper GI tract	736	1.85	\$97.95	\$54.24	\$19.59
74246	S	Contrast x-ray upper GI tract	736	1.85	\$97.95	\$54.24	\$19.59
74247	S	Contrast x-ray upper GI tract	736	1.85	\$97.95	\$54.24	\$19.59
74249	S	Contrast x-ray upper GI tract	736	1.85	\$97.95	\$54.24	\$19.59
74250	S	X-ray exam of small bowel	736	1.85	\$97.95	\$54.24	\$19.59
74251	S	X-ray exam of small bowel	736	1.85	\$97.95	\$54.24	\$19.59
74260	S	X-ray exam of small bowel	736	1.85	\$97.95	\$54.24	\$19.59
74270	S	Contrast x-ray exam of colon	736	1.85	\$97.95	\$54.24	\$19.59
74280	S	Contrast x-ray exam of colon	736	1.85	\$97.95	\$54.24	\$19.59
74283	S	Contrast x-ray exam of colon	736	1.85	\$97.95	\$54.24	\$19.59
74290	S	Contrast x-ray, gallbladder	736	1.85	\$97.95	\$54.24	\$19.59
74291	S	Contrast x-rays, gallbladder	736	1.85	\$97.95	\$54.24	\$19.59
74300	C	X-ray bile ducts, pancreas					
74301	C	Additional x-rays at surgery					
74305	X	X-ray bile ducts, pancreas	706	1.96	\$103.82	\$57.63	\$20.76
74320	X	Contrast x-ray of bile ducts	706	1.96	\$103.82	\$57.63	\$20.76
74327	S	X-ray for bile stone removal	738	4.48	\$237.03	\$133.34	\$47.41

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
74328	X	Xray for bile duct endoscopy	706	1.96	\$103.82	\$57.63	\$20.76
74329	X	X-ray for pancreas endoscopy	706	1.96	\$103.82	\$57.63	\$20.76
74330	X	Xray,bile/pancreas endoscopy	706	1.96	\$103.82	\$57.63	\$20.76
74340	X	X-ray guide for GI tube	716	1.59	\$84.23	\$47.91	\$16.85
74350	X	X-ray guide, stomach tube	706	1.96	\$103.82	\$57.63	\$20.76
74355	X	X-ray guide, intestinal tube	706	1.96	\$103.82	\$57.63	\$20.76
74360	S	X-ray guide, GI dilation	738	4.48	\$237.03	\$133.34	\$47.41
74363	S	X-ray, bile duct dilation	738	4.48	\$237.03	\$133.34	\$47.41
74400	S	Contrast x-ray urinary tract	737	2.81	\$148.88	\$86.56	\$29.78
74405	S	Contrast x-ray urinary tract	737	2.81	\$148.88	\$86.56	\$29.78
74410	S	Contrast x-ray urinary tract	737	2.81	\$148.88	\$86.56	\$29.78
74415	S	Contrast x-ray urinary tract	737	2.81	\$148.88	\$86.56	\$29.78
74420	S	Contrast x-ray urinary tract	737	2.81	\$148.88	\$86.56	\$29.78
74425	S	Contrast x-ray urinary tract	737	2.81	\$148.88	\$86.56	\$29.78
74430	S	Contrast x-ray of bladder	737	2.81	\$148.88	\$86.56	\$29.78
74440	S	Xray exam male genital tract	737	2.81	\$148.88	\$86.56	\$29.78
74445	S	X-ray exam of penis	737	2.81	\$148.88	\$86.56	\$29.78
74450	S	X-ray exam urethra/bladder	737	2.81	\$148.88	\$86.56	\$29.78
74455	S	X-ray exam urethra/bladder	737	2.81	\$148.88	\$86.56	\$29.78
74470	X	X-ray exam of kidney lesion	706	1.96	\$103.82	\$57.63	\$20.76
74475	S	Xray control catheter insert	738	4.48	\$237.03	\$133.34	\$47.41
74480	S	Xray control catheter insert	738	4.48	\$237.03	\$133.34	\$47.41
74485	S	X-ray guide, GU dilation	738	4.48	\$237.03	\$133.34	\$47.41
74710	X	X-ray measurement of pelvis	700	0.78	\$41.14	\$22.37	\$8.23
74740	X	X-ray female genital tract	706	1.96	\$103.82	\$57.63	\$20.76
74742	X	X-ray fallopian tube	706	1.96	\$103.82	\$57.63	\$20.76
74775	S	X-ray exam of perineum	737	2.81	\$148.88	\$86.56	\$29.78
75552	S	Magnetic image, myocardium	726	7.96	\$421.16	\$258.09	\$84.23
75553	S	Magnetic image, myocardium	726	7.96	\$421.16	\$258.09	\$84.23
75554	S	Cardiac MRI/function	726	7.96	\$421.16	\$258.09	\$84.23
75555	S	Cardiac MRI/limited study	726	7.96	\$421.16	\$258.09	\$84.23
75556	E	Cardiac MRI/flow mapping					
75600	S	Contrast x-ray exam of aorta	739	5.83	\$308.53	\$168.82	\$61.71
75605	S	Contrast x-ray exam of aorta	739	5.83	\$308.53	\$168.82	\$61.71
75625	S	Contrast x-ray exam of aorta	739	5.83	\$308.53	\$168.82	\$61.71
75630	S	X-ray aorta, leg arteries	739	5.83	\$308.53	\$168.82	\$61.71
75650	S	Artery x-rays, head & neck	739	5.83	\$308.53	\$168.82	\$61.71
75658	S	X-ray exam of arm arteries	739	5.83	\$308.53	\$168.82	\$61.71
75660	S	Artery x-rays, head & neck	739	5.83	\$308.53	\$168.82	\$61.71
75662	S	Artery x-rays, head & neck	739	5.83	\$308.53	\$168.82	\$61.71
75665	S	Artery x-rays, head & neck	739	5.83	\$308.53	\$168.82	\$61.71
75671	S	Artery x-rays, head & neck	739	5.83	\$308.53	\$168.82	\$61.71
75676	S	Artery x-rays, neck	739	5.83	\$308.53	\$168.82	\$61.71
75680	S	Artery x-rays, neck	739	5.83	\$308.53	\$168.82	\$61.71
75685	S	Artery x-rays, spine	739	5.83	\$308.53	\$168.82	\$61.71
75705	S	Artery x-rays, spine	739	5.83	\$308.53	\$168.82	\$61.71
75710	S	Artery x-rays, arm/leg	739	5.83	\$308.53	\$168.82	\$61.71
75716	S	Artery x-rays, arms/legs	739	5.83	\$308.53	\$168.82	\$61.71
75722	S	Artery x-rays, kidney	739	5.83	\$308.53	\$168.82	\$61.71
75724	S	Artery x-rays, kidneys	739	5.83	\$308.53	\$168.82	\$61.71
75726	S	Artery x-rays, abdomen	739	5.83	\$308.53	\$168.82	\$61.71
75731	S	Artery x-rays, adrenal gland	739	5.83	\$308.53	\$168.82	\$61.71
75733	S	Artery x-rays,adrenal glands	739	5.83	\$308.53	\$168.82	\$61.71
75736	S	Artery x-rays, pelvis	739	5.83	\$308.53	\$168.82	\$61.71
75741	S	Artery x-rays, lung	739	5.83	\$308.53	\$168.82	\$61.71
75743	S	Artery x-rays, lungs	739	5.83	\$308.53	\$168.82	\$61.71
75746	S	Artery x-rays, lung	739	5.83	\$308.53	\$168.82	\$61.71
75756	S	Artery x-rays, chest	739	5.83	\$308.53	\$168.82	\$61.71
75774	S	Artery x-ray, each vessel	739	5.83	\$308.53	\$168.82	\$61.71
75790	S	Visualize A-V shunt	739	5.83	\$308.53	\$168.82	\$61.71
75801	X	Lymph vessel x-ray, arm/leg	706	1.96	\$103.82	\$57.63	\$20.76
75803	X	Lymph vessel x-ray,arms/legs	706	1.96	\$103.82	\$57.63	\$20.76
75805	X	Lymph vessel x-ray, trunk	706	1.96	\$103.82	\$57.63	\$20.76
75807	X	Lymph vessel x-ray, trunk	706	1.96	\$103.82	\$57.63	\$20.76
75809	X	Nonvascular shunt, x-ray	706	1.96	\$103.82	\$57.63	\$20.76
75810	S	Vein x-ray, spleen/liver	739	5.83	\$308.53	\$168.82	\$61.71
75820	S	Vein x-ray, arm/leg	739	5.83	\$308.53	\$168.82	\$61.71
75822	S	Vein x-ray, arms/legs	739	5.83	\$308.53	\$168.82	\$61.71
75825	S	Vein x-ray, trunk	739	5.83	\$308.53	\$168.82	\$61.71
75827	S	Vein x-ray, chest	739	5.83	\$308.53	\$168.82	\$61.71
75831	S	Vein x-ray, kidney	739	5.83	\$308.53	\$168.82	\$61.71
75833	S	Vein x-ray, kidneys	739	5.83	\$308.53	\$168.82	\$61.71
75840	S	Vein x-ray, adrenal gland	739	5.83	\$308.53	\$168.82	\$61.71
75842	S	Vein x-ray, adrenal glands	739	5.83	\$308.53	\$168.82	\$61.71
75860	S	Vein x-ray, neck	739	5.83	\$308.53	\$168.82	\$61.71

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
75870	S	Vein x-ray, skull	739	5.83	\$308.53	\$168.82	\$61.71
75872	S	Vein x-ray, skull	739	5.83	\$308.53	\$168.82	\$61.71
75880	S	Vein x-ray, eye socket	739	5.83	\$308.53	\$168.82	\$61.71
75885	S	Vein x-ray, liver	739	5.83	\$308.53	\$168.82	\$61.71
75887	S	Vein x-ray, liver	739	5.83	\$308.53	\$168.82	\$61.71
75889	S	Vein x-ray, liver	739	5.83	\$308.53	\$168.82	\$61.71
75891	S	Vein x-ray, liver	739	5.83	\$308.53	\$168.82	\$61.71
75893	N	Venous sampling by catheter					
75894	C	Xrays, transcatheter therapy					
75896	C	Xrays, transcatheter therapy					
75898	X	Follow-up angiogram	706	1.96	\$103.82	\$57.63	\$20.76
75900	C	Arterial catheter exchange					
75940	C	X-ray placement, vein filter					
75945	C	Intravascular us					
75946	C	Intravascular us					
75960	C	Transcatheter intro, stent					
75961	C	Retrieval, broken catheter					
75962	C	Repair arterial blockage					
75964	C	Repair artery blockage, each					
75966	C	Repair arterial blockage					
75968	C	Repair artery blockage, each					
75970	C	Vascular biopsy					
75978	C	Repair venous blockage					
75980	S	Contrast xray exam bile duct	738	4.48	\$237.03	\$133.34	\$47.41
75982	S	Contrast xray exam bile duct	738	4.48	\$237.03	\$133.34	\$47.41
75984	S	Xray control catheter change	738	4.48	\$237.03	\$133.34	\$47.41
75989	X	Abscess drainage under x-ray	716	1.59	\$84.23	\$47.91	\$16.85
75992	C	Atherectomy, x-ray exam					
75993	C	Atherectomy, x-ray exam					
75994	C	Atherectomy, x-ray exam					
75995	C	Atherectomy, x-ray exam					
75996	C	Atherectomy, x-ray exam					
76000	X	Fluoroscope examination	716	1.59	\$84.23	\$47.91	\$16.85
76001	X	Fluoroscope exam, extensive	716	1.59	\$84.23	\$47.91	\$16.85
76003	X	Needle localization by x-ray	716	1.59	\$84.23	\$47.91	\$16.85
76010	X	X-ray, nose to rectum	700	0.78	\$41.14	\$22.37	\$8.23
76020	X	X-rays for bone age	700	0.78	\$41.14	\$22.37	\$8.23
76040	X	X-rays, bone evaluation	700	0.78	\$41.14	\$22.37	\$8.23
76061	X	X-rays, bone survey	700	0.78	\$41.14	\$22.37	\$8.23
76062	X	X-rays, bone survey	700	0.78	\$41.14	\$22.37	\$8.23
76065	X	X-rays, bone evaluation	700	0.78	\$41.14	\$22.37	\$8.23
76066	X	Joint(s) survey, single film	700	0.78	\$41.14	\$22.37	\$8.23
76070	E	CT scan, bone density study					
76075	X	Dual energy x-ray study	706	1.96	\$103.82	\$57.63	\$20.76
76076	X	Dual energy x-ray study	700	0.78	\$41.14	\$22.37	\$8.23
76078	X	Photodensitometry	700	0.78	\$41.14	\$22.37	\$8.23
76080	X	X-ray exam of fistula	706	1.96	\$103.82	\$57.63	\$20.76
76086	X	X-ray of mammary duct	706	1.96	\$103.82	\$57.63	\$20.76
76088	X	X-ray of mammary ducts	706	1.96	\$103.82	\$57.63	\$20.76
76090	S	Mammogram, one breast	746	0.69	\$36.24	\$19.44	\$7.25
76091	S	Mammogram, both breasts	746	0.69	\$36.24	\$19.44	\$7.25
76092	A	Mammogram, screening					
76093	S	Magnetic image, breast	726	7.96	\$421.16	\$258.09	\$84.23
76094	S	Magnetic image, both breasts	726	7.96	\$421.16	\$258.09	\$84.23
76095	X	Stereotactic breast biopsy	706	1.96	\$103.82	\$57.63	\$20.76
76096	X	X-ray of needle wire, breast	706	1.96	\$103.82	\$57.63	\$20.76
76098	X	X-ray exam, breast specimen	700	0.78	\$41.14	\$22.37	\$8.23
76100	X	X-ray exam of body section	700	0.78	\$41.14	\$22.37	\$8.23
76101	X	Complex body section x-ray	706	1.96	\$103.82	\$57.63	\$20.76
76102	X	Complex body section x-rays	706	1.96	\$103.82	\$57.63	\$20.76
76120	X	Cinematic x-rays	700	0.78	\$41.14	\$22.37	\$8.23
76125	X	Cinematic x-rays	700	0.78	\$41.14	\$22.37	\$8.23
76140	E	X-ray consultation					
76150	X	X-ray exam, dry process	700	0.78	\$41.14	\$22.37	\$8.23
76350	N	Special x-ray contrast study					
76355	S	CAT scan for localization	710	5.06	\$267.39	\$176.28	\$53.48
76360	S	CAT scan for needle biopsy	710	5.06	\$267.39	\$176.28	\$53.48
76365	S	CAT scan for cyst aspiration	710	5.06	\$267.39	\$176.28	\$53.48
76370	S	CAT scan for therapy guide	710	5.06	\$267.39	\$176.28	\$53.48
76375	S	3d/holograph reconstr add-on	710	5.06	\$267.39	\$176.28	\$53.48
76380	S	CAT scan follow-up study	710	5.06	\$267.39	\$176.28	\$53.48
76390	S	Mr spectroscopy	726	7.96	\$421.16	\$258.09	\$84.23
76400	X	Magnetic image, bone marrow	726	7.96	\$421.16	\$258.09	\$84.23
76499	X	Radiographic procedure	700	0.78	\$41.14	\$22.37	\$8.23
76506	S	Echo exam of head	747	1.65	\$87.17	\$54.69	\$17.43

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
76511	S	Echo exam of eye	747	1.65	\$87.17	\$54.69	\$17.43
76512	S	Echo exam of eye	747	1.65	\$87.17	\$54.69	\$17.43
76513	S	Echo exam of eye, water bath	747	1.65	\$87.17	\$54.69	\$17.43
76516	S	Echo exam of eye	747	1.65	\$87.17	\$54.69	\$17.43
76519	S	Echo exam of eye	747	1.65	\$87.17	\$54.69	\$17.43
76529	S	Echo exam of eye	747	1.65	\$87.17	\$54.69	\$17.43
76536	S	Echo exam of head and neck	747	1.65	\$87.17	\$54.69	\$17.43
76604	S	Echo exam of chest	747	1.65	\$87.17	\$54.69	\$17.43
76645	S	Echo exam of breast	747	1.65	\$87.17	\$54.69	\$17.43
76700	S	Echo exam of abdomen	747	1.65	\$87.17	\$54.69	\$17.43
76705	S	Echo exam of abdomen	747	1.65	\$87.17	\$54.69	\$17.43
76770	S	Echo exam abdomen back wall	747	1.65	\$87.17	\$54.69	\$17.43
76775	S	Echo exam abdomen back wall	747	1.65	\$87.17	\$54.69	\$17.43
76778	S	Echo exam kidney transplant	747	1.65	\$87.17	\$54.69	\$17.43
76800	S	Echo exam spinal canal	747	1.65	\$87.17	\$54.69	\$17.43
76805	S	Echo exam of pregnant uterus	747	1.65	\$87.17	\$54.69	\$17.43
76810	S	Echo exam of pregnant uterus	747	1.65	\$87.17	\$54.69	\$17.43
76815	S	Echo exam of pregnant uterus	747	1.65	\$87.17	\$54.69	\$17.43
76816	S	Echo exam followup or repeat	747	1.65	\$87.17	\$54.69	\$17.43
76818	S	Fetal biophysical profile	747	1.65	\$87.17	\$54.69	\$17.43
76825	X	Echo exam of fetal heart	957	2.83	\$149.86	\$117.07	\$29.97
76826	X	Echo exam of fetal heart	957	2.83	\$149.86	\$117.07	\$29.97
76827	X	Echo exam of fetal heart	957	2.83	\$149.86	\$117.07	\$29.97
76828	X	Echo exam of fetal heart	957	2.83	\$149.86	\$117.07	\$29.97
76830	S	Echo exam, transvaginal	747	1.65	\$87.17	\$54.69	\$17.43
76831	S	Echo exam, uterus	747	1.65	\$87.17	\$54.69	\$17.43
76856	S	Echo exam of pelvis	747	1.65	\$87.17	\$54.69	\$17.43
76857	S	Echo exam of pelvis	747	1.65	\$87.17	\$54.69	\$17.43
76870	S	Echo exam of scrotum	747	1.65	\$87.17	\$54.69	\$17.43
76872	S	Echo exam, transrectal	747	1.65	\$87.17	\$54.69	\$17.43
76880	S	Echo exam of extremity	747	1.65	\$87.17	\$54.69	\$17.43
76885	S	Echo exam, infant hips	747	1.65	\$87.17	\$54.69	\$17.43
76886	S	Echo exam, infant hips	747	1.65	\$87.17	\$54.69	\$17.43
76930	X	Echo guide for heart sac tap	749	2.46	\$130.27	\$76.16	\$26.05
76932	X	Echo guide for heart biopsy	749	2.46	\$130.27	\$76.16	\$26.05
76934	X	Echo guide for chest tap	749	2.46	\$130.27	\$76.16	\$26.05
76936	X	Echo guide for artery repair	749	2.46	\$130.27	\$76.16	\$26.05
76938	X	Echo exam for drainage	749	2.46	\$130.27	\$76.16	\$26.05
76941	X	Echo guide for transfusion	749	2.46	\$130.27	\$76.16	\$26.05
76942	X	Echo guide for biopsy	749	2.46	\$130.27	\$76.16	\$26.05
76945	X	Echo guide, villus sampling	749	2.46	\$130.27	\$76.16	\$26.05
76946	X	Echo guide for amniocentesis	749	2.46	\$130.27	\$76.16	\$26.05
76948	X	Echo guide, ova aspiration	749	2.46	\$130.27	\$76.16	\$26.05
76950	X	Echo guidance radiotherapy	749	2.46	\$130.27	\$76.16	\$26.05
76960	X	Echo guidance radiotherapy	749	2.46	\$130.27	\$76.16	\$26.05
76965	X	Echo guidance radiotherapy	749	2.46	\$130.27	\$76.16	\$26.05
76970	S	Ultrasound exam follow-up	747	1.65	\$87.17	\$54.69	\$17.43
76975	S	GI endoscopic ultrasound	747	1.65	\$87.17	\$54.69	\$17.43
76986	S	Echo exam at surgery	747	1.65	\$87.17	\$54.69	\$17.43
76999	S	Echo examination procedure	747	1.65	\$87.17	\$54.69	\$17.43
77261	X	Radiation therapy planning	750	0.93	\$48.97	\$25.54	\$9.79
77262	X	Radiation therapy planning	750	0.93	\$48.97	\$25.54	\$9.79
77263	X	Radiation therapy planning	750	0.93	\$48.97	\$25.54	\$9.79
77280	X	Set radiation therapy field	752	3.56	\$188.05	\$88.82	\$37.61
77285	X	Set radiation therapy field	752	3.56	\$188.05	\$88.82	\$37.61
77290	X	Set radiation therapy field	752	3.56	\$188.05	\$88.82	\$37.61
77295	X	Set radiation therapy field	752	3.56	\$188.05	\$88.82	\$37.61
77299	X	Radiation therapy planning	751	1.07	\$56.81	\$33.22	\$11.36
77300	X	Radiation therapy dose plan	751	1.07	\$56.81	\$33.22	\$11.36
77305	X	Radiation therapy dose plan	751	1.07	\$56.81	\$33.22	\$11.36
77310	X	Radiation therapy dose plan	751	1.07	\$56.81	\$33.22	\$11.36
77315	X	Radiation therapy dose plan	751	1.07	\$56.81	\$33.22	\$11.36
77321	X	Radiation therapy port plan	751	1.07	\$56.81	\$33.22	\$11.36
77326	X	Radiation therapy dose plan	751	1.07	\$56.81	\$33.22	\$11.36
77327	X	Radiation therapy dose plan	751	1.07	\$56.81	\$33.22	\$11.36
77328	X	Radiation therapy dose plan	751	1.07	\$56.81	\$33.22	\$11.36
77331	X	Special radiation dosimetry	751	1.07	\$56.81	\$33.22	\$11.36
77332	X	Radiation treatment aid(s)	751	1.07	\$56.81	\$33.22	\$11.36
77333	X	Radiation treatment aid(s)	751	1.07	\$56.81	\$33.22	\$11.36
77334	X	Radiation treatment aid(s)	751	1.07	\$56.81	\$33.22	\$11.36
77336	X	Radiation physics consu	750	0.93	\$48.97	\$25.54	\$9.79
77370	X	Radiation physics consult	750	0.93	\$48.97	\$25.54	\$9.79
77399	X	External radiation dosimetry	750	0.93	\$48.97	\$25.54	\$9.79
77401	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77402	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
77403	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77404	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77406	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77407	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77408	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77409	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77411	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77412	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77413	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77414	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77416	S	Radiation treatment delivery	757	2.20	\$116.55	\$52.43	\$23.31
77417	X	Radiology port film(s)	700	0.78	\$41.14	\$22.37	\$8.23
77419	E	Weekly radiation therapy					
77420	E	Weekly radiation therapy					
77425	E	Weekly radiation therapy					
77430	E	Weekly radiation therapy					
77431	X	Radiation therapy management	750	0.93	\$48.97	\$25.54	\$9.79
77432	X	Stereotactic radiation trmt	750	0.93	\$48.97	\$25.54	\$9.79
77470	S	Special radiation treatment	757	2.20	\$116.55	\$52.43	\$23.31
77499	N	Radiation therapy management					
77600	S	Hyperthermia treatment	758	3.41	\$180.22	\$76.84	\$36.04
77605	S	Hyperthermia treatment	758	3.41	\$180.22	\$76.84	\$36.04
77610	S	Hyperthermia treatment	758	3.41	\$180.22	\$76.84	\$36.04
77615	S	Hyperthermia treatment	758	3.41	\$180.22	\$76.84	\$36.04
77620	S	Hyperthermia treatment	758	3.41	\$180.22	\$76.84	\$36.04
77750	S	Infuse radioactive materials	759	8.09	\$428.02	\$160.01	\$85.60
77761	S	Radioelement application	759	8.09	\$428.02	\$160.01	\$85.60
77762	S	Radioelement application	759	8.09	\$428.02	\$160.01	\$85.60
77763	S	Radioelement application	759	8.09	\$428.02	\$160.01	\$85.60
77776	S	Radioelement application	759	8.09	\$428.02	\$160.01	\$85.60
77777	S	Radioelement application	759	8.09	\$428.02	\$160.01	\$85.60
77778	S	Radioelement application	759	8.09	\$428.02	\$160.01	\$85.60
77781	S	High intensity brachytherapy	759	8.09	\$428.02	\$160.01	\$85.60
77782	S	High intensity brachytherapy	759	8.09	\$428.02	\$160.01	\$85.60
77783	S	High intensity brachytherapy	759	8.09	\$428.02	\$160.01	\$85.60
77784	S	High intensity brachytherapy	759	8.09	\$428.02	\$160.01	\$85.60
77789	S	Radioelement application	759	8.09	\$428.02	\$160.01	\$85.60
77790	N	Radioelement handling					
77799	S	Radium/radioisotope therapy	759	8.09	\$428.02	\$160.01	\$85.60
78000	S	Thyroid, single uptake	761	2.06	\$108.72	\$61.47	\$21.74
78001	S	Thyroid, multiple uptakes	762	1.80	\$95.01	\$51.53	\$19.00
78003	S	Thyroid suppress/stimul	762	1.80	\$95.01	\$51.53	\$19.00
78006	S	Thyroid, imaging with uptake	771	3.81	\$201.77	\$116.84	\$40.35
78007	S	Thyroid, image, mult uptakes	772	4.28	\$226.25	\$127.92	\$45.25
78010	S	Thyroid imaging	771	3.81	\$201.77	\$116.84	\$40.35
78011	S	Thyroid imaging with flow	771	3.81	\$201.77	\$116.84	\$40.35
78015	S	Thyroid met imaging	771	3.81	\$201.77	\$116.84	\$40.35
78016	S	Thyroid met imaging/studies	772	4.28	\$226.25	\$127.92	\$45.25
78017	S	Thyroid met imaging, mult	772	4.28	\$226.25	\$127.92	\$45.25
78018	S	Thyroid, met imaging, body	772	4.28	\$226.25	\$127.92	\$45.25
78070	S	Parathyroid nuclear imaging	772	4.28	\$226.25	\$127.92	\$45.25
78075	S	Adrenal nuclear imaging	772	4.28	\$226.25	\$127.92	\$45.25
78099	S	Endocrine nuclear procedure	761	2.06	\$108.72	\$61.47	\$21.74
78102	S	Bone marrow imaging, ltd	771	3.81	\$201.77	\$116.84	\$40.35
78103	S	Bone marrow imaging, mult	771	3.81	\$201.77	\$116.84	\$40.35
78104	S	Bone marrow imaging, body	771	3.81	\$201.77	\$116.84	\$40.35
78110	S	Plasma volume, single	761	2.06	\$108.72	\$61.47	\$21.74
78111	S	Plasma volume, multiple	761	2.06	\$108.72	\$61.47	\$21.74
78120	S	Red cell mass, single	761	2.06	\$108.72	\$61.47	\$21.74
78121	S	Red cell mass, multiple	762	1.80	\$95.01	\$51.53	\$19.00
78122	S	Blood volume	762	1.80	\$95.01	\$51.53	\$19.00
78130	S	Red cell survival study	762	1.80	\$95.01	\$51.53	\$19.00
78135	S	Red cell survival kinetics	762	1.80	\$95.01	\$51.53	\$19.00
78140	S	Red cell sequestration	762	1.80	\$95.01	\$51.53	\$19.00
78160	S	Plasma iron turnover	762	1.80	\$95.01	\$51.53	\$19.00
78162	S	Iron absorption exam	762	1.80	\$95.01	\$51.53	\$19.00
78170	S	Red cell iron utilization	762	1.80	\$95.01	\$51.53	\$19.00
78172	S	Total body iron estimation	762	1.80	\$95.01	\$51.53	\$19.00
78185	S	Spleen imaging	771	3.81	\$201.77	\$116.84	\$40.35
78190	S	Platelet survival, kinetics	762	1.80	\$95.01	\$51.53	\$19.00
78191	S	Platelet survival	762	1.80	\$95.01	\$51.53	\$19.00
78195	S	Lymph system imaging	772	4.28	\$226.25	\$127.92	\$45.25
78199	S	Blood/lymph nuclear exam	761	2.06	\$108.72	\$61.47	\$21.74
78201	S	Liver imaging	771	3.81	\$201.77	\$116.84	\$40.35
78202	S	Liver imaging with flow	771	3.81	\$201.77	\$116.84	\$40.35

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
78205	S	Liver imaging (3D)	781	5.37	\$284.04	\$145.77	\$56.81
78215	S	Liver and spleen imaging	771	3.81	\$201.77	\$116.84	\$40.35
78216	S	Liver & spleen image, flow	771	3.81	\$201.77	\$116.84	\$40.35
78220	S	Liver function study	772	4.28	\$226.25	\$127.92	\$45.25
78223	S	Hepatobiliary imaging	772	4.28	\$226.25	\$127.92	\$45.25
78230	S	Salivary gland imaging	771	3.81	\$201.77	\$116.84	\$40.35
78231	S	Serial salivary imaging	771	3.81	\$201.77	\$116.84	\$40.35
78232	S	Salivary gland function exam	772	4.28	\$226.25	\$127.92	\$45.25
78258	S	Esophageal motility study	772	4.28	\$226.25	\$127.92	\$45.25
78261	S	Gastric mucosa imaging	771	3.81	\$201.77	\$116.84	\$40.35
78262	S	Gastroesophageal reflux exam	772	4.28	\$226.25	\$127.92	\$45.25
78264	S	Gastric emptying study	772	4.28	\$226.25	\$127.92	\$45.25
78270	S	Vit B-12 absorption exam	761	2.06	\$108.72	\$61.47	\$21.74
78271	S	Vit B-12 absorp exam, IF	761	2.06	\$108.72	\$61.47	\$21.74
78272	S	Vit B-12 absorp, combined	761	2.06	\$108.72	\$61.47	\$21.74
78278	S	Acute GI blood loss imaging	772	4.28	\$226.25	\$127.92	\$45.25
78282	S	GI protein loss exam	761	2.06	\$108.72	\$61.47	\$21.74
78290	S	Meckel's divert exam	771	3.81	\$201.77	\$116.84	\$40.35
78291	S	Leveen/shunt patency exam	772	4.28	\$226.25	\$127.92	\$45.25
78299	S	GI nuclear procedure	761	2.06	\$108.72	\$61.47	\$21.74
78300	S	Bone imaging, limited area	771	3.81	\$201.77	\$116.84	\$40.35
78305	S	Bone imaging, multiple areas	771	3.81	\$201.77	\$116.84	\$40.35
78306	S	Bone imaging, whole body	771	3.81	\$201.77	\$116.84	\$40.35
78315	S	Bone imaging, 3 phase	772	4.28	\$226.25	\$127.92	\$45.25
78320	S	Bone imaging (3D)	781	5.37	\$284.04	\$145.77	\$56.81
78350	X	Bone mineral, single photon	700	0.78	\$41.14	\$22.37	\$8.23
78351	E	Bone mineral, dual photon	771	3.81	\$201.77	\$116.84	\$40.35
78399	S	Musculoskeletal nuclear exam	762	1.80	\$95.01	\$51.53	\$19.00
78414	S	Non-imaging heart function	771	3.81	\$201.77	\$116.84	\$40.35
78428	S	Cardiac shunt imaging	771	3.81	\$201.77	\$116.84	\$40.35
78445	S	Vascular flow imaging	771	3.81	\$201.77	\$116.84	\$40.35
78455	S	Venous thrombosis study	762	1.80	\$95.01	\$51.53	\$19.00
78457	S	Venous thrombosis imaging	771	3.81	\$201.77	\$116.84	\$40.35
78458	S	Ven thrombosis images, bilat	771	3.81	\$201.77	\$116.84	\$40.35
78459	S	Heart muscle imaging (PET)	760	17.91	\$947.13	\$419.46	\$189.43
78460	S	Heart muscle blood single	771	3.81	\$201.77	\$116.84	\$40.35
78461	S	Heart muscle blood multiple	772	4.28	\$226.25	\$127.92	\$45.25
78464	S	Heart image (3D) single	781	5.37	\$284.04	\$145.77	\$56.81
78465	S	Heart image (3D) multiple	782	9.50	\$502.46	\$275.04	\$100.49
78466	S	Heart infarct image	771	3.81	\$201.77	\$116.84	\$40.35
78468	S	Heart infarct image, EF	772	4.28	\$226.25	\$127.92	\$45.25
78469	S	Heart infarct image (3D)	781	5.37	\$284.04	\$145.77	\$56.81
78472	S	Gated heart, resting	772	4.28	\$226.25	\$127.92	\$45.25
78473	S	Gated heart, multiple	772	4.28	\$226.25	\$127.92	\$45.25
78478	S	Heart wall motion (add-on)	771	3.81	\$201.77	\$116.84	\$40.35
78480	S	Heart function, (add-on)	771	3.81	\$201.77	\$116.84	\$40.35
78481	S	Heart first pass single	771	3.81	\$201.77	\$116.84	\$40.35
78483	S	Heart first pass multiple	772	4.28	\$226.25	\$127.92	\$45.25
78491	E	Heart image (pet) single	762	1.80	\$95.01	\$51.53	\$19.00
78492	E	Heart image (pet) multiple	771	3.81	\$201.77	\$116.84	\$40.35
78499	S	Cardiovascular nuclear exam	771	3.81	\$201.77	\$116.84	\$40.35
78580	S	Lung perfusion imaging	772	4.28	\$226.25	\$127.92	\$45.25
78584	S	Lung V/Q image single breath	772	4.28	\$226.25	\$127.92	\$45.25
78585	S	Lung V/Q imaging	771	3.81	\$201.77	\$116.84	\$40.35
78586	S	Aerosol lung image, single	771	3.81	\$201.77	\$116.84	\$40.35
78587	S	Aerosol lung image, multiple	771	3.81	\$201.77	\$116.84	\$40.35
78591	S	Vent image, 1 breath, 1 proj	771	3.81	\$201.77	\$116.84	\$40.35
78593	S	Vent image, 1 proj, gas	771	3.81	\$201.77	\$116.84	\$40.35
78594	S	Vent image, mult proj, gas	772	4.28	\$226.25	\$127.92	\$45.25
78596	S	Lung differential function	772	4.28	\$226.25	\$127.92	\$45.25
78599	S	Respiratory nuclear exam	771	3.81	\$201.77	\$116.84	\$40.35
78600	S	Brain imaging, ltd static	771	3.81	\$201.77	\$116.84	\$40.35
78601	S	Brain ltd imaging & flow	771	3.81	\$201.77	\$116.84	\$40.35
78605	S	Brain imaging, complete	771	3.81	\$201.77	\$116.84	\$40.35
78606	S	Brain imaging comp & flow	772	4.28	\$226.25	\$127.92	\$45.25
78607	S	Brain imaging (3D)	781	5.37	\$284.04	\$145.77	\$56.81
78608	S	Brain imaging (PET)	760	17.91	\$947.13	\$419.46	\$189.43
78609	S	Brain imaging (PET)	760	17.91	\$947.13	\$419.46	\$189.43
78610	S	Brain flow imaging only	771	3.81	\$201.77	\$116.84	\$40.35
78615	S	Cerebral blood flow imaging	772	4.28	\$226.25	\$127.92	\$45.25
78630	S	Cerebrospinal fluid scan	772	4.28	\$226.25	\$127.92	\$45.25
78635	S	CSF ventriculography	772	4.28	\$226.25	\$127.92	\$45.25
78645	S	CSF shunt evaluation	772	4.28	\$226.25	\$127.92	\$45.25
78647	S	Cerebrospinal fluid scan	781	5.37	\$284.04	\$145.77	\$56.81
78650	S	CSF leakage imaging	772	4.28	\$226.25	\$127.92	\$45.25

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
78660	S	Nuclear exam of tear flow	771	3.81	\$201.77	\$116.84	\$40.35
78699	S	Nervous system nuclear exam	771	3.81	\$201.77	\$116.84	\$40.35
78700	S	Kidney imaging, static	771	3.81	\$201.77	\$116.84	\$40.35
78701	S	Kidney imaging with flow	771	3.81	\$201.77	\$116.84	\$40.35
78704	S	Imaging renogram	771	3.81	\$201.77	\$116.84	\$40.35
78707	S	Kidney flow & function image	771	3.81	\$201.77	\$116.84	\$40.35
78708	S	Kidney flow & function image	772	4.28	\$226.25	\$127.92	\$45.25
78709	S	Kidney flow & function image	772	4.28	\$226.25	\$127.92	\$45.25
78710	S	Kidney imaging (3D)	781	5.37	\$284.04	\$145.77	\$56.81
78715	S	Renal vascular flow exam	771	3.81	\$201.77	\$116.84	\$40.35
78725	S	Kidney function study	761	2.06	\$108.72	\$61.47	\$21.74
78730	S	Urinary bladder retention	771	3.81	\$201.77	\$116.84	\$40.35
78740	S	Ureteral reflux study	772	4.28	\$226.25	\$127.92	\$45.25
78760	S	Testicular imaging	771	3.81	\$201.77	\$116.84	\$40.35
78761	S	Testicular imaging & flow	771	3.81	\$201.77	\$116.84	\$40.35
78799	S	Genitourinary nuclear exam	771	3.81	\$201.77	\$116.84	\$40.35
78800	S	Tumor imaging, limited area	772	4.28	\$226.25	\$127.92	\$45.25
78801	S	Tumor imaging, mult areas	772	4.28	\$226.25	\$127.92	\$45.25
78802	S	Tumor imaging, whole body	772	4.28	\$226.25	\$127.92	\$45.25
78803	S	Tumor imaging (3D)	782	9.50	\$502.46	\$275.04	\$100.49
78805	S	Abscess imaging, ltd area	772	4.28	\$226.25	\$127.92	\$45.25
78806	S	Abscess imaging, whole body	772	4.28	\$226.25	\$127.92	\$45.25
78807	S	Nuclear localization/abscess	782	9.50	\$502.46	\$275.04	\$100.49
78810	S	Tumor imaging (PET)	760	17.91	\$947.13	\$419.46	\$189.43
78890	N	Nuclear medicine data proc					
78891	N	Nuclear med data proc					
78990	E	Provide diag radionuclide(s)					
78999	S	Nuclear diagnostic exam	761	2.06	\$108.72	\$61.47	\$21.74
79000	S	Initial hyperthyroid therapy	792	4.80	\$253.68	\$144.19	\$50.74
79001	S	Repeat hyperthyroid therapy	791	16.26	\$859.96	\$562.06	\$171.99
79020	S	Thyroid ablation	792	4.80	\$253.68	\$144.19	\$50.74
79030	S	Thyroid ablation, carcinoma	792	4.80	\$253.68	\$144.19	\$50.74
79035	S	Thyroid metastatic therapy	792	4.80	\$253.68	\$144.19	\$50.74
79100	S	Hematopoietic nuclear therapy	791	16.26	\$859.96	\$562.06	\$171.99
79200	S	Intracavitary nuc treatment	792	4.80	\$253.68	\$144.19	\$50.74
79300	S	Interstitial nuclear therapy	791	16.26	\$859.96	\$562.06	\$171.99
79400	S	Nonhemato nuclear therapy	791	16.26	\$859.96	\$562.06	\$171.99
79420	S	Intravascular nuc therapy	791	16.26	\$859.96	\$562.06	\$171.99
79440	S	Nuclear joint therapy	791	16.26	\$859.96	\$562.06	\$171.99
79900	N	Provide ther radiopharm(s)					
79999	S	Nuclear medicine therapy	791	16.26	\$859.96	\$562.06	\$171.99
80049	A	Metabolic panel, basic					
80050	A	General health panel					
80051	A	Electrolyte panel					
80054	A	Comprehen metabolic panel					
80055	A	Obstetric panel					
80058	A	Hepatic function panel					
80059	A	Hepatitis panel					
80061	A	Lipid panel					
80072	A	Arthritis panel					
80090	A	Torch antibody panel					
80091	A	Thyroid panel					
80092	A	Thyroid panel w/TSH					
80100	A	Drug screen					
80101	A	Drug screen					
80102	A	Drug confirmation					
80103	N	Drug analysis, tissue prep					
80150	A	Assay of amikacin					
80152	A	Assay of amitriptyline					
80154	A	Assay of benzodiazepines					
80156	A	Assay carbamazepine					
80158	A	Assay of cyclosporine					
80160	A	Assay of desipramine					
80162	A	Assay for digoxin					
80164	A	Assay, dipropylacetic acid					
80166	A	Assay of doxepin					
80168	A	Assay of ethosuximide					
80170	A	Gentamicin					
80172	A	Assay for gold					
80174	A	Assay of imipramine					
80176	A	Assay for lidocaine					
80178	A	Assay for lithium					
80182	A	Assay for nortriptyline					
80184	A	Assay for phenobarbital					
80185	A	Assay for phenytoin					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
80186	A	Assay for phenytoin, free .....	.....	.....	.....	.....	.....
80188	A	Assay for primidone .....	.....	.....	.....	.....	.....
80190	A	Assay for procainamide .....	.....	.....	.....	.....	.....
80192	A	Assay for procainamide .....	.....	.....	.....	.....	.....
80194	A	Assay for quinidine .....	.....	.....	.....	.....	.....
80196	A	Assay for salicylate .....	.....	.....	.....	.....	.....
80197	A	Assay for tacrolimus .....	.....	.....	.....	.....	.....
80198	A	Assay for theophylline .....	.....	.....	.....	.....	.....
80200	A	Assay for tobramycin .....	.....	.....	.....	.....	.....
80201	A	Assay for topiramate .....	.....	.....	.....	.....	.....
80202	A	Assay for vancomycin .....	.....	.....	.....	.....	.....
80299	A	Quantitative assay, drug .....	.....	.....	.....	.....	.....
80400	A	Acth stimulation panel .....	.....	.....	.....	.....	.....
80402	A	Acth stimulation panel .....	.....	.....	.....	.....	.....
80406	A	Acth stimulation panel .....	.....	.....	.....	.....	.....
80408	A	Aldosterone suppression eval .....	.....	.....	.....	.....	.....
80410	A	Calcitonin stim panel .....	.....	.....	.....	.....	.....
80412	A	CRH stimulation panel .....	.....	.....	.....	.....	.....
80414	A	Testosterone response .....	.....	.....	.....	.....	.....
80415	A	Estradiol response panel .....	.....	.....	.....	.....	.....
80416	A	Renin stimulation panel .....	.....	.....	.....	.....	.....
80417	A	Renin stimulation panel .....	.....	.....	.....	.....	.....
80418	A	Pituitary evaluation panel .....	.....	.....	.....	.....	.....
80420	A	Dexamethasone panel .....	.....	.....	.....	.....	.....
80422	A	Glucagon tolerance panel .....	.....	.....	.....	.....	.....
80424	A	Glucagon tolerance panel .....	.....	.....	.....	.....	.....
80426	A	Gonadotropin hormone panel .....	.....	.....	.....	.....	.....
80428	A	Growth hormone panel .....	.....	.....	.....	.....	.....
80430	A	Growth hormone panel .....	.....	.....	.....	.....	.....
80432	A	Insulin suppression panel .....	.....	.....	.....	.....	.....
80434	A	Insulin tolerance panel .....	.....	.....	.....	.....	.....
80435	A	Insulin tolerance panel .....	.....	.....	.....	.....	.....
80436	A	Metyrapone panel .....	.....	.....	.....	.....	.....
80438	A	TRH stimulation panel .....	.....	.....	.....	.....	.....
80439	A	TRH stimulation panel .....	.....	.....	.....	.....	.....
80440	A	TRH stimulation panel .....	.....	.....	.....	.....	.....
80500	X	Lab pathology consultation	882	0.39	\$20.57	\$11.75	\$4.11
80502	X	Lab pathology consultation	882	0.39	\$20.57	\$11.75	\$4.11
81000	A	Urinalysis, nonauto, w/scope .....	.....	.....	.....	.....	.....
81001	A	Urinalysis, auto, w/scope .....	.....	.....	.....	.....	.....
81002	A	Urinalysis nonauto w/o scope .....	.....	.....	.....	.....	.....
81003	A	Urinalysis, auto, w/o scope .....	.....	.....	.....	.....	.....
81005	A	Urinalysis .....	.....	.....	.....	.....	.....
81007	A	Urine screen for bacteria .....	.....	.....	.....	.....	.....
81015	A	Microscopic exam of urine .....	.....	.....	.....	.....	.....
81020	A	Urinalysis, glass test .....	.....	.....	.....	.....	.....
81025	A	Urine pregnancy test .....	.....	.....	.....	.....	.....
81050	A	Urinalysis, volume measure .....	.....	.....	.....	.....	.....
81099	A	Urinalysis test procedure .....	.....	.....	.....	.....	.....
82000	A	Assay blood acetaldehyde .....	.....	.....	.....	.....	.....
82003	A	Assay acetaminophen .....	.....	.....	.....	.....	.....
82009	A	Test for acetone/ketones .....	.....	.....	.....	.....	.....
82010	A	Acetone assay .....	.....	.....	.....	.....	.....
82013	A	Acetylcholinesterase assay .....	.....	.....	.....	.....	.....
82024	A	ACTH .....	.....	.....	.....	.....	.....
82030	A	ADP & AMP .....	.....	.....	.....	.....	.....
82040	A	Assay serum albumin .....	.....	.....	.....	.....	.....
82042	A	Assay urine albumin .....	.....	.....	.....	.....	.....
82043	A	Microalbumin, quantitative .....	.....	.....	.....	.....	.....
82044	A	Microalbumin, semiquant .....	.....	.....	.....	.....	.....
82055	A	Assay ethanol .....	.....	.....	.....	.....	.....
82075	A	Assay breath ethanol .....	.....	.....	.....	.....	.....
82085	A	Assay of aldolase .....	.....	.....	.....	.....	.....
82088	A	Aldosterone .....	.....	.....	.....	.....	.....
82101	A	Assay of urine alkaloids .....	.....	.....	.....	.....	.....
82103	A	Alpha-1-antitrypsin, total .....	.....	.....	.....	.....	.....
82104	A	Alpha-1-antitrypsin, pheno .....	.....	.....	.....	.....	.....
82105	A	Alpha-fetoprotein, serum .....	.....	.....	.....	.....	.....
82106	A	Alpha-fetoprotein; amniotic .....	.....	.....	.....	.....	.....
82108	A	Assay, aluminum .....	.....	.....	.....	.....	.....
82128	A	Test for amino acids .....	.....	.....	.....	.....	.....
82130	A	Amino acids analysis .....	.....	.....	.....	.....	.....
82131	A	Amino acids					
82135	A	Assay, aminolevulinic acid					
82140	A	Assay of ammonia					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
82143	A	Amniotic fluid scan .....	.....	.....	.....	.....	.....
82145	A	Assay of amphetamines .....	.....	.....	.....	.....	.....
82150	A	Assay of amylase .....	.....	.....	.....	.....	.....
82154	A	Androstenediol glucuronide .....	.....	.....	.....	.....	.....
82157	A	Assay of androstenedione .....	.....	.....	.....	.....	.....
82160	A	Androsterone assay .....	.....	.....	.....	.....	.....
82163	A	Assay of angiotensin II .....	.....	.....	.....	.....	.....
82164	A	Angiotensin I enzyme test .....	.....	.....	.....	.....	.....
82172	A	Apolipoprotein .....	.....	.....	.....	.....	.....
82175	A	Assay of arsenic .....	.....	.....	.....	.....	.....
82180	A	Assay of ascorbic acid .....	.....	.....	.....	.....	.....
82190	A	Atomic absorption .....	.....	.....	.....	.....	.....
82205	A	Assay of barbiturates .....	.....	.....	.....	.....	.....
82232	A	Beta-2 protein .....	.....	.....	.....	.....	.....
82239	A	Bile acids, total .....	.....	.....	.....	.....	.....
82240	A	Bile acids, cholyglycine .....	.....	.....	.....	.....	.....
82250	A	Assay bilirubin .....	.....	.....	.....	.....	.....
82251	A	Assay bilirubin .....	.....	.....	.....	.....	.....
82252	A	Fecal bilirubin test .....	.....	.....	.....	.....	.....
82270	A	Test feces for blood .....	.....	.....	.....	.....	.....
82273	A	Test for blood, other source .....	.....	.....	.....	.....	.....
82286	A	Assay of bradykinin .....	.....	.....	.....	.....	.....
82300	A	Assay cadmium .....	.....	.....	.....	.....	.....
82306	A	Assay of vitamin D .....	.....	.....	.....	.....	.....
82307	A	Assay of vitamin D .....	.....	.....	.....	.....	.....
82308	A	Assay of calcitonin .....	.....	.....	.....	.....	.....
82310	A	Assay calcium .....	.....	.....	.....	.....	.....
82330	A	Assay calcium .....	.....	.....	.....	.....	.....
82331	A	Calcium infusion test .....	.....	.....	.....	.....	.....
82340	A	Assay calcium in urine .....	.....	.....	.....	.....	.....
82355	A	Calculus (stone) analysis .....	.....	.....	.....	.....	.....
82360	A	Calculus (stone) assay .....	.....	.....	.....	.....	.....
82365	A	Calculus (stone) assay .....	.....	.....	.....	.....	.....
82370	A	X-ray assay, calculus (stone) .....	.....	.....	.....	.....	.....
82374	A	Assay blood carbon dioxide .....	.....	.....	.....	.....	.....
82375	A	Assay blood carbon monoxide .....	.....	.....	.....	.....	.....
82376	A	Test for carbon monoxide .....	.....	.....	.....	.....	.....
82378	A	Carcinoembryonic antigen .....	.....	.....	.....	.....	.....
82380	A	Assay carotene .....	.....	.....	.....	.....	.....
82382	A	Assay urine catecholamines .....	.....	.....	.....	.....	.....
82383	A	Assay blood catecholamines .....	.....	.....	.....	.....	.....
82384	A	Assay three catecholamines .....	.....	.....	.....	.....	.....
82387	A	Cathepsin-D .....	.....	.....	.....	.....	.....
82390	A	Assay ceruloplasmin .....	.....	.....	.....	.....	.....
82397	A	Chemiluminescent assay .....	.....	.....	.....	.....	.....
82415	A	Assay chloramphenicol .....	.....	.....	.....	.....	.....
82435	A	Assay blood chloride .....	.....	.....	.....	.....	.....
82436	A	Assay urine chloride .....	.....	.....	.....	.....	.....
82438	A	Assay other fluid chlorides .....	.....	.....	.....	.....	.....
82441	A	Test for chlorohydrocarbons .....	.....	.....	.....	.....	.....
82465	A	Assay serum cholesterol .....	.....	.....	.....	.....	.....
82480	A	Assay serum cholinesterase .....	.....	.....	.....	.....	.....
82482	A	Assay rbc cholinesterase .....	.....	.....	.....	.....	.....
82485	A	Assay chondroitin sulfate .....	.....	.....	.....	.....	.....
82486	A	Gas/liquid chromatography .....	.....	.....	.....	.....	.....
82487	A	Paper chromatography .....	.....	.....	.....	.....	.....
82488	A	Paper chromatography .....	.....	.....	.....	.....	.....
82489	A	Thin layer chromatography .....	.....	.....	.....	.....	.....
82491	A	Chromatography, quantitative .....	.....	.....	.....	.....	.....
82495	A	Assay chromium .....	.....	.....	.....	.....	.....
82507	A	Assay citrate .....	.....	.....	.....	.....	.....
82520	A	Assay for cocaine .....	.....	.....	.....	.....	.....
82523	A	Collagen crosslinks .....	.....	.....	.....	.....	.....
82525	A	Assay copper .....	.....	.....	.....	.....	.....
82528	A	Assay corticosterone .....	.....	.....	.....	.....	.....
82530	A	Cortisol, free .....	.....	.....	.....	.....	.....
82533	A	Total cortisol .....	.....	.....	.....	.....	.....
82540	A	Assay creatine .....	.....	.....	.....	.....	.....
82550	A	Assay CK (CPK) .....	.....	.....	.....	.....	.....
82552	A	Assay CPK in blood .....	.....	.....	.....	.....	.....
82553	A	Creatine, MB fraction .....	.....	.....	.....	.....	.....
82554	A	Creatine, isoforms .....	.....	.....	.....	.....	.....
82565	A	Assay creatinine					
82570	A	Assay urine creatinine					
82575	A	Creatinine clearance test					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
82585	A	Assay cryofibrinogen .....	.....	.....	.....	.....	.....
82595	A	Assay cryoglobulin .....	.....	.....	.....	.....	.....
82600	A	Assay cyanide .....	.....	.....	.....	.....	.....
82607	A	Vitamin B-12 .....	.....	.....	.....	.....	.....
82608	A	B-12 binding capacity .....	.....	.....	.....	.....	.....
82615	A	Test for urine cystines .....	.....	.....	.....	.....	.....
82626	A	Dehydroepiandrosterone .....	.....	.....	.....	.....	.....
82627	A	Dehydroepiandrosterone .....	.....	.....	.....	.....	.....
82633	A	Desoxycorticoster one .....	.....	.....	.....	.....	.....
82634	A	Deoxycortisol .....	.....	.....	.....	.....	.....
82638	A	Assay dibucaine number .....	.....	.....	.....	.....	.....
82646	A	Assay of dihydrocodeinone .....	.....	.....	.....	.....	.....
82649	A	Assay of dihydromorphin one .....	.....	.....	.....	.....	.....
82651	A	Dihydrotestosterone assay .....	.....	.....	.....	.....	.....
82652	A	Assay, dihydroxyvitamin D .....	.....	.....	.....	.....	.....
82654	A	Assay of dimethadione .....	.....	.....	.....	.....	.....
82664	A	Electrophoretic test .....	.....	.....	.....	.....	.....
82666	A	Epiandrosterone assay .....	.....	.....	.....	.....	.....
82668	A	Erythropoietin .....	.....	.....	.....	.....	.....
82670	A	Estradiol .....	.....	.....	.....	.....	.....
82671	A	Estrogens assay .....	.....	.....	.....	.....	.....
82672	A	Estrogen assay .....	.....	.....	.....	.....	.....
82677	A	Estriol .....	.....	.....	.....	.....	.....
82679	A	Estrone .....	.....	.....	.....	.....	.....
82690	A	Ethchlorvynol .....	.....	.....	.....	.....	.....
82693	A	Ethylene glycol .....	.....	.....	.....	.....	.....
82696	A	Etiocolanalone .....	.....	.....	.....	.....	.....
82705	A	Fats/lipids, feces, qualitative .....	.....	.....	.....	.....	.....
82710	A	Fats/lipids, feces, quantitative .....	.....	.....	.....	.....	.....
82715	A	Fecal fat assay .....	.....	.....	.....	.....	.....
82725	A	Assay blood fatty acids .....	.....	.....	.....	.....	.....
82728	A	Assay ferritin .....	.....	.....	.....	.....	.....
82735	A	Assay fluoride .....	.....	.....	.....	.....	.....
82742	A	Assay of flurazepam .....	.....	.....	.....	.....	.....
82746	A	Blood folic acid serum .....	.....	.....	.....	.....	.....
82747	A	Folic acid, RBC .....	.....	.....	.....	.....	.....
82757	A	Assay semen fructose .....	.....	.....	.....	.....	.....
82759	A	RBC galactokinase assay .....	.....	.....	.....	.....	.....
82760	A	Assay galactose .....	.....	.....	.....	.....	.....
82775	A	Assay galactose transferase .....	.....	.....	.....	.....	.....
82776	A	Galactose transferase test .....	.....	.....	.....	.....	.....
82784	A	Assay gammaglobulin IgM .....	.....	.....	.....	.....	.....
82785	A	Assay, gammaglobulin IgE .....	.....	.....	.....	.....	.....
82787	A	IgG1, 2, 3 and 4 .....	.....	.....	.....	.....	.....
82800	A	Blood pH .....	.....	.....	.....	.....	.....
82803	A	Blood gases: pH, pO2 & pCO2 .....	.....	.....	.....	.....	.....
82805	A	Blood gases W/O2 saturation .....	.....	.....	.....	.....	.....
82810	A	Blood gases, O2 sat only .....	.....	.....	.....	.....	.....
82820	A	Hemoglobin-oxygen affinity .....	.....	.....	.....	.....	.....
82926	A	Assay gastric acid .....	.....	.....	.....	.....	.....
82928	A	Assay gastric acid .....	.....	.....	.....	.....	.....
82938	A	Gastrin test .....	.....	.....	.....	.....	.....
82941	A	Assay of gastrin .....	.....	.....	.....	.....	.....
82943	A	Assay of glucagon .....	.....	.....	.....	.....	.....
82946	A	Glucagon tolerance test .....	.....	.....	.....	.....	.....
82947	A	Assay quantitative, glucose .....	.....	.....	.....	.....	.....
82948	A	Reagent strip/blood glucose .....	.....	.....	.....	.....	.....
82950	A	Glucose test .....	.....	.....	.....	.....	.....
82951	A	Glucose tolerance test (GTT) .....	.....	.....	.....	.....	.....
82952	A	GTT-added samples .....	.....	.....	.....	.....	.....
82953	A	Glucose-tolbutamide test .....	.....	.....	.....	.....	.....
82955	A	Assay G6PD enzyme .....	.....	.....	.....	.....	.....
82960	A	Test for G6PD enzyme .....	.....	.....	.....	.....	.....
82962	A	Glucose blood test .....	.....	.....	.....	.....	.....
82963	A	Glucosidase assay .....	.....	.....	.....	.....	.....
82965	A	Assay GDH enzyme .....	.....	.....	.....	.....	.....
82975	A	Assay glutamine .....	.....	.....	.....	.....	.....
82977	A	Assay of GGT .....	.....	.....	.....	.....	.....
82978	A	Glutathione assay .....	.....	.....	.....	.....	.....
82979	A	Assay RBC glutathione enzyme .....	.....	.....	.....	.....	.....
82980	A	Assay of glutethimide .....	.....	.....	.....	.....	.....
82985	A	Glycated protein .....	.....	.....	.....	.....	.....
83001	A	Gonadotropin (FSH)					
83002	A	Gonadotropin (LH)					
83003	A	Assay growth hormone (HGH)					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
83008	A	Assay guanosine .....	.....	.....	.....	.....	.....
83010	A	Quant assay haptoglobin .....	.....	.....	.....	.....	.....
83012	A	Assay haptoglobins .....	.....	.....	.....	.....	.....
83015	A	Heavy metal screen .....	.....	.....	.....	.....	.....
83018	A	Quantitative screen, metals .....	.....	.....	.....	.....	.....
83019	A	Breath isotope test .....	.....	.....	.....	.....	.....
83020	A	Assay hemoglobin .....	.....	.....	.....	.....	.....
83026	A	Hemoglobin, copper sulfate .....	.....	.....	.....	.....	.....
83030	A	Fetal hemoglobin assay .....	.....	.....	.....	.....	.....
83033	A	Fetal fecal hemoglobin assay .....	.....	.....	.....	.....	.....
83036	A	Glycated hemoglobin test .....	.....	.....	.....	.....	.....
83045	A	Blood methemoglobin test .....	.....	.....	.....	.....	.....
83050	A	Blood methemoglobin assay .....	.....	.....	.....	.....	.....
83051	A	Assay plasma hemoglobin .....	.....	.....	.....	.....	.....
83055	A	Blood sulfhemoglobin test .....	.....	.....	.....	.....	.....
83060	A	Blood sulfhemoglobin assay .....	.....	.....	.....	.....	.....
83065	A	Hemoglobin heat assay .....	.....	.....	.....	.....	.....
83068	A	Hemoglobin stability screen .....	.....	.....	.....	.....	.....
83069	A	Assay urine hemoglobin .....	.....	.....	.....	.....	.....
83070	A	Qualt assay hemosiderin .....	.....	.....	.....	.....	.....
83071	A	Quant assay of hemosiderin .....	.....	.....	.....	.....	.....
83088	A	Assay histamine .....	.....	.....	.....	.....	.....
83150	A	Assay for HVA .....	.....	.....	.....	.....	.....
83491	A	Assay of corticosteroids .....	.....	.....	.....	.....	.....
83497	A	Assay 5-HIAA .....	.....	.....	.....	.....	.....
83498	A	Assay of progesterone .....	.....	.....	.....	.....	.....
83499	A	Assay of progesterone .....	.....	.....	.....	.....	.....
83500	A	Assay free hydroxyproline .....	.....	.....	.....	.....	.....
83505	A	Assay total hydroxyproline .....	.....	.....	.....	.....	.....
83516	A	Immunoassay, non antibody .....	.....	.....	.....	.....	.....
83518	A	Immunoassay, dipstick .....	.....	.....	.....	.....	.....
83519	A	Immunoassay nonantibody .....	.....	.....	.....	.....	.....
83520	A	Immunoassay, RIA .....	.....	.....	.....	.....	.....
83525	A	Assay of insulin .....	.....	.....	.....	.....	.....
83527	A	Assay of insulin .....	.....	.....	.....	.....	.....
83528	A	Assay intrinsic factor .....	.....	.....	.....	.....	.....
83540	A	Assay iron .....	.....	.....	.....	.....	.....
83550	A	Iron binding test .....	.....	.....	.....	.....	.....
83570	A	Assay IDH enzyme .....	.....	.....	.....	.....	.....
83582	A	Assay ketogenic steroids .....	.....	.....	.....	.....	.....
83586	A	Assay 17-(17-KS)ketosteroids .....	.....	.....	.....	.....	.....
83593	A	Fractionation ketosteroids .....	.....	.....	.....	.....	.....
83605	A	Lactic acid assay .....	.....	.....	.....	.....	.....
83615	A	Lactate (LD) (LDH) enzyme .....	.....	.....	.....	.....	.....
83625	A	Assay LDH enzymes .....	.....	.....	.....	.....	.....
83632	A	Placental lactogen .....	.....	.....	.....	.....	.....
83633	A	Test urine for lactose .....	.....	.....	.....	.....	.....
83634	A	Assay urine for lactose .....	.....	.....	.....	.....	.....
83655	A	Assay for lead .....	.....	.....	.....	.....	.....
83661	A	Assay L/S ratio .....	.....	.....	.....	.....	.....
83662	A	L/S ratio, foam stability .....	.....	.....	.....	.....	.....
83670	A	Assay LAP enzyme .....	.....	.....	.....	.....	.....
83690	A	Assay lipase .....	.....	.....	.....	.....	.....
83715	A	Assay blood lipoproteins .....	.....	.....	.....	.....	.....
83717	A	Assay blood lipoproteins .....	.....	.....	.....	.....	.....
83718	A	Blood lipoprotein assay .....	.....	.....	.....	.....	.....
83719	A	Blood lipoprotein assay .....	.....	.....	.....	.....	.....
83721	A	Blood lipoprotein assay .....	.....	.....	.....	.....	.....
83727	A	LRH hormone assay .....	.....	.....	.....	.....	.....
83735	A	Assay magnesium .....	.....	.....	.....	.....	.....
83775	A	Assay of md enzyme .....	.....	.....	.....	.....	.....
83785	A	Assay of manganese .....	.....	.....	.....	.....	.....
83805	A	Assay of meprobamate .....	.....	.....	.....	.....	.....
83825	A	Assay mercury .....	.....	.....	.....	.....	.....
83835	A	Assay metanephrines .....	.....	.....	.....	.....	.....
83840	A	Assay methadone .....	.....	.....	.....	.....	.....
83857	A	Assay methemalbumin .....	.....	.....	.....	.....	.....
83858	A	Assay methsuximide .....	.....	.....	.....	.....	.....
83864	A	Mucopolysaccharides .....	.....	.....	.....	.....	.....
83866	A	Mucopolysaccharides screen .....	.....	.....	.....	.....	.....
83872	A	Assay synovial fluid mucin .....	.....	.....	.....	.....	.....
83873	A	Assay, CSF protein .....	.....	.....	.....	.....	.....
83874	A	Myoglobin					
83883	A	Nephelometry, not specified					
83885	A	Assay for nickel					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
83887	A	Assay nicotine .....	.....	.....	.....	.....	.....
83890	A	Molecular diagnostics .....	.....	.....	.....	.....	.....
83892	A	Molecular diagnostics .....	.....	.....	.....	.....	.....
83894	A	Molecular diagnostics .....	.....	.....	.....	.....	.....
83896	A	Molecular diagnostics .....	.....	.....	.....	.....	.....
83898	A	Molecular diagnostics .....	.....	.....	.....	.....	.....
83902	A	Molecular diagnostics .....	.....	.....	.....	.....	.....
83912	A	Genetic examination .....	.....	.....	.....	.....	.....
83915	A	Assay nucleotidase .....	.....	.....	.....	.....	.....
83916	A	Oligoclonal bands .....	.....	.....	.....	.....	.....
83918	A	Assay organic acids .....	.....	.....	.....	.....	.....
83925	A	Opiates .....	.....	.....	.....	.....	.....
83930	A	Assay blood osmolality .....	.....	.....	.....	.....	.....
83935	A	Assay urine osmolality .....	.....	.....	.....	.....	.....
83937	A	Assay for osteocalcin .....	.....	.....	.....	.....	.....
83945	A	Assay oxalate .....	.....	.....	.....	.....	.....
83970	A	Assay of parathormone .....	.....	.....	.....	.....	.....
83986	A	Assay body fluid acidity .....	.....	.....	.....	.....	.....
83992	A	Assay for phencyclidine .....	.....	.....	.....	.....	.....
84022	A	Assay of phenothiazine .....	.....	.....	.....	.....	.....
84030	A	Assay blood PKU .....	.....	.....	.....	.....	.....
84035	A	Assay phenylketones .....	.....	.....	.....	.....	.....
84060	A	Assay acid phosphatase .....	.....	.....	.....	.....	.....
84061	A	Phosphatase, forensic exam .....	.....	.....	.....	.....	.....
84066	A	Assay prostate phosphatase .....	.....	.....	.....	.....	.....
84075	A	Assay alkaline phosphatase .....	.....	.....	.....	.....	.....
84078	A	Assay alkaline phosphatase .....	.....	.....	.....	.....	.....
84080	A	Assay alkaline phosphatases .....	.....	.....	.....	.....	.....
84081	A	Amniotic fluid enzyme test .....	.....	.....	.....	.....	.....
84085	A	Assay RBC PG6D enzyme .....	.....	.....	.....	.....	.....
84087	A	Assay phosphohexose enzymes .....	.....	.....	.....	.....	.....
84100	A	Assay phosphorus .....	.....	.....	.....	.....	.....
84105	A	Assay urine phosphorus .....	.....	.....	.....	.....	.....
84106	A	Test for porphobilinogen .....	.....	.....	.....	.....	.....
84110	A	Assay porphobilinogen .....	.....	.....	.....	.....	.....
84119	A	Test urine for porphyrins .....	.....	.....	.....	.....	.....
84120	A	Assay urine porphyrins .....	.....	.....	.....	.....	.....
84126	A	Assay feces porphyrins .....	.....	.....	.....	.....	.....
84127	A	Porphyrins, feces .....	.....	.....	.....	.....	.....
84132	A	Assay serum potassium .....	.....	.....	.....	.....	.....
84133	A	Assay urine potassium .....	.....	.....	.....	.....	.....
84134	A	Prealbumin .....	.....	.....	.....	.....	.....
84135	A	Assay pregnanediol .....	.....	.....	.....	.....	.....
84138	A	Assay pregnanetriol .....	.....	.....	.....	.....	.....
84140	A	Assay for pregnenolone .....	.....	.....	.....	.....	.....
84143	A	Assay/17-hydroxypregnenolone .....	.....	.....	.....	.....	.....
84144	A	Assay progesterone .....	.....	.....	.....	.....	.....
84146	A	Assay for prolactin .....	.....	.....	.....	.....	.....
84150	A	Assay of prostaglandin .....	.....	.....	.....	.....	.....
84153	A	Prostate specific antigen .....	.....	.....	.....	.....	.....
84155	A	Assay protein .....	.....	.....	.....	.....	.....
84160	A	Assay serum protein .....	.....	.....	.....	.....	.....
84165	A	Assay serum proteins .....	.....	.....	.....	.....	.....
84181	A	Western blot test .....	.....	.....	.....	.....	.....
84182	A	Protein, western blot test .....	.....	.....	.....	.....	.....
84202	A	Assay RBC protoporphyrin .....	.....	.....	.....	.....	.....
84203	A	Test RBC protoporphyrin .....	.....	.....	.....	.....	.....
84206	A	Assay of proinsulin .....	.....	.....	.....	.....	.....
84207	A	Assay vitamin B-6 .....	.....	.....	.....	.....	.....
84210	A	Assay pyruvate .....	.....	.....	.....	.....	.....
84220	A	Assay pyruvate kinase .....	.....	.....	.....	.....	.....
84228	A	Assay quinine .....	.....	.....	.....	.....	.....
84233	A	Assay estrogen .....	.....	.....	.....	.....	.....
84234	A	Assay progesterone .....	.....	.....	.....	.....	.....
84235	A	Assay endocrine hormone .....	.....	.....	.....	.....	.....
84238	A	Assay non-endocrine receptor .....	.....	.....	.....	.....	.....
84244	A	Assay of renin .....	.....	.....	.....	.....	.....
84252	A	Assay vitamin B-2 .....	.....	.....	.....	.....	.....
84255	A	Assay selenium .....	.....	.....	.....	.....	.....
84260	A	Assay serotonin .....	.....	.....	.....	.....	.....
84270	A	Sex hormone globulin (SHBG) .....	.....	.....	.....	.....	.....
84275	A	Assay sialic acid .....	.....	.....	.....	.....	.....
84285	A	Assay silica					
84295	A	Assay serum sodium					
84300	A	Assay urine sodium					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
84305	A	Somatomedin .....	.....	.....	.....	.....	.....
84307	A	Somatostatin .....	.....	.....	.....	.....	.....
84311	A	Spectrophotometry .....	.....	.....	.....	.....	.....
84315	A	Body fluid specific gravity .....	.....	.....	.....	.....	.....
84375	A	Chromatogram assay, sugars .....	.....	.....	.....	.....	.....
84392	A	Assay urine sulfate .....	.....	.....	.....	.....	.....
84402	A	Testosterone .....	.....	.....	.....	.....	.....
84403	A	Assay total testosterone .....	.....	.....	.....	.....	.....
84425	A	Assay vitamin B-1 .....	.....	.....	.....	.....	.....
84430	A	Assay thiocyanate .....	.....	.....	.....	.....	.....
84432	A	Thyroglobulin .....	.....	.....	.....	.....	.....
84436	A	Assay, total thyroxine .....	.....	.....	.....	.....	.....
84437	A	Assay neonatal thyroxine .....	.....	.....	.....	.....	.....
84439	A	Assay, free thyroxine .....	.....	.....	.....	.....	.....
84442	A	Thyroid activity (TBG) assay .....	.....	.....	.....	.....	.....
84443	A	Assay thyroid stim hormone .....	.....	.....	.....	.....	.....
84445	A	Thyroid immunoglobulins TSI .....	.....	.....	.....	.....	.....
84446	A	Assay vitamin E .....	.....	.....	.....	.....	.....
84449	A	Assay for transcortin .....	.....	.....	.....	.....	.....
84450	A	Transferase (AST) (SGOT) .....	.....	.....	.....	.....	.....
84460	A	Alanine amino (ALT) (SGPT) .....	.....	.....	.....	.....	.....
84466	A	Transferrin .....	.....	.....	.....	.....	.....
84478	A	Assay triglycerides .....	.....	.....	.....	.....	.....
84479	A	Assay thyroid (t-3 or t-4) .....	.....	.....	.....	.....	.....
84480	A	Assay triiodothyronine (t-3) .....	.....	.....	.....	.....	.....
84481	A	Free assay (FT-3) .....	.....	.....	.....	.....	.....
84482	A	T3 reverse .....	.....	.....	.....	.....	.....
84484	A	Troponin, quant .....	.....	.....	.....	.....	.....
84485	A	Assay duodenal fluid trypsin .....	.....	.....	.....	.....	.....
84488	A	Test feces for trypsin .....	.....	.....	.....	.....	.....
84490	A	Assay feces for trypsin .....	.....	.....	.....	.....	.....
84510	A	Assay tyrosine .....	.....	.....	.....	.....	.....
84512	A	Troponin, qual .....	.....	.....	.....	.....	.....
84520	A	Assay urea nitrogen .....	.....	.....	.....	.....	.....
84525	A	Urea nitrogen semi-quant .....	.....	.....	.....	.....	.....
84540	A	Assay urine urea-N .....	.....	.....	.....	.....	.....
84545	A	Urea-N clearance test .....	.....	.....	.....	.....	.....
84550	A	Assay blood uric acid .....	.....	.....	.....	.....	.....
84560	A	Assay urine uric acid .....	.....	.....	.....	.....	.....
84577	A	Assay feces urobilinogen .....	.....	.....	.....	.....	.....
84578	A	Test urine urobilinogen .....	.....	.....	.....	.....	.....
84580	A	Assay urine urobilinogen .....	.....	.....	.....	.....	.....
84583	A	Assay urine urobilinogen .....	.....	.....	.....	.....	.....
84585	A	Assay urine VMA .....	.....	.....	.....	.....	.....
84586	A	VIP assay .....	.....	.....	.....	.....	.....
84588	A	Assay vasopressin .....	.....	.....	.....	.....	.....
84590	A	Assay vitamin-A .....	.....	.....	.....	.....	.....
84597	A	Assay vitamin-K .....	.....	.....	.....	.....	.....
84600	A	Assay for volatiles .....	.....	.....	.....	.....	.....
84620	A	Xylose tolerance test .....	.....	.....	.....	.....	.....
84630	A	Assay zinc .....	.....	.....	.....	.....	.....
84681	A	Assay C-peptide .....	.....	.....	.....	.....	.....
84702	A	Chorionic gonadotropin test .....	.....	.....	.....	.....	.....
84703	A	Chorionic gonadotropin assay .....	.....	.....	.....	.....	.....
84830	A	Ovulation tests .....	.....	.....	.....	.....	.....
84999	A	Clinical chemistry test .....	.....	.....	.....	.....	.....
85002	A	Bleeding time test .....	.....	.....	.....	.....	.....
85007	A	Differential WBC count .....	.....	.....	.....	.....	.....
85008	A	Nondifferential WBC count .....	.....	.....	.....	.....	.....
85009	A	Differential WBC count .....	.....	.....	.....	.....	.....
85013	A	Hematocrit .....	.....	.....	.....	.....	.....
85014	A	Hematocrit .....	.....	.....	.....	.....	.....
85018	A	Hemoglobin .....	.....	.....	.....	.....	.....
85021	A	Automated hemogram .....	.....	.....	.....	.....	.....
85022	A	Automated hemogram .....	.....	.....	.....	.....	.....
85023	A	Automated hemogram .....	.....	.....	.....	.....	.....
85024	A	Automated hemogram .....	.....	.....	.....	.....	.....
85025	A	Automated hemogram .....	.....	.....	.....	.....	.....
85027	A	Automated hemogram .....	.....	.....	.....	.....	.....
85029	A	Automated hemogram .....	.....	.....	.....	.....	.....
85030	A	Automated hemogram .....	.....	.....	.....	.....	.....
85031	A	Manual hemogram, complete cbc .....	.....	.....	.....	.....	.....
85041	A	Red blood cell (RBC) count					
85044	A	Reticulocyte count					
85045	A	Reticulocyte count					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
85048	A	White blood cell (WBC) count					
85060	X	Blood smear interpretation	882	0.39	\$20.57	\$11.75	\$4.11
85095	T	Bone marrow aspiration	121	0.67	\$35.26	\$21.02	\$7.05
85097	X	Bone marrow interpretation	882	0.39	\$20.57	\$11.75	\$4.11
85102	T	Bone marrow biopsy	121	0.67	\$35.26	\$21.02	\$7.05
85130	A	Chromogenic substrate assay					
85170	A	Blood clot retraction					
85175	A	Blood clot lysis time					
85210	A	Blood clot factor II test					
85220	A	Blood clot factor V test					
85230	A	Blood clot factor VII test					
85240	A	Blood clot factor VIII test					
85244	A	Blood clot factor VIII test					
85245	A	Blood clot factor VIII test					
85246	A	Blood clot factor VIII test					
85247	A	Blood clot factor VIII test					
85250	A	Blood clot factor IX test					
85260	A	Blood clot factor X test					
85270	A	Blood clot factor XI test					
85280	A	Blood clot factor XII test					
85290	A	Blood clot factor XIII test					
85291	A	Blood clot factor XIII test					
85292	A	Blood clot factor assay					
85293	A	Blood clot factor assay					
85300	A	Antithrombin III test					
85301	A	Antithrombin III test					
85302	A	Blood clot inhibitor antigen					
85303	A	Blood clot inhibitor test					
85305	A	Blood clot inhibitor assay					
85306	A	Blood clot inhibitor test					
85335	A	Factor inhibitor test					
85337	A	Thrombomodulin					
85345	A	Coagulation time					
85347	A	Coagulation time					
85348	A	Coagulation time					
85360	A	Euglobulin lysis					
85362	A	Fibrin degradation products					
85366	A	Fibrinogen test					
85370	A	Fibrinogen test					
85378	A	Fibrin degradation					
85379	A	Fibrin degradation					
85384	A	Fibrinogen					
85385	A	Fibrinogen					
85390	A	Fibrinolysins screen					
85400	A	Fibrinolytic plasmin					
85410	A	Fibrinolytic antiplasmin					
85415	A	Fibrinolytic plasminogen					
85420	A	Fibrinolytic plasminogen					
85421	A	Fibrinolytic plasminogen					
85441	A	Heinz bodies; direct					
85445	A	Heinz bodies; induced					
85460	A	Hemoglobin, fetal					
85461	A	Hemoglobin, fetal					
85475	A	Hemolysin					
85520	A	Heparin assay					
85525	A	Heparin					
85530	A	Heparin-protamine tolerance					
85535	A	Iron stain, blood cells					
85540	A	Wbc alkaline phosphatase					
85547	A	RBC mechanical fragility					
85549	A	Muramidase					
85555	A	RBC osmotic fragility					
85557	A	RBC osmotic fragility					
85576	A	Blood platelet aggregation					
85585	A	Blood platelet estimation					
85590	A	Platelet manual count					
85595	A	Platelet count, automated					
85597	A	Platelet neutralization					
85610	A	Prothrombin time					
85611	A	Prothrombin test					
85612	A	Viper venom prothrombin time					
85613	A	Russell viper venom, diluted					
85635	A	Reptilase test					
85651	A	Rbc sed rate, nonauto					
85652	A	Rbc sed rate, auto					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
85660	A	RBC sickle cell test .....	.....	.....	.....	.....	.....
85670	A	Thrombin time, plasma .....	.....	.....	.....	.....	.....
85675	A	Thrombin time, titer .....	.....	.....	.....	.....	.....
85705	A	Thromboplastin inhibition .....	.....	.....	.....	.....	.....
85730	A	Thromboplastin time, partial .....	.....	.....	.....	.....	.....
85732	A	Thromboplastin time, partial .....	.....	.....	.....	.....	.....
85810	A	Blood viscosity examination .....	.....	.....	.....	.....	.....
85999	A	Hematology procedure .....	.....	.....	.....	.....	.....
86000	A	Agglutinins; febrile .....	.....	.....	.....	.....	.....
86003	A	Allergen specific IgE .....	.....	.....	.....	.....	.....
86005	A	Allergen specific IgE .....	.....	.....	.....	.....	.....
86021	A	WBC antibody identification .....	.....	.....	.....	.....	.....
86022	A	Platelet antibodies .....	.....	.....	.....	.....	.....
86023	A	Immunoglobulin assay .....	.....	.....	.....	.....	.....
86038	A	Antinuclear antibodies .....	.....	.....	.....	.....	.....
86039	A	Antinuclear antibodies (ANA) .....	.....	.....	.....	.....	.....
86060	A	Antistreptolysin O titer .....	.....	.....	.....	.....	.....
86063	A	Antistreptolysin O screen .....	.....	.....	.....	.....	.....
86077	X	Physician blood bank service	882	0.39	\$20.57	\$11.75	\$4.11
86078	X	Physician blood bank service	882	0.39	\$20.57	\$11.75	\$4.11
86079	X	Physician blood bank service	882	0.39	\$20.57	\$11.75	\$4.11
86140	A	C-reactive protein .....	.....	.....	.....	.....	.....
86147	A	Cardiolipin antibody .....	.....	.....	.....	.....	.....
86148	A	Phospholipid antibody .....	.....	.....	.....	.....	.....
86155	A	Chemotaxis assay .....	.....	.....	.....	.....	.....
86156	A	Cold agglutinin screen .....	.....	.....	.....	.....	.....
86157	A	Cold agglutinin, titer .....	.....	.....	.....	.....	.....
86160	A	Complement, antigen .....	.....	.....	.....	.....	.....
86161	A	Complement/function activity .....	.....	.....	.....	.....	.....
86162	A	Complement, total (CH50) .....	.....	.....	.....	.....	.....
86171	A	Complement fixation, each .....	.....	.....	.....	.....	.....
86185	A	Counterimmunoelectrophoresis .....	.....	.....	.....	.....	.....
86215	A	Deoxyribonuclease, antibody .....	.....	.....	.....	.....	.....
86225	A	DNA antibody .....	.....	.....	.....	.....	.....
86226	A	DNA antibody, single strand .....	.....	.....	.....	.....	.....
86235	A	Nuclear antigen antibody .....	.....	.....	.....	.....	.....
86243	A	Fc receptor .....	.....	.....	.....	.....	.....
86255	A	Fluorescent antibody; screen .....	.....	.....	.....	.....	.....
86256	A	Fluorescent antibody; titer .....	.....	.....	.....	.....	.....
86277	A	Growth hormone antibody .....	.....	.....	.....	.....	.....
86280	A	Hemagglutination inhibition .....	.....	.....	.....	.....	.....
86308	A	Heterophile antibodies .....	.....	.....	.....	.....	.....
86309	A	Heterophile antibodies .....	.....	.....	.....	.....	.....
86310	A	Heterophile antibodies .....	.....	.....	.....	.....	.....
86316	A	Immunoassay, tumor antigen .....	.....	.....	.....	.....	.....
86317	A	Immunoassay, infectious agent .....	.....	.....	.....	.....	.....
86318	A	Immunoassay, infectious agent .....	.....	.....	.....	.....	.....
86320	A	Serum immunoelectrophoresis .....	.....	.....	.....	.....	.....
86325	A	Other immunoelectrophoresis .....	.....	.....	.....	.....	.....
86327	A	Immunoelectrophoresis assay .....	.....	.....	.....	.....	.....
86329	A	Immunodiffusion .....	.....	.....	.....	.....	.....
86331	A	Immunodiffusion ouchterlony .....	.....	.....	.....	.....	.....
86332	A	Immune complex assay .....	.....	.....	.....	.....	.....
86334	A	Immunofixation procedure .....	.....	.....	.....	.....	.....
86337	A	Insulin antibodies .....	.....	.....	.....	.....	.....
86340	A	Intrinsic factor antibody .....	.....	.....	.....	.....	.....
86341	A	Islet cell antibody .....	.....	.....	.....	.....	.....
86343	A	Leukocyte histamine release .....	.....	.....	.....	.....	.....
86344	A	Leukocyte phagocytosis .....	.....	.....	.....	.....	.....
86353	A	Lymphocyte transformation .....	.....	.....	.....	.....	.....
86359	A	T cells, total count .....	.....	.....	.....	.....	.....
86360	A	T cell absolute count/ratio .....	.....	.....	.....	.....	.....
86361	A	T cell absolute count .....	.....	.....	.....	.....	.....
86376	A	Microsomal antibody .....	.....	.....	.....	.....	.....
86378	A	Migration inhibitory factor .....	.....	.....	.....	.....	.....
86382	A	Neutralization test, viral .....	.....	.....	.....	.....	.....
86384	A	Nitroblue tetrazolium dye .....	.....	.....	.....	.....	.....
86403	A	Particle agglutination test .....	.....	.....	.....	.....	.....
86406	A	Particle agglutination test .....	.....	.....	.....	.....	.....
86430	A	Rheumatoid factor test .....	.....	.....	.....	.....	.....
86431	A	Rheumatoid factor, quant .....	.....	.....	.....	.....	.....
86485	X	Skin test, candida	861	0.13	\$6.86	\$3.62	\$1.37
86490	X	Coccidioidomycosis skin test	861	0.13	\$6.86	\$3.62	\$1.37
86510	X	Histoplasmosis skin test	861	0.13	\$6.86	\$3.62	\$1.37
86580	X	TB intradermal test	861	0.13	\$6.86	\$3.62	\$1.37

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
86585	X	TB tine test	861	0.13	\$6.86	\$3.62	\$1.37
86586	X	Skin test, unlisted	861	0.13	\$6.86	\$3.62	\$1.37
86588	A	Streptococcus, direct screen					
86590	A	Streptokinase, antibody					
86592	A	Blood serology, qualitative					
86593	A	Blood serology, quantitative					
86602	A	Antinomyces antibody					
86603	A	Adenovirus, antibody					
86606	A	Aspergillus antibody					
86609	A	Bacterium, antibody					
86612	A	Blastomyces, antibody					
86615	A	Bordetella antibody					
86617	A	Lyme disease antibody					
86618	A	Lyme disease antibody					
86619	A	Borrelia antibody					
86622	A	Brucella, antibody					
86625	A	Campylobacter, antibody					
86628	A	Candida, antibody					
86631	A	Chlamydia, antibody					
86632	A	Chlamydia, IgM, antibody					
86635	A	Coccidioides, antibody					
86638	A	Q fever antibody					
86641	A	Cryptococcus antibody					
86644	A	CMV antibody					
86645	A	CMV antibody, IgM					
86648	A	Diphtheria antibody					
86651	A	Encephalitis antibody					
86652	A	Encephalitis antibody					
86653	A	Encephalitis, antibody					
86654	A	Encephalitis, antibody					
86658	A	Enterovirus, antibody					
86663	A	Epstein-barr antibody					
86664	A	Epstein-barr antibody					
86665	A	Epstein-barr, antibody					
86668	A	Francisella tularensis					
86671	A	Fungus, antibody					
86674	A	Giardia lamblia					
86677	A	Helicobacter pylori					
86682	A	Helminth, antibody					
86684	A	Hemophilus influenza					
86687	A	HTLV I					
86688	A	HTLV-II					
86689	A	HTLV/HIV confirmatory test					
86692	A	Hepatitis, delta agent					
86694	A	Herpes simplex test					
86695	A	Herpes simplex test					
86698	A	Histoplasma					
86701	A	HIV-1					
86702	A	HIV-2					
86703	A	HIV-1/HIV-2, single assay					
86704	A	Hep b core ab test, igg & m					
86705	A	Hep b core ab test, igm					
86706	A	Hepatitis b surface ab test					
86707	A	Hepatitis be ab test					
86708	A	Hep a ab test, igg & m					
86709	A	Hep a ab test, igm					
86710	A	Influenza virus					
86713	A	Legionella					
86717	A	Leishmania					
86720	A	Leptospirosis					
86723	A	Listeria monocytogenes					
86727	A	Lymph choriomeningitis					
86729	A	Lympho venereum					
86732	A	Mucormycosis					
86735	A	Mumps					
86738	A	Mycoplasma					
86741	A	Neisseria meningitidis					
86744	A	Nocardia					
86747	A	Parvovirus					
86750	A	Malaria					
86753	A	Protozoa, not elsewhere					
86756	A	Respiratory virus					
86759	A	Rotavirus					
86762	A	Rubella					
86765	A	Rubeola					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
86768	A	Salmonella .....	.....	.....	.....	.....	.....
86771	A	Shigella .....	.....	.....	.....	.....	.....
86774	A	Tetanus .....	.....	.....	.....	.....	.....
86777	A	Toxoplasma .....	.....	.....	.....	.....	.....
86778	A	Toxoplasma, IgM .....	.....	.....	.....	.....	.....
86781	A	Treponema pallidum confirm .....	.....	.....	.....	.....	.....
86784	A	Trichinella .....	.....	.....	.....	.....	.....
86787	A	Varicella-zoster .....	.....	.....	.....	.....	.....
86790	A	Virus, not specified .....	.....	.....	.....	.....	.....
86793	A	Yersinia .....	.....	.....	.....	.....	.....
86800	A	Thyroglobulin antibody .....	.....	.....	.....	.....	.....
86803	A	Hepatitis c ab test .....	.....	.....	.....	.....	.....
86804	A	Hep c ab test, confirm .....	.....	.....	.....	.....	.....
86805	A	Lymphocytotoxicity assay .....	.....	.....	.....	.....	.....
86806	A	Lymphocytotoxicity assay .....	.....	.....	.....	.....	.....
86807	A	Cytotoxic antibody screening .....	.....	.....	.....	.....	.....
86808	A	Cytotoxic antibody screening .....	.....	.....	.....	.....	.....
86812	A	HLA typing, A, B, or C .....	.....	.....	.....	.....	.....
86813	A	HLA typing, A, B, or C .....	.....	.....	.....	.....	.....
86816	A	HLA typing, DR/DQ .....	.....	.....	.....	.....	.....
86817	A	HLA typing, DR/DQ .....	.....	.....	.....	.....	.....
86821	A	Lymphocyte culture, mixed .....	.....	.....	.....	.....	.....
86822	A	Lymphocyte culture, primed .....	.....	.....	.....	.....	.....
86849	A	Immunology procedure .....	.....	.....	.....	.....	.....
86850	A	RBC antibody screen .....	.....	.....	.....	.....	.....
86860	A	RBC antibody elution .....	.....	.....	.....	.....	.....
86870	A	RBC antibody identification .....	.....	.....	.....	.....	.....
86880	A	Coombs test .....	.....	.....	.....	.....	.....
86885	A	Coombs test .....	.....	.....	.....	.....	.....
86886	A	Coombs test .....	.....	.....	.....	.....	.....
86890	A	Autologous blood process .....	.....	.....	.....	.....	.....
86891	A	Autologous blood, op salvage .....	.....	.....	.....	.....	.....
86900	A	Blood typing, ABO .....	.....	.....	.....	.....	.....
86901	A	Blood typing, Rh (D) .....	.....	.....	.....	.....	.....
86903	A	Blood typing, antigen screen .....	.....	.....	.....	.....	.....
86904	A	Blood typing, patient serum .....	.....	.....	.....	.....	.....
86905	A	Blood typing, RBC antigens .....	.....	.....	.....	.....	.....
86906	A	Blood typing, Rh phenotype .....	.....	.....	.....	.....	.....
86910	E	Blood typing, paternity test .....	.....	.....	.....	.....	.....
86911	E	Blood typing, antigen system .....	.....	.....	.....	.....	.....
86915	A	Bone marrow .....	.....	.....	.....	.....	.....
86920	A	Compatibility test .....	.....	.....	.....	.....	.....
86921	A	Compatibility test .....	.....	.....	.....	.....	.....
86922	A	Compatibility test .....	.....	.....	.....	.....	.....
86927	A	Plasma, fresh frozen .....	.....	.....	.....	.....	.....
86930	A	Frozen blood prep .....	.....	.....	.....	.....	.....
86931	A	Frozen blood thaw .....	.....	.....	.....	.....	.....
86932	A	Frozen blood, freeze/thaw .....	.....	.....	.....	.....	.....
86940	A	Hemolysins/agglutinins auto .....	.....	.....	.....	.....	.....
86941	A	Hemolysins/agglutinins .....	.....	.....	.....	.....	.....
86945	A	Blood product/irradiation .....	.....	.....	.....	.....	.....
86950	A	Leukocyte transfusion .....	.....	.....	.....	.....	.....
86965	A	Pooling blood platelets .....	.....	.....	.....	.....	.....
86970	A	RBC pretreatment .....	.....	.....	.....	.....	.....
86971	A	RBC pretreatment .....	.....	.....	.....	.....	.....
86972	A	RBC pretreatment .....	.....	.....	.....	.....	.....
86975	A	RBC pretreatment, serum .....	.....	.....	.....	.....	.....
86976	A	RBC pretreatment, serum .....	.....	.....	.....	.....	.....
86977	A	RBC pretreatment, serum .....	.....	.....	.....	.....	.....
86978	A	RBC pretreatment, serum .....	.....	.....	.....	.....	.....
86985	A	Split blood or products .....	.....	.....	.....	.....	.....
86999	A	Transfusion procedure .....	.....	.....	.....	.....	.....
87001	A	Small animal inoculation .....	.....	.....	.....	.....	.....
87003	A	Small animal inoculation .....	.....	.....	.....	.....	.....
87015	A	Specimen concentration .....	.....	.....	.....	.....	.....
87040	A	Blood culture for bacteria .....	.....	.....	.....	.....	.....
87045	A	Stool culture for bacteria .....	.....	.....	.....	.....	.....
87060	A	Nose/throat culture, bacteria .....	.....	.....	.....	.....	.....
87070	A	Culture specimen, bacteria .....	.....	.....	.....	.....	.....
87072	A	Culture of specimen by kit .....	.....	.....	.....	.....	.....
87075	A	Culture specimen, bacteria .....	.....	.....	.....	.....	.....
87076	A	Bacteria identification .....	.....	.....	.....	.....	.....
87081	A	Bacteria culture screen					
87082	A	Culture of specimen by kit					
87083	A	Culture of specimen by kit					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
87084	A	Culture of specimen by kit .....	.....	.....	.....	.....	.....
87085	A	Culture of specimen by kit .....	.....	.....	.....	.....	.....
87086	A	Urine culture, colony count .....	.....	.....	.....	.....	.....
87087	A	Urine bacteria culture .....	.....	.....	.....	.....	.....
87088	A	Urine bacteria culture .....	.....	.....	.....	.....	.....
87101	A	Skin fungus culture .....	.....	.....	.....	.....	.....
87102	A	Fungus isolation culture .....	.....	.....	.....	.....	.....
87103	A	Blood fungus culture .....	.....	.....	.....	.....	.....
87106	A	Fungus identification .....	.....	.....	.....	.....	.....
87109	A	Mycoplasma culture .....	.....	.....	.....	.....	.....
87110	A	Culture, chlamydia .....	.....	.....	.....	.....	.....
87116	A	Mycobacteria culture .....	.....	.....	.....	.....	.....
87117	A	Mycobacteria culture .....	.....	.....	.....	.....	.....
87118	A	Mycobacteria identification .....	.....	.....	.....	.....	.....
87140	A	Culture typing, fluorescent .....	.....	.....	.....	.....	.....
87143	A	Culture typing, GLC method .....	.....	.....	.....	.....	.....
87145	A	Culture typing, phage method .....	.....	.....	.....	.....	.....
87147	A	Culture typing, serologic .....	.....	.....	.....	.....	.....
87151	A	Culture typing, serologic .....	.....	.....	.....	.....	.....
87155	A	Culture typing, precipitin .....	.....	.....	.....	.....	.....
87158	A	Culture typing, added method .....	.....	.....	.....	.....	.....
87163	A	Special microbiology culture .....	.....	.....	.....	.....	.....
87164	A	Dark field examination .....	.....	.....	.....	.....	.....
87166	A	Dark field examination .....	.....	.....	.....	.....	.....
87174	A	Endotoxin, bacterial .....	.....	.....	.....	.....	.....
87175	A	Assay, endotoxin, bacterial .....	.....	.....	.....	.....	.....
87176	A	Endotoxin, bacterial .....	.....	.....	.....	.....	.....
87177	A	Ova and parasites smears .....	.....	.....	.....	.....	.....
87181	A	Antibiotic sensitivity, each .....	.....	.....	.....	.....	.....
87184	A	Antibiotic sensitivity, each .....	.....	.....	.....	.....	.....
87186	A	Antibiotic sensitivity, MIC .....	.....	.....	.....	.....	.....
87187	A	Antibiotic sensitivity, MBC .....	.....	.....	.....	.....	.....
87188	A	Antibiotic sensitivity, each .....	.....	.....	.....	.....	.....
87190	A	TB antibiotic sensitivity .....	.....	.....	.....	.....	.....
87192	A	Antibiotic sensitivity, each .....	.....	.....	.....	.....	.....
87197	A	Bactericidal level, serum .....	.....	.....	.....	.....	.....
87205	A	Smear, stain & interpret .....	.....	.....	.....	.....	.....
87206	A	Smear, stain & interpret .....	.....	.....	.....	.....	.....
87207	A	Smear, stain & interpret .....	.....	.....	.....	.....	.....
87208	A	Smear, stain & interpret .....	.....	.....	.....	.....	.....
87210	A	Smear, stain & interpret .....	.....	.....	.....	.....	.....
87211	A	Smear, stain & interpret .....	.....	.....	.....	.....	.....
87220	A	Tissue exam for fungi .....	.....	.....	.....	.....	.....
87230	A	Assay, toxin or antitoxin .....	.....	.....	.....	.....	.....
87250	A	Virus inoculation for test .....	.....	.....	.....	.....	.....
87252	A	Virus inoculation for test .....	.....	.....	.....	.....	.....
87253	A	Virus inoculation for test .....	.....	.....	.....	.....	.....
87260	A	Adenovirus ag, dfa .....	.....	.....	.....	.....	.....
87265	A	Pertussis ag, dfa .....	.....	.....	.....	.....	.....
87270	A	Chylmd trach ag, dfa .....	.....	.....	.....	.....	.....
87272	A	Cryptosporidium ag, dfa .....	.....	.....	.....	.....	.....
87274	A	Herpes simplex ag, dfa .....	.....	.....	.....	.....	.....
87276	A	Influenza ag, dfa .....	.....	.....	.....	.....	.....
87278	A	Legion pneumo ag, dfa .....	.....	.....	.....	.....	.....
87280	A	Resp syncytial ag, dfa .....	.....	.....	.....	.....	.....
87285	A	Trepon pallidum ag, dfa .....	.....	.....	.....	.....	.....
87290	A	Varicella ag, dfa .....	.....	.....	.....	.....	.....
87299	A	Ag detection nos, dfa .....	.....	.....	.....	.....	.....
87301	A	Adenovirus ag, eia .....	.....	.....	.....	.....	.....
87320	A	Chylmd trach ag, eia .....	.....	.....	.....	.....	.....
87324	A	Clostridium ag, eia .....	.....	.....	.....	.....	.....
87328	A	Cryptospor ag, eia .....	.....	.....	.....	.....	.....
87332	A	Cytomegalovirus ag, eia .....	.....	.....	.....	.....	.....
87335	A	E coli 0157 ag, eia .....	.....	.....	.....	.....	.....
87340	A	Hepatitis b surface ag, eia .....	.....	.....	.....	.....	.....
87350	A	Hepatitis b ag, eia .....	.....	.....	.....	.....	.....
87380	A	Hepatitis delta ag, eia .....	.....	.....	.....	.....	.....
87385	A	Histoplasma capsul ag, eia .....	.....	.....	.....	.....	.....
87390	A	Hiv-1 ag, eia .....	.....	.....	.....	.....	.....
87391	A	Hiv-2 ag, eia .....	.....	.....	.....	.....	.....
87420	A	Resp syncytial ag, eia .....	.....	.....	.....	.....	.....
87425	A	Rotavirus ag, eia .....	.....	.....	.....	.....	.....
87430	A	Strep a ag, eia					
87449	A	Ag detect nos, eia, mult					
87450	A	Ag detect nos, eia, single					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
87470	A	Bartonella, dna, dir probe .....	.....	.....	.....	.....	.....
87471	A	Bartonella, dna, amp probe .....	.....	.....	.....	.....	.....
87472	A	Bartonella, dna, quant .....	.....	.....	.....	.....	.....
87475	A	Lyme dis, dna, dir probe .....	.....	.....	.....	.....	.....
87476	A	Lyme dis, dna, amp probe .....	.....	.....	.....	.....	.....
87477	A	Lyme dis, dna, quant .....	.....	.....	.....	.....	.....
87480	A	Candida, dna, dir probe .....	.....	.....	.....	.....	.....
87481	A	Candida, dna, amp probe .....	.....	.....	.....	.....	.....
87482	A	Candida, dna, quant .....	.....	.....	.....	.....	.....
87485	A	Chylmd pneum, dna, dir probe .....	.....	.....	.....	.....	.....
87486	A	Chylmd pneum, dna, amp probe .....	.....	.....	.....	.....	.....
87487	A	Chylmd pneum, dna, quant .....	.....	.....	.....	.....	.....
87490	A	Chylmd trach, dna, dir probe .....	.....	.....	.....	.....	.....
87491	A	Chylmd trach, dna, amp probe .....	.....	.....	.....	.....	.....
87492	A	Chylmd trach, dna, quant .....	.....	.....	.....	.....	.....
87495	A	Cytomeg, dna, dir probe .....	.....	.....	.....	.....	.....
87496	A	Cytomeg, dna, amp probe .....	.....	.....	.....	.....	.....
87497	A	Cytomeg, dna, quant .....	.....	.....	.....	.....	.....
87510	A	Gardner vag, dna, dir probe .....	.....	.....	.....	.....	.....
87511	A	Gardner vag, dna, amp probe .....	.....	.....	.....	.....	.....
87512	A	Gardner vag, dna, quant .....	.....	.....	.....	.....	.....
87515	A	Hepatitis b, dna, dir probe .....	.....	.....	.....	.....	.....
87516	A	Hepatitis b, dna, amp probe .....	.....	.....	.....	.....	.....
87517	A	Hepatitis b, dna, quant .....	.....	.....	.....	.....	.....
87520	A	Hepatitis c, rna, dir probe .....	.....	.....	.....	.....	.....
87521	A	Hepatitis c, rna, amp probe .....	.....	.....	.....	.....	.....
87522	A	Hepatitis c, rna, quant .....	.....	.....	.....	.....	.....
87525	A	Hepatitis g, dna, dir probe .....	.....	.....	.....	.....	.....
87526	A	Hepatitis g, dna, amp probe .....	.....	.....	.....	.....	.....
87527	A	Hepatitis g, dna, quant .....	.....	.....	.....	.....	.....
87528	A	Hsv, dna, dir probe .....	.....	.....	.....	.....	.....
87529	A	Hsv, dna, amp probe .....	.....	.....	.....	.....	.....
87530	A	Hsv, dna, quant .....	.....	.....	.....	.....	.....
87531	A	Hhv-6, dna, dir probe .....	.....	.....	.....	.....	.....
87532	A	Hhv-6, dna, amp probe .....	.....	.....	.....	.....	.....
87533	A	Hhv-6, dna, quant .....	.....	.....	.....	.....	.....
87534	A	Hiv-1, dna, dir probe .....	.....	.....	.....	.....	.....
87535	A	Hiv-1, dna, amp probe .....	.....	.....	.....	.....	.....
87536	A	Hiv-1, dna, quant .....	.....	.....	.....	.....	.....
87537	A	Hiv-2, dna, dir probe .....	.....	.....	.....	.....	.....
87538	A	Hiv-2, dna, amp probe .....	.....	.....	.....	.....	.....
87539	A	Hiv-2, dna, quant .....	.....	.....	.....	.....	.....
87540	A	Legion pneumo, dna, dir prob .....	.....	.....	.....	.....	.....
87541	A	Legion pneumo, dna, amp prob .....	.....	.....	.....	.....	.....
87542	A	Legion pneumo, dna, quant .....	.....	.....	.....	.....	.....
87550	A	Mycobacteria, dna, dir probe .....	.....	.....	.....	.....	.....
87551	A	Mycobacteria, dna, amp probe .....	.....	.....	.....	.....	.....
87552	A	Mycobacteria, dna, quant .....	.....	.....	.....	.....	.....
87555	A	M.tuberculo, dna, dir probe .....	.....	.....	.....	.....	.....
87556	A	M.tuberculo, dna, amp probe .....	.....	.....	.....	.....	.....
87557	A	M.tuberculo, dna, quant .....	.....	.....	.....	.....	.....
87560	A	M.avium-intra, dna, dir prob .....	.....	.....	.....	.....	.....
87561	A	M.avium-intra, dna, amp prob .....	.....	.....	.....	.....	.....
87562	A	M.avium-intra, dna, quant .....	.....	.....	.....	.....	.....
87580	A	M.pneumon, dna, dir probe .....	.....	.....	.....	.....	.....
87581	A	M.pneumon, dna, amp probe .....	.....	.....	.....	.....	.....
87582	A	M.pneumon, dna, quant .....	.....	.....	.....	.....	.....
87590	A	N.gonorrhoeae, dna, dir prob .....	.....	.....	.....	.....	.....
87591	A	N.gonorrhoeae, dna, amp prob .....	.....	.....	.....	.....	.....
87592	A	N.gonorrhoeae, dna, quant .....	.....	.....	.....	.....	.....
87620	A	Hpv, dna, dir probe .....	.....	.....	.....	.....	.....
87621	A	Hpv, dna, amp probe .....	.....	.....	.....	.....	.....
87622	A	Hpv, dna, quant .....	.....	.....	.....	.....	.....
87650	A	Strep a, dna, dir probe .....	.....	.....	.....	.....	.....
87651	A	Strep a, dna, amp probe .....	.....	.....	.....	.....	.....
87652	A	Strep a, dna, quant .....	.....	.....	.....	.....	.....
87797	A	Detect agent nos, dna, dir .....	.....	.....	.....	.....	.....
87798	A	Detect agent nos, dna, amp .....	.....	.....	.....	.....	.....
87799	A	Detect agent nos, dna, quant .....	.....	.....	.....	.....	.....
87810	A	Chylmd trach assay w/optic .....	.....	.....	.....	.....	.....
87850	A	N. gonorrhoeae assay w/optic .....	.....	.....	.....	.....	.....
87880	A	Strep a assay w/optic .....	.....	.....	.....	.....	.....
87899	A	Agent nos assay w/optic					
87999	A	Microbiology procedure					
88000	E	Autopsy (necropsy), gross					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
88005	E	Autopsy (necropsy), gross .....	.....	.....	.....	.....	.....
88007	E	Autopsy (necropsy), gross .....	.....	.....	.....	.....	.....
88012	E	Autopsy (necropsy), gross .....	.....	.....	.....	.....	.....
88014	E	Autopsy (necropsy), gross .....	.....	.....	.....	.....	.....
88016	E	Autopsy (necropsy), gross .....	.....	.....	.....	.....	.....
88020	E	Autopsy (necropsy), complete .....	.....	.....	.....	.....	.....
88025	E	Autopsy (necropsy), complete .....	.....	.....	.....	.....	.....
88027	E	Autopsy (necropsy), complete .....	.....	.....	.....	.....	.....
88028	E	Autopsy (necropsy), complete .....	.....	.....	.....	.....	.....
88029	E	Autopsy (necropsy), complete .....	.....	.....	.....	.....	.....
88036	E	Limited autopsy .....	.....	.....	.....	.....	.....
88037	E	Limited autopsy .....	.....	.....	.....	.....	.....
88040	E	Forensic autopsy (necropsy) .....	.....	.....	.....	.....	.....
88045	E	Coroner's autopsy (necropsy) .....	.....	.....	.....	.....	.....
88099	E	Necropsy (autopsy) procedure .....	.....	.....	.....	.....	.....
88104	X	Cytopathology, fluids	882	0.39	\$20.57	\$11.75	\$4.11
88106	X	Cytopathology, fluids	882	0.39	\$20.57	\$11.75	\$4.11
88107	X	Cytopathology, fluids	882	0.39	\$20.57	\$11.75	\$4.11
88108	X	Cytopath, concentrate tech	882	0.39	\$20.57	\$11.75	\$4.11
88125	X	Forensic cytopathology	881	0.20	\$10.77	\$6.78	\$2.15
88130	A	Sex chromatin identification .....	.....	.....	.....	.....	.....
88140	A	Sex chromatin identification .....	.....	.....	.....	.....	.....
88141	N	Cytopath cerv/vag interpret .....	.....	.....	.....	.....	.....
88142	A	Cytopath cerv/vag thin layer .....	.....	.....	.....	.....	.....
88150	A	Cytopath cerv/vag .....	.....	.....	.....	.....	.....
88152	A	Cytopath cerv/vag auto .....	.....	.....	.....	.....	.....
88155	A	Cytopath cerv/vag index .....	.....	.....	.....	.....	.....
88156	A	Cytopath cerv/vag tbs .....	.....	.....	.....	.....	.....
88158	A	Cytopath cerv/vag tbs auto .....	.....	.....	.....	.....	.....
88160	X	Cytopath smear, other source	882	0.39	\$20.57	\$11.75	\$4.11
88161	X	Cytopath smear, other source	882	0.39	\$20.57	\$11.75	\$4.11
88162	X	Cytopath smear, other source	882	0.39	\$20.57	\$11.75	\$4.11
88170	T	Fine needle aspiration	121	0.67	\$35.26	\$21.02	\$7.05
88171	T	Fine needle aspiration	121	0.67	\$35.26	\$21.02	\$7.05
88172	X	Evaluation of smear	882	0.39	\$20.57	\$11.75	\$4.11
88173	X	Interpretation of smear	882	0.39	\$20.57	\$11.75	\$4.11
88180	X	Cell marker study	882	0.39	\$20.57	\$11.75	\$4.11
88182	X	Cell marker study	882	0.39	\$20.57	\$11.75	\$4.11
88199	X	Cytopathology procedure	881	0.20	\$10.77	\$6.78	\$2.15
88230	A	Tissue culture, lymphocyte .....	.....	.....	.....	.....	.....
88233	A	Tissue culture, skin/biopsy .....	.....	.....	.....	.....	.....
88235	A	Tissue culture, placenta .....	.....	.....	.....	.....	.....
88237	A	Tissue culture, bone marrow .....	.....	.....	.....	.....	.....
88239	A	Tissue culture, other .....	.....	.....	.....	.....	.....
88245	A	Chromosome analysis .....	.....	.....	.....	.....	.....
88248	A	Chromosome analysis .....	.....	.....	.....	.....	.....
88250	A	Chromosome analysis .....	.....	.....	.....	.....	.....
88260	A	Chromosome analysis: 5 cells .....	.....	.....	.....	.....	.....
88261	A	Chromosome analysis: 5 cells .....	.....	.....	.....	.....	.....
88262	A	Chromosome count:15–20 cells .....	.....	.....	.....	.....	.....
88263	A	Chromosome analysis:45 cells .....	.....	.....	.....	.....	.....
88267	A	Chromosome analysis:placenta .....	.....	.....	.....	.....	.....
88269	A	Chromosome analysis:amniotic .....	.....	.....	.....	.....	.....
88280	A	Chromosome karyotype study .....	.....	.....	.....	.....	.....
88283	A	Chromosome banding study .....	.....	.....	.....	.....	.....
88285	A	Chromosome count: additional .....	.....	.....	.....	.....	.....
88289	A	Chromosome study: additional .....	.....	.....	.....	.....	.....
88299	A	Cytogenetic study .....	.....	.....	.....	.....	.....
88300	X	Surg path, gross	881	0.20	\$10.77	\$6.78	\$2.15
88302	X	Tissue exam by pathologist	882	0.39	\$20.57	\$11.75	\$4.11
88304	X	Tissue exam by pathologist	882	0.39	\$20.57	\$11.75	\$4.11
88305	X	Tissue exam by pathologist	882	0.39	\$20.57	\$11.75	\$4.11
88307	X	Tissue exam by pathologist	883	0.65	\$34.28	\$20.34	\$6.86
88309	X	Tissue exam by pathologist	883	0.65	\$34.28	\$20.34	\$6.86
88311	X	Decalcify tissue	881	0.20	\$10.77	\$6.78	\$2.15
88312	X	Special stains	882	0.39	\$20.57	\$11.75	\$4.11
88313	X	Special stains	881	0.20	\$10.77	\$6.78	\$2.15
88314	X	Histochemical stain	882	0.39	\$20.57	\$11.75	\$4.11
88318	X	Chemical histochemistry	882	0.39	\$20.57	\$11.75	\$4.11
88319	X	Enzyme histochemistry	882	0.39	\$20.57	\$11.75	\$4.11
88321	X	Microslide consultation	882	0.39	\$20.57	\$11.75	\$4.11
88323	X	Microslide consultation	882	0.39	\$20.57	\$11.75	\$4.11
88325	X	Comprehensive review of data	882	0.39	\$20.57	\$11.75	\$4.11
88329	X	Pathology consult in surgery	882	0.39	\$20.57	\$11.75	\$4.11
88331	X	Pathology consult in surgery	882	0.39	\$20.57	\$11.75	\$4.11

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
88332	X	Pathology consult in surgery	882	0.39	\$20.57	\$11.75	\$4.11
88342	X	Immunocytochemistry	882	0.39	\$20.57	\$11.75	\$4.11
88346	X	Immunofluorescent study	882	0.39	\$20.57	\$11.75	\$4.11
88347	X	Immunofluorescent study	882	0.39	\$20.57	\$11.75	\$4.11
88348	X	Electron microscopy	883	0.65	\$34.28	\$20.34	\$6.86
88349	X	Scanning electron microscopy	883	0.65	\$34.28	\$20.34	\$6.86
88355	X	Analysis, skeletal muscle	883	0.65	\$34.28	\$20.34	\$6.86
88356	X	Analysis, nerve	883	0.65	\$34.28	\$20.34	\$6.86
88358	X	Analysis, tumor	883	0.65	\$34.28	\$20.34	\$6.86
88362	X	Nerve teasing preparations	883	0.65	\$34.28	\$20.34	\$6.86
88365	X	Tissue hybridization	883	0.65	\$34.28	\$20.34	\$6.86
88371	A	Protein, western blot tissue					
88372	A	Protein analysis w/probe					
88399	X	Surgical pathology procedure	881	0.20	\$10.77	\$6.78	\$2.15
89050	A	Body fluid cell count					
89051	A	Body fluid cell count					
89060	A	Exam, synovial fluid crystals					
89100	X	Sample intestinal contents	928	3.11	\$164.55	\$83.85	\$32.91
89105	X	Sample intestinal contents	928	3.11	\$164.55	\$83.85	\$32.91
89125	A	Specimen fat stain					
89130	X	Sample stomach contents	928	3.11	\$164.55	\$83.85	\$32.91
89132	X	Sample stomach contents	928	3.11	\$164.55	\$83.85	\$32.91
89135	X	Sample stomach contents	928	3.11	\$164.55	\$83.85	\$32.91
89136	X	Sample stomach contents	928	3.11	\$164.55	\$83.85	\$32.91
89140	X	Sample stomach contents	928	3.11	\$164.55	\$83.85	\$32.91
89141	X	Sample stomach contents	928	3.11	\$164.55	\$83.85	\$32.91
89160	A	Exam feces for meat fibers					
89190	A	Nasal smear for eosinophils					
89250	A	Fertilization of oocyte					
89251	A	Culture oocyte w/embryos					
89252	A	Assist oocyte fertilization					
89253	A	Embryo hatching					
89254	A	Oocyte identification					
89255	A	Prepare embryo for transfer					
89256	A	Prepare cryopreserved embryo					
89257	A	Sperm identification					
89258	A	Cryopreservation, embryo					
89259	A	Cryopreservation, sperm					
89260	A	Sperm isolation, simple					
89261	A	Sperm isolation, complex					
89300	A	Semen analysis					
89310	A	Semen analysis					
89320	A	Semen analysis					
89325	A	Sperm antibody test					
89329	A	Sperm evaluation test					
89330	A	Evaluation, cervical mucus					
89350	X	Sputum specimen collection	881	0.20	\$10.77	\$6.78	\$2.15
89355	A	Exam feces for starch					
89360	X	Collect sweat for test	881	0.20	\$10.77	\$6.78	\$2.15
89365	A	Water load test					
89399	X	Pathology lab procedure	881	0.20	\$10.77	\$6.78	\$2.15
90700	X	DTaP immunization	901	0.07	\$3.92	\$2.49	0.78
90701	X	DTP immunization	901	0.07	\$3.92	\$2.49	0.78
90702	X	DT immunization	901	0.07	\$3.92	\$2.49	0.78
90703	X	Tetanus immunization	901	0.07	\$3.92	\$2.49	0.78
90704	X	Mumps immunization	901	0.07	\$3.92	\$2.49	0.78
90705	X	Measles immunization	901	0.07	\$3.92	\$2.49	0.78
90706	X	Rubella immunization	901	0.07	\$3.92	\$2.49	0.78
90707	X	MMR virus immunization	902	1.78	\$94.03	\$41.58	\$18.81
90708	X	Measles-rubella immunization	901	0.07	\$3.92	\$2.49	0.78
90709	X	Rubella & mumps immunization	901	0.07	\$3.92	\$2.49	0.78
90710	X	Combined vaccine	901	0.07	\$3.92	\$2.49	0.78
90711	X	Combined vaccine	901	0.07	\$3.92	\$2.49	0.78
90712	X	Oral poliovirus immunization	902	1.78	\$94.03	\$41.58	\$18.81
90713	X	Poliomyelitis immunization	902	1.78	\$94.03	\$41.58	\$18.81
90714	X	Typhoid immunization	901	0.07	\$3.92	\$2.49	0.78
90716	X	Chicken pox vaccine	902	1.78	\$94.03	\$41.58	\$18.81
90717	X	Yellow fever immunization	902	1.78	\$94.03	\$41.58	\$18.81
90718	X	Td immunization	901	0.07	\$3.92	\$2.49	0.78
90719	X	Diphtheria immunization	901	0.07	\$3.92	\$2.49	0.78
90720	X	DTP/HIB vaccine	902	1.78	\$94.03	\$41.58	\$18.81
90721	X	Dtap/hib vaccine	903	1.17	\$61.71	\$25.76	\$12.34
90724	X	Influenza immunization	901	0.07	\$3.92	\$2.49	0.78
90725	X	Cholera immunization	901	0.07	\$3.92	\$2.49	0.78
90726	X	Rabies immunization	903	1.17	\$61.71	\$25.76	\$12.34

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
90727	X	Plague immunization	903	1.17	\$61.71	\$25.76	\$12.34
90728	X	BCG immunization	903	1.17	\$61.71	\$25.76	\$12.34
90730	X	Hepatitis A vaccine	901	0.07	\$3.92	\$2.49	0.78
90732	X	Pneumococcal immunization	901	0.07	\$3.92	\$2.49	0.78
90733	X	Meningococcal immunization	902	1.78	\$94.03	\$41.58	\$18.81
90735	X	Encephalitis virus vaccine	903	1.17	\$61.71	\$25.76	\$12.34
90737	X	Influenza B immunization	902	1.78	\$94.03	\$41.58	\$18.81
90741	X	Passive immunization, ISG	902	1.78	\$94.03	\$41.58	\$18.81
90742	X	Special passive immunization	903	1.17	\$61.71	\$25.76	\$12.34
90744	X	Hepatitis B vaccine, under 11	902	1.78	\$94.03	\$41.58	\$18.81
90745	X	Hepatitis B vaccine, 11–19	902	1.78	\$94.03	\$41.58	\$18.81
90746	X	Hepatitis B vaccine, over 20	902	1.78	\$94.03	\$41.58	\$18.81
90747	X	Hepatitis B vaccine, ill pat	902	1.78	\$94.03	\$41.58	\$18.81
90748	X	Hepatitis b/hib vaccine	901	0.07	\$3.92	\$2.49	0.78
90749	X	Immunization procedure	901	0.07	\$3.92	\$2.49	0.78
90780	X	IV infusion therapy, 1 hour	906	1.46	\$77.38	\$42.49	\$15.48
90781	X	IV infusion, additional hour	906	1.46	\$77.38	\$42.49	\$15.48
90782	X	Injection (SC)/(IM)	907	0.85	\$45.05	\$11.98	\$9.01
90783	X	Injection (IA)	907	0.85	\$45.05	\$11.98	\$9.01
90784	X	Injection (IV)	907	0.85	\$45.05	\$11.98	\$9.01
90788	X	Injection of antibiotic	907	0.85	\$45.05	\$11.98	\$9.01
90799	X	Therapeutic/diag injection	907	0.85	\$45.05	\$11.98	\$9.01
90801	S	Psy dx interview	092	1.57	\$83.25	\$21.92	\$16.65
90802	S	Intac psy dx interview	092	1.57	\$83.25	\$21.92	\$16.65
90804	S	Psytx, office (20–30)	091	1.19	\$62.69	\$15.37	\$12.54
90805	S	Psytx, office (20–30) w/e&m	091	1.19	\$62.69	\$15.37	\$12.54
90806	S	Psytx, office (45–50)	092	1.57	\$83.25	\$21.92	\$16.65
90807	S	Psytx, office (45–50) w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90808	S	Psytx, office (75–80)	092	1.57	\$83.25	\$21.92	\$16.65
90809	S	Psytx, office (75–80) w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90810	S	Intac psytx, office (20–30)	091	1.19	\$62.69	\$15.37	\$12.54
90811	S	Intac psytx, off 20–30 w/e&m	091	1.19	\$62.69	\$15.37	\$12.54
90812	S	Intac psytx, office (45–50)	092	1.57	\$83.25	\$21.92	\$16.65
90813	S	Intac psytx, off 45–50 w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90814	S	Intac psytx, office (75–80)	092	1.57	\$83.25	\$21.92	\$16.65
90815	S	Intac psytx, off 75–80 w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90816	S	Psytx, hosp (20–30)	091	1.19	\$62.69	\$15.37	\$12.54
90817	S	Psytx, hosp (20–30) w/e&m	091	1.19	\$62.69	\$15.37	\$12.54
90818	S	Psytx, hosp (45–50)	092	1.57	\$83.25	\$21.92	\$16.65
90819	S	Psytx, hosp (45–50) w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90821	S	Psytx, hosp (75–80)	092	1.57	\$83.25	\$21.92	\$16.65
90822	S	Psytx, hosp (75–80) w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90823	S	Intac psytx, hosp (20–30)	091	1.19	\$62.69	\$15.37	\$12.54
90824	S	Intac psytx, hsp 20–30 w/e&m	091	1.19	\$62.69	\$15.37	\$12.54
90826	S	Intac psytx, hosp (45–50)	092	1.57	\$83.25	\$21.92	\$16.65
90827	S	Intac psytx, hsp 45–50 w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90828	S	Intac psytx, hosp (75–80)	092	1.57	\$83.25	\$21.92	\$16.65
90829	S	Intac psytx, hsp 75–80 w/e&m	092	1.57	\$83.25	\$21.92	\$16.65
90845	S	Psychoanalysis	092	1.57	\$83.25	\$21.92	\$16.65
90846	S	Family psytx w/o patient	093	1.54	\$81.29	\$20.11	\$16.26
90847	S	Family psytx w/patient	093	1.54	\$81.29	\$20.11	\$16.26
90849	S	Multiple family group psytx	094	1.24	\$65.62	\$20.11	\$13.12
90853	S	Group psychotherapy	094	1.24	\$65.62	\$20.11	\$13.12
90857	S	Intac group psytx	094	1.24	\$65.62	\$20.11	\$13.12
90862	X	Medication management	090	0.85	\$45.05	\$12.43	\$9.01
90865	S	Narcosynthesis	092	1.57	\$83.25	\$21.92	\$16.65
90870	S	Electroconvulsive therapy	919	3.17	\$167.49	\$80.00	\$33.50
90871	S	Electroconvulsive therapy	919	3.17	\$167.49	\$80.00	\$33.50
90875	E	Psychophysiological therapy					
90876	E	Psychophysiological therapy					
90880	S	Hypnotherapy	092	1.57	\$83.25	\$21.92	\$16.65
90882	E	Environmental manipulation					
90885	N	Psy evaluation of records					
90887	N	Consultation with family					
90889	N	Preparation of report					
90899	S	Psychiatric service/therapy	091	1.19	\$62.69	\$15.37	\$12.54
90901	S	Biofeedback, any method	920	1.17	\$61.71	\$29.61	\$12.34
90911	S	Biofeedback peri/uro/rectal	920	1.17	\$61.71	\$29.61	\$12.34
90918	A	ESRD related services, month					
90919	A	ESRD related services, month					
90920	A	ESRD related services, month					
90921	A	ESRD related services, month					
90922	A	ESRD related services, day					
90923	A	Esrd related services, day					
90924	A	Esrd related services, day					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
90925	A	Esrd related services, day					
90935	S	Hemodialysis, one evaluation	926	4.28	\$226.25	\$69.83	\$45.25
90937	S	Hemodialysis, repeated eval	926	4.28	\$226.25	\$69.83	\$45.25
90945	S	Dialysis, one evaluation	926	4.28	\$226.25	\$69.83	\$45.25
90947	S	Dialysis, repeated eval	926	4.28	\$226.25	\$69.83	\$45.25
90989	E	Dialysis training/complete					
90993	N	Dialysis training/incomplete					
90997	S	Hemoperfusion	926	4.28	\$226.25	\$69.83	\$45.25
90999	S	Dialysis procedure	926	4.28	\$226.25	\$69.83	\$45.25
91000	X	Esophageal intubation	928	3.11	\$164.55	\$83.85	\$32.91
91010	X	Esophagus motility study	928	3.11	\$164.55	\$83.85	\$32.91
91011	X	Esophagus motility study	928	3.11	\$164.55	\$83.85	\$32.91
91012	X	Esophagus motility study	928	3.11	\$164.55	\$83.85	\$32.91
91020	X	Gastric motility	928	3.11	\$164.55	\$83.85	\$32.91
91030	X	Acid perfusion of esophagus	928	3.11	\$164.55	\$83.85	\$32.91
91032	X	Esophagus, acid reflux test	928	3.11	\$164.55	\$83.85	\$32.91
91033	X	Prolonged acid reflux test	928	3.11	\$164.55	\$83.85	\$32.91
91052	X	Gastric analysis test	928	3.11	\$164.55	\$83.85	\$32.91
91055	X	Gastric intubation for smear	928	3.11	\$164.55	\$83.85	\$32.91
91060	X	Gastric saline load test	928	3.11	\$164.55	\$83.85	\$32.91
91065	X	Breath hydrogen test	928	3.11	\$164.55	\$83.85	\$32.91
91100	X	Pass intestine bleeding tube	928	3.11	\$164.55	\$83.85	\$32.91
91105	X	Gastric intubation treatment	928	3.11	\$164.55	\$83.85	\$32.91
91122	N	Anal pressure record					
91299	X	Gastroenterology procedure	928	3.11	\$164.55	\$83.85	\$32.91
92002	V	Eye exam, new patient	913				
92004	V	Eye exam, new patient	915				
92012	V	Eye exam established pt	913				
92014	V	Eye exam & treatment	915				
92015	E	Refraction					
92018	T	New eye exam & treatment	676	6.30	\$333.01	\$140.35	\$66.6
92019	T	Eye exam & treatment	676	6.30	\$333.01	\$140.35	\$66.6
92020	N	Special eye evaluation					
92060	X	Special eye evaluation	930	1.02	\$53.87	\$22.83	\$10.77
92065	X	Orthoptic/pleoptic training	930	1.02	\$53.87	\$22.83	\$10.77
92070	N	Fitting of contact lens					
92081	X	Visual field examination(s)	930	1.02	\$53.87	\$22.83	\$10.77
92082	X	Visual field examination(s)	930	1.02	\$53.87	\$22.83	\$10.77
92083	X	Visual field examination(s)	930	1.02	\$53.87	\$22.83	\$10.77
92100	N	Serial tonometry exam(s)					
92120	X	Tonography & eye evaluation	931	0.74	\$39.18	\$21.47	\$7.84
92130	X	Water provocation tonography	931	0.74	\$39.18	\$21.47	\$7.84
92140	X	Glaucoma provocative tests	930	1.02	\$53.87	\$22.83	\$10.77
92225	N	Special eye exam, initial					
92226	N	Special eye exam, subsequent					
92230	X	Eye exam with photos	931	0.74	\$39.18	\$21.47	\$7.84
92235	X	Eye exam with photos	932	2.52	\$133.21	\$65.09	\$26.64
92240	X	Icg angiography	931	0.74	\$39.18	\$21.47	\$7.84
92250	X	Eye exam with photos	931	0.74	\$39.18	\$21.47	\$7.84
92260	N	Ophthalmoscopy/dynamometry					
92265	X	Eye muscle evaluation	932	2.52	\$133.21	\$65.09	\$26.64
92270	X	Electro-oculography	932	2.52	\$133.21	\$65.09	\$26.64
92275	X	Electroretinography	981	1.46	\$77.38	\$41.81	\$15.48
92283	X	Color vision examination	930	1.02	\$53.87	\$22.83	\$10.77
92284	X	Dark adaptation eye exam	930	1.02	\$53.87	\$22.83	\$10.77
92285	X	Eye photography	930	1.02	\$53.87	\$22.83	\$10.77
92286	X	Internal eye photography	932	2.52	\$133.21	\$65.09	\$26.64
92287	X	Internal eye photography	932	2.52	\$133.21	\$65.09	\$26.64
92310	E	Contact lens fitting					
92311	X	Contact lens fitting	936	0.52	\$27.42	\$9.49	\$5.48
92312	X	Contact lens fitting	936	0.52	\$27.42	\$9.49	\$5.48
92313	X	Contact lens fitting	936	0.52	\$27.42	\$9.49	\$5.48
92314	E	Prescription of contact lens					
92315	X	Prescription of contact lens	936	0.52	\$27.42	\$9.49	\$5.48
92316	X	Prescription of contact lens	936	0.52	\$27.42	\$9.49	\$5.48
92317	X	Prescription of contact lens	936	0.52	\$27.42	\$9.49	\$5.48
92325	X	Modification of contact lens	936	0.52	\$27.42	\$9.49	\$5.48
92326	X	Replacement of contact lens	936	0.52	\$27.42	\$9.49	\$5.48
92330	X	Fitting of artificial eye	936	0.52	\$27.42	\$9.49	\$5.48
92335	N	Fitting of artificial eye					
92340	E	Fitting of spectacles					
92341	E	Fitting of spectacles					
92342	E	Fitting of spectacles					
92352	X	Special spectacles fitting	936	0.52	\$27.42	\$9.49	\$5.48
92353	X	Special spectacles fitting	936	0.52	\$27.42	\$9.49	\$5.48

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
92354	X	Special spectacles fitting	936	0.52	\$27.42	\$9.49	\$5.48
92355	X	Special spectacles fitting	936	0.52	\$27.42	\$9.49	\$5.48
92358	X	Eye prosthesis service	936	0.52	\$27.42	\$9.49	\$5.48
92370	E	Repair & adjust spectacles					
92371	X	Repair & adjust spectacles	936	0.52	\$27.42	\$9.49	\$5.48
92390	E	Supply of spectacles					
92391	E	Supply of contact lenses					
92392	E	Supply of low vision aids					
92393	E	Supply of artificial eye					
92395	E	Supply of spectacles					
92396	E	Supply of contact lenses					
92499	X	Eye service or procedure	931	0.74	\$39.18	\$21.47	\$7.84
92502	T	Ear and throat examination	311	1.43	\$75.42	\$20.57	\$15.08
92504	N	Ear microscopy examination					
92506	A	Speech & hearing evaluation					
92507	A	Speech/hearing therapy					
92508	A	Speech/hearing therapy					
92510	A	Rehab for ear implant					
92511	T	Nasopharyngos-	331	0.69	\$36.24	\$14.01	\$7.25
		copy					
92512	X	Nasal function studies	940	3.04	\$160.63	\$51.98	\$32.13
92516	X	Facial nerve function test	940	3.04	\$160.63	\$51.98	\$32.13
92520	X	Laryngeal function studies	940	3.04	\$160.63	\$51.98	\$32.13
92525	A	Oral function evaluation					
92526	A	Oral function therapy					
92531	N	Spontaneous nystagmus study					
92532	N	Positional nystagmus study					
92533	N	Caloric vestibular test					
92534	N	Optokinetic nystagmus					
92541	X	Spontaneous nystagmus test	940	3.04	\$160.63	\$51.98	\$32.13
92542	X	Positional nystagmus test	940	3.04	\$160.63	\$51.98	\$32.13
92543	X	Caloric vestibular test	940	3.04	\$160.63	\$51.98	\$32.13
92544	X	Optokinetic nystagmus test	940	3.04	\$160.63	\$51.98	\$32.13
92545	X	Oscillating tracking test	940	3.04	\$160.63	\$51.98	\$32.13
92546	X	Sinusoidal rotational test	940	3.04	\$160.63	\$51.98	\$32.13
92547	X	Supplemental electrical test	940	3.04	\$160.63	\$51.98	\$32.13
92548	X	Posturography	940	3.04	\$160.63	\$51.98	\$32.13
92551	E	Pure tone hearing test, air					
92552	X	Pure tone audiometry, air	941	0.74	\$39.18	\$13.56	\$7.84
92553	X	Audiometry, air & bone	941	0.74	\$39.18	\$13.56	\$7.84
92555	X	Speech threshold audiometry	941	0.74	\$39.18	\$13.56	\$7.84
92556	X	Speech audiometry, complete	941	0.74	\$39.18	\$13.56	\$7.84
92557	X	Comprehensive hearing test	942	1.48	\$78.36	\$22.15	\$15.67
92559	E	Group audiometric testing					
92560	E	Bekesy audiometry, screen					
92561	X	Bekesy audiometry, diagnosis	942	1.48	\$78.36	\$22.15	\$15.67
92562	X	Loudness balance test	942	1.48	\$78.36	\$22.15	\$15.67
92563	X	Tone decay hearing test	942	1.48	\$78.36	\$22.15	\$15.67
92564	X	Sisi hearing test	942	1.48	\$78.36	\$22.15	\$15.67
92565	X	Stenger test, pure tone	942	1.48	\$78.36	\$22.15	\$15.67
92567	X	Tympanometry	941	0.74	\$39.18	\$13.56	\$7.84
92568	X	Acoustic reflex testing	942	1.48	\$78.36	\$22.15	\$15.67
92569	X	Acoustic reflex decay test	942	1.48	\$78.36	\$22.15	\$15.67
92571	X	Filtered speech hearing test	942	1.48	\$78.36	\$22.15	\$15.67
92572	X	Staggered spondaic word test	942	1.48	\$78.36	\$22.15	\$15.67
92573	X	Lombard test	942	1.48	\$78.36	\$22.15	\$15.67
92575	X	Sensorineural acuity test	942	1.48	\$78.36	\$22.15	\$15.67
92576	X	Synthetic sentence test	942	1.48	\$78.36	\$22.15	\$15.67
92577	X	Stenger test, speech	942	1.48	\$78.36	\$22.15	\$15.67
92579	X	Visual audiometry (vra)	942	1.48	\$78.36	\$22.15	\$15.67
92582	X	Conditioning play audiometry	942	1.48	\$78.36	\$22.15	\$15.67
92583	X	Select picture audiometry	942	1.48	\$78.36	\$22.15	\$15.67
92584	X	Electrocochleography	940	3.04	\$160.63	\$51.98	\$32.13
92585	X	Auditory evoked potential	982	1.39	\$73.46	\$38.87	\$14.69
92587	X	Evoked auditory test	940	3.04	\$160.63	\$51.98	\$32.13
92588	X	Evoked auditory test	940	3.04	\$160.63	\$51.98	\$32.13
92589	X	Auditory function test(s)	942	1.48	\$78.36	\$22.15	\$15.67
92590	E	Hearing aid exam, one ear					
92591	E	Hearing aid exam, both ears					
92592	E	Hearing aid check, one ear					
92593	E	Hearing aid check, both ears					
92594	E	Electro hearing aid test, one					
92595	E	Electro hearing aid test, both					
92596	X	Ear protector evaluation	942	1.48	\$78.36	\$22.15	\$15.67
92597	A	Oral speech device eval					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
92598	A	Modify oral speech device					
92599	X	ENT procedure/service	941	0.74	\$39.18	\$13.56	\$7.84
92950	S	Heart/lung resuscitation(CPR	947	4.07	\$215.48	\$109.61	\$43.10
92953	S	Temporary external pacing	947	4.07	\$215.48	\$109.61	\$43.10
92960	S	Heart electroconversion	947	4.07	\$215.48	\$109.61	\$43.10
92970	C	Cardioassist, internal					
92971	C	Cardioassist, external					
92975	C	Dissolve clot, heart vessel					
92977	C	Dissolve clot, heart vessel					
92978	C	Intravas us, heart (add-on)					
92979	C	Intravas us, heart (add-on)					
92980	C	Insert intracoronary stent					
92981	C	Insert intracoronary stent					
92982	C	Coronary artery dilation					
92984	C	Coronary artery dilation					
92986	C	Revision of aortic valve					
92987	C	Revision of mitral valve					
92990	C	Revision of pulmonary valve					
92992	C	Revision of heart chamber					
92993	C	Revision of heart chamber					
92995	C	Coronary atherectomy					
92996	C	Coronary atherectomy					
92997	C	Pul art balloon repair, perc					
92998	C	Pul art balloon repair, perc					
93000	N	Electrocardiogram, complete					
93005	X	Electrocardiogram, tracing	950	0.35	\$18.61	\$15.82	\$3.72
93010	N	Electrocardiogram report					
93012	X	Transmission of ecg	956	1.11	\$58.77	\$55.82	\$11.75
93014	N	Report on transmitted ecg					
93015	N	Cardiovascular stress test					
93016	N	Cardiovascular stress test					
93017	X	Cardiovascular stress test	949	1.46	\$77.38	\$62.83	\$15.48
93018	N	Cardiovascular stress test					
93024	X	Cardiac drug stress test	949	1.46	\$77.38	\$62.83	\$15.48
93040	N	Rhythm ECG with report					
93041	X	Rhythm ECG, tracing	950	0.35	\$18.61	\$15.82	\$3.72
93042	N	Rhythm ECG, report					
93224	X	ECG monitor/report, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93225	X	ECG monitor/record, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93226	X	ECG monitor/report, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93227	N	ECG monitor/review, 24 hrs					
93230	X	ECG monitor/report, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93231	X	Ecg monitor/record, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93232	X	ECG monitor/report, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93233	N	ECG monitor/review, 24 hrs					
93235	X	ECG monitor/report, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93236	X	ECG monitor/report, 24 hrs	956	1.11	\$58.77	\$55.82	\$11.75
93237	N	ECG monitor/review, 24 hrs					
93268	X	ECG record/review	956	1.11	\$58.77	\$55.82	\$11.75
93270	X	ECG recording	956	1.11	\$58.77	\$55.82	\$11.75
93271	X	Ecg/monitoring and anaylsis	956	1.11	\$58.77	\$55.82	\$11.75
93272	N	Ecg/review,interpret only					
93278	X	ECG/signal-averaged	956	1.11	\$58.77	\$55.82	\$11.75
93303	X	Echo transthoracic	957	2.83	\$149.86	\$117.07	\$29.97
93304	X	Echo transthoracic	957	2.83	\$149.86	\$117.07	\$29.97
93307	X	Echo exam of heart	957	2.83	\$149.86	\$117.07	\$29.97
93308	X	Echo exam of heart	957	2.83	\$149.86	\$117.07	\$29.97
93312	X	Echo transesophageal	957	2.83	\$149.86	\$117.07	\$29.97
93313	X	Echo transesophageal	957	2.83	\$149.86	\$117.07	\$29.97
93314	N	Echo transesophageal					
93315	X	Echo transesophageal	957	2.83	\$149.86	\$117.07	\$29.97
93316	X	Echo transesophageal	957	2.83	\$149.86	\$117.07	\$29.97
93317	N	Echo transesophageal					
93320	X	Doppler echo exam, heart	957	2.83	\$149.86	\$117.07	\$29.97
93321	X	Doppler echo exam, heart	957	2.83	\$149.86	\$117.07	\$29.97
93325	X	Doppler color flow	957	2.83	\$149.86	\$117.07	\$29.97
93350	X	Echo transthoracic	957	2.83	\$149.86	\$117.07	\$29.97
93501	T	Right heart catheterization	958	26.11	\$1,381.03	\$659.47	\$276.21
93503	T	Insert/place heart catheter	958	26.11	\$1,381.03	\$659.47	\$276.21
93505	T	Biopsy of heart lining	958	26.11	\$1,381.03	\$659.47	\$276.21
93508	T	Cath placement, angiography	343	9.52	\$503.44	\$224.87	\$100.69
93510	T	Left heart catheterization	958	26.11	\$1,381.03	\$659.47	\$276.21
93511	T	Left heart catheterization	958	26.11	\$1,381.03	\$659.47	\$276.21
93514	T	Left heart catheterization	958	26.11	\$1,381.03	\$659.47	\$276.21
93524	T	Left heart catheterization	958	26.11	\$1,381.03	\$659.47	\$276.21

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
93526	T	Rt & Lt heart catheters	958	26.11	\$1,381.03	\$659.47	\$276.21
93527	T	Rt & Lt heart catheters	958	26.11	\$1,381.03	\$659.47	\$276.21
93528	T	Rt & Lt heart catheters	958	26.11	\$1,381.03	\$659.47	\$276.21
93529	T	Rt, Lt heart catheterization	958	26.11	\$1,381.03	\$659.47	\$276.21
93530	T	Rt heart cath, congenital	958	26.11	\$1,381.03	\$659.47	\$276.21
93531	T	R & I heart cath, congenital	958	26.11	\$1,381.03	\$659.47	\$276.21
93532	T	R & I heart cath, congenital	958	26.11	\$1,381.03	\$659.47	\$276.21
93533	T	R & I heart cath, congenital	958	26.11	\$1,381.03	\$659.47	\$276.21
93536	T	Insert circulation assi	958	26.11	\$1,381.03	\$659.47	\$276.21
93539	N	Injection, cardiac cath .....	.....	.....	.....	.....	.....
93540	N	Injection, cardiac cath .....	.....	.....	.....	.....	.....
93541	N	Injection for lung angiogram .....	.....	.....	.....	.....	.....
93542	N	Injection for heart x-rays .....	.....	.....	.....	.....	.....
93543	N	Injection for heart x-rays .....	.....	.....	.....	.....	.....
93544	N	Injection for aortography .....	.....	.....	.....	.....	.....
93545	N	Injection for coronary xrays .....	.....	.....	.....	.....	.....
93555	N	Imaging, cardiac cath .....	.....	.....	.....	.....	.....
93556	N	Imaging, cardiac cath .....	.....	.....	.....	.....	.....
93561	N	Cardiac output measurement .....	.....	.....	.....	.....	.....
93562	N	Cardiac output measurement .....	.....	.....	.....	.....	.....
93600	S	Bundle of His recording	960	4.24	\$224.29	\$144.41	\$44.86
93602	S	Intra-atrial recording	960	4.24	\$224.29	\$144.41	\$44.86
93603	S	Right ventricular recording	960	4.24	\$224.29	\$144.41	\$44.86
93607	S	Right ventricular recording	960	4.24	\$224.29	\$144.41	\$44.86
93609	S	Mapping of tachycardia	960	4.24	\$224.29	\$144.41	\$44.86
93610	S	Intra-atrial pacing	960	4.24	\$224.29	\$144.41	\$44.86
93612	S	Intraventricular pacing	960	4.24	\$224.29	\$144.41	\$44.86
93615	S	Esophageal recording	960	4.24	\$224.29	\$144.41	\$44.86
93616	S	Esophageal recording	960	4.24	\$224.29	\$144.41	\$44.86
93618	S	Heart rhythm pacing	960	4.24	\$224.29	\$144.41	\$44.86
93619	S	Electrophysiology evaluation	960	4.24	\$224.29	\$144.41	\$44.86
93620	S	Electrophysiology evaluation	960	4.24	\$224.29	\$144.41	\$44.86
93621	S	Electrophysiology evaluation	960	4.24	\$224.29	\$144.41	\$44.86
93622	S	Electrophysiology evaluation	960	4.24	\$224.29	\$144.41	\$44.86
93623	S	Stimulation, pacing heart	960	4.24	\$224.29	\$144.41	\$44.86
93624	S	Electrophysiologic study	960	4.24	\$224.29	\$144.41	\$44.86
93631	S	Heart pacing, mapping	960	4.24	\$224.29	\$144.41	\$44.86
93640	S	Evaluation heart device	960	4.24	\$224.29	\$144.41	\$44.86
93641	S	Electrophysiology evaluation	960	4.24	\$224.29	\$144.41	\$44.86
93642	S	Electrophysiology evaluation	960	4.24	\$224.29	\$144.41	\$44.86
93650	S	Ablate heart dysrhythm focus	960	4.24	\$224.29	\$144.41	\$44.86
93651	S	Ablate heart dysrhythm focus	960	4.24	\$224.29	\$144.41	\$44.86
93652	S	Ablate heart dysrhythm focus	960	4.24	\$224.29	\$144.41	\$44.86
93660	S	Tilt table evaluation	960	4.24	\$224.29	\$144.41	\$44.86
93720	X	Total body plethysmography	967	1.70	\$90.11	\$57.40	\$18.02
93721	X	Plethysmography tracing	967	1.70	\$90.11	\$57.40	\$18.02
93722	N	Plethysmography report .....	.....	.....	.....	.....	.....
93724	S	Analyze pacemaker system	960	4.24	\$224.29	\$144.41	\$44.86
93731	X	Analyze pacemaker system	966	0.39	\$20.57	\$12.43	\$4.11
93732	X	Analyze pacemaker system	966	0.39	\$20.57	\$12.43	\$4.11
93733	X	Telephone analysis, pacemaker	966	0.39	\$20.57	\$12.43	\$4.11
93734	X	Analyze pacemaker system	966	0.39	\$20.57	\$12.43	\$4.11
93735	X	Analyze pacemaker system	966	0.39	\$20.57	\$12.43	\$4.11
93736	X	Telephone analysis, pacemaker	966	0.39	\$20.57	\$12.43	\$4.11
93737	X	Analyze cardio/defibrillator	966	0.39	\$20.57	\$12.43	\$4.11
93738	X	Analyze cardio/defibrillator	966	0.39	\$20.57	\$12.43	\$4.11
93740	X	Temperature gradient studies	967	1.70	\$90.11	\$57.40	\$18.02
93760	E	Cephalic thermogram .....	.....	.....	.....	.....	.....
93762	E	Peripheral thermogram .....	.....	.....	.....	.....	.....
93770	N	Measure venous pressure .....	.....	.....	.....	.....	.....
93784	E	Ambulatory BP monitoring .....	.....	.....	.....	.....	.....
93786	E	Ambulatory BP recording .....	.....	.....	.....	.....	.....
93788	E	Ambulatory BP analysis .....	.....	.....	.....	.....	.....
93790	E	Review/report BP recording .....	.....	.....	.....	.....	.....
93797	X	Cardiac rehab	948	0.81	\$43.10	\$16.95	\$8.62
93798	X	Cardiac rehab/monitor	948	0.81	\$43.10	\$16.95	\$8.62
93799	X	Cardiovascular procedure	967	1.70	\$90.11	\$57.40	\$18.02
93875	X	Extracranial study	968	2.37	\$125.37	\$79.55	\$25.07
93880	X	Extracranial study	968	2.37	\$125.37	\$79.55	\$25.07
93882	X	Extracranial study	968	2.37	\$125.37	\$79.55	\$25.07
93886	X	Intracranial study	968	2.37	\$125.37	\$79.55	\$25.07
93888	X	Intracranial study	968	2.37	\$125.37	\$79.55	\$25.07
93922	X	Extremity study	967	1.70	\$90.11	\$57.40	\$18.02
93923	X	Extremity study	967	1.70	\$90.11	\$57.40	\$18.02
93924	X	Extremity study	967	1.70	\$90.11	\$57.40	\$18.02

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
93925	X	Lower extremity study	968	2.37	\$125.37	\$79.55	\$25.07
93926	X	Lower extremity study	968	2.37	\$125.37	\$79.55	\$25.07
93930	X	Upper extremity study	968	2.37	\$125.37	\$79.55	\$25.07
93931	X	Upper extremity study	968	2.37	\$125.37	\$79.55	\$25.07
93965	X	Extremity study	967	1.70	\$90.11	\$57.40	\$18.02
93970	X	Extremity study	968	2.37	\$125.37	\$79.55	\$25.07
93971	X	Extremity study	968	2.37	\$125.37	\$79.55	\$25.07
93975	X	Vascular study	968	2.37	\$125.37	\$79.55	\$25.07
93976	X	Vascular study	968	2.37	\$125.37	\$79.55	\$25.07
93978	X	Vascular study	968	2.37	\$125.37	\$79.55	\$25.07
93979	X	Vascular study	968	2.37	\$125.37	\$79.55	\$25.07
93980	X	Penile vascular study	968	2.37	\$125.37	\$79.55	\$25.07
93981	X	Penile vascular study	968	2.37	\$125.37	\$79.55	\$25.07
93990	X	Doppler flow testing	968	2.37	\$125.37	\$79.55	\$25.07
94010	X	Breathing capacity test	971	0.78	\$41.14	\$21.47	\$8.23
94060	X	Evaluation of wheezing	971	0.78	\$41.14	\$21.47	\$8.23
94070	S	Evaluation of wheezing	973	1.89	\$99.90	\$55.82	\$19.98
94150	N	Vital capacity test .....	.....	.....	.....	.....	.....
94200	X	Lung function test (MBC/MVV)	971	0.78	\$41.14	\$21.47	\$8.23
94240	X	Residual lung capacity	972	1.02	\$53.87	\$29.38	\$10.77
94250	X	Expired gas collection	971	0.78	\$41.14	\$21.47	\$8.23
94260	X	Thoracic gas volume	971	0.78	\$41.14	\$21.47	\$8.23
94350	X	Lung nitrogen washout curve	972	1.02	\$53.87	\$29.38	\$10.77
94360	X	Measure airflow resistance	971	0.78	\$41.14	\$21.47	\$8.23
94370	X	Breath airway closing volume	972	1.02	\$53.87	\$29.38	\$10.77
94375	X	Respiratory flow volume loop	971	0.78	\$41.14	\$21.47	\$8.23
94400	X	CO2 breathing response curve	971	0.78	\$41.14	\$21.47	\$8.23
94450	X	Hypoxia response curve	971	0.78	\$41.14	\$21.47	\$8.23
94620	S	Pulmonary stress testing	973	1.89	\$99.90	\$55.82	\$19.98
94640	S	Airway inhalation treatment	976	0.44	\$23.30	\$14.92	\$4.66
94642	S	Aerosol inhalation treatment	976	0.44	\$23.30	\$14.92	\$4.66
94650	S	Pressure breathing (IPPB)	976	0.44	\$23.30	\$14.92	\$4.66
94651	S	Pressure breathing (IPPB)	976	0.44	\$23.30	\$14.92	\$4.66
94652	C	Pressure breathing (IPPB) .....	.....	.....	.....	.....	.....
94656	C	Initial ventilator mgmt .....	.....	.....	.....	.....	.....
94657	S	Cont. ventilator	976	0.44	\$23.30	\$14.92	\$4.66
94660	S	Pos airway pressure, CPAP	976	0.44	\$23.30	\$14.92	\$4.66
94662	S	Neg pressure ventilation, cnp	976	0.44	\$23.30	\$14.92	\$4.66
94664	S	Aerosol or vapor inhalations	976	0.44	\$23.30	\$14.92	\$4.66
94665	S	Aerosol or vapor inhalations	976	0.44	\$23.30	\$14.92	\$4.66
94667	S	Chest wall manipulation	976	0.44	\$23.30	\$14.92	\$4.66
94668	S	Chest wall manipulation	976	0.44	\$23.30	\$14.92	\$4.66
94680	X	Exhaled air analysis: O2	972	1.02	\$53.87	\$29.38	\$10.77
94681	X	Exhaled air analysis: O2, CO2	972	1.02	\$53.87	\$29.38	\$10.77
94690	X	Exhaled air analysis	972	1.02	\$53.87	\$29.38	\$10.77
94720	X	Monoxide diffusing capacity	972	1.02	\$53.87	\$29.38	\$10.77
94725	X	Membrane diffusion capacity	972	1.02	\$53.87	\$29.38	\$10.77
94750	S	Pulmonary compliance study	973	1.89	\$99.90	\$55.82	\$19.98
94760	N	Measure blood oxygen level .....	.....	.....	.....	.....	.....
94761	N	Measure blood oxygen level .....	.....	.....	.....	.....	.....
94762	X	Measure blood oxygen level	971	0.78	\$41.14	\$21.47	\$8.23
94770	X	Exhaled carbon dioxide test	971	0.78	\$41.14	\$21.47	\$8.23
94772	S	Breath recording, infant	973	1.89	\$99.90	\$55.82	\$19.98
94799	X	Pulmonary service/procedure	971	0.78	\$41.14	\$21.47	\$8.23
95004	X	Allergy skin tests	977	0.63	\$33.30	\$12.66	\$6.66
95010	X	Sensitivity skin tests	977	0.63	\$33.30	\$12.66	\$6.66
95015	X	Sensitivity skin tests	977	0.63	\$33.30	\$12.66	\$6.66
95024	X	Allergy skin tests	977	0.63	\$33.30	\$12.66	\$6.66
95027	X	Skin end point titration	977	0.63	\$33.30	\$12.66	\$6.66
95028	X	Allergy skin tests	977	0.63	\$33.30	\$12.66	\$6.66
95044	X	Allergy patch tests	977	0.63	\$33.30	\$12.66	\$6.66
95052	X	Photo patch test	977	0.63	\$33.30	\$12.66	\$6.66
95056	X	Photosensitivity tests	977	0.63	\$33.30	\$12.66	\$6.66
95060	X	Eye allergy tests	977	0.63	\$33.30	\$12.66	\$6.66
95065	X	Nose allergy test	977	0.63	\$33.30	\$12.66	\$6.66
95070	S	Bronchial allergy tests	973	1.89	\$99.90	\$55.82	\$19.98
95071	S	Bronchial allergy tests	973	1.89	\$99.90	\$55.82	\$19.98
95075	X	Ingestion challenge test	928	3.11	\$164.55	\$83.85	\$32.91
95078	X	Provocative testing	977	0.63	\$33.30	\$12.66	\$6.66
95115	X	Immunotherapy, one injection	978	0.31	\$16.65	\$3.39	\$3.33
95117	X	Immunotherapy injections	978	0.31	\$16.65	\$3.39	\$3.33
95120	E	Immunotherapy, one injection .....	.....	.....	.....	.....	.....
95125	E	Immunotherapy, many antigens .....	.....	.....	.....	.....	.....
95130	E	Immunotherapy, insect venom					
95131	E	Immunotherapy, insect venoms					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
95132	E	Immunotherapy, insect venoms .....	.....	.....	.....	.....	.....
95133	E	Immunotherapy, insect venoms .....	.....	.....	.....	.....	.....
95134	E	Immunotherapy, insect venoms .....	.....	.....	.....	.....	.....
95144	X	Antigen therapy services	978	0.31	\$16.65	\$3.39	\$3.33
95145	X	Antigen therapy services	978	0.31	\$16.65	\$3.39	\$3.33
95146	X	Antigen therapy services	978	0.31	\$16.65	\$3.39	\$3.33
95147	X	Antigen therapy services	978	0.31	\$16.65	\$3.39	\$3.33
95148	X	Antigen therapy services	978	0.31	\$16.65	\$3.39	\$3.33
95149	X	Antigen therapy services	901	0.07	\$3.92	\$2.49	\$.78
95165	X	Antigen therapy services	978	0.31	\$16.65	\$3.39	\$3.33
95170	X	Antigen therapy services	901	0.07	\$3.92	\$2.49	\$.78
95180	X	Rapid desensitization	977	0.63	\$33.30	\$12.66	\$6.66
95199	X	Allergy immunology services	977	0.63	\$33.30	\$12.66	\$6.66
95805	S	Multiple sleep latency test	979	10.17	\$537.72	\$288.83	\$107.54
95806	S	Sleep study, unattended	979	10.17	\$537.72	\$288.83	\$107.54
95807	S	Sleep study, attended	979	10.17	\$537.72	\$288.83	\$107.54
95808	S	Polysomnography, 1-3	979	10.17	\$537.72	\$288.83	\$107.54
95810	S	Polysomnography, 4 or more	979	10.17	\$537.72	\$288.83	\$107.54
95811	S	Polysomnography w/cpap	979	10.17	\$537.72	\$288.83	\$107.54
95812	S	Electroencephalogram (EEG)	979	10.17	\$537.72	\$288.83	\$107.54
95813	S	Electroencephalogram (EEG)	979	10.17	\$537.72	\$288.83	\$107.54
95816	X	Electroencephalogram (EEG)	980	2.15	\$113.62	\$57.86	\$22.72
95819	X	Electroencephalogram (EEG)	980	2.15	\$113.62	\$57.86	\$22.72
95822	X	Sleep electroencephalogram	980	2.15	\$113.62	\$57.86	\$22.72
95824	X	Electroencephalography	980	2.15	\$113.62	\$57.86	\$22.72
95827	S	Night electroencephalogram	979	10.17	\$537.72	\$288.83	\$107.54
95829	X	Surgery electrocorticogram	980	2.15	\$113.62	\$57.86	\$22.72
95830	N	Insert electrodes for EEG .....	.....	.....	.....	.....	.....
95831	N	Limb muscle testing, manual .....	.....	.....	.....	.....	.....
95832	N	Hand muscle testing, manual .....	.....	.....	.....	.....	.....
95833	N	Body muscle testing, manual .....	.....	.....	.....	.....	.....
95834	N	Body muscle testing, manual .....	.....	.....	.....	.....	.....
95851	N	Range of motion measurements .....	.....	.....	.....	.....	.....
95852	N	Range of motion measurements .....	.....	.....	.....	.....	.....
95857	X	Tensilon test	981	1.46	\$77.38	\$41.81	\$15.48
95858	X	Tensilon test & myogram	982	1.39	\$73.46	\$38.87	\$14.69
95860	X	Muscle test, one limb	982	1.39	\$73.46	\$38.87	\$14.69
95861	X	Muscle test, two limbs	982	1.39	\$73.46	\$38.87	\$14.69
95863	X	Muscle test, 3 limbs	982	1.39	\$73.46	\$38.87	\$14.69
95864	X	Muscle test, 4 limbs	982	1.39	\$73.46	\$38.87	\$14.69
95867	X	Muscle test, head or neck	981	1.46	\$77.38	\$41.81	\$15.48
95868	X	Muscle test, head or neck	982	1.39	\$73.46	\$38.87	\$14.69
95869	X	Muscle test, thor paraspinal	981	1.46	\$77.38	\$41.81	\$15.48
95870	X	Muscle test, non-paraspinal	981	1.46	\$77.38	\$41.81	\$15.48
95872	X	Muscle test, one fiber	982	1.39	\$73.46	\$38.87	\$14.69
95875	X	Limb exercise test	982	1.39	\$73.46	\$38.87	\$14.69
95900	X	Motor nerve conduction test	981	1.46	\$77.38	\$41.81	\$15.48
95903	X	Motor nerve conduction test	982	1.39	\$73.46	\$38.87	\$14.69
95904	X	Sense nerve conduction test	982	1.39	\$73.46	\$38.87	\$14.69
95920	C	Intraoperative nerve testing .....	.....	.....	.....	.....	.....
95921	X	Autonomic nervous func test	981	1.46	\$77.38	\$41.81	\$15.48
95922	X	Autonomic nervous func test	981	1.46	\$77.38	\$41.81	\$15.48
95923	X	Autonomic nervous func test	981	1.46	\$77.38	\$41.81	\$15.48
95925	X	Somatosensory testing	982	1.39	\$73.46	\$38.87	\$14.69
95926	X	Somatosensory testing	981	1.46	\$77.38	\$41.81	\$15.48
95927	X	Somatosensory testing	981	1.46	\$77.38	\$41.81	\$15.48
95930	X	Visual evoked potential test	981	1.46	\$77.38	\$41.81	\$15.48
95933	X	Blink reflex test	981	1.46	\$77.38	\$41.81	\$15.48
95934	X	'h' reflex test	981	1.46	\$77.38	\$41.81	\$15.48
95936	X	'h' reflex test	981	1.46	\$77.38	\$41.81	\$15.48
95937	X	Neuromuscular junction test	981	1.46	\$77.38	\$41.81	\$15.48
95950	X	Ambulatory eeg monitoring	981	1.46	\$77.38	\$41.81	\$15.48
95951	S	EEG monitoring/videorecord	979	10.17	\$537.72	\$288.83	\$107.54
95953	S	EEG monitoring/computer	979	10.17	\$537.72	\$288.83	\$107.54
95954	S	EEG monitoring/giving drugs	979	10.17	\$537.72	\$288.83	\$107.54
95955	X	EEG during surgery	980	2.15	\$113.62	\$57.86	\$22.72
95956	N	EEG monitoring/cable/radio .....	.....	.....	.....	.....	.....
95957	N	EEG digital analysis .....	.....	.....	.....	.....	.....
95958	S	EEG monitoring/function test	979	10.17	\$537.72	\$288.83	\$107.54
95961	C	Electrode stimulation, brain .....	.....	.....	.....	.....	.....
95962	C	Electrode stimulation, brain .....	.....	.....	.....	.....	.....
95999	N	Neurological procedure .....	.....	.....	.....	.....	.....
96100	X	Psychological testing	089	2.54	\$134.19	\$37.29	\$26.84
96105	X	Assessment of aphasia	089	2.54	\$134.19	\$37.29	\$26.84
96110	X	Developmental test, lim	089	2.54	\$134.19	\$37.29	\$26.84

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
96111	X	Developmental test, extend	089	2.54	\$134.19	\$37.29	\$26.84
96115	X	Neurobehavior status exam	089	2.54	\$134.19	\$37.29	\$26.84
96117	X	Neuropsych test battery	089	2.54	\$134.19	\$37.29	\$26.84
96400	S	Chemotherapy, (SC)/(IM)	987	0.65	\$34.28	\$13.33	\$6.86
96405	S	Intralesional chemo admin	987	0.65	\$34.28	\$13.33	\$6.86
96406	S	Intralesional chemo admin	987	0.65	\$34.28	\$13.33	\$6.86
96408	S	Chemotherapy, push technique	988	4.15	\$219.40	\$97.63	\$43.88
96410	S	Chemotherapy, infusion method	988	4.15	\$219.40	\$97.63	\$43.88
96412	S	Chemotherapy, infusion method	988	4.15	\$219.40	\$97.63	\$43.88
96414	S	Chemotherapy, infusion method	989	1.72	\$91.09	\$40.68	\$18.22
96420	S	Chemotherapy, push technique	988	4.15	\$219.40	\$97.63	\$43.88
96422	S	Chemotherapy, infusion method	988	4.15	\$219.40	\$97.63	\$43.88
96423	S	Chemotherapy, infusion method	988	4.15	\$219.40	\$97.63	\$43.88
96425	S	Chemotherapy, infusion method	989	1.72	\$91.09	\$40.68	\$18.22
96440	S	Chemotherapy, intracavitary	989	1.72	\$91.09	\$40.68	\$18.22
96445	S	Chemotherapy, intracavitary	989	1.72	\$91.09	\$40.68	\$18.22
96450	S	Chemotherapy, into CNS	989	1.72	\$91.09	\$40.68	\$18.22
96520	E	Pump refilling, maintenance					
96530	E	Pump refilling, maintenance					
96542	S	Chemotherapy injection	989	1.72	\$91.09	\$40.68	\$18.22
96545	N	Provide chemotherapy agent					
96549	S	Chemotherapy, unspecified	987	0.65	\$34.28	\$13.33	\$6.86
96900	S	Ultraviolet light therapy	990	0.43	\$22.53	\$8.14	\$4.51
96902	N	Trichogram					
96910	S	Photochemotherapy with UV-B	990	0.43	\$22.53	\$8.14	\$4.51
96912	S	Photochemotherapy with UV-A	990	0.43	\$22.53	\$8.14	\$4.51
96913	S	Photochemotherapy, UV-A or B	990	0.43	\$22.53	\$8.14	\$4.51
96999	S	Dermatological procedure	990	0.43	\$22.53	\$8.14	\$4.51
97001	A	Pt evaluation					
97002	A	Pt re-evaluation					
97003	A	Ot evaluation					
97004	A	Ot re-evaluation					
97010	A	Hot or cold packs therapy					
97012	A	Mechanical traction therapy					
97014	A	Electric stimulation therapy					
97016	A	Vasopneumatic device therapy					
97018	A	Paraffin bath therapy					
97020	A	Microwave therapy					
97022	A	Whirlpool therapy					
97024	A	Diathermy treatment					
97026	A	Infrared therapy					
97028	A	Ultraviolet therapy					
97032	A	Electrical stimulation					
97033	A	Electric current therapy					
97034	A	Contrast bath therapy					
97035	A	Ultrasound therapy					
97036	A	Hydrotherapy					
97039	A	Physical therapy treatment					
97110	A	Therapeutic exercises					
97112	A	Neuromuscular reeducation					
97113	A	Aquatic therapy/exercises					
97116	A	Gait training therapy					
97122	A	Manual traction therapy					
97124	A	Massage therapy					
97139	A	Physical medicine procedure					
97150	A	Group therapeutic procedures					
97250	S	Myofascial release	997	0.69	\$36.24	\$7.25	\$7.25
97260	S	Regional manipulation	997	0.69	\$36.24	\$7.25	\$7.25
97261	S	Supplemental manipulations	997	0.69	\$36.24	\$7.25	\$7.25
97265	A	Joint mobilization					
97504	A	Orthotic training					
97520	A	Prosthetic training					
97530	A	Therapeutic activities					
97535	A	Self care mngmt training					
97537	A	Community/work reintegration					
97542	A	Wheelchair mngement training					
97545	A	Work hardening					
97546	A	Work hardening					
97703	A	Prosthetic checkout					
97750	A	Physical performance test					
97770	A	Cognitive skills development					
97780	E	Acupuncture w/o stim					
97781	E	Acupuncture w/stim					
97799	A	Physical medicine procedure					
98925	S	Osteopathic manipulation	997	0.69	\$36.24	\$7.25	\$7.25

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
98926	S	Osteopathic manipulation	997	0.69	\$36.24	\$7.25	\$7.25
98927	S	Osteopathic manipulation	997	0.69	\$36.24	\$7.25	\$7.25
98928	S	Osteopathic manipulation	997	0.69	\$36.24	\$7.25	\$7.25
98929	S	Osteopathic manipulation	997	0.69	\$36.24	\$7.25	\$7.25
98940	S	Chiropractic manipulation	997	0.69	\$36.24	\$7.25	\$7.25
98941	S	Chiropractic manipulation	997	0.69	\$36.24	\$7.25	\$7.25
98942	S	Chiropractic manipulation	997	0.69	\$36.24	\$7.25	\$7.25
98943	E	Chiropractic manipulation .....	.....	.....	.....	.....	.....
99000	E	Specimen handling .....	.....	.....	.....	.....	.....
99001	N	Specimen handling .....	.....	.....	.....	.....	.....
99002	E	Device handling .....	.....	.....	.....	.....	.....
99024	N	Post-op follow-up visit .....	.....	.....	.....	.....	.....
99025	N	Initial surgical evaluation .....	.....	.....	.....	.....	.....
99050	E	Medical services after hrs .....	.....	.....	.....	.....	.....
99052	E	Medical services at night .....	.....	.....	.....	.....	.....
99054	E	Medical services, unusual hrs .....	.....	.....	.....	.....	.....
99056	E	Non-office medical services .....	.....	.....	.....	.....	.....
99058	N	Office emergency care .....	.....	.....	.....	.....	.....
99070	E	Special supplies .....	.....	.....	.....	.....	.....
99071	E	Patient education materials .....	.....	.....	.....	.....	.....
99075	E	Medical testimony .....	.....	.....	.....	.....	.....
99078	S	Group health education	921	.....	.....	.....	.....
99080	E	Special reports or forms .....	.....	.....	.....	.....	.....
99082	E	Unusual physician travel .....	.....	.....	.....	.....	.....
99090	E	Computer data analysis .....	.....	.....	.....	.....	.....
99100	N	Special anesthesia service .....	.....	.....	.....	.....	.....
99116	N	Anesthesia with hypothermia .....	.....	.....	.....	.....	.....
99135	N	Special anesthesia procedure .....	.....	.....	.....	.....	.....
99140	N	Emergency anesthesia .....	.....	.....	.....	.....	.....
99141	N	Sedation, iv/im or inhalant .....	.....	.....	.....	.....	.....
99142	N	Sedation, oral/rectal/nasal .....	.....	.....	.....	.....	.....
99175	N	Induction of vomiting .....	.....	.....	.....	.....	.....
99183	S	Hyperbaric oxygen therapy	969	2.65	\$140.06	\$141.70	\$28.01
99185	N	Regional hypothermia .....	.....	.....	.....	.....	.....
99186	N	Total body hypothermia .....	.....	.....	.....	.....	.....
99190	C	Special pump services .....	.....	.....	.....	.....	.....
99191	C	Special pump services .....	.....	.....	.....	.....	.....
99192	C	Special pump services .....	.....	.....	.....	.....	.....
99195	X	Phlebotomy	999	0.43	\$22.53	\$10.85	\$4.51
99199	N	Special service or report .....	.....	.....	.....	.....	.....
99201	V	Office/outpatient visit, new	911	.....	.....	.....	.....
99202	V	Office/outpatient visit, new	911	.....	.....	.....	.....
99203	V	Office/outpatient visit, new	913	.....	.....	.....	.....
99204	V	Office/outpatient visit, new	915	.....	.....	.....	.....
99205	V	Office/outpatient visit, new	915	.....	.....	.....	.....
99211	V	Office/outpatient visit, est	911	.....	.....	.....	.....
99212	V	Office/outpatient visit, est	911	.....	.....	.....	.....
99213	V	Office/outpatient visit, est	913	.....	.....	.....	.....
99214	V	Office/outpatient visit, est	915	.....	.....	.....	.....
99215	V	Office/outpatient visit, est	915	.....	.....	.....	.....
99217	N	Observation care discharge .....	.....	.....	.....	.....	.....
99218	N	Observation care .....	.....	.....	.....	.....	.....
99219	N	Observation care .....	.....	.....	.....	.....	.....
99220	N	Observation care .....	.....	.....	.....	.....	.....
99221	E	Initial hospital care .....	.....	.....	.....	.....	.....
99222	E	Initial hospital care .....	.....	.....	.....	.....	.....
99223	E	Initial hospital care .....	.....	.....	.....	.....	.....
99231	E	Subsequent hospital care .....	.....	.....	.....	.....	.....
99232	E	Subsequent hospital care .....	.....	.....	.....	.....	.....
99233	E	Subsequent hospital care .....	.....	.....	.....	.....	.....
99234	C	Observ/hosp same date .....	.....	.....	.....	.....	.....
99235	C	Observ/hosp same date .....	.....	.....	.....	.....	.....
99236	C	Observ/hosp same date .....	.....	.....	.....	.....	.....
99238	E	Hospital discharge day .....	.....	.....	.....	.....	.....
99239	E	Hospital discharge day .....	.....	.....	.....	.....	.....
99241	V	Office consultation	911	.....	.....	.....	.....
99242	V	Office consultation	911	.....	.....	.....	.....
99243	V	Office consultation	913	.....	.....	.....	.....
99244	V	Office consultation	915	.....	.....	.....	.....
99245	V	Office consultation	915	.....	.....	.....	.....
99251	C	Initial inpatient consult .....	.....	.....	.....	.....	.....
99252	C	Initial inpatient consult .....	.....	.....	.....	.....	.....
99253	C	Initial inpatient consult					
99254	C	Initial inpatient consult					
99255	C	Initial inpatient consult					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
99261	C	Follow-up inpatient consult					
99262	C	Follow-up inpatient consult					
99263	C	Follow-up inpatient consult					
99271	V	Confirmatory consultation	911				
99272	V	Confirmatory consultation	911				
99273	V	Confirmatory consultation	913				
99274	V	Confirmatory consultation	915				
99275	V	Confirmatory consultation	915				
99281	V	Emergency dept visit	951				
99282	V	Emergency dept visit	951				
99283	V	Emergency dept visit	953				
99284	V	Emergency dept visit	955				
99285	V	Emergency dept visit	955				
99288	E	Direct advanced life support					
99291	S	Critical care, first hour	900	7.44	\$393.74	\$144.87	\$78.75
99292	N	Critical care, addl 30 min					
99295	C	Neonatal critical care					
99296	C	Neonatal critical care					
99297	C	Neonatal critical care					
99301	E	Nursing facility care					
99302	E	Nursing facility care					
99303	E	Nursing facility care					
99311	E	Nursing facility care, subseq					
99312	E	Nursing facility care, subseq					
99313	E	Nursing facility care, subseq					
99315	E	Nursing fac discharge day					
99316	E	Nursing fac discharge day					
99321	N	Rest home visit, new patient					
99322	N	Rest home visit, new patient					
99323	N	Rest home visit, new patient					
99331	N	Rest home visit, estab pat					
99332	N	Rest home visit, estab pat					
99333	N	Rest home visit, estab pat					
99341	N	Home visit, new patient					
99342	N	Home visit, new patient					
99343	N	Home visit, new patient					
99344	N	Home visit, new patient					
99345	N	Home visit, new patient					
99347	N	Home visit, estab patient					
99348	N	Home visit, estab patient					
99349	N	Home visit, estab patient					
99350	N	Home visit, estab patient					
99354	N	Prolonged service, office					
99355	N	Prolonged service, office					
99356	C	Prolonged service, inpatient					
99357	C	Prolonged service, inpatient					
99358	N	Prolonged serv, w/o contact					
99359	N	Prolonged serv, w/o contact					
99360	E	Physician standby services					
99361	E	Physician/team conference					
99362	E	Physician/team conference					
99371	E	Physician phone consultation					
99372	E	Physician phone consultation					
99373	E	Physician phone consultation					
99374	E	Home health care supervision					
99375	E	Home health care supervision					
99377	E	Hospice care supervision					
99378	E	Hospice care supervision					
99379	E	Nursing fac care supervision					
99380	E	Nursing fac care supervision					
99381	E	Preventive visit, new, infant					
99382	E	Preventive visit, new, age 1–4					
99383	E	Preventive visit, new, age 5–11					
99384	E	Preventive visit, new, 12–17					
99385	E	Preventive visit, new, 18–39					
99386	E	Preventive visit, new, 40–64					
99387	E	Preventive visit, new, 65 & over					
99391	E	Preventive visit, est, infant					
99392	E	Preventive visit, est, age 1–4					
99393	E	Preventive visit, est, age 5–11					
99394	E	Preventive visit, est, 12–17					
99395	E	Preventive visit, est, 18–39					
99396	E	Preventive visit, est, 40–64					
99397	E	Preventive visit, est, 65 & over					
99401	E	Preventive counseling, indiv					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
99402	E	Preventive counseling, indiv .....	.....	.....	.....	.....	.....
99403	E	Preventive counseling, indiv .....	.....	.....	.....	.....	.....
99404	E	Preventive counseling, indiv .....	.....	.....	.....	.....	.....
99411	E	Preventive counseling, group .....	.....	.....	.....	.....	.....
99412	E	Preventive counseling, group .....	.....	.....	.....	.....	.....
99420	E	Health risk assessment test .....	.....	.....	.....	.....	.....
99429	E	Unlisted preventive service .....	.....	.....	.....	.....	.....
99431	N	Initial care, normal newborn .....	.....	.....	.....	.....	.....
99432	N	Newborn care not in hospital .....	.....	.....	.....	.....	.....
99433	C	Normal newborn care, hospital .....	.....	.....	.....	.....	.....
99435	E	Hospital NB discharge day .....	.....	.....	.....	.....	.....
99436	N	Attendance, birth .....	.....	.....	.....	.....	.....
99440	S	Newborn resuscitation	947	4.07	\$215.48	\$109.61	\$43.10
99450	E	Life/disability evaluation .....	.....	.....	.....	.....	.....
99455	N	Disability examination .....	.....	.....	.....	.....	.....
99456	N	Disability examination .....	.....	.....	.....	.....	.....
99499	N	Unlisted E/M service .....	.....	.....	.....	.....	.....
A0021	E	Outside state ambulance serv .....	.....	.....	.....	.....	.....
A0030	A	Air ambulance service .....	.....	.....	.....	.....	.....
A0040	A	Helicopter ambulance service .....	.....	.....	.....	.....	.....
A0050	A	Water amb service emergency .....	.....	.....	.....	.....	.....
A0080	E	Noninterest escort in non er .....	.....	.....	.....	.....	.....
A0090	E	Interest escort in non er .....	.....	.....	.....	.....	.....
A0100	E	Nonemergency transport taxi .....	.....	.....	.....	.....	.....
A0110	E	Nonemergency transport bus .....	.....	.....	.....	.....	.....
A0120	E	Noner transport mini-bus .....	.....	.....	.....	.....	.....
A0130	E	Noner transport wheelch van .....	.....	.....	.....	.....	.....
A0140	E	Nonemergency transport air .....	.....	.....	.....	.....	.....
A0160	E	Noner transport case worker .....	.....	.....	.....	.....	.....
A0170	E	Noner transport parking fees .....	.....	.....	.....	.....	.....
A0180	E	Noner transport lodgng recip .....	.....	.....	.....	.....	.....
A0190	E	Noner transport meals recip .....	.....	.....	.....	.....	.....
A0200	E	Noner transport lodgng esct .....	.....	.....	.....	.....	.....
A0210	E	Noner transport meals escort .....	.....	.....	.....	.....	.....
A0225	A	Neonatal emergency transport .....	.....	.....	.....	.....	.....
A0300	A	Ambulance basic non-emerg all .....	.....	.....	.....	.....	.....
A0302	A	Ambulance basic emergency all .....	.....	.....	.....	.....	.....
A0304	A	Amb adv non-er no serv all .....	.....	.....	.....	.....	.....
A0306	A	Amb adv non-er spec serv all .....	.....	.....	.....	.....	.....
A0308	A	Amb adv er no spec serv all .....	.....	.....	.....	.....	.....
A0310	A	Amb adv er spec serv all .....	.....	.....	.....	.....	.....
A0320	A	Amb basic non-er + supplies .....	.....	.....	.....	.....	.....
A0322	A	Amb basic emerg + supplies .....	.....	.....	.....	.....	.....
A0324	A	Adv non-er serv sep mileage .....	.....	.....	.....	.....	.....
A0326	A	Adv non-er no serv sep mile .....	.....	.....	.....	.....	.....
A0328	A	Adv er no serv sep mileage .....	.....	.....	.....	.....	.....
A0330	A	Adv er spec serv sep mile .....	.....	.....	.....	.....	.....
A0340	A	Amb basic non-er + mileage .....	.....	.....	.....	.....	.....
A0342	A	Ambul basic emer + mileage .....	.....	.....	.....	.....	.....
A0344	A	Amb adv non-er no serv +mile .....	.....	.....	.....	.....	.....
A0346	A	Amb adv non-er serv + mile .....	.....	.....	.....	.....	.....
A0348	A	Adv emer no spec serv + mile .....	.....	.....	.....	.....	.....
A0350	A	Adv emer spec serv + mileage .....	.....	.....	.....	.....	.....
A0360	A	Basic non-er sep mile & supp .....	.....	.....	.....	.....	.....
A0362	A	Basic emer sep mile & supply .....	.....	.....	.....	.....	.....
A0364	A	Adv non-er no serv sep mi & su .....	.....	.....	.....	.....	.....
A0366	A	Adv non-er serv sep mil & supp .....	.....	.....	.....	.....	.....
A0368	A	Adv er no serv sep mile & supp .....	.....	.....	.....	.....	.....
A0370	A	Adv er spec serv sep mi & supp .....	.....	.....	.....	.....	.....
A0380	A	Basic life support mileage .....	.....	.....	.....	.....	.....
A0382	A	Basic support routine suppl .....	.....	.....	.....	.....	.....
A0384	A	Bls defibrillation supplies .....	.....	.....	.....	.....	.....
A0390	A	Advanced life support mileage .....	.....	.....	.....	.....	.....
A0392	A	Als defibrillation supplies .....	.....	.....	.....	.....	.....
A0394	A	Als IV drug therapy supplies .....	.....	.....	.....	.....	.....
A0396	A	Als esophageal intub suppl .....	.....	.....	.....	.....	.....
A0398	A	Als routine disposble suppl .....	.....	.....	.....	.....	.....
A0420	A	Ambulance waiting 1/2 hr .....	.....	.....	.....	.....	.....
A0422	A	Ambulance 02 life sustaining .....	.....	.....	.....	.....	.....
A0424	A	Extra ambulance attendant .....	.....	.....	.....	.....	.....
A0888	E	Noncovered ambulance mileage .....	.....	.....	.....	.....	.....
A0999	A	Unlisted ambulance service .....	.....	.....	.....	.....	.....
A4206	A	1 CC sterile syringe & needle					
A4207	A	2 CC sterile syringe & needle					
A4208	A	3 CC sterile syringe & needle					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A4209	A	5+ CC sterile syringe & needle .....	.....	.....	.....	.....	.....
A4210	E	Nonneedle injection device .....	.....	.....	.....	.....	.....
A4211	A	Supp for self-adm injections .....	.....	.....	.....	.....	.....
A4212	A	Non coring needle or stylet .....	.....	.....	.....	.....	.....
A4213	A	20+ CC syringe only .....	.....	.....	.....	.....	.....
A4214	A	30 CC sterile water/saline .....	.....	.....	.....	.....	.....
A4215	A	Sterile needle .....	.....	.....	.....	.....	.....
A4220	A	Infusion pump refill kit .....	.....	.....	.....	.....	.....
A4221	A	Maint drug infus cath per wk .....	.....	.....	.....	.....	.....
A4222	A	Drug infusion pump supplies .....	.....	.....	.....	.....	.....
A4230	E	Infus insulin pump non needl .....	.....	.....	.....	.....	.....
A4231	E	Infusion insulin pump needle .....	.....	.....	.....	.....	.....
A4232	E	Syringe w/needle insulin 3cc .....	.....	.....	.....	.....	.....
A4244	A	Alcohol or peroxide per pint .....	.....	.....	.....	.....	.....
A4245	A	Alcohol wipes per box .....	.....	.....	.....	.....	.....
A4246	A	Betadine/phisohex solution .....	.....	.....	.....	.....	.....
A4247	A	Betadine/iodine swabs/wipes .....	.....	.....	.....	.....	.....
A4250	E	Urine reagent strips/tablets .....	.....	.....	.....	.....	.....
A4253	A	Blood glucose/reagent strips .....	.....	.....	.....	.....	.....
A4254	A	Battery for glucose monitor .....	.....	.....	.....	.....	.....
A4255	A	Glucose monitor platforms .....	.....	.....	.....	.....	.....
A4256	A	Calibrator solution/chips .....	.....	.....	.....	.....	.....
A4258	A	Lancet device each .....	.....	.....	.....	.....	.....
A4259	A	Lancets per box .....	.....	.....	.....	.....	.....
A4260	E	Levonorgestrel implant .....	.....	.....	.....	.....	.....
A4262	N	Temporary tear duct plug .....	.....	.....	.....	.....	.....
A4263	A	Permanent tear duct plug .....	.....	.....	.....	.....	.....
A4265	A	Paraffin .....	.....	.....	.....	.....	.....
A4270	A	Disposable endoscope sheath .....	.....	.....	.....	.....	.....
A4300	A	Cath impl vasc access portal .....	.....	.....	.....	.....	.....
A4301	A	Implantable access syst perc .....	.....	.....	.....	.....	.....
A4305	A	Drug delivery system >=50 ML .....	.....	.....	.....	.....	.....
A4306	A	Drug delivery system <=5 ML .....	.....	.....	.....	.....	.....
A4310	A	Insert tray w/o bag/cath .....	.....	.....	.....	.....	.....
A4311	A	Catheter w/o bag 2-way latex .....	.....	.....	.....	.....	.....
A4312	A	Cath w/o bag 2-way silicone .....	.....	.....	.....	.....	.....
A4313	A	Catheter w/bag 3-way .....	.....	.....	.....	.....	.....
A4314	A	Cath w/drainage 2-way latex .....	.....	.....	.....	.....	.....
A4315	A	Cath w/drainage 2-way silcne .....	.....	.....	.....	.....	.....
A4316	A	Cath w/drainage 3-way .....	.....	.....	.....	.....	.....
A4320	A	Irrigation tray .....	.....	.....	.....	.....	.....
A4321	A	Cath therapeutic irrig agent .....	.....	.....	.....	.....	.....
A4322	A	Irrigation syringe .....	.....	.....	.....	.....	.....
A4323	A	Saline irrigation solution .....	.....	.....	.....	.....	.....
A4326	A	Male external catheter .....	.....	.....	.....	.....	.....
A4327	A	Fem urinary collect dev cup .....	.....	.....	.....	.....	.....
A4328	A	Fem urinary collect pouch .....	.....	.....	.....	.....	.....
A4329	A	External catheter start set .....	.....	.....	.....	.....	.....
A4330	A	Stool collection pouch .....	.....	.....	.....	.....	.....
A4335	A	Incontinence supply .....	.....	.....	.....	.....	.....
A4338	A	Indwelling catheter latex .....	.....	.....	.....	.....	.....
A4340	A	Indwelling catheter special .....	.....	.....	.....	.....	.....
A4344	A	Cath indw foley 2 way silicn .....	.....	.....	.....	.....	.....
A4346	A	Cath indw foley 3 way .....	.....	.....	.....	.....	.....
A4347	A	Male external catheter .....	.....	.....	.....	.....	.....
A4351	A	Straight tip urine catheter .....	.....	.....	.....	.....	.....
A4352	A	Coude tip urinary catheter .....	.....	.....	.....	.....	.....
A4353	A	Intermittent urinary cath .....	.....	.....	.....	.....	.....
A4354	A	Cath insertion tray w/bag .....	.....	.....	.....	.....	.....
A4355	A	Bladder irrigation tubing .....	.....	.....	.....	.....	.....
A4356	A	Ext ureth clmp or compr dvc .....	.....	.....	.....	.....	.....
A4357	A	Bedside drainage bag .....	.....	.....	.....	.....	.....
A4358	A	Urinary leg bag .....	.....	.....	.....	.....	.....
A4359	A	Urinary suspensory w/o leg b .....	.....	.....	.....	.....	.....
A4361	A	Ostomy face plate .....	.....	.....	.....	.....	.....
A4362	A	Solid skin barrier .....	.....	.....	.....	.....	.....
A4363	A	Liquid skin barrier .....	.....	.....	.....	.....	.....
A4364	A	Ostomy/cath adhesive .....	.....	.....	.....	.....	.....
A4365	A	Ostomy adhesive remover wipe .....	.....	.....	.....	.....	.....
A4367	A	Ostomy belt .....	.....	.....	.....	.....	.....
A4368	A	Ostomy filter .....	.....	.....	.....	.....	.....
A4397	A	Irrigation supply sleeve .....	.....	.....	.....	.....	.....
A4398	A	Ostomy irrigation bag					
A4399	A	Ostomy irrig cone/cath w brs					
A4400	A	Ostomy irrigation set					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A4402	A	Lubricant per ounce .....	.....	.....	.....	.....	.....
A4404	A	Ostomy ring each .....	.....	.....	.....	.....	.....
A4421	A	Ostomy supply misc .....	.....	.....	.....	.....	.....
A4454	A	Tape all types all sizes .....	.....	.....	.....	.....	.....
A4455	A	Adhesive remover per ounce .....	.....	.....	.....	.....	.....
A4460	A	Elastic compression bandage .....	.....	.....	.....	.....	.....
A4462	A	Abdmnl drssng holder/binder .....	.....	.....	.....	.....	.....
A4465	A	Non-elastic extremity binder .....	.....	.....	.....	.....	.....
A4470	A	Gravlee jet washer .....	.....	.....	.....	.....	.....
A4480	A	Vabra aspirator .....	.....	.....	.....	.....	.....
A4481	A	Tracheostoma filter .....	.....	.....	.....	.....	.....
A4490	E	Above knee surgical stocking .....	.....	.....	.....	.....	.....
A4495	E	Thigh length surg stocking .....	.....	.....	.....	.....	.....
A4500	E	Below knee surgical stocking .....	.....	.....	.....	.....	.....
A4510	E	Full length surg stocking .....	.....	.....	.....	.....	.....
A4550	E	Surgical trays .....	.....	.....	.....	.....	.....
A4554	E	Disposable underpads .....	.....	.....	.....	.....	.....
A4556	A	Electrodes .....	.....	.....	.....	.....	.....
A4557	A	Lead wires .....	.....	.....	.....	.....	.....
A4558	A	Conductive paste or gel .....	.....	.....	.....	.....	.....
A4560	A	Pessary .....	.....	.....	.....	.....	.....
A4565	A	Slings .....	.....	.....	.....	.....	.....
A4570	A	Splint .....	.....	.....	.....	.....	.....
A4572	A	Rib belt .....	.....	.....	.....	.....	.....
A4575	E	Hyperbaric o2 chamber disps .....	.....	.....	.....	.....	.....
A4580	A	Cast supplies (plaster) .....	.....	.....	.....	.....	.....
A4590	A	Special casting material .....	.....	.....	.....	.....	.....
A4595	A	TENS suppl 2 lead per month .....	.....	.....	.....	.....	.....
A4611	A	Heavy duty battery .....	.....	.....	.....	.....	.....
A4612	A	Battery cables .....	.....	.....	.....	.....	.....
A4613	A	Battery charger .....	.....	.....	.....	.....	.....
A4615	A	Cannula nasal .....	.....	.....	.....	.....	.....
A4616	A	Tubing (oxygen) per foot .....	.....	.....	.....	.....	.....
A4617	A	Mouth piece .....	.....	.....	.....	.....	.....
A4618	A	Breathing circuits .....	.....	.....	.....	.....	.....
A4619	A	Face tent .....	.....	.....	.....	.....	.....
A4620	A	Variable concentration mask .....	.....	.....	.....	.....	.....
A4621	A	Tracheotomy mask or collar .....	.....	.....	.....	.....	.....
A4622	A	Tracheostomy or larngectomy .....	.....	.....	.....	.....	.....
A4623	A	Tracheostomy inner cannula .....	.....	.....	.....	.....	.....
A4624	A	Tracheal suction tube .....	.....	.....	.....	.....	.....
A4625	A	Trach care kit for new trach .....	.....	.....	.....	.....	.....
A4626	A	Tracheostomy cleaning brush .....	.....	.....	.....	.....	.....
A4627	E	Spacer bag/reservoir .....	.....	.....	.....	.....	.....
A4628	A	Oropharyngeal suction cath .....	.....	.....	.....	.....	.....
A4629	A	Tracheostomy care kit .....	.....	.....	.....	.....	.....
A4630	A	Repl bat t.e.n.s. own by pt .....	.....	.....	.....	.....	.....
A4631	A	Wheelchair battery .....	.....	.....	.....	.....	.....
A4635	A	Underarm crutch pad .....	.....	.....	.....	.....	.....
A4636	A	Handgrip for cane etc .....	.....	.....	.....	.....	.....
A4637	A	Repl tip cane/crutch/walker .....	.....	.....	.....	.....	.....
A4640	A	Alternating pressure pad .....	.....	.....	.....	.....	.....
A4641	N	Diagnostic imaging agent .....	.....	.....	.....	.....	.....
A4642	N	Satumomab pendetide per dose .....	.....	.....	.....	.....	.....
A4643	N	High dose contrast MRI .....	.....	.....	.....	.....	.....
A4644	N	Contrast 100–199 MGs iodine .....	.....	.....	.....	.....	.....
A4645	N	Contrast 200–299 MGs iodine .....	.....	.....	.....	.....	.....
A4646	N	Contrast 300–399 MGs iodine .....	.....	.....	.....	.....	.....
A4647	N	Supp-paramagnetic contr mat .....	.....	.....	.....	.....	.....
A4649	A	Surgical supplies .....	.....	.....	.....	.....	.....
A4650	A	Supp esrd centrifuge .....	.....	.....	.....	.....	.....
A4655	A	Esrd syringe/needle .....	.....	.....	.....	.....	.....
A4660	A	Esrd blood pressure device .....	.....	.....	.....	.....	.....
A4663	A	Esrd blood pressure cuff .....	.....	.....	.....	.....	.....
A4670	E	Auto blood pressure monitor .....	.....	.....	.....	.....	.....
A4680	A	Activated carbon filters .....	.....	.....	.....	.....	.....
A4690	A	Dialyzers .....	.....	.....	.....	.....	.....
A4700	A	Standard dialysate solution .....	.....	.....	.....	.....	.....
A4705	A	Bicarb dialysate solution .....	.....	.....	.....	.....	.....
A4712	A	Sterile water .....	.....	.....	.....	.....	.....
A4714	A	Treated water for dialysis .....	.....	.....	.....	.....	.....
A4730	A	Fistula cannulation set dial .....	.....	.....	.....	.....	.....
A4735	A	Local/topical anesthetics					
A4740	A	Esrd shunt accessory					
A4750	A	Arterial or venous tubing					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A4755	A	Arterial and venous tubing .....	.....	.....	.....	.....	.....
A4760	A	Standard testing solution .....	.....	.....	.....	.....	.....
A4765	A	Dialysate concentrate .....	.....	.....	.....	.....	.....
A4770	A	Blood testing supplies .....	.....	.....	.....	.....	.....
A4771	A	Blood clotting time tube .....	.....	.....	.....	.....	.....
A4772	A	Dextrostick/glucose strips .....	.....	.....	.....	.....	.....
A4773	A	Hemostix .....	.....	.....	.....	.....	.....
A4774	A	Ammonia test paper .....	.....	.....	.....	.....	.....
A4780	A	Esrd sterilizing agent .....	.....	.....	.....	.....	.....
A4790	A	Esrd cleansing agents .....	.....	.....	.....	.....	.....
A4800	A	Heparin/antidote dialysis .....	.....	.....	.....	.....	.....
A4820	A	Supplies hemodialysis kit .....	.....	.....	.....	.....	.....
A4850	A	Rubber tipped hemostats .....	.....	.....	.....	.....	.....
A4860	A	Disposable catheter caps .....	.....	.....	.....	.....	.....
A4870	A	Plumbing/electrical work .....	.....	.....	.....	.....	.....
A4880	A	Water storage tanks .....	.....	.....	.....	.....	.....
A4890	A	Contracts/repair/maintenance .....	.....	.....	.....	.....	.....
A4900	A	Capd supply kit .....	.....	.....	.....	.....	.....
A4901	A	Capd supply kit .....	.....	.....	.....	.....	.....
A4905	A	lpd supply kit .....	.....	.....	.....	.....	.....
A4910	A	Esrd nonmedical supplies .....	.....	.....	.....	.....	.....
A4912	A	Gomco drain bottle .....	.....	.....	.....	.....	.....
A4913	A	Esrd supply .....	.....	.....	.....	.....	.....
A4914	A	Preparation kit .....	.....	.....	.....	.....	.....
A4918	A	Venous pressure clamp .....	.....	.....	.....	.....	.....
A4919	A	Supp dialysis dialyzer holde .....	.....	.....	.....	.....	.....
A4920	A	Harvard pressure clamp .....	.....	.....	.....	.....	.....
A4921	A	Measuring cylinder .....	.....	.....	.....	.....	.....
A4927	A	Gloves .....	.....	.....	.....	.....	.....
A5051	A	Pouch clsd w barr attached .....	.....	.....	.....	.....	.....
A5052	A	Clsd ostomy pouch w/o barr .....	.....	.....	.....	.....	.....
A5053	A	Clsd ostomy pouch faceplate .....	.....	.....	.....	.....	.....
A5054	A	Clsd ostomy pouch w/flange .....	.....	.....	.....	.....	.....
A5055	A	Stoma cap .....	.....	.....	.....	.....	.....
A5061	A	Pouch drainable w barrier at .....	.....	.....	.....	.....	.....
A5062	A	Drnble ostomy pouch w/o barr .....	.....	.....	.....	.....	.....
A5063	A	Drain ostomy pouch w/flange .....	.....	.....	.....	.....	.....
A5064	E	Drain ostomy pouch w/fceplte .....	.....	.....	.....	.....	.....
A5065	E	Drain ostomy pouch on fcppte .....	.....	.....	.....	.....	.....
A5071	A	Urinary pouch w/barrier .....	.....	.....	.....	.....	.....
A5072	A	Urinary pouch w/o barrier .....	.....	.....	.....	.....	.....
A5073	A	Urinary pouch on barr w/flng .....	.....	.....	.....	.....	.....
A5074	E	Urinary pouch w/faceplate .....	.....	.....	.....	.....	.....
A5075	E	Urinary pouch on faceplate .....	.....	.....	.....	.....	.....
A5081	A	Continent stoma plug .....	.....	.....	.....	.....	.....
A5082	A	Continent stoma catheter .....	.....	.....	.....	.....	.....
A5093	A	Ostomy accessory convex inse .....	.....	.....	.....	.....	.....
A5102	A	Bedside drain btl w/wo tube .....	.....	.....	.....	.....	.....
A5105	A	Urinary suspensory .....	.....	.....	.....	.....	.....
A5112	A	Urinary leg bag .....	.....	.....	.....	.....	.....
A5113	A	Latex leg strap .....	.....	.....	.....	.....	.....
A5114	A	Foam/fabric leg strap .....	.....	.....	.....	.....	.....
A5119	A	Skin barrier wipes box pr 50 .....	.....	.....	.....	.....	.....
A5121	A	Solid skin barrier 6x6 .....	.....	.....	.....	.....	.....
A5122	A	Solid skin barrier 8x8 .....	.....	.....	.....	.....	.....
A5123	A	Skin barrier with flange .....	.....	.....	.....	.....	.....
A5126	A	Adhesive disc/foam pad .....	.....	.....	.....	.....	.....
A5131	A	Appliance cleaner .....	.....	.....	.....	.....	.....
A5149	A	Incontinence/ostomy supply .....	.....	.....	.....	.....	.....
A5500	A	Diab shoe for density insert .....	.....	.....	.....	.....	.....
A5501	A	Diabetic custom molded shoe .....	.....	.....	.....	.....	.....
A5502	A	Diabetic shoe density insert .....	.....	.....	.....	.....	.....
A5503	A	Diabetic shoe w/roller/rockr .....	.....	.....	.....	.....	.....
A5504	A	Diabetic shoe with wedge .....	.....	.....	.....	.....	.....
A5505	A	Diab shoe w/metatarsal bar .....	.....	.....	.....	.....	.....
A5506	A	Diabetic shoe w/off set heel .....	.....	.....	.....	.....	.....
A5507	A	Modification diabetic shoe .....	.....	.....	.....	.....	.....
A6020	A	Collagen dressing cover ea .....	.....	.....	.....	.....	.....
A6025	E	Silicone gel sheet, each .....	.....	.....	.....	.....	.....
A6154	A	Wound pouch each .....	.....	.....	.....	.....	.....
A6196	A	Alginate dressing <=16 sq in .....	.....	.....	.....	.....	.....
A6197	A	Alginate drsg >16 <=48 sq in .....	.....	.....	.....	.....	.....
A6198	A	Alginate dressing > 48 sq in					
A6199	A	Alginate drsg wound filler					
A6203	A	Composite drsg <= 16 sq in					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A6204	A	Composite drsg >16<=48 sq in .....	.....	.....	.....	.....	.....
A6205	A	Composite drsg > 48 sq in .....	.....	.....	.....	.....	.....
A6206	A	Contact layer <= 16 sq in .....	.....	.....	.....	.....	.....
A6207	A	Contact layer >16<= 48 sq in .....	.....	.....	.....	.....	.....
A6208	A	Contact layer > 48 sq in .....	.....	.....	.....	.....	.....
A6209	A	Foam drsg <=16 sq in w/o bdr .....	.....	.....	.....	.....	.....
A6210	A	Foam drg >16<=48 sq in w/o b .....	.....	.....	.....	.....	.....
A6211	A	Foam drg > 48 sq in w/o bdr .....	.....	.....	.....	.....	.....
A6212	A	Foam drg <=16 sq in w/border .....	.....	.....	.....	.....	.....
A6213	A	Foam drg >16<=48 sq in w/bdr .....	.....	.....	.....	.....	.....
A6214	A	Foam drg > 48 sq in w/border .....	.....	.....	.....	.....	.....
A6215	A	Foam dressing wound filler .....	.....	.....	.....	.....	.....
A6216	A	Non-sterile gauze<=16 sq in .....	.....	.....	.....	.....	.....
A6217	A	Non-sterile gauze>16<=48 sq .....	.....	.....	.....	.....	.....
A6218	A	Non-sterile gauze > 48 sq in .....	.....	.....	.....	.....	.....
A6219	A	Gauze <= 16 sq in w/border .....	.....	.....	.....	.....	.....
A6220	A	Gauze >16 <=48 sq in w/bdr .....	.....	.....	.....	.....	.....
A6221	A	Gauze > 48 sq in w/border .....	.....	.....	.....	.....	.....
A6222	A	Gauze <=16 in no w/sal w/o b .....	.....	.....	.....	.....	.....
A6223	A	Gauze >16<=48 no w/sal w/o b .....	.....	.....	.....	.....	.....
A6224	A	Gauze > 48 in no w/sal w/o b .....	.....	.....	.....	.....	.....
A6228	A	Gauze <= 16 sq in water/sal .....	.....	.....	.....	.....	.....
A6229	A	Gauze >16<=48 sq in watr/sal .....	.....	.....	.....	.....	.....
A6230	A	Gauze > 48 sq in water/saline .....	.....	.....	.....	.....	.....
A6234	A	Hydrocolld drg <=16 w/o bdr .....	.....	.....	.....	.....	.....
A6235	A	Hydrocolld drg >16<=48 w/o b .....	.....	.....	.....	.....	.....
A6236	A	Hydrocolld drg > 48 in w/o b .....	.....	.....	.....	.....	.....
A6237	A	Hydrocolld drg <=16 in w/bdr .....	.....	.....	.....	.....	.....
A6238	A	Hydrocolld drg >16<=48 w/bdr .....	.....	.....	.....	.....	.....
A6239	A	Hydrocolld drg > 48 in w/bdr .....	.....	.....	.....	.....	.....
A6240	A	Hydrocolld drg filler paste .....	.....	.....	.....	.....	.....
A6241	A	Hydrocolloid drg filler dry .....	.....	.....	.....	.....	.....
A6242	A	Hydrogel drg <=16 in w/o bdr .....	.....	.....	.....	.....	.....
A6243	A	Hydrogel drg >16<=48 w/o bdr .....	.....	.....	.....	.....	.....
A6244	A	Hydrogel drg >48 in w/o bdr .....	.....	.....	.....	.....	.....
A6245	A	Hydrogel drg <= 16 in w/bdr .....	.....	.....	.....	.....	.....
A6246	A	Hydrogel drg >16<=48 in w/b .....	.....	.....	.....	.....	.....
A6247	A	Hydrogel drg > 48 sq in w/b .....	.....	.....	.....	.....	.....
A6248	A	Hydrogel drsg gel filler .....	.....	.....	.....	.....	.....
A6250	A	Skin seal protect moisturizr .....	.....	.....	.....	.....	.....
A6251	A	Absorpt drg <=16 sq in w/o b .....	.....	.....	.....	.....	.....
A6252	A	Absorpt drg >16 <=48 w/o bdr .....	.....	.....	.....	.....	.....
A6253	A	Absorpt drg > 48 sq in w/o b .....	.....	.....	.....	.....	.....
A6254	A	Absorpt drg <=16 sq in w/bdr .....	.....	.....	.....	.....	.....
A6255	A	Absorpt drg >16<=48 in w/bdr .....	.....	.....	.....	.....	.....
A6256	A	Absorpt drg > 48 sq in w/bdr .....	.....	.....	.....	.....	.....
A6257	A	Transparent film <= 16 sq in .....	.....	.....	.....	.....	.....
A6258	A	Transparent film >16<=48 in .....	.....	.....	.....	.....	.....
A6259	A	Transparent film > 48 sq in .....	.....	.....	.....	.....	.....
A6260	A	Wound cleanser any type/size .....	.....	.....	.....	.....	.....
A6261	A	Wound filler gel/paste/oz .....	.....	.....	.....	.....	.....
A6262	A	Wound filler dry form/gram .....	.....	.....	.....	.....	.....
A6263	A	Non-sterile elastic gauze/yard .....	.....	.....	.....	.....	.....
A6264	A	Non-sterile no elastic gauze .....	.....	.....	.....	.....	.....
A6265	A	Tape per 18 sq inches .....	.....	.....	.....	.....	.....
A6266	A	Impreg gauze no h20/sal/yard .....	.....	.....	.....	.....	.....
A6402	A	Sterile gauze <= 16 sq in .....	.....	.....	.....	.....	.....
A6403	A	Sterile gauze>16 <= 48 sq in .....	.....	.....	.....	.....	.....
A6404	A	Sterile gauze > 48 sq in .....	.....	.....	.....	.....	.....
A6405	A	Sterile elastic gauze/yard .....	.....	.....	.....	.....	.....
A6406	A	Sterile non-elastic gauze/yard .....	.....	.....	.....	.....	.....
A9150	E	Misc/exper non-prescript dru .....	.....	.....	.....	.....	.....
A9160	E	Podiatrist non-covered servi .....	.....	.....	.....	.....	.....
A9170	E	Chiropractor non-covered ser .....	.....	.....	.....	.....	.....
A9190	E	Misc/expe personal comfort i .....	.....	.....	.....	.....	.....
A9270	E	Non-covered item or service .....	.....	.....	.....	.....	.....
A9300	E	Exercise equipment .....	.....	.....	.....	.....	.....
A9500	N	Technetium TC 99m sestamibi .....	.....	.....	.....	.....	.....
A9502	N	Technetium TC99M tetrofosmin .....	.....	.....	.....	.....	.....
A9503	N	Technetium TC 99m medronate .....	.....	.....	.....	.....	.....
A9505	N	Thallous chloride TL 201/mci .....	.....	.....	.....	.....	.....
A9600	N	Strontium-89 chloride .....	.....	.....	.....	.....	.....
B4034	A	Enter feed supkit syr by day					
B4035	A	Enteral feed supp pump per d					
B4036	A	Enteral feed sup kit grav by					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
B4081	A	Enteral ng tubing w/ stylet .....	.....	.....	.....	.....	.....
B4082	A	Enteral ng tubing w/o stylet .....	.....	.....	.....	.....	.....
B4083	A	Enteral stomach tube levine .....	.....	.....	.....	.....	.....
B4084	A	Gastrostomy/jejunostomy tubi .....	.....	.....	.....	.....	.....
B4085	A	Gastrostomy tube w/ring each .....	.....	.....	.....	.....	.....
B4150	A	Enteral formulae category i .....	.....	.....	.....	.....	.....
B4151	A	Enteral formulae category i- .....	.....	.....	.....	.....	.....
B4152	A	Enteral formulae category ii .....	.....	.....	.....	.....	.....
B4153	A	Enteral formulae category ii .....	.....	.....	.....	.....	.....
B4154	A	Enteral formulae category IV .....	.....	.....	.....	.....	.....
B4155	A	Enteral formulae category v .....	.....	.....	.....	.....	.....
B4156	A	Enteral formulae category vi .....	.....	.....	.....	.....	.....
B4164	A	Parenteral 50% dextrose solu .....	.....	.....	.....	.....	.....
B4168	A	Parenteral sol amino acid 3. ....	.....	.....	.....	.....	.....
B4172	A	Parenteral sol amino acid 5. ....	.....	.....	.....	.....	.....
B4176	A	Parenteral sol amino acid 7- .....	.....	.....	.....	.....	.....
B4178	A	Parenteral sol amino acid > .....	.....	.....	.....	.....	.....
B4180	A	Parenteral sol carb > 50% .....	.....	.....	.....	.....	.....
B4184	A	Parenteral sol lipids 10% .....	.....	.....	.....	.....	.....
B4186	A	Parenteral sol lipids 20% .....	.....	.....	.....	.....	.....
B4189	A	Parenteral sol amino acid & .....	.....	.....	.....	.....	.....
B4193	A	Parenteral sol 52-73 gm prot .....	.....	.....	.....	.....	.....
B4197	A	Parenteral sol 74-100 gm pro .....	.....	.....	.....	.....	.....
B4199	A	Parenteral sol > 100gm prote .....	.....	.....	.....	.....	.....
B4216	A	Parenteral nutrition additiv .....	.....	.....	.....	.....	.....
B4220	A	Parenteral supply kit premix .....	.....	.....	.....	.....	.....
B4222	A	Parenteral supply kit homemi .....	.....	.....	.....	.....	.....
B4224	A	Parenteral administration ki .....	.....	.....	.....	.....	.....
B5000	A	Parenteral sol renal-amirosoy .....	.....	.....	.....	.....	.....
B5100	A	Parenteral sol hepatic-fream .....	.....	.....	.....	.....	.....
B5200	A	Parenteral sol stres-brnch c .....	.....	.....	.....	.....	.....
B9000	A	Enter infusion pump w/o alrm .....	.....	.....	.....	.....	.....
B9002	A	Enteral infusion pump w/ ala .....	.....	.....	.....	.....	.....
B9004	A	Parenteral infus pump portab .....	.....	.....	.....	.....	.....
B9006	A	Parenteral infus pump statio .....	.....	.....	.....	.....	.....
B9998	A	Enteral supp not otherwise c .....	.....	.....	.....	.....	.....
B9999	A	Parenteral supp not othrws c .....	.....	.....	.....	.....	.....
D0120	E	Periodic oral evaluation .....	.....	.....	.....	.....	.....
D0140	E	Limit oral eval problm focus .....	.....	.....	.....	.....	.....
D0150	S	Comprehensive oral evaluation	031	1.33	\$70.52	\$14.10	\$14.10
D0160	E	Extensv oral eval prob focus .....	.....	.....	.....	.....	.....
D0210	E	Intraor complete film series .....	.....	.....	.....	.....	.....
D0220	E	Intraoral periapical first f .....	.....	.....	.....	.....	.....
D0230	E	Intraoral periapical ea add .....	.....	.....	.....	.....	.....
D0240	S	Intraoral occlusal film	031	1.33	\$70.52	\$14.10	\$14.10
D0250	S	Extraoral first film	031	1.33	\$70.52	\$14.10	\$14.10
D0260	S	Extraoral ea additional film	031	1.33	\$70.52	\$14.10	\$14.10
D0270	S	Dental bitewing single film	031	1.33	\$70.52	\$14.10	\$14.10
D0272	S	Dental bitewings two films	031	1.33	\$70.52	\$14.10	\$14.10
D0274	S	Dental bitewings four films	031	1.33	\$70.52	\$14.10	\$14.10
D0290	E	Dental film skull/facial bon .....	.....	.....	.....	.....	.....
D0310	E	Dental sallography .....	.....	.....	.....	.....	.....
D0320	E	Dental tmj arthrogram incl i .....	.....	.....	.....	.....	.....
D0321	E	Dental other tmj films .....	.....	.....	.....	.....	.....
D0322	E	Dental tomographic survey .....	.....	.....	.....	.....	.....
D0330	E	Dental panoramic film .....	.....	.....	.....	.....	.....
D0340	E	Dental cephalometric film .....	.....	.....	.....	.....	.....
D0415	E	Bacteriologic study .....	.....	.....	.....	.....	.....
D0425	E	Caries susceptibility test .....	.....	.....	.....	.....	.....
D0460	S	Pulp vitality test	031	1.33	\$70.52	\$14.10	\$14.10
D0470	E	Diagnostic casts .....	.....	.....	.....	.....	.....
D0471	S	Diagnostic photographs	031	1.33	\$70.52	\$14.10	\$14.10
D0501	S	Histopathologic examinations	031	1.33	\$70.52	\$14.10	\$14.10
D0502	S	Other oral pathology procedu	031	1.33	\$70.52	\$14.10	\$14.10
D0999	S	Unspecified diagnostic proce	031	1.33	\$70.52	\$14.10	\$14.10
D1110	E	Dental prophylaxis adult .....	.....	.....	.....	.....	.....
D1120	E	Dental prophylaxis child .....	.....	.....	.....	.....	.....
D1201	E	Topical fluor w prophy child .....	.....	.....	.....	.....	.....
D1203	E	Topical fluor w/o prophy chi .....	.....	.....	.....	.....	.....
D1204	E	Topical fluor w/o prophy adu .....	.....	.....	.....	.....	.....
D1205	E	Topical fluoride w/ prophy a .....	.....	.....	.....	.....	.....
D1310	E	Nutri counsel-control caries .....	.....	.....	.....	.....	.....
D1320	E	Tobacco counseling					
D1330	E	Oral hygiene instruction					
D1351	E	Dental sealant per tooth					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D1510	S	Space maintainer fxd unilat	031	1.33	\$70.52	\$14.10	\$14.10
D1515	S	Fixed bilat space maintainer	031	1.33	\$70.52	\$14.10	\$14.10
D1520	S	Remove unilat space maintain	031	1.33	\$70.52	\$14.10	\$14.10
D1525	S	Remove bilat space maintain	031	1.33	\$70.52	\$14.10	\$14.10
D1550	S	Recement space maintainer	031	1.33	\$70.52	\$14.10	\$14.10
D2110	E	Amalgam one surface primary					
D2120	E	Amalgam two surfaces primary					
D2130	E	Amalgam three surfaces prima					
D2131	E	Amalgam four/more surf prima					
D2140	E	Amalgam one surface permanen					
D2150	E	Amalgam two surfaces permane					
D2160	E	Amalgam three surfaces perma					
D2161	E	Amalgam 4 or > surfaces perm					
D2210	E	Silcate cement per restorat					
D2330	E	Resin one surface-anterior					
D2331	E	Resin two surfaces-anterior					
D2332	E	Resin three surfaces-anterio					
D2335	E	Resin 4/> surf or w incis an					
D2336	E	Composite resin crown					
D2380	E	Resin one surf poster primar					
D2381	E	Resin two surf poster primar					
D2382	E	Resin three/more surf post p					
D2385	E	Resin one surf poster perman					
D2386	E	Resin two surf poster perman					
D2387	E	Resin three/more surf post p					
D2410	E	Dental gold foil one surface					
D2420	E	Dental gold foil two surface					
D2430	E	Dental gold foil three surfa					
D2510	E	Dental inlay metalic 1 surf					
D2520	E	Dental inlay metalic 2 surf					
D2530	E	Dental inlay metl 3/more sur					
D2543	E	Dental onlay metalic 3 surf					
D2544	E	Dental onlay metl 4/more sur					
D2610	E	Inlay porcelain/ceramic 1 su					
D2620	E	Inlay porcelain/ceramic 2 su					
D2630	E	Dental onlay porc 3/more sur					
D2642	E	Dental onlay porcelin 2 surf					
D2643	E	Dental onlay porcelin 3 surf					
D2644	E	Dental onlay porc 4/more sur					
D2650	E	Inlay composite/resin one su					
D2651	E	Inlay composite/resin two su					
D2652	E	Dental inlay resin 3/mre sur					
D2662	E	Dental onlay resin 2 surface					
D2663	E	Dental onlay resin 3 surface					
D2664	E	Dental onlay resin 4/mre sur					
D2710	E	Crown resin laboratory					
D2720	E	Crown resin w/ high noble me					
D2721	E	Crown resin w/ base metal					
D2722	E	Crown resin w/ noble metal					
D2740	E	Crown porcelain/ceramic subs					
D2750	E	Crown porcelain w/ h noble m					
D2751	E	Crown porcelain fused base m					
D2752	E	Crown porcelain w/ noble met					
D2790	E	Crown full cast high noble m					
D2791	E	Crown full cast base metal					
D2792	E	Crown full cast noble metal					
D2810	E	Crown 3/4 cast metallic					
D2910	E	Dental recement inlay					
D2920	E	Dental recement crown					
D2930	E	Prefab stnlss steel crwn pri					
D2931	E	Prefab stnlss steel crown pe					
D2932	E	Prefabricated resin crown					
D2933	E	Prefab stainless steel crown					
D2940	E	Dental sedative filling					
D2950	E	Core build-up incl any pins					
D2951	E	Tooth pin retention					
D2952	E	Post and core cast + crown					
D2954	E	Prefab post/core + crown					
D2955	E	Post removal					
D2960	E	Laminate labial veneer					
D2961	E	Lab labial veneer resin					
D2962	E	Lab labial veneer porcelain					
D2970	S	Temporary-fractured tooth	031	1.33	\$70.52	\$14.10	\$14.10
D2980	E	Crown repair					
D2990	S	Dental unspec restorative pr	031	1.33	\$70.52	\$14.10	\$14.10

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D3110	E	Pulp cap direct .....	.....	.....	.....	.....	.....
D3120	E	Pulp cap indirect .....	.....	.....	.....	.....	.....
D3220	E	Therapeutic pulpotomy .....	.....	.....	.....	.....	.....
D3230	E	Pulpal therapy anterior prim .....	.....	.....	.....	.....	.....
D3240	E	Pulpal therapy posterior pri .....	.....	.....	.....	.....	.....
D3310	E	Anterior .....	.....	.....	.....	.....	.....
D3320	E	Root canal therapy 2 canals .....	.....	.....	.....	.....	.....
D3330	E	Root canal therapy 3 canals .....	.....	.....	.....	.....	.....
D3346	E	Retreat root canal anterior .....	.....	.....	.....	.....	.....
D3347	E	Retreat root canal bicuspid .....	.....	.....	.....	.....	.....
D3348	E	Retreat root canal molar .....	.....	.....	.....	.....	.....
D3351	E	Apexification/recalc initial .....	.....	.....	.....	.....	.....
D3352	E	Apexification/recalc interim .....	.....	.....	.....	.....	.....
D3353	E	Apexification/recalc final .....	.....	.....	.....	.....	.....
D3410	E	Apicoect/perirad surg anter .....	.....	.....	.....	.....	.....
D3421	E	Root surgery bicuspid .....	.....	.....	.....	.....	.....
D3425	E	Root surgery molar .....	.....	.....	.....	.....	.....
D3426	E	Root surgery ea add root .....	.....	.....	.....	.....	.....
D3430	E	Retrograde filling .....	.....	.....	.....	.....	.....
D3450	E	Root amputation .....	.....	.....	.....	.....	.....
D3460	S	Endodontic endosseous implan	031	1.33	\$70.52	\$14.10	\$14.10
D3470	E	Intentional replantation .....	.....	.....	.....	.....	.....
D3910	E	Isolation-tooth w rubb dam .....	.....	.....	.....	.....	.....
D3920	E	Tooth splitting .....	.....	.....	.....	.....	.....
D3950	E	Canal prep/fitting of dowel .....	.....	.....	.....	.....	.....
D3960	E	Bleaching of discolored toot .....	.....	.....	.....	.....	.....
D3999	S	Endodontic procedure	031	1.33	\$70.52	\$14.10	\$14.10
D4210	E	Gingivectomy/plasty per quad .....	.....	.....	.....	.....	.....
D4211	E	Gingivectomy/plasty per toot .....	.....	.....	.....	.....	.....
D4220	E	Gingival curettage per quadr .....	.....	.....	.....	.....	.....
D4240	E	Gingival flap proc w/ planin .....	.....	.....	.....	.....	.....
D4249	E	Crown lengthen hard tissue .....	.....	.....	.....	.....	.....
D4250	S	Mucogingival surg per quadra	031	1.33	\$70.52	\$14.10	\$14.10
D4260	S	Osseous surgery per quadrant	031	1.33	\$70.52	\$14.10	\$14.10
D4263	S	Bone replce graft first site	031	1.33	\$70.52	\$14.10	\$14.10
D4264	S	Bone replce graft each add	031	1.33	\$70.52	\$14.10	\$14.10
D4266	E	Guided tiss regen resorbable .....	.....	.....	.....	.....	.....
D4267	E	Guided tiss regen nonresorb .....	.....	.....	.....	.....	.....
D4270	S	Pedicle soft tissue graft pr	031	1.33	\$70.52	\$14.10	\$14.10
D4271	S	Free soft tissue graft proc	031	1.33	\$70.52	\$14.10	\$14.10
D4273	S	Subepithelial tissue graft	031	1.33	\$70.52	\$14.10	\$14.10
D4274	E	Distal/proximal wedge proc .....	.....	.....	.....	.....	.....
D4320	E	Provision splnt intracoronal .....	.....	.....	.....	.....	.....
D4321	E	Provisional splint extracoro .....	.....	.....	.....	.....	.....
D4341	E	Periodontal scaling & root .....	.....	.....	.....	.....	.....
D4355	S	Full mouth debridement	031	1.33	\$70.52	\$14.10	\$14.10
D4381	S	Localized chemo delivery	031	1.33	\$70.52	\$14.10	\$14.10
D4910	E	Periodontal maint procedures .....	.....	.....	.....	.....	.....
D4920	E	Unscheduled dressing change .....	.....	.....	.....	.....	.....
D4999	E	Unspecified periodontal proc .....	.....	.....	.....	.....	.....
D5110	E	Dentures complete maxillary .....	.....	.....	.....	.....	.....
D5120	E	Dentures complete mandible .....	.....	.....	.....	.....	.....
D5130	E	Dentures immediat maxillary .....	.....	.....	.....	.....	.....
D5140	E	Dentures immediat mandible .....	.....	.....	.....	.....	.....
D5211	E	Dentures maxill part resin .....	.....	.....	.....	.....	.....
D5212	E	Dentures mand part resin .....	.....	.....	.....	.....	.....
D5213	E	Dentures maxill part metal .....	.....	.....	.....	.....	.....
D5214	E	Dentures mandibl part metal .....	.....	.....	.....	.....	.....
D5281	E	Removable partial denture .....	.....	.....	.....	.....	.....
D5410	E	Dentures adjust cmplt maxil .....	.....	.....	.....	.....	.....
D5411	E	Dentures adjust cmplt mand .....	.....	.....	.....	.....	.....
D5421	E	Dentures adjust part maxill .....	.....	.....	.....	.....	.....
D5422	E	Dentures adjust part mandbl .....	.....	.....	.....	.....	.....
D5510	E	Dentur repr broken compl bas .....	.....	.....	.....	.....	.....
D5520	E	Replace denture teeth complt .....	.....	.....	.....	.....	.....
D5610	E	Dentures repair resin base .....	.....	.....	.....	.....	.....
D5620	E	Rep part denture cast frame .....	.....	.....	.....	.....	.....
D5630	E	Rep partial denture clasp .....	.....	.....	.....	.....	.....
D5640	E	Replace part denture teeth .....	.....	.....	.....	.....	.....
D5650	E	Add tooth to partial denture .....	.....	.....	.....	.....	.....
D5660	E	Add clasp to partial denture .....	.....	.....	.....	.....	.....
D5710	E	Dentures rebase cmplt maxil .....	.....	.....	.....	.....	.....
D5711	E	Dentures rebase cmplt mand .....	.....	.....	.....	.....	.....
D5720	E	Dentures rebase part maxill					
D5721	E	Dentures rebase part mandbl					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D5730	E	Denture reln cmplt maxil ch .....	.....	.....	.....	.....	.....
D5731	E	Denture reln cmplt mand chr .....	.....	.....	.....	.....	.....
D5740	E	Denture reln part maxil chr .....	.....	.....	.....	.....	.....
D5741	E	Denture reln part mand chr .....	.....	.....	.....	.....	.....
D5750	E	Denture reln cmplt max lab .....	.....	.....	.....	.....	.....
D5751	E	Denture reln cmplt mand lab .....	.....	.....	.....	.....	.....
D5760	E	Denture reln part maxil lab .....	.....	.....	.....	.....	.....
D5761	E	Denture reln part mand lab .....	.....	.....	.....	.....	.....
D5810	E	Denture interm cmplt maxill .....	.....	.....	.....	.....	.....
D5811	E	Denture interm cmplt mandbl .....	.....	.....	.....	.....	.....
D5820	E	Denture interm part maxill .....	.....	.....	.....	.....	.....
D5821	E	Denture interm part mandbl .....	.....	.....	.....	.....	.....
D5850	E	Denture tiss conditn maxill .....	.....	.....	.....	.....	.....
D5851	E	Denture tiss conditn mandbl .....	.....	.....	.....	.....	.....
D5860	E	Overdenture complete .....	.....	.....	.....	.....	.....
D5861	E	Overdenture partial .....	.....	.....	.....	.....	.....
D5862	E	Precision attachment .....	.....	.....	.....	.....	.....
D5899	E	Removable prosthodontic proc .....	.....	.....	.....	.....	.....
D5911	S	Facial moulage sectional	031	1.33	\$70.52	\$14.10	\$14.10
D5912	S	Facial moulage complete	031	1.33	\$70.52	\$14.10	\$14.10
D5913	E	Nasal prosthesis .....	.....	.....	.....	.....	.....
D5914	E	Auricular prosthesis .....	.....	.....	.....	.....	.....
D5915	E	Orbital prosthesis .....	.....	.....	.....	.....	.....
D5916	E	Ocular prosthesis .....	.....	.....	.....	.....	.....
D5919	E	Facial prosthesis .....	.....	.....	.....	.....	.....
D5922	E	Nasal septal prosthesis .....	.....	.....	.....	.....	.....
D5923	E	Ocular prosthesis interim .....	.....	.....	.....	.....	.....
D5924	E	Cranial prosthesis .....	.....	.....	.....	.....	.....
D5925	E	Facial augmentation implant .....	.....	.....	.....	.....	.....
D5926	E	Replacement nasal prosthesis .....	.....	.....	.....	.....	.....
D5927	E	Auricular replacement .....	.....	.....	.....	.....	.....
D5928	E	Orbital replacement .....	.....	.....	.....	.....	.....
D5929	E	Facial replacement .....	.....	.....	.....	.....	.....
D5931	E	Surgical obturator .....	.....	.....	.....	.....	.....
D5932	E	Postsurgical obturator .....	.....	.....	.....	.....	.....
D5933	E	Refitting of obturator .....	.....	.....	.....	.....	.....
D5934	E	Mandibular flange prosthesis .....	.....	.....	.....	.....	.....
D5935	E	Mandibular denture prosth .....	.....	.....	.....	.....	.....
D5936	E	Temp obturator prosthesis .....	.....	.....	.....	.....	.....
D5937	E	Trismus appliance .....	.....	.....	.....	.....	.....
D5951	E	Feeding aid .....	.....	.....	.....	.....	.....
D5952	E	Pediatric speech aid .....	.....	.....	.....	.....	.....
D5953	E	Adult speech aid .....	.....	.....	.....	.....	.....
D5954	E	Superimposed prosthesis .....	.....	.....	.....	.....	.....
D5955	E	Palatal lift prosthesis .....	.....	.....	.....	.....	.....
D5958	E	Intraoral con def inter plt .....	.....	.....	.....	.....	.....
D5959	E	Intraoral con def mod palat .....	.....	.....	.....	.....	.....
D5960	E	Modify speech aid prosthesis .....	.....	.....	.....	.....	.....
D5982	E	Surgical stent .....	.....	.....	.....	.....	.....
D5983	S	Radiation applicator	031	1.33	\$70.52	\$14.10	\$14.10
D5984	S	Radiation shield	031	1.33	\$70.52	\$14.10	\$14.10
D5985	S	Radiation cone locator	031	1.33	\$70.52	\$14.10	\$14.10
D5986	E	Fluoride applicator .....	.....	.....	.....	.....	.....
D5987	S	Commissure splint	031	1.33	\$70.52	\$14.10	\$14.10
D5988	E	Surgical splint .....	.....	.....	.....	.....	.....
D5999	E	Maxillofacial prosthesis .....	.....	.....	.....	.....	.....
D6010	E	Odontics endosteal implant .....	.....	.....	.....	.....	.....
D6020	E	Odontics abutment placement .....	.....	.....	.....	.....	.....
D6040	E	Odontics eposteal implant .....	.....	.....	.....	.....	.....
D6050	E	Odontics transosteal implnt .....	.....	.....	.....	.....	.....
D6055	E	Implant connecting bar .....	.....	.....	.....	.....	.....
D6080	E	Implant maintenance .....	.....	.....	.....	.....	.....
D6090	E	Repair implant .....	.....	.....	.....	.....	.....
D6095	E	Odontics repr abutment .....	.....	.....	.....	.....	.....
D6100	E	Removal of implant .....	.....	.....	.....	.....	.....
D6199	E	Implant procedure .....	.....	.....	.....	.....	.....
D6210	E	Prosthodont high noble metal .....	.....	.....	.....	.....	.....
D6211	E	Bridge base metal cast .....	.....	.....	.....	.....	.....
D6212	E	Bridge noble metal cast .....	.....	.....	.....	.....	.....
D6240	E	Bridge porcelain high noble .....	.....	.....	.....	.....	.....
D6241	E	Bridge porcelain base metal .....	.....	.....	.....	.....	.....
D6242	E	Bridge porcelain nobel metal .....	.....	.....	.....	.....	.....
D6250	E	Bridge resin w/high noble					
D6251	E	Bridge resin base metal					
D6252	E	Bridge resin w/noble metal					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D6520	E	Dental retainer two surfaces					
D6530	E	Retainer metallic 3+ surface					
D6543	E	Dental retainr onlay 3 surf					
D6544	E	Dental retainr onlay 4/more					
D6545	E	Dental retainr cast metl					
D6720	E	Retain crown resin w hi nble					
D6721	E	Crown resin w/base metal					
D6722	E	Crown resin w/noble metal					
D6750	E	Crown porcelain high noble					
D6751	E	Crown porcelain base metal					
D6752	E	Crown porcelain noble metal					
D6780	E	Crown 3/4 high noble metal					
D6790	E	Crown full high noble metal					
D6791	E	Crown full base metal cast					
D6792	E	Crown full noble metal cast					
D6920	S	Dental connector bar	031	1.33	\$70.52	\$14.10	\$14.10
D6930	E	Dental recement bridge					
D6940	E	Stress breaker					
D6950	E	Precision attachment					
D6970	E	Post & core plus retainer					
D6971	E	Cast post bridge retainer					
D6972	E	Prefab post & core plus reta					
D6973	E	Core build up for retainer					
D6975	E	Coping metal					
D6980	E	Bridge repair					
D6999	E	Fixed prosthodontic proc					
D7110	S	Oral surgery single tooth	031	1.33	\$70.52	\$14.10	\$14.10
D7120	S	Each add tooth extraction	031	1.33	\$70.52	\$14.10	\$14.10
D7130	S	Tooth root removal	031	1.33	\$70.52	\$14.10	\$14.10
D7210	S	Rem imp tooth w mucoper flp	031	1.33	\$70.52	\$14.10	\$14.10
D7220	S	Impact tooth remov soft tiss	031	1.33	\$70.52	\$14.10	\$14.10
D7230	S	Impact tooth remov part bony	031	1.33	\$70.52	\$14.10	\$14.10
D7240	S	Impact tooth remov comp bony	031	1.33	\$70.52	\$14.10	\$14.10
D7241	S	Impact tooth rem bony w/comp	031	1.33	\$70.52	\$14.10	\$14.10
D7250	S	Tooth root removal	031	1.33	\$70.52	\$14.10	\$14.10
D7260	S	Oral antral fistula closure	031	1.33	\$70.52	\$14.10	\$14.10
D7270	E	Tooth reimplantation					
D7272	E	Tooth transplantation					
D7280	E	Exposure impact tooth orthod					
D7281	E	Exposure tooth aid eruption					
D7285	E	Biopsy of oral tissue hard					
D7286	E	Biopsy of oral tissue soft					
D7290	E	Repositioning of teeth					
D7291	S	Transseptal fiberotomy	031	1.33	\$70.52	\$14.10	\$14.10
D7310	E	Alveoplasty w/ extraction					
D7320	E	Alveoplasty w/o extraction					
D7340	E	Vestibuloplasty ridge extens					
D7350	E	Vestibuloplasty exten graft					
D7410	E	Rad exc lesion up to 1.25 cm					
D7420	E	Lesion > 1.25 cm					
D7430	E	Exc benign tumor to 1.25 cm					
D7431	E	Benign tumor exc > 1.25 cm					
D7440	E	Malig tumor exc to 1.25 cm					
D7441	E	Malig tumor > 1.25 cm					
D7450	E	Rem odontogen cyst to 1.25cm					
D7451	E	Rem odontogen cyst > 1.25 cm					
D7460	E	Rem nonodonto cyst to 1.25cm					
D7461	E	Rem nonodonto cyst > 1.25 cm					
D7465	E	Lesion destruction					
D7470	E	Rem exostosis maxilla/mandib					
D7480	E	Partial ostectomy					
D7490	E	Mandible resection					
D7510	E	I&d abscc intraoral soft tiss					
D7520	E	I&d abscess extraoral					
D7530	E	Removal fb skin/areolar tiss					
D7540	E	Removal of fb reaction					
D7550	E	Removal of sloughed off bone					
D7560	E	Maxillary sinusotomy					
D7610	E	Maxilla open reduct simple					
D7620	E	Clsd reduct simpl maxilla fx					
D7630	E	Open red simpl mandible fx					
D7640	E	Clsd red simpl mandible fx					
D7650	E	Open red simp malar/zygom fx					
D7660	E	Clsd red simp malar/zygom fx					
D7670	E	Open red simple alveolus fx					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D7680	E	Reduct simple facial bone fx .....	.....	.....	.....	.....	.....
D7710	E	Maxilla open reduct compound .....	.....	.....	.....	.....	.....
D7720	E	Clsd reduct compd maxilla fx .....	.....	.....	.....	.....	.....
D7730	E	Open reduct compd mandble fx .....	.....	.....	.....	.....	.....
D7740	E	Clsd reduct compd mandble fx .....	.....	.....	.....	.....	.....
D7750	E	Open red comp malar/zygma fx .....	.....	.....	.....	.....	.....
D7760	E	Clsd red comp malar/zygma fx .....	.....	.....	.....	.....	.....
D7770	E	Open reduct compd alveolus fx .....	.....	.....	.....	.....	.....
D7780	E	Reduct compnd facial bone fx .....	.....	.....	.....	.....	.....
D7810	E	Tmj open reduct-dislocation .....	.....	.....	.....	.....	.....
D7820	E	Closed tmp manipulation .....	.....	.....	.....	.....	.....
D7830	E	Tmj manipulation under anest .....	.....	.....	.....	.....	.....
D7840	E	Removal of tmj condyle .....	.....	.....	.....	.....	.....
D7850	E	Tmj meniscectomy .....	.....	.....	.....	.....	.....
D7852	E	Tmj repair of joint disc .....	.....	.....	.....	.....	.....
D7854	E	Tmj excisn of joint membrane .....	.....	.....	.....	.....	.....
D7856	E	Tmj cutting of a muscle .....	.....	.....	.....	.....	.....
D7858	E	Tmj reconstruction .....	.....	.....	.....	.....	.....
D7860	E	Tmj cutting into joint .....	.....	.....	.....	.....	.....
D7865	E	Tmj reshaping components .....	.....	.....	.....	.....	.....
D7870	E	Tmj aspiration joint fluid .....	.....	.....	.....	.....	.....
D7872	E	Tmj diagnostic arthroscopy .....	.....	.....	.....	.....	.....
D7873	E	Tmj arthroscopy lysis adhesn .....	.....	.....	.....	.....	.....
D7874	E	Tmj arthroscopy disc reposit .....	.....	.....	.....	.....	.....
D7875	E	Tmj arthroscopy synovectomy .....	.....	.....	.....	.....	.....
D7876	E	Tmj arthroscopy discectomy .....	.....	.....	.....	.....	.....
D7877	E	Tmj arthroscopy debridement .....	.....	.....	.....	.....	.....
D7880	E	Occlusal orthotic appliance .....	.....	.....	.....	.....	.....
D7899	E	Tmj unspecified therapy .....	.....	.....	.....	.....	.....
D7910	E	Dent sutur recent wnd to 5cm .....	.....	.....	.....	.....	.....
D7911	E	Dental suture wound to 5 cm .....	.....	.....	.....	.....	.....
D7912	E	Suture complicate wnd > 5 cm .....	.....	.....	.....	.....	.....
D7920	E	Dental skin graft .....	.....	.....	.....	.....	.....
D7940	S	Reshaping bone orthognathic	031	1.33	\$70.52	\$14.10	\$14.10
D7941	E	Bone cutting ramus closed .....	.....	.....	.....	.....	.....
D7942	E	Bone cutting ramus open .....	.....	.....	.....	.....	.....
D7943	E	Cutting ramus open w/graft .....	.....	.....	.....	.....	.....
D7944	E	Bone cutting segmented .....	.....	.....	.....	.....	.....
D7945	E	Bone cutting body mandible .....	.....	.....	.....	.....	.....
D7946	E	Reconstruction maxilla total .....	.....	.....	.....	.....	.....
D7947	E	Reconstruct maxilla segment .....	.....	.....	.....	.....	.....
D7948	E	Reconstruct midface no graft .....	.....	.....	.....	.....	.....
D7949	E	Reconstruct midface w/graft .....	.....	.....	.....	.....	.....
D7950	E	Mandible graft .....	.....	.....	.....	.....	.....
D7955	E	Repair maxillofacial defects .....	.....	.....	.....	.....	.....
D7960	E	Frenulectomy/frenulotomy .....	.....	.....	.....	.....	.....
D7970	E	Excision hyperplastic tissue .....	.....	.....	.....	.....	.....
D7971	E	Excision pericoronal gingiva .....	.....	.....	.....	.....	.....
D7980	E	Sialolithotomy .....	.....	.....	.....	.....	.....
D7981	E	Excision of salivary gland .....	.....	.....	.....	.....	.....
D7982	E	Sialodochoplasty .....	.....	.....	.....	.....	.....
D7983	E	Closure of salivary fistula .....	.....	.....	.....	.....	.....
D7990	E	Emergency tracheotomy .....	.....	.....	.....	.....	.....
D7991	E	Dental coronoidectomy .....	.....	.....	.....	.....	.....
D7995	E	Synthetic graft facial bones .....	.....	.....	.....	.....	.....
D7996	E	Implant mandible for augment .....	.....	.....	.....	.....	.....
D7999	E	Oral surgery procedure .....	.....	.....	.....	.....	.....
D8010	E	Limited dental tx primary .....	.....	.....	.....	.....	.....
D8020	E	Limited dental tx transition .....	.....	.....	.....	.....	.....
D8030	E	Limited dental tx adolescent .....	.....	.....	.....	.....	.....
D8040	E	Limited dental tx adult .....	.....	.....	.....	.....	.....
D8050	E	Intercep dental tx primary .....	.....	.....	.....	.....	.....
D8060	E	Intercep dental tx transiti .....	.....	.....	.....	.....	.....
D8070	E	Compre dental tx transition .....	.....	.....	.....	.....	.....
D8080	E	Compre dental tx adolescent .....	.....	.....	.....	.....	.....
D8090	E	Compre dental tx adult .....	.....	.....	.....	.....	.....
D8210	E	Orthodontic rem appliance tx .....	.....	.....	.....	.....	.....
D8220	E	Fixed appliance therapy habt .....	.....	.....	.....	.....	.....
D8660	E	Preorthodontic tx visit .....	.....	.....	.....	.....	.....
D8670	E	Periodic orthodontic tx visit .....	.....	.....	.....	.....	.....
D8680	E	Orthodontic retention .....	.....	.....	.....	.....	.....
D8690	E	Orthodontic treatment .....	.....	.....	.....	.....	.....
D8999	E	Orthodontic procedure					
D9110	N	Tx dental pain minor proc					
D9210	E	Dent anesthesia w/o surgery					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D9211	E	Regional block anesthesia .....	.....	.....	.....	.....	.....
D9212	E	Trigeminal block anesthesia .....	.....	.....	.....	.....	.....
D9215	E	Local anesthesia .....	.....	.....	.....	.....	.....
D9220	E	General anesthesia .....	.....	.....	.....	.....	.....
D9221	E	General anesthesia ea ad 15m .....	.....	.....	.....	.....	.....
D9230	N	Analgesia .....	.....	.....	.....	.....	.....
D9240	E	Intravenous sedation .....	.....	.....	.....	.....	.....
D9310	E	Dental consultation .....	.....	.....	.....	.....	.....
D9410	E	Dental house call .....	.....	.....	.....	.....	.....
D9420	E	Hospital call .....	.....	.....	.....	.....	.....
D9430	E	Office visit during hours .....	.....	.....	.....	.....	.....
D9440	E	Office visit after hours .....	.....	.....	.....	.....	.....
D9610	E	Dent therapeutic drug inject .....	.....	.....	.....	.....	.....
D9630	S	Other drugs/medicaments	031	1.33	\$70.52	\$14.10	\$14.10
D9910	E	Dent appl desensitizing med .....	.....	.....	.....	.....	.....
D9920	E	Behavior management .....	.....	.....	.....	.....	.....
D9930	S	Treatment of complications	031	1.33	\$70.52	\$14.10	\$14.10
D9940	S	Dental occlusal guard	031	1.33	\$70.52	\$14.10	\$14.10
D9941	E	Fabrication athletic guard .....	.....	.....	.....	.....	.....
D9950	S	Occlusion analysis	031	1.33	\$70.52	\$14.10	\$14.10
D9951	S	Limited occlusal adjustment	031	1.33	\$70.52	\$14.10	\$14.10
D9952	S	Complete occlusal adjustment	031	1.33	\$70.52	\$14.10	\$14.10
D9970	E	Enamel microabrasion .....	.....	.....	.....	.....	.....
D9999	E	Adjunctive procedure .....	.....	.....	.....	.....	.....
E0100	A	Cane adjust/fixed with tip .....	.....	.....	.....	.....	.....
E0105	A	Cane adjust/fixed quad/3 pro .....	.....	.....	.....	.....	.....
E0110	A	Crutch forearm pair .....	.....	.....	.....	.....	.....
E0111	A	Crutch forearm each .....	.....	.....	.....	.....	.....
E0112	A	Crutch underarm pair wood .....	.....	.....	.....	.....	.....
E0113	A	Crutch underarm each wood .....	.....	.....	.....	.....	.....
E0114	A	Crutch underarm pair no wood .....	.....	.....	.....	.....	.....
E0116	A	Crutch underarm each no wood .....	.....	.....	.....	.....	.....
E0130	A	Walker rigid adjust/fixed ht .....	.....	.....	.....	.....	.....
E0135	A	Walker folding adjust/fixed .....	.....	.....	.....	.....	.....
E0141	A	Rigid walker wheeled wo seat .....	.....	.....	.....	.....	.....
E0142	A	Walker rigid wheeled with se .....	.....	.....	.....	.....	.....
E0143	A	Walker folding wheeled w/o s .....	.....	.....	.....	.....	.....
E0145	A	Walker whled seat/crutch att .....	.....	.....	.....	.....	.....
E0146	A	Folding walker wheels w seat .....	.....	.....	.....	.....	.....
E0147	A	Walker variable wheel resist .....	.....	.....	.....	.....	.....
E0153	A	Forearm crutch platform atta .....	.....	.....	.....	.....	.....
E0154	A	Walker platform attachment .....	.....	.....	.....	.....	.....
E0155	A	Walker rigd pick-up/wheel at .....	.....	.....	.....	.....	.....
E0156	A	Walker seat attachment .....	.....	.....	.....	.....	.....
E0157	A	Walker crutch attachment .....	.....	.....	.....	.....	.....
E0158	A	Walker leg extensions .....	.....	.....	.....	.....	.....
E0159	A	Brake for wheeled walker .....	.....	.....	.....	.....	.....
E0160	A	Sitz type bath or equipment .....	.....	.....	.....	.....	.....
E0161	A	Sitz bath/equipment w/faucet .....	.....	.....	.....	.....	.....
E0162	A	Sitz bath chair .....	.....	.....	.....	.....	.....
E0163	A	Commode chair stationry fxd .....	.....	.....	.....	.....	.....
E0164	A	Commode chair mobile fixed a .....	.....	.....	.....	.....	.....
E0165	A	Commode chair stationry det .....	.....	.....	.....	.....	.....
E0166	A	Commode chair mobile detach .....	.....	.....	.....	.....	.....
E0167	A	Commode chair pail or pan .....	.....	.....	.....	.....	.....
E0175	A	Commode chair foot rest .....	.....	.....	.....	.....	.....
E0176	A	Air pressre pad/cushion nonp .....	.....	.....	.....	.....	.....
E0177	A	Water press pad/cushion nonp .....	.....	.....	.....	.....	.....
E0178	A	Gel pressre pad/cushion nonp .....	.....	.....	.....	.....	.....
E0179	A	Dry pressre pad/cushion nonp .....	.....	.....	.....	.....	.....
E0180	A	Press pad alternating w pump .....	.....	.....	.....	.....	.....
E0181	A	Press pad alternating w/ pum .....	.....	.....	.....	.....	.....
E0182	A	Pressure pad alternating pum .....	.....	.....	.....	.....	.....
E0184	A	Dry pressure mattress .....	.....	.....	.....	.....	.....
E0185	A	Gel pressure mattress pad .....	.....	.....	.....	.....	.....
E0186	A	Air pressure mattress .....	.....	.....	.....	.....	.....
E0187	A	Water pressure mattress .....	.....	.....	.....	.....	.....
E0188	E	Synthetic sheepskin pad .....	.....	.....	.....	.....	.....
E0189	E	Lambswool sheepskin pad .....	.....	.....	.....	.....	.....
E0191	A	Protector heel or elbow .....	.....	.....	.....	.....	.....
E0192	A	Pad wheelchr low press/posit .....	.....	.....	.....	.....	.....
E0193	A	Powered air flotation bed .....	.....	.....	.....	.....	.....
E0194	A	Air fluidized bed					
E0196	A	Gel pressure mattress					
E0197	A	Air pressure pad for mattresses					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E0198	A	Water pressure pad for mattr .....	.....	.....	.....	.....	.....
E0199	A	Dry pressure pad for mattresses .....	.....	.....	.....	.....	.....
E0200	A	Heat lamp without stand .....	.....	.....	.....	.....	.....
E0202	A	Phototherapy light w/ photom .....	.....	.....	.....	.....	.....
E0205	A	Heat lamp with stand .....	.....	.....	.....	.....	.....
E0210	A	Electric heat pad standard .....	.....	.....	.....	.....	.....
E0215	A	Electric heat pad moist .....	.....	.....	.....	.....	.....
E0217	A	Water circ heat pad w pump .....	.....	.....	.....	.....	.....
E0218	A	Water circ cold pad w pump .....	.....	.....	.....	.....	.....
E0220	A	Hot water bottle .....	.....	.....	.....	.....	.....
E0225	A	Hydrocollator unit .....	.....	.....	.....	.....	.....
E0230	A	Ice cap or collar .....	.....	.....	.....	.....	.....
E0235	A	Paraffin bath unit portable .....	.....	.....	.....	.....	.....
E0236	A	Pump for water circulating p .....	.....	.....	.....	.....	.....
E0238	A	Heat pad non-electric moist .....	.....	.....	.....	.....	.....
E0239	A	Hydrocollator unit portable .....	.....	.....	.....	.....	.....
E0241	E	Bath tub wall rail .....	.....	.....	.....	.....	.....
E0242	E	Bath tub rail floor .....	.....	.....	.....	.....	.....
E0243	E	Toilet rail .....	.....	.....	.....	.....	.....
E0244	E	Toilet seat raised .....	.....	.....	.....	.....	.....
E0245	E	Tub stool or bench .....	.....	.....	.....	.....	.....
E0246	A	Transfer tub rail attachment .....	.....	.....	.....	.....	.....
E0249	A	Pad water circulating heat u .....	.....	.....	.....	.....	.....
E0250	A	Hosp bed fixed ht w/ mattresses .....	.....	.....	.....	.....	.....
E0251	A	Hosp bed fixd ht w/o mattresses .....	.....	.....	.....	.....	.....
E0255	A	Hospital bed var ht w/ mattr .....	.....	.....	.....	.....	.....
E0256	A	Hospital bed var ht w/o matt .....	.....	.....	.....	.....	.....
E0260	A	Hosp bed semi-electr w/ matt .....	.....	.....	.....	.....	.....
E0261	A	Hosp bed semi-electr w/o mat .....	.....	.....	.....	.....	.....
E0265	A	Hosp bed total electr w/ matt .....	.....	.....	.....	.....	.....
E0266	A	Hosp bed total elec w/o matt .....	.....	.....	.....	.....	.....
E0270	A	Hospital bed institutional t .....	.....	.....	.....	.....	.....
E0271	A	Mattress innerspring .....	.....	.....	.....	.....	.....
E0272	A	Mattress foam rubber .....	.....	.....	.....	.....	.....
E0273	A	Bed board .....	.....	.....	.....	.....	.....
E0274	A	Over-bed table .....	.....	.....	.....	.....	.....
E0275	A	Bed pan standard .....	.....	.....	.....	.....	.....
E0276	A	Bed pan fracture .....	.....	.....	.....	.....	.....
E0277	A	Powered pres-redu air mattr .....	.....	.....	.....	.....	.....
E0280	A	Bed cradle .....	.....	.....	.....	.....	.....
E0290	A	Hosp bed fx ht w/o rails w/m .....	.....	.....	.....	.....	.....
E0291	A	Hosp bed fx ht w/o rail w/o .....	.....	.....	.....	.....	.....
E0292	A	Hosp bed var ht w/o rail w/o .....	.....	.....	.....	.....	.....
E0293	A	Hosp bed var ht w/o rail w/ .....	.....	.....	.....	.....	.....
E0294	A	Hosp bed semi-elect w/ mattr .....	.....	.....	.....	.....	.....
E0295	A	Hosp bed semi-elect w/o matt .....	.....	.....	.....	.....	.....
E0296	A	Hosp bed total elect w/ matt .....	.....	.....	.....	.....	.....
E0297	A	Hosp bed total elect w/o mat .....	.....	.....	.....	.....	.....
E0305	A	Rails bed side half length .....	.....	.....	.....	.....	.....
E0310	A	Rails bed side full length .....	.....	.....	.....	.....	.....
E0315	A	Bed accessory brd/tbl/supprt .....	.....	.....	.....	.....	.....
E0325	A	Urinal male jug-type .....	.....	.....	.....	.....	.....
E0326	A	Urinal female jug-type .....	.....	.....	.....	.....	.....
E0350	A	Control unit bowel system .....	.....	.....	.....	.....	.....
E0352	A	Disposable pack w/bowel syst .....	.....	.....	.....	.....	.....
E0370	A	Air elevator for heel .....	.....	.....	.....	.....	.....
E0371	A	Nonpower mattress overlay .....	.....	.....	.....	.....	.....
E0372	A	Powered air mattress overlay .....	.....	.....	.....	.....	.....
E0373	A	Nonpowered pressure mattress .....	.....	.....	.....	.....	.....
E0424	A	Stationary compressed gas O2 .....	.....	.....	.....	.....	.....
E0425	A	Gas system stationary compre .....	.....	.....	.....	.....	.....
E0430	A	Oxygen system gas portable .....	.....	.....	.....	.....	.....
E0431	A	Portable gaseous O2 .....	.....	.....	.....	.....	.....
E0434	A	Portable liquid O2 .....	.....	.....	.....	.....	.....
E0435	A	Oxygen system liquid portabl .....	.....	.....	.....	.....	.....
E0439	A	Stationary liquid O2 .....	.....	.....	.....	.....	.....
E0440	A	Oxygen system liquid station .....	.....	.....	.....	.....	.....
E0441	A	Oxygen contents gas per/unit .....	.....	.....	.....	.....	.....
E0442	A	Oxygen contents liq per/unit .....	.....	.....	.....	.....	.....
E0443	A	Port O2 contents gas/unit .....	.....	.....	.....	.....	.....
E0444	A	Port O2 contents liq/unit .....	.....	.....	.....	.....	.....
E0450	A	Volume vent stationary/porta .....	.....	.....	.....	.....	.....
E0452	A	Intermit assis device w cpap					
E0453	A	Ventilator 12 hrs/less per d					
E0455	A	Oxygen tent excl croup/ped t					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E0457	A	Chest shell .....	.....	.....	.....	.....	.....
E0459	A	Chest wrap .....	.....	.....	.....	.....	.....
E0460	A	Neg press vent portabl/statn .....	.....	.....	.....	.....	.....
E0462	A	Rocking bed w/ or w/o side r .....	.....	.....	.....	.....	.....
E0480	A	Percussor elect/pneum home m .....	.....	.....	.....	.....	.....
E0500	A	Ippb all types .....	.....	.....	.....	.....	.....
E0550	A	Humidif extens suppl w ippb .....	.....	.....	.....	.....	.....
E0555	A	Humidifier for use w/ regula .....	.....	.....	.....	.....	.....
E0560	A	Humidifier supplemental w/ i .....	.....	.....	.....	.....	.....
E0565	A	Compressor air power source .....	.....	.....	.....	.....	.....
E0570	A	Nebulizer with compression .....	.....	.....	.....	.....	.....
E0575	A	Nebulizer ultrasonic .....	.....	.....	.....	.....	.....
E0580	A	Nebulizer for use w/ regulat .....	.....	.....	.....	.....	.....
E0585	A	Nebulizer w/ compressor & he .....	.....	.....	.....	.....	.....
E0600	A	Suction pump portab hom modl .....	.....	.....	.....	.....	.....
E0601	A	Cont airway pressure device .....	.....	.....	.....	.....	.....
E0605	A	Vaporizer room type .....	.....	.....	.....	.....	.....
E0606	A	Drainage board postural .....	.....	.....	.....	.....	.....
E0607	A	Blood glucose monitor home .....	.....	.....	.....	.....	.....
E0608	A	Apnea monitor .....	.....	.....	.....	.....	.....
E0609	A	Blood gluc mon w/special fea .....	.....	.....	.....	.....	.....
E0610	A	Pacemaker monitr audible/vis .....	.....	.....	.....	.....	.....
E0615	A	Pacemaker monitr digital/vis .....	.....	.....	.....	.....	.....
E0621	A	Patient lift sling or seat .....	.....	.....	.....	.....	.....
E0625	A	Patient lift bathroom or toi .....	.....	.....	.....	.....	.....
E0627	A	Seat lift incorp lift-chair .....	.....	.....	.....	.....	.....
E0628	A	Seat lift for pt furn-electr .....	.....	.....	.....	.....	.....
E0629	A	Seat lift for pt furn-non-el .....	.....	.....	.....	.....	.....
E0630	A	Patient lift hydraulic .....	.....	.....	.....	.....	.....
E0635	A	Patient lift electric .....	.....	.....	.....	.....	.....
E0650	A	Pneuma compresor non-segment .....	.....	.....	.....	.....	.....
E0651	A	Pneum compressor segmental .....	.....	.....	.....	.....	.....
E0652	A	Pneum compres w/cal pressure .....	.....	.....	.....	.....	.....
E0655	A	Pneumatic appliance half arm .....	.....	.....	.....	.....	.....
E0660	A	Pneumatic appliance full leg .....	.....	.....	.....	.....	.....
E0665	A	Pneumatic appliance full arm .....	.....	.....	.....	.....	.....
E0666	A	Pneumatic appliance half leg .....	.....	.....	.....	.....	.....
E0667	A	Seg pneumatic appl full leg .....	.....	.....	.....	.....	.....
E0668	A	Seg pneumatic appl full arm .....	.....	.....	.....	.....	.....
E0669	A	Seg pneumatic appli half leg .....	.....	.....	.....	.....	.....
E0671	A	Pressure pneum appl full leg .....	.....	.....	.....	.....	.....
E0672	A	Pressure pneum appl full arm .....	.....	.....	.....	.....	.....
E0673	A	Pressure pneum appl half leg .....	.....	.....	.....	.....	.....
E0690	A	Ultraviolet cabinet .....	.....	.....	.....	.....	.....
E0700	A	Safety equipment .....	.....	.....	.....	.....	.....
E0710	A	Restraints any type .....	.....	.....	.....	.....	.....
E0720	A	Tens two lead .....	.....	.....	.....	.....	.....
E0730	A	Tens four lead .....	.....	.....	.....	.....	.....
E0731	A	Conductive garment for tens/ .....	.....	.....	.....	.....	.....
E0740	A	Incontinence treatment systm .....	.....	.....	.....	.....	.....
E0744	A	Neuromuscular stim for scoli .....	.....	.....	.....	.....	.....
E0745	A	Neuromuscular stim for shock .....	.....	.....	.....	.....	.....
E0746	A	Electromyograph biofeedback .....	.....	.....	.....	.....	.....
E0747	A	Elec osteogen stim not spine .....	.....	.....	.....	.....	.....
E0748	A	Elec osteogen stim spinal .....	.....	.....	.....	.....	.....
E0749	A	Elec osteogen stim implanted .....	.....	.....	.....	.....	.....
E0751	A	Pulse generator or receiver .....	.....	.....	.....	.....	.....
E0753	A	Neurostimul electrodes/leads .....	.....	.....	.....	.....	.....
E0755	A	Electronic salivary reflex s .....	.....	.....	.....	.....	.....
E0760	A	Osteogen ultrasound stimltor .....	.....	.....	.....	.....	.....
E0776	A	Iv pole .....	.....	.....	.....	.....	.....
E0781	A	External ambulatory infus pu .....	.....	.....	.....	.....	.....
E0782	A	Non-programable infusion pump .....	.....	.....	.....	.....	.....
E0783	A	Programmable infusion pump .....	.....	.....	.....	.....	.....
E0784	A	Ext amb infusn pump insulin .....	.....	.....	.....	.....	.....
E0791	A	Parenteral infusion pump sta .....	.....	.....	.....	.....	.....
E0840	A	Tract frame attach headboard .....	.....	.....	.....	.....	.....
E0850	A	Traction stand free standing .....	.....	.....	.....	.....	.....
E0855	A	Cervical traction equipment .....	.....	.....	.....	.....	.....
E0860	A	Tract equip cervical tract .....	.....	.....	.....	.....	.....
E0870	A	Tract frame attach footboard .....	.....	.....	.....	.....	.....
E0880	A	Trac stand free stand extrem .....	.....	.....	.....	.....	.....
E0890	A	Traction frame attach pelvic					
E0900	A	Trac stand free stand pelvic					
E0910	A	Trapeze bar attached to bed					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E0920	A	Fracture frame attached to b .....	.....	.....	.....	.....	.....
E0930	A	Fracture frame free standing .....	.....	.....	.....	.....	.....
E0935	A	Exercise device passive moti .....	.....	.....	.....	.....	.....
E0940	A	Trapeze bar free standing .....	.....	.....	.....	.....	.....
E0941	A	Gravity assisted traction de .....	.....	.....	.....	.....	.....
E0942	A	Cervical head harness/halter .....	.....	.....	.....	.....	.....
E0943	A	Cervical pillow .....	.....	.....	.....	.....	.....
E0944	A	Pelvic belt/harness/boot .....	.....	.....	.....	.....	.....
E0945	A	Belt/harness extremity .....	.....	.....	.....	.....	.....
E0946	A	Fracture frame dual w cross .....	.....	.....	.....	.....	.....
E0947	A	Fracture frame attachmnts pe .....	.....	.....	.....	.....	.....
E0948	A	Fracture frame attachmnts ce .....	.....	.....	.....	.....	.....
E0950	A	Tray .....	.....	.....	.....	.....	.....
E0951	A	Loop heel .....	.....	.....	.....	.....	.....
E0952	A	Loop tie .....	.....	.....	.....	.....	.....
E0953	A	Pneumatic tire .....	.....	.....	.....	.....	.....
E0954	A	Wheelchair semi-pneumatic ca .....	.....	.....	.....	.....	.....
E0958	A	Whlchr att-conv 1 arm drive .....	.....	.....	.....	.....	.....
E0959	A	Amputee adapter .....	.....	.....	.....	.....	.....
E0961	A	Wheelchair brake extension .....	.....	.....	.....	.....	.....
E0962	A	Wheelchair 1 inch cushion .....	.....	.....	.....	.....	.....
E0963	A	Wheelchair 2 inch cushion .....	.....	.....	.....	.....	.....
E0964	A	Wheelchair 3 inch cushion .....	.....	.....	.....	.....	.....
E0965	A	Wheelchair 4 inch cushion .....	.....	.....	.....	.....	.....
E0966	A	Wheelchair head rest extensi .....	.....	.....	.....	.....	.....
E0967	A	Wheelchair hand rims .....	.....	.....	.....	.....	.....
E0968	A	Wheelchair commode seat .....	.....	.....	.....	.....	.....
E0969	A	Wheelchair narrowing device .....	.....	.....	.....	.....	.....
E0970	A	Wheelchair no. 2 footplates .....	.....	.....	.....	.....	.....
E0971	A	Wheelchair anti-tipping devi .....	.....	.....	.....	.....	.....
E0972	A	Transfer board or device .....	.....	.....	.....	.....	.....
E0973	A	Wheelchair adjustabl height .....	.....	.....	.....	.....	.....
E0974	A	Wheelchair grade-aid .....	.....	.....	.....	.....	.....
E0975	A	Wheelchair reinforced seat u .....	.....	.....	.....	.....	.....
E0976	A	Wheelchair reinforced back u .....	.....	.....	.....	.....	.....
E0977	A	Wheelchair wedge cushion .....	.....	.....	.....	.....	.....
E0978	A	Wheelchair belt w/airplane b .....	.....	.....	.....	.....	.....
E0979	A	Wheelchair belt with velcro .....	.....	.....	.....	.....	.....
E0980	A	Wheelchair safety vest .....	.....	.....	.....	.....	.....
E0990	A	Whelchair elevating leg res .....	.....	.....	.....	.....	.....
E0991	A	Wheelchair upholstery seat .....	.....	.....	.....	.....	.....
E0992	A	Wheelchair solid seat insert .....	.....	.....	.....	.....	.....
E0993	A	Wheelchair back upholstery .....	.....	.....	.....	.....	.....
E0994	A	Wheelchair arm rest .....	.....	.....	.....	.....	.....
E0995	A	Wheelchair calf rest .....	.....	.....	.....	.....	.....
E0996	A	Wheelchair tire solid .....	.....	.....	.....	.....	.....
E0997	A	Wheelchair caster w/ a fork .....	.....	.....	.....	.....	.....
E0998	A	Wheelchair caster w/o a fork .....	.....	.....	.....	.....	.....
E0999	A	Wheelchr pneumatic tire w/wh .....	.....	.....	.....	.....	.....
E1000	A	Wheelchair tire pneumatic ca .....	.....	.....	.....	.....	.....
E1001	A	Wheelchair wheel .....	.....	.....	.....	.....	.....
E1031	A	Rollabout chair with casters .....	.....	.....	.....	.....	.....
E1050	A	Whelchr fxd full length arms .....	.....	.....	.....	.....	.....
E1060	A	Wheelchair detachable arms .....	.....	.....	.....	.....	.....
E1065	A	Wheelchair power attachment .....	.....	.....	.....	.....	.....
E1066	A	Wheelchair battery charger .....	.....	.....	.....	.....	.....
E1069	A	Wheelchair deep cycle batter .....	.....	.....	.....	.....	.....
E1070	A	Wheelchair detachable foot r .....	.....	.....	.....	.....	.....
E1083	A	Hemi-wheelchair fixed arms .....	.....	.....	.....	.....	.....
E1084	A	Hemi-wheelchair detachable a .....	.....	.....	.....	.....	.....
E1085	A	Hemi-wheelchair fixed arms .....	.....	.....	.....	.....	.....
E1086	A	Hemi-wheelchair detachable a .....	.....	.....	.....	.....	.....
E1087	A	Wheelchair lightwt fixed arm .....	.....	.....	.....	.....	.....
E1088	A	Wheelchair lightweight det a .....	.....	.....	.....	.....	.....
E1089	A	Wheelchair lightwt fixed arm .....	.....	.....	.....	.....	.....
E1090	A	Wheelchair lightweight det a .....	.....	.....	.....	.....	.....
E1091	A	Wheelchair youth .....	.....	.....	.....	.....	.....
E1092	A	Wheelchair wide w/ leg rests .....	.....	.....	.....	.....	.....
E1093	A	Wheelchair wide w/ foot rest .....	.....	.....	.....	.....	.....
E1100	A	Whchr s-recl fxd arm leg res .....	.....	.....	.....	.....	.....
E1110	A	Wheelchair semi-recl detach .....	.....	.....	.....	.....	.....
E1130	A	Whlchr stand fxd arm ft rest .....	.....	.....	.....	.....	.....
E1140	A	Wheelchair standard detach a					
E1150	A	Wheelchair standard w/ leg r					
E1160	A	Wheelchair fixed arms					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E1170	A	Whlchr ampu fxd arm leg rest .....	.....	.....	.....	.....	.....
E1171	A	Wheelchair amputee w/o leg r .....	.....	.....	.....	.....	.....
E1172	A	Wheelchair amputee detach ar .....	.....	.....	.....	.....	.....
E1180	A	Wheelchair amputee w/ foot r .....	.....	.....	.....	.....	.....
E1190	A	Wheelchair amputee w/ leg re .....	.....	.....	.....	.....	.....
E1195	A	Wheelchair amputee heavy dut .....	.....	.....	.....	.....	.....
E1200	A	Wheelchair amputee fixed arm .....	.....	.....	.....	.....	.....
E1210	A	Whlchr moto ful arm leg rest .....	.....	.....	.....	.....	.....
E1211	A	Wheelchair motorized w/ det .....	.....	.....	.....	.....	.....
E1212	A	Wheelchair motorized w full .....	.....	.....	.....	.....	.....
E1213	A	Wheelchair motorized w/ det .....	.....	.....	.....	.....	.....
E1220	A	Whlchr special size/constrc .....	.....	.....	.....	.....	.....
E1221	A	Wheelchair spec size w foot .....	.....	.....	.....	.....	.....
E1222	A	Wheelchair spec size w/ leg .....	.....	.....	.....	.....	.....
E1223	A	Wheelchair spec size w foot .....	.....	.....	.....	.....	.....
E1224	A	Wheelchair spec size w/ leg .....	.....	.....	.....	.....	.....
E1225	A	Wheelchair spec sz semi-recl .....	.....	.....	.....	.....	.....
E1226	A	Wheelchair spec sz full-recl .....	.....	.....	.....	.....	.....
E1227	A	Wheelchair spec sz spec ht a .....	.....	.....	.....	.....	.....
E1228	A	Wheelchair spec sz spec ht b .....	.....	.....	.....	.....	.....
E1230	A	Power operated vehicle .....	.....	.....	.....	.....	.....
E1240	A	Whlchr litwt det arm leg rest .....	.....	.....	.....	.....	.....
E1250	A	Wheelchair lightwt fixed arm .....	.....	.....	.....	.....	.....
E1260	A	Wheelchair lightwt foot rest .....	.....	.....	.....	.....	.....
E1270	A	Wheelchair lightweight leg r .....	.....	.....	.....	.....	.....
E1280	A	Whlchr h-duty det arm leg res .....	.....	.....	.....	.....	.....
E1285	A	Wheelchair heavy duty fixed .....	.....	.....	.....	.....	.....
E1290	A	Wheelchair hvy duty detach a .....	.....	.....	.....	.....	.....
E1295	A	Wheelchair heavy duty fixed .....	.....	.....	.....	.....	.....
E1296	A	Wheelchair special seat heig .....	.....	.....	.....	.....	.....
E1297	A	Wheelchair special seat dept .....	.....	.....	.....	.....	.....
E1298	A	Wheelchair spec seat depth/w .....	.....	.....	.....	.....	.....
E1300	A	Whirlpool portable .....	.....	.....	.....	.....	.....
E1310	A	Whirlpool non-portable .....	.....	.....	.....	.....	.....
E1340	A	Repair for DME, per 15 min .....	.....	.....	.....	.....	.....
E1353	A	Oxygen supplies regulator .....	.....	.....	.....	.....	.....
E1355	A	Oxygen supplies stand/rack .....	.....	.....	.....	.....	.....
E1372	A	Oxy suppl heater for nebuliz .....	.....	.....	.....	.....	.....
E1375	A	Oxygen suppl nebulizer porta .....	.....	.....	.....	.....	.....
E1377	A	Oxygen concentrator to 244 c .....	.....	.....	.....	.....	.....
E1378	A	Oxygen concentrator to 488 c .....	.....	.....	.....	.....	.....
E1379	A	Oxygen concentrator to 732 c .....	.....	.....	.....	.....	.....
E1380	A	Oxygen concentrator to 976 c .....	.....	.....	.....	.....	.....
E1381	A	Oxygen concentrat to 1220 cu .....	.....	.....	.....	.....	.....
E1382	A	Oxygen concentrat to 1464 cu .....	.....	.....	.....	.....	.....
E1383	A	Oxygen concentrat to 1708 cu .....	.....	.....	.....	.....	.....
E1384	A	Oxygen concentrat to 1952 cu .....	.....	.....	.....	.....	.....
E1385	A	Oxygen concentrator > 1952 c .....	.....	.....	.....	.....	.....
E1399	A	Durable medical equipment mi .....	.....	.....	.....	.....	.....
E1400	A	Oxygen concentrator < 2 lite .....	.....	.....	.....	.....	.....
E1401	A	Oxygen concentrator 2-3 lite .....	.....	.....	.....	.....	.....
E1402	A	Oxygen concentrator 3-4 lite .....	.....	.....	.....	.....	.....
E1403	A	Oxygen concentrator 4-5 lite .....	.....	.....	.....	.....	.....
E1404	A	Oxygen concentrator > 5 lite .....	.....	.....	.....	.....	.....
E1405	A	O2/water vapor enrich w/heat .....	.....	.....	.....	.....	.....
E1406	A	O2/water vapor enrich w/o he .....	.....	.....	.....	.....	.....
E1510	A	Kidney dialysate delivry sys .....	.....	.....	.....	.....	.....
E1520	A	Heparin infusion pump for di .....	.....	.....	.....	.....	.....
E1530	A	Air bubble detector for dial .....	.....	.....	.....	.....	.....
E1540	A	Pressure alarm for dialysis .....	.....	.....	.....	.....	.....
E1550	A	Bath conductivity meter .....	.....	.....	.....	.....	.....
E1560	A	Blood leak detector for dial .....	.....	.....	.....	.....	.....
E1570	A	Adjustable chair for esrd pt .....	.....	.....	.....	.....	.....
E1575	A	Transducer protector/fluid b .....	.....	.....	.....	.....	.....
E1580	A	Unipuncture control system .....	.....	.....	.....	.....	.....
E1590	A	Hemodialysis machine .....	.....	.....	.....	.....	.....
E1592	A	Auto interm peritoneal dialy .....	.....	.....	.....	.....	.....
E1594	A	Cycler dialysis machine .....	.....	.....	.....	.....	.....
E1600	A	Deliv/install equip for dial .....	.....	.....	.....	.....	.....
E1610	A	Reverse osmosis water purifi .....	.....	.....	.....	.....	.....
E1615	A	Deionizer water purification .....	.....	.....	.....	.....	.....
E1620	A	Blood pump for dialysis .....	.....	.....	.....	.....	.....
E1625	A	Water softening system .....	.....	.....	.....	.....	.....
E1630	A	Reciprocating peritoneal dia					
E1632	A	Wearable artificial kidney					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E1635	A	Compact travel hemodialyzer .....	.....	.....	.....	.....	.....
E1636	A	Sorbent cartridges for dialy .....	.....	.....	.....	.....	.....
E1640	A	Replacement components for d .....	.....	.....	.....	.....	.....
E1699	A	Dialysis equipment unspecifi .....	.....	.....	.....	.....	.....
E1700	A	Jaw motion rehab system .....	.....	.....	.....	.....	.....
E1701	A	Repl cushions for jaw motion .....	.....	.....	.....	.....	.....
E1702	A	Repl measr scales jaw motion .....	.....	.....	.....	.....	.....
E1800	A	Adjust elbow ext/flex device .....	.....	.....	.....	.....	.....
E1805	A	Adjust wrist ext/flex device .....	.....	.....	.....	.....	.....
E1810	A	Adjust knee ext/flex device .....	.....	.....	.....	.....	.....
E1815	A	Adjust ankle ext/flex device .....	.....	.....	.....	.....	.....
E1820	A	Soft interface material .....	.....	.....	.....	.....	.....
E1825	A	Adjust finger ext/flex devc .....	.....	.....	.....	.....	.....
E1830	A	Adjust toe ext/flex device .....	.....	.....	.....	.....	.....
G0001	N	Drawing blood for specimen .....	.....	.....	.....	.....	.....
G0002	N	Temporary urinary catheter .....	.....	.....	.....	.....	.....
G0004	X	ECG transm phys review & int	956	1.11	\$58.77	\$55.82	\$11.75
G0005	X	ECG 24 hour recording	956	1.11	\$58.77	\$55.82	\$11.75
G0006	X	ECG transmission & analysis	956	1.11	\$58.77	\$55.82	\$11.75
G0007	N	ECG phy review & interpret .....	.....	.....	.....	.....	.....
G0008	X	Admin influenza virus vac	901	0.07	\$3.92	\$2.49	\$0.78
G0009	X	Admin pneumococcal vaccine	901	0.07	\$3.92	\$2.49	\$0.78
G0010	X	Admin hepatitis b vaccine	902	1.78	\$94.03	\$41.58	\$18.81
G0015	X	Post symptom ECG tracing	956	1.11	\$58.77	\$55.82	\$11.75
G0016	N	Post symptom ECG md review .....	.....	.....	.....	.....	.....
G0025	X	Collagen skin test kit	881	0.20	\$10.77	\$6.78	\$2.15
G0026	A	Fecal leukocyte examination .....	.....	.....	.....	.....	.....
G0027	A	Semen analysis .....	.....	.....	.....	.....	.....
G0030	S	PET imaging prev PET single	760	17.91	\$947.13	\$419.46	\$189.43
G0031	S	PET imaging prev PET multiple	760	17.91	\$947.13	\$419.46	\$189.43
G0032	S	PET follow SPECT 78464 singl	760	17.91	\$947.13	\$419.46	\$189.43
G0033	S	PET follow SPECT 78464 mult	760	17.91	\$947.13	\$419.46	\$189.43
G0034	S	PET follow SPECT 76865 singl	760	17.91	\$947.13	\$419.46	\$189.43
G0035	S	PET follow SPECT 78465 mult	760	17.91	\$947.13	\$419.46	\$189.43
G0036	S	PET follow cornry angio sing	760	17.91	\$947.13	\$419.46	\$189.43
G0037	S	PET follow cornry angio mult	760	17.91	\$947.13	\$419.46	\$189.43
G0038	S	PET follow myocard perf sing	760	17.91	\$947.13	\$419.46	\$189.43
G0039	S	PET follow myocard perf mult	760	17.91	\$947.13	\$419.46	\$189.43
G0040	S	PET follow stress echo singl	760	17.91	\$947.13	\$419.46	\$189.43
G0041	S	PET follow stress echo mult	760	17.91	\$947.13	\$419.46	\$189.43
G0042	S	PET follow ventriculogm sing	760	17.91	\$947.13	\$419.46	\$189.43
G0043	S	PET follow ventriculogm mult	760	17.91	\$947.13	\$419.46	\$189.43
G0044	S	PET following rest ECG singl	760	17.91	\$947.13	\$419.46	\$189.43
G0045	S	PET following rest ECG mult	760	17.91	\$947.13	\$419.46	\$189.43
G0046	S	PET follow stress ECG singl	760	17.91	\$947.13	\$419.46	\$189.43
G0047	S	PET follow stress ECG mult	760	17.91	\$947.13	\$419.46	\$189.43
G0050	S	Residual urine by ultrasound	747	1.65	\$87.17	\$54.69	\$17.43
G0101	V	CA screen;pelvic/breast exam	913	.....	.....	.....	.....
G0104	T	CA screen;flexi sigmoidscope	446	2.59	\$137.12	\$65.09	\$27.42
G0105	T	Colorectal scrn; hi risk ind	426	6.85	\$362.40	\$187.81	\$72.48
G0106	S	Colon CA screen;barium enema	736	1.85	\$97.95	\$54.24	\$19.59
G0107	A	CA screen; fecal blood test .....	.....	.....	.....	.....	.....
G0110	A	Nett pulm-rehab educ; ind .....	.....	.....	.....	.....	.....
G0111	A	Nett pulm-rehab educ; group .....	.....	.....	.....	.....	.....
G0112	A	Nett;nutrition guid, initial .....	.....	.....	.....	.....	.....
G0113	A	Nett;nutrition guid,subseqnt .....	.....	.....	.....	.....	.....
G0114	A	Nett; psychosocial consult .....	.....	.....	.....	.....	.....
G0115	A	Nett; psychological testing .....	.....	.....	.....	.....	.....
G0116	A	Nett; psychosocial counsel .....	.....	.....	.....	.....	.....
G0120	S	Colon ca scrn; barium enema	736	1.85	\$97.95	\$54.24	\$19.59
G0121	E	Colon ca scrn; barium enema .....	.....	.....	.....	.....	.....
G0122	E	Colon ca scrn; barium enema .....	.....	.....	.....	.....	.....
J0120	N	Tetracyclin injection .....	.....	.....	.....	.....	.....
J0150	N	Injection adenosine 6 MG .....	.....	.....	.....	.....	.....
J0170	N	Adrenalin epinephrin inject .....	.....	.....	.....	.....	.....
J0190	N	Inj biperiden lactate/5 mg .....	.....	.....	.....	.....	.....
J0205	N	Alglucerase injection .....	.....	.....	.....	.....	.....
J0207	N	Amifostine .....	.....	.....	.....	.....	.....
J0210	N	Methyldopate hcl injection .....	.....	.....	.....	.....	.....
J0256	N	Alpha 1-proteinase 500 MG .....	.....	.....	.....	.....	.....
J0270	E	Alprostadil for injection .....	.....	.....	.....	.....	.....
J0280	N	Aminophyllin 250 MG inj .....	.....	.....	.....	.....	.....
J0290	N	Ampicillin 500 MG inj					
J0295	N	Ampicillin sodium per 1.5 gm					
J0300	N	Amobarbital 125 MG inj					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J0330	N	Succinylcholine chloride inj .....	.....	.....	.....	.....	.....
J0340	N	Nandrolon phenpropionate inj .....	.....	.....	.....	.....	.....
J0350	N	Injection anistreplase 30 u .....	.....	.....	.....	.....	.....
J0360	N	Hydralazine hcl injection .....	.....	.....	.....	.....	.....
J0380	N	Inj metaraminol bitartrate .....	.....	.....	.....	.....	.....
J0390	N	Chloroquine injection .....	.....	.....	.....	.....	.....
J0400	N	Inj trimethaphan camsylate .....	.....	.....	.....	.....	.....
J0460	N	Atropine sulfate injection .....	.....	.....	.....	.....	.....
J0470	N	Dimecaprol injection .....	.....	.....	.....	.....	.....
J0475	N	Baclofen 10 MG injection .....	.....	.....	.....	.....	.....
J0500	N	Dicyclomine injection .....	.....	.....	.....	.....	.....
J0510	N	Benzquinamide injection .....	.....	.....	.....	.....	.....
J0515	N	Inj benztropine mesylate .....	.....	.....	.....	.....	.....
J0520	N	Bethanechol chloride inject .....	.....	.....	.....	.....	.....
J0530	N	Penicillin g benzathine inj .....	.....	.....	.....	.....	.....
J0540	N	Penicillin g benzathine inj .....	.....	.....	.....	.....	.....
J0550	N	Penicillin g benzathine inj .....	.....	.....	.....	.....	.....
J0560	N	Penicillin g benzathine inj .....	.....	.....	.....	.....	.....
J0570	N	Penicillin g benzathine inj .....	.....	.....	.....	.....	.....
J0580	N	Penicillin g benzathine inj .....	.....	.....	.....	.....	.....
J0585	N	Botulinum toxin a per unit .....	.....	.....	.....	.....	.....
J0590	N	Ethylnorepinephrine hcl inj .....	.....	.....	.....	.....	.....
J0600	N	Edetate calcium disodium inj .....	.....	.....	.....	.....	.....
J0610	N	Calcium gluconate injection .....	.....	.....	.....	.....	.....
J0620	N	Calcium glycer & lact/10 ML .....	.....	.....	.....	.....	.....
J0630	N	Calcitonin salmon injection .....	.....	.....	.....	.....	.....
J0635	N	Calcitriol injection .....	.....	.....	.....	.....	.....
J0640	X	Leucovorin calcium injection	064	4.17	\$220.38	\$140.12	\$44.08
J0670	N	Inj mepivacaine HCL/10 ml .....	.....	.....	.....	.....	.....
J0690	N	Cefazolin sodium injection .....	.....	.....	.....	.....	.....
J0694	N	Cefoxitin sodium injection .....	.....	.....	.....	.....	.....
J0695	N	Cefonocid sodium injection .....	.....	.....	.....	.....	.....
J0696	N	Ceftriaxone sodium injection .....	.....	.....	.....	.....	.....
J0697	N	Sterile cefuroxime injection .....	.....	.....	.....	.....	.....
J0698	N	Cefotaxime sodium injection .....	.....	.....	.....	.....	.....
J0702	N	Betamethasone acet&sod phosp .....	.....	.....	.....	.....	.....
J0704	N	Betamethasone sod phosp/4 MG .....	.....	.....	.....	.....	.....
J0710	N	Cephapirin sodium injection .....	.....	.....	.....	.....	.....
J0713	N	Inj ceftazidime per 500 mg .....	.....	.....	.....	.....	.....
J0715	N	Ceftizoxime sodium / 500 MG .....	.....	.....	.....	.....	.....
J0720	N	Chloramphenicol sodium injec .....	.....	.....	.....	.....	.....
J0725	N	Chorionic gonadotropin/1000u .....	.....	.....	.....	.....	.....
J0730	N	Chlorpheniramin maleate inj .....	.....	.....	.....	.....	.....
J0735	N	Clonidine hydrochloride .....	.....	.....	.....	.....	.....
J0740	N	Cidofovir injection .....	.....	.....	.....	.....	.....
J0743	N	Cilastatin sodium injection .....	.....	.....	.....	.....	.....
J0745	N	Inj codeine phosphate /30 MG .....	.....	.....	.....	.....	.....
J0760	N	Colchicine injection .....	.....	.....	.....	.....	.....
J0770	N	Colistimethate sodium inj .....	.....	.....	.....	.....	.....
J0780	N	Prochlorperazine injection .....	.....	.....	.....	.....	.....
J0800	N	Corticotropin injection .....	.....	.....	.....	.....	.....
J0810	N	Cortisone injection .....	.....	.....	.....	.....	.....
J0835	N	Inj cosyntropin per 0.25 MG .....	.....	.....	.....	.....	.....
J0850	N	Cytomegalovirus imm IV /vial .....	.....	.....	.....	.....	.....
J0895	N	Deferoxamine mesylate inj .....	.....	.....	.....	.....	.....
J0900	N	Testosterone enanthate inj .....	.....	.....	.....	.....	.....
J0945	N	Brompheniramine maleate inj .....	.....	.....	.....	.....	.....
J0970	N	Estradiol valerate injection .....	.....	.....	.....	.....	.....
J1000	N	Depo-estradiol cypionate inj .....	.....	.....	.....	.....	.....
J1020	N	Methylprednisolone 20 MG inj .....	.....	.....	.....	.....	.....
J1030	N	Methylprednisolone 40 MG inj .....	.....	.....	.....	.....	.....
J1040	N	Methylprednisolone 80 MG inj .....	.....	.....	.....	.....	.....
J1050	N	Medroxyprogesterone inj .....	.....	.....	.....	.....	.....
J1055	E	Medrxyprogester acetate inj .....	.....	.....	.....	.....	.....
J1060	N	Testosterone cypionate 1 ML .....	.....	.....	.....	.....	.....
J1070	N	Testosterone cypionat 100 MG .....	.....	.....	.....	.....	.....
J1080	N	Testosterone cypionat 200 MG .....	.....	.....	.....	.....	.....
J1090	N	Testosterone cypionate 50 MG .....	.....	.....	.....	.....	.....
J1095	N	Inj dexamethasone acetate .....	.....	.....	.....	.....	.....
J1100	N	Dexamethasone sodium phos .....	.....	.....	.....	.....	.....
J1110	N	Inj dihydroergotamine mesylt .....	.....	.....	.....	.....	.....
J1120	N	Acetazolamid sodium injectio .....	.....	.....	.....	.....	.....
J1160	N	Digoxin injection					
J1165	N	Phenytoin sodium injection					
J1170	N	Hydromorphone injection					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J1180	N	Dyphylline injection .....	.....	.....	.....	.....	.....
J1190	N	Dexrazoxane HCl injection .....	.....	.....	.....	.....	.....
J1200	N	Diphenhydramine hcl injectio .....	.....	.....	.....	.....	.....
J1205	N	Chlorothiazide sodium inj .....	.....	.....	.....	.....	.....
J1212	N	Dimethyl sulfoxide 50% 50 ML .....	.....	.....	.....	.....	.....
J1230	N	Methadone injection .....	.....	.....	.....	.....	.....
J1240	N	Dimenhydrinate injection .....	.....	.....	.....	.....	.....
J1245	N	Dipyridamole injection .....	.....	.....	.....	.....	.....
J1250	N	Inj dobutamine HCL/250 mg .....	.....	.....	.....	.....	.....
J1320	N	Amitriptyline injection .....	.....	.....	.....	.....	.....
J1325	N	Epoprostenol injection .....	.....	.....	.....	.....	.....
J1330	N	Ergonovine maleate injection .....	.....	.....	.....	.....	.....
J1362	N	Erythromycin glucep / 250 MG .....	.....	.....	.....	.....	.....
J1364	N	Erythro lactobionate /500 MG .....	.....	.....	.....	.....	.....
J1380	N	Estradiol valerate 10 MG inj .....	.....	.....	.....	.....	.....
J1390	N	Estradiol valerate 20 MG inj .....	.....	.....	.....	.....	.....
J1410	N	Inj estrogen conjugate 25 MG .....	.....	.....	.....	.....	.....
J1435	N	Injection estrone per 1 MG .....	.....	.....	.....	.....	.....
J1436	N	Etidronate disodium inj .....	.....	.....	.....	.....	.....
J1440	N	Filgrastim 300 mcg injecton .....	.....	.....	.....	.....	.....
J1441	N	Filgrastim 480 mcg injection .....	.....	.....	.....	.....	.....
J1455	N	Foscarnet sodium injection .....	.....	.....	.....	.....	.....
J1460	N	Gamma globulin 1 CC inj .....	.....	.....	.....	.....	.....
J1470	N	Gamma globulin 2 CC inj .....	.....	.....	.....	.....	.....
J1480	N	Gamma globulin 3 CC inj .....	.....	.....	.....	.....	.....
J1490	N	Gamma globulin 4 CC inj .....	.....	.....	.....	.....	.....
J1500	N	Gamma globulin 5 CC inj .....	.....	.....	.....	.....	.....
J1510	N	Gamma globulin 6 CC inj .....	.....	.....	.....	.....	.....
J1520	N	Gamma globulin 7 CC inj .....	.....	.....	.....	.....	.....
J1530	N	Gamma globulin 8 CC inj .....	.....	.....	.....	.....	.....
J1540	N	Gamma globulin 9 CC inj .....	.....	.....	.....	.....	.....
J1550	N	Gamma globulin 10 CC inj .....	.....	.....	.....	.....	.....
J1560	N	Gamma globulin > 10 CC inj .....	.....	.....	.....	.....	.....
J1561	N	Immune globulin 500 mg .....	.....	.....	.....	.....	.....
J1562	N	Immune globulin 5 gms .....	.....	.....	.....	.....	.....
J1565	N	RSV-ivig .....	.....	.....	.....	.....	.....
J1570	N	Ganciclovir sodium injection .....	.....	.....	.....	.....	.....
J1580	N	Garamycin gentamicin inj .....	.....	.....	.....	.....	.....
J1600	N	Gold sodium thiomaleate inj .....	.....	.....	.....	.....	.....
J1610	N	Glucagon hydrochloride/1 MG .....	.....	.....	.....	.....	.....
J1620	N	Gonadorelin hydroch/ 100 mcg .....	.....	.....	.....	.....	.....
J1626	N	Granisetron HCl injection .....	.....	.....	.....	.....	.....
J1630	N	Haloperidol injection .....	.....	.....	.....	.....	.....
J1631	N	Haloperidol decanoate inj .....	.....	.....	.....	.....	.....
J1642	N	Inj heparin sodium per 10 u .....	.....	.....	.....	.....	.....
J1644	N	Inj heparin sodium per 1000u .....	.....	.....	.....	.....	.....
J1645	N	Dalteparin sodium .....	.....	.....	.....	.....	.....
J1650	N	Inj enoxaparin sodium 30 mg .....	.....	.....	.....	.....	.....
J1670	N	Tetanus immune globulin inj .....	.....	.....	.....	.....	.....
J1690	N	Prednisolone tebutate inj .....	.....	.....	.....	.....	.....
J1700	N	Hydrocortisone acetate inj .....	.....	.....	.....	.....	.....
J1710	N	Hydrocortisone sodium ph inj .....	.....	.....	.....	.....	.....
J1720	N	Hydrocortisone sodium succ i .....	.....	.....	.....	.....	.....
J1730	N	Diazoxide injection .....	.....	.....	.....	.....	.....
J1739	N	Hydroxyprogesterone cap 125 .....	.....	.....	.....	.....	.....
J1741	N	Hydroxyprogesterone cap 250 .....	.....	.....	.....	.....	.....
J1742	N	Ibutilide fumarate injection .....	.....	.....	.....	.....	.....
J1760	N	Iron dextran 2 CC inj .....	.....	.....	.....	.....	.....
J1770	N	Iron dextran 5 CC inj .....	.....	.....	.....	.....	.....
J1780	N	Iron dextran 10 CC inj .....	.....	.....	.....	.....	.....
J1785	N	Injection imiglucerase /unit .....	.....	.....	.....	.....	.....
J1790	N	Droperidol injection .....	.....	.....	.....	.....	.....
J1800	N	Propranolol injection .....	.....	.....	.....	.....	.....
J1810	N	Droperidol/fentanyl inj .....	.....	.....	.....	.....	.....
J1820	N	Insulin injection .....	.....	.....	.....	.....	.....
J1825	N	Interferon beta-1a .....	.....	.....	.....	.....	.....
J1830	N	Interferon beta-1b / .25 MG .....	.....	.....	.....	.....	.....
J1840	N	Kanamycin sulfate 500 MG inj .....	.....	.....	.....	.....	.....
J1850	N	Kanamycin sulfate 75 MG inj .....	.....	.....	.....	.....	.....
J1885	N	Ketorolac tromethamine inj .....	.....	.....	.....	.....	.....
J1890	N	Cephalothin sodium injection .....	.....	.....	.....	.....	.....
J1910	N	Kutapressin injection .....	.....	.....	.....	.....	.....
J1930	N	Propiomazine injection .....	.....	.....	.....	.....	.....
J1940	N	Furosemide injection					
J1950	X	Leuprolide acetate /3.75 MG	064	4.17	\$220.38	\$140.12	\$44.08

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J1955	N	Inj levocarnitine per 1 gm .....	.....	.....	.....	.....	.....
J1960	N	Levorphanol tartrate inj .....	.....	.....	.....	.....	.....
J1970	N	Methotrimeprazine injection .....	.....	.....	.....	.....	.....
J1980	N	Hyoscyamine sulfate inj .....	.....	.....	.....	.....	.....
J1990	N	Chlordiazepoxide injection .....	.....	.....	.....	.....	.....
J2000	N	Lidocaine injection .....	.....	.....	.....	.....	.....
J2010	N	Lincomycin injection .....	.....	.....	.....	.....	.....
J2060	N	Lorazepam injection .....	.....	.....	.....	.....	.....
J2150	N	Mannitol injection .....	.....	.....	.....	.....	.....
J2175	N	Meperidine hydrochl /100 MG .....	.....	.....	.....	.....	.....
J2180	N	Meperidine/promethazine inj .....	.....	.....	.....	.....	.....
J2210	N	Methylergonovin maleate inj .....	.....	.....	.....	.....	.....
J2240	N	Metocurine iodide injection .....	.....	.....	.....	.....	.....
J2250	N	Inj midazolam hydrochloride .....	.....	.....	.....	.....	.....
J2260	N	Inj millirone lactate / 5 ML .....	.....	.....	.....	.....	.....
J2270	N	Morphine sulfate injection .....	.....	.....	.....	.....	.....
J2275	N	Morphine sulfate injection .....	.....	.....	.....	.....	.....
J2300	N	Inj nalbuphine hydrochloride .....	.....	.....	.....	.....	.....
J2310	N	Inj naloxone hydrochloride .....	.....	.....	.....	.....	.....
J2320	N	Nandrolone decanoate 50 MG .....	.....	.....	.....	.....	.....
J2321	N	Nandrolone decanoate 100 MG .....	.....	.....	.....	.....	.....
J2322	N	Nandrolone decanoate 200 MG .....	.....	.....	.....	.....	.....
J2330	N	Thiothixene injection .....	.....	.....	.....	.....	.....
J2350	N	Niacinamide/niacin injection .....	.....	.....	.....	.....	.....
J2360	N	Orphenadrine injection .....	.....	.....	.....	.....	.....
J2370	N	Phenylephrine hcl injection .....	.....	.....	.....	.....	.....
J2400	N	Chloroprocaine hcl injection .....	.....	.....	.....	.....	.....
J2405	N	Ondansetron hcl injection .....	.....	.....	.....	.....	.....
J2410	N	Oxymorphone hcl injection .....	.....	.....	.....	.....	.....
J2430	N	Pamidronate disodium /30 MG .....	.....	.....	.....	.....	.....
J2440	N	Papaverin hcl injection .....	.....	.....	.....	.....	.....
J2460	N	Oxytetracycline injection .....	.....	.....	.....	.....	.....
J2480	N	Hydrochlorides of opium inj .....	.....	.....	.....	.....	.....
J2510	N	Penicillin g procaine inj .....	.....	.....	.....	.....	.....
J2512	N	Inj pentagastrin per 2 ML .....	.....	.....	.....	.....	.....
J2515	N	Pentobarbital sodium inj .....	.....	.....	.....	.....	.....
J2540	N	Penicillin g potassium inj .....	.....	.....	.....	.....	.....
J2545	A	Pentamidine isethionte/300mg .....	.....	.....	.....	.....	.....
J2550	N	Promethazine hcl injection .....	.....	.....	.....	.....	.....
J2560	N	Phenobarbital sodium inj .....	.....	.....	.....	.....	.....
J2590	N	Oxytocin injection .....	.....	.....	.....	.....	.....
J2597	N	Inj desmopressin acetate .....	.....	.....	.....	.....	.....
J2640	N	Prednisolone sodium ph inj .....	.....	.....	.....	.....	.....
J2650	N	Prednisolone acetate inj .....	.....	.....	.....	.....	.....
J2670	N	Totazoline hcl injection .....	.....	.....	.....	.....	.....
J2675	N	Inj progesterone per 50 MG .....	.....	.....	.....	.....	.....
J2680	N	Fluphenazine decanoate 25 MG .....	.....	.....	.....	.....	.....
J2690	N	Procainamide hcl injection .....	.....	.....	.....	.....	.....
J2700	N	Oxacillin sodium injecton .....	.....	.....	.....	.....	.....
J2710	N	Neostigmine methylsifte inj .....	.....	.....	.....	.....	.....
J2720	N	Inj protamine sulfate/10 MG .....	.....	.....	.....	.....	.....
J2725	N	Inj protirelin per 250 mcg .....	.....	.....	.....	.....	.....
J2730	N	Pralidoxime chloride inj .....	.....	.....	.....	.....	.....
J2760	N	Phentolaine mesylate inj .....	.....	.....	.....	.....	.....
J2765	N	Metoclopramide hcl injection .....	.....	.....	.....	.....	.....
J2790	N	Rho d immune globulin inj .....	.....	.....	.....	.....	.....
J2800	N	Methocarbamol injection .....	.....	.....	.....	.....	.....
J2810	N	Inj theophylline per 40 MG .....	.....	.....	.....	.....	.....
J2820	N	Sargramostim injection .....	.....	.....	.....	.....	.....
J2860	N	Secobarbital sodium inj .....	.....	.....	.....	.....	.....
J2910	N	Aurothioglucose injection .....	.....	.....	.....	.....	.....
J2912	N	Sodium chloride injection .....	.....	.....	.....	.....	.....
J2920	N	Methylprednisolone injection .....	.....	.....	.....	.....	.....
J2930	N	Methylprednisolone injection .....	.....	.....	.....	.....	.....
J2950	N	Promazine hcl injecton .....	.....	.....	.....	.....	.....
J2970	N	Methicillin sodium injection .....	.....	.....	.....	.....	.....
J2995	N	Inj streptokinase /250000 IU .....	.....	.....	.....	.....	.....
J2996	N	Alteplase recombinant inj .....	.....	.....	.....	.....	.....
J3000	N	Streptomycin injection .....	.....	.....	.....	.....	.....
J3010	N	Fentanyl citrate injecton .....	.....	.....	.....	.....	.....
J3030	N	Sumatriptan succinate / 6 MG .....	.....	.....	.....	.....	.....
J3070	N	Pentazocine hcl injecton .....	.....	.....	.....	.....	.....
J3080	N	Chlorprothixene injection					
J3105	N	Terbutaline sulfate inj					
J3120	N	Testosterone enanthate inj					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J3130	N	Testosterone enanthate inj .....	.....	.....	.....	.....	.....
J3140	N	Testosterone suspension inj .....	.....	.....	.....	.....	.....
J3150	N	Testosteron propionate inj .....	.....	.....	.....	.....	.....
J3230	N	Chlorpromazine hcl injection .....	.....	.....	.....	.....	.....
J3240	N	Thyrotropin injection .....	.....	.....	.....	.....	.....
J3250	N	Trimethobenzamide hcl inj .....	.....	.....	.....	.....	.....
J3260	N	Tobramycin sulfate injection .....	.....	.....	.....	.....	.....
J3265	N	Injection tobramycin 10 mg/ml .....	.....	.....	.....	.....	.....
J3270	N	Imipramine hcl injection .....	.....	.....	.....	.....	.....
J3280	N	Thiethylperazine maleate inj .....	.....	.....	.....	.....	.....
J3301	N	Triamcinolone acetonide inj .....	.....	.....	.....	.....	.....
J3302	N	Triamcinolone diacetate inj .....	.....	.....	.....	.....	.....
J3303	N	Triamcinolone hexacetonol inj .....	.....	.....	.....	.....	.....
J3305	N	Inj trimetrexate glucuronate .....	.....	.....	.....	.....	.....
J3310	N	Perphenazine injection .....	.....	.....	.....	.....	.....
J3320	N	Spectinomycin di-hcl inj .....	.....	.....	.....	.....	.....
J3350	N	Urea injection .....	.....	.....	.....	.....	.....
J3360	N	Diazepam injection .....	.....	.....	.....	.....	.....
J3364	N	Urokinase 5000 IU injection .....	.....	.....	.....	.....	.....
J3365	N	Urokinase 250,000 IU inj .....	.....	.....	.....	.....	.....
J3370	E	Vancomycin hcl injection .....	.....	.....	.....	.....	.....
J3390	N	Methoxamine injection .....	.....	.....	.....	.....	.....
J3400	N	Trifluoromazine hcl inj .....	.....	.....	.....	.....	.....
J3410	N	Hydroxyzine hcl injection .....	.....	.....	.....	.....	.....
J3420	N	Vitamin b12 injection .....	.....	.....	.....	.....	.....
J3430	N	Vitamin k phytonadione inj .....	.....	.....	.....	.....	.....
J3450	N	Mephentermine sulfate inj .....	.....	.....	.....	.....	.....
J3470	N	Hyaluronidase injection .....	.....	.....	.....	.....	.....
J3475	N	Inj magnesium sulfate .....	.....	.....	.....	.....	.....
J3480	N	Inj potassium chloride .....	.....	.....	.....	.....	.....
J3490	N	Drugs unclassified injection .....	.....	.....	.....	.....	.....
J3520	E	Edetate disodium per 150 mg .....	.....	.....	.....	.....	.....
J3530	N	Nasal vaccine inhalation .....	.....	.....	.....	.....	.....
J3535	E	Metered dose inhaler drug .....	.....	.....	.....	.....	.....
J3570	E	Laetrile amygdalin vit B17 .....	.....	.....	.....	.....	.....
J7030	A	Normal saline solution infus .....	.....	.....	.....	.....	.....
J7040	A	Normal saline solution infus .....	.....	.....	.....	.....	.....
J7042	A	5% dextrose/normal saline .....	.....	.....	.....	.....	.....
J7050	A	Normal saline solution infus .....	.....	.....	.....	.....	.....
J7051	A	Sterile saline/water .....	.....	.....	.....	.....	.....
J7060	A	5% dextrose/water .....	.....	.....	.....	.....	.....
J7070	A	D5w infusion .....	.....	.....	.....	.....	.....
J7100	A	Dextran 40 infusion .....	.....	.....	.....	.....	.....
J7110	A	Dextran 75 infusion .....	.....	.....	.....	.....	.....
J7120	A	Ringers lactate infusion .....	.....	.....	.....	.....	.....
J7130	A	Hypertonic saline solution .....	.....	.....	.....	.....	.....
J7190	N	Factor viii .....	.....	.....	.....	.....	.....
J7191	N	Factor VIII (porcine) .....	.....	.....	.....	.....	.....
J7192	N	Factor viii recombinant .....	.....	.....	.....	.....	.....
J7194	N	Factor ix complex .....	.....	.....	.....	.....	.....
J7196	N	Othr hemophilia clot factors .....	.....	.....	.....	.....	.....
J7197	N	Antithrombin iii injection .....	.....	.....	.....	.....	.....
J7300	E	Intraut copper contraceptive .....	.....	.....	.....	.....	.....
J7310	N	Ganciclovir long act implant .....	.....	.....	.....	.....	.....
J7500	N	Azathiop po tab 50mg 100s ea .....	.....	.....	.....	.....	.....
J7501	N	Azathioprine parenteral .....	.....	.....	.....	.....	.....
J7503	N	Cyclosporine parenteral .....	.....	.....	.....	.....	.....
J7504	N	Lymphocyte immune globulin .....	.....	.....	.....	.....	.....
J7505	N	Monoclonal antibodies .....	.....	.....	.....	.....	.....
J7506	N	Prednisone oral .....	.....	.....	.....	.....	.....
J7507	N	Tacrolimus oral per 1 MG .....	.....	.....	.....	.....	.....
J7508	N	Tacrolimus oral per 5 MG .....	.....	.....	.....	.....	.....
J7509	N	Methylprednisolone oral .....	.....	.....	.....	.....	.....
J7510	N	Prednisolone oral per 5 mg .....	.....	.....	.....	.....	.....
J7599	N	Immunosuppressive drug noc .....	.....	.....	.....	.....	.....
J7610	A	Acetylcysteine 10% injection .....	.....	.....	.....	.....	.....
J7615	A	Acetylcysteine 20% injection .....	.....	.....	.....	.....	.....
J7620	A	Albuterol sulfate .083%/ml .....	.....	.....	.....	.....	.....
J7625	A	Albuterol sulfate .5% inj .....	.....	.....	.....	.....	.....
J7627	A	Bitolterolmesylate inhal sol .....	.....	.....	.....	.....	.....
J7630	A	Cromolyn sodium injection .....	.....	.....	.....	.....	.....
J7640	A	Epinephrine injection .....	.....	.....	.....	.....	.....
J7645	A	Ipratropium bromide .02%/ml					
J7650	A	Isoetharine hcl .1% inj					
J7651	A	Isoetharine hcl .125% inj					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J7652	A	Isoetharine hcl .167% inj .....	.....	.....	.....	.....	.....
J7653	A	Isoetharine hcl .2%/ inj .....	.....	.....	.....	.....	.....
J7654	A	Isoetharine hcl .25% inj .....	.....	.....	.....	.....	.....
J7655	A	Isoetharine hcl 1% inj .....	.....	.....	.....	.....	.....
J7660	A	Isoproterenol hcl .5% inj .....	.....	.....	.....	.....	.....
J7665	A	Isoproterenol hcl 1% inj .....	.....	.....	.....	.....	.....
J7670	A	Metaproterenol sulfate .4% .....	.....	.....	.....	.....	.....
J7672	A	Metaproterenol sulfate .6% .....	.....	.....	.....	.....	.....
J7675	A	Metaproterenol sulfate 5% .....	.....	.....	.....	.....	.....
J7699	A	Inhalation solution for DME .....	.....	.....	.....	.....	.....
J7799	A	Non-inhalation drug for DME .....	.....	.....	.....	.....	.....
J8499	E	Oral prescrip drug non chemo .....	.....	.....	.....	.....	.....
J8530	N	Cyclophosphamide oral 25 MG .....	.....	.....	.....	.....	.....
J8560	N	Etoposide oral 50 MG .....	.....	.....	.....	.....	.....
J8600	N	Melphalan oral 2 MG .....	.....	.....	.....	.....	.....
J8610	X	Methotrexate oral 2.5 MG	061	1.04	\$54.85	\$36.61	\$10.97
J8999	X	Oral prescription drug chemo	061	1.04	\$54.85	\$36.61	\$10.97
J9000	X	Doxorubic hcl 10 MG vl chemo	062	1.69	\$89.13	\$36.61	\$17.83
J9015	X	Aldesleukin/single use vial	061	1.04	\$54.85	\$36.61	\$10.97
J9020	X	Asparaginase injection	062	1.69	\$89.13	\$36.61	\$17.83
J9031	X	Bcg live intravesical vac	063	2.89	\$152.79	\$110.97	\$30.56
J9040	X	Bleomycin sulfate injection	063	2.89	\$152.79	\$110.97	\$30.56
J9045	X	Carboplatin injection	063	2.89	\$152.79	\$110.97	\$30.56
J9050	X	Carmus bischl nitro inj	063	2.89	\$152.79	\$110.97	\$30.56
J9060	X	Cisplatin 10 MG injecton	062	1.69	\$89.13	\$36.61	\$17.83
J9062	X	Cisplatin 50 MG injecton	063	2.89	\$152.79	\$110.97	\$30.56
J9065	X	Inj cladribine per 1 MG	062	1.69	\$89.13	\$36.61	\$17.83
J9070	X	Cyclophosphamide 100 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9080	X	Cyclophosphamide 200 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9090	X	Cyclophosphamide 500 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9091	X	Cyclophosphamide 1.0 grm inj	062	1.69	\$89.13	\$36.61	\$17.83
J9092	X	Cyclophosphamide 2.0 grm inj	062	1.69	\$89.13	\$36.61	\$17.83
J9093	X	Cyclophosphamide lyophilized	061	1.04	\$54.85	\$36.61	\$10.97
J9094	X	Cyclophosphamide lyophilized	061	1.04	\$54.85	\$36.61	\$10.97
J9095	X	Cyclophosphamide lyophilized	061	1.04	\$54.85	\$36.61	\$10.97
J9096	X	Cyclophosphamide lyophilized	062	1.69	\$89.13	\$36.61	\$17.83
J9097	X	Cyclophosphamide lyophilized	062	1.69	\$89.13	\$36.61	\$17.83
J9100	X	Cytarabine hcl 100 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9110	X	Cytarabine hcl 500 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9120	X	Dactinomycin actinomycin d	061	1.04	\$54.85	\$36.61	\$10.97
J9130	X	Dacarbazine 10 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9140	X	Dacarbazine 200 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9150	X	Dauorubicin	062	1.69	\$89.13	\$36.61	\$17.83
J9165	X	Diethylstilbestrol injection	061	1.04	\$54.85	\$36.61	\$10.97
J9170	X	Docetaxel	061	1.04	\$54.85	\$36.61	\$10.97
J9181	X	Etoposide 10 MG inj	061	1.04	\$54.85	\$36.61	\$10.97
J9182	X	Etoposide 100 MG inj	063	2.89	\$152.79	\$110.97	\$30.56
J9185	X	Fludarabine phosphate inj	063	2.89	\$152.79	\$110.97	\$30.56
J9190	X	Fluorouracil injection	061	1.04	\$54.85	\$36.61	\$10.97
J9200	X	Floxuridine injection	063	2.89	\$152.79	\$110.97	\$30.56
J9201	X	Gemcitabine HCl	061	1.04	\$54.85	\$36.61	\$10.97
J9202	X	Goserelin acetate implant	063	2.89	\$152.79	\$110.97	\$30.56
J9206	X	Irinotecan injection	061	1.04	\$54.85	\$36.61	\$10.97
J9208	X	Ifosfomide injection	063	2.89	\$152.79	\$110.97	\$30.56
J9209	X	Mesna injection	063	2.89	\$152.79	\$110.97	\$30.56
J9211	X	Idarubicin hcl injecton	062	1.69	\$89.13	\$36.61	\$17.83
J9213	X	Interferon alfa-2a inj	062	1.69	\$89.13	\$36.61	\$17.83
J9214	X	Interferon alfa-2b inj	061	1.04	\$54.85	\$36.61	\$10.97
J9215	X	Interferon alfa-n3 inj	061	1.04	\$54.85	\$36.61	\$10.97
J9216	X	Interferon gamma 1-b inj	063	2.89	\$152.79	\$110.97	\$30.56
J9217	X	Leuprolide acetate suspnsion	064	4.17	\$220.38	\$140.12	\$44.08
J9218	X	Leuprolide acetate injecton	061	1.04	\$54.85	\$36.61	\$10.97
J9230	X	Mechlorethamine hcl inj	061	1.04	\$54.85	\$36.61	\$10.97
J9245	X	Inj melphalan hydrochl 50 MG	064	4.17	\$220.38	\$140.12	\$44.08
J9250	X	Methotrexate sodium inj	061	1.04	\$54.85	\$36.61	\$10.97
J9260	X	Methotrexate sodium inj	061	1.04	\$54.85	\$36.61	\$10.97
J9265	X	Paclitaxel injection	062	1.69	\$89.13	\$36.61	\$17.83
J9266	X	Pegaspargase/singl dose vial	061	1.04	\$54.85	\$36.61	\$10.97
J9268	X	Pentostatin injection	062	1.69	\$89.13	\$36.61	\$17.83
J9270	X	Plicamycin (mithramycin) inj	063	2.89	\$152.79	\$110.97	\$30.56
J9280	X	Mitomycin 5 MG inj	063	2.89	\$152.79	\$110.97	\$30.56
J9290	X	Mitomycin 20 MG inj	064	4.17	\$220.38	\$140.12	\$44.08
J9291	X	Mitomycin 40 MG inj	064	4.17	\$220.38	\$140.12	\$44.08
J9293	X	Mitoxantrone hydrochl / 5 MG	064	4.17	\$220.38	\$140.12	\$44.08
J9320	X	Streptozocin injection	063	2.89	\$152.79	\$110.97	\$30.56

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J9340	X	Thiotepa injection	063	2.89	\$152.79	\$110.97	\$30.56
J9350	X	Topotecan	061	1.04	\$54.85	\$36.61	\$10.97
J9360	X	Vinblastine sulfate inj	061	1.04	\$54.85	\$36.61	\$10.97
J9370	X	Vincristine sulfate 1 MG inj	062	1.69	\$89.13	\$36.61	\$17.83
J9375	X	Vincristine sulfate 2 MG inj	063	2.89	\$152.79	\$110.97	\$30.56
J9380	X	Vincristine sulfate 5 MG inj	063	2.89	\$152.79	\$110.97	\$30.56
J9390	X	Vinorelbine tartrate/10 mg	061	1.04	\$54.85	\$36.61	\$10.97
J9600	X	Porfimer sodium	061	1.04	\$54.85	\$36.61	\$10.97
J9999	X	Chemotherapy drug	061	1.04	\$54.85	\$36.61	\$10.97
K0001	A	Standard wheelchair					
K0002	A	Std hemi (low seat) whlchr					
K0003	A	Lightweight wheelchair					
K0004	A	High strength ltwt whlchr					
K0005	A	Ultralightweight wheelchair					
K0006	A	Heavy duty wheelchair					
K0007	A	Extra heavy duty wheelchair					
K0008	A	Cstm manual wheelchair/base					
K0009	A	Other manual wheelchair/base					
K0010	A	Std wt frame power whlchr					
K0011	A	Std wt pwr whlchr w control					
K0012	A	Ltwt portbl power whlchr					
K0013	A	Custom power whlchr base					
K0014	A	Other power whlchr base					
K0015	A	Detach non-adjus hght armrst					
K0016	A	Detach adjust armrst complete					
K0017	A	Detach adjust armrest base					
K0018	A	Detach adjust armrst upper					
K0019	A	Arm pad each					
K0020	A	Fixed adjust armrest pair					
K0021	A	Anti-tipping device each					
K0022	A	Reinforced back upholstery					
K0023	A	Planr back insrt foam w/strp					
K0024	A	Plnr back insrt foam w/hrdwr					
K0025	A	Hook-on headrest extension					
K0026	A	Back upholst lgtwt whlchr					
K0027	A	Back upholst other whlchr					
K0028	A	Fully reclining back					
K0029	A	Reinforced seat upholstery					
K0030	A	Solid plnr seat sngl dnsfoam					
K0031	A	Safety belt/pelvic strap					
K0032	A	Seat upholst lgtwt whlchr					
K0033	A	Seat upholstery other whlchr					
K0034	A	Heel loop each					
K0035	A	Heel loop with ankle strap					
K0036	A	Toe loop each					
K0037	A	High mount flip-up footrest					
K0038	A	Leg strap each					
K0039	A	Leg strap h style each					
K0040	A	Adjustable angle footplate					
K0041	A	Large size footplate each					
K0042	A	Standard size footplate each					
K0043	A	Ftrst lower extension tube					
K0044	A	Ftrst upper hanger bracket					
K0045	A	Footrest complete assembly					
K0046	A	Elevat legrest low extension					
K0047	A	Elevat legrest up hangr brack					
K0048	A	Elevate legrest complete					
K0049	A	Calf pad each					
K0050	A	Ratchet assembly					
K0051	A	Cam release assem ftrst/lgrst					
K0052	A	Swingaway detach footrest					
K0053	A	Elevate footrest articulate					
K0054	A	Seat wdth 10–12/15/17/20 wc					
K0055	A	Seat dpth 15/17/18 ltwt wc					
K0056	A	Seat ht <17 or <=21 ltwt wc					
K0057	A	Seat wdth 19/20 hvy dty wc					
K0058	A	Seat dpth 17/18 power wc					
K0059	A	Plastic coated handrim each					
K0060	A	Steel handrim each					
K0061	A	Aluminum handrim each					
K0062	A	Handrim 8–10 vert/obliq proj					
K0063	A	Hndrm 12–16 vert/obliq proj					
K0064	A	Zero pressure tube flat free					
K0065	A	Spoke protectors					
K0066	A	Solid tire any size each					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS ²	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
K0067	A	Pneumatic tire any size each .....	.....	.....	.....	.....	.....
K0068	A	Pneumatic tire tube each .....	.....	.....	.....	.....	.....
K0069	A	Rear whl complete solid tire .....	.....	.....	.....	.....	.....
K0070	A	Rear whl compl pneum tire .....	.....	.....	.....	.....	.....
K0071	A	Front castr compl pneum tire .....	.....	.....	.....	.....	.....
K0072	A	Frnt cstr cmpl sem-pneum tir .....	.....	.....	.....	.....	.....
K0073	A	Caster pin lock each .....	.....	.....	.....	.....	.....
K0074	A	Pneumatic caster tire each .....	.....	.....	.....	.....	.....
K0075	A	Semi-pneumatic caster tire .....	.....	.....	.....	.....	.....
K0076	A	Solid caster tire each .....	.....	.....	.....	.....	.....
K0077	A	Front caster assem complete .....	.....	.....	.....	.....	.....
K0078	A	Pneumatic caster tire tube .....	.....	.....	.....	.....	.....
K0079	A	Wheel lock extension pair .....	.....	.....	.....	.....	.....
K0080	A	Anti-rollback device pair .....	.....	.....	.....	.....	.....
K0081	A	Wheel lock assembly complete .....	.....	.....	.....	.....	.....
K0082	A	22 nf deep cycl acid battery .....	.....	.....	.....	.....	.....
K0083	A	22 nf gel cell battery each .....	.....	.....	.....	.....	.....
K0084	A	Grp 24 deep cycl acid battry .....	.....	.....	.....	.....	.....
K0085	A	Group 24 gel cell battery .....	.....	.....	.....	.....	.....
K0086	A	U-1 lead acid battery each .....	.....	.....	.....	.....	.....
K0087	A	U-1 gel cell battery each .....	.....	.....	.....	.....	.....
K0088	A	Battry chrgr acid/gel cell .....	.....	.....	.....	.....	.....
K0089	A	Battery charger dual mode .....	.....	.....	.....	.....	.....
K0090	A	Rear tire power wheelchair .....	.....	.....	.....	.....	.....
K0091	A	Rear tire tube power whlchr .....	.....	.....	.....	.....	.....
K0092	A	Rear assem cmplt powr whlchr .....	.....	.....	.....	.....	.....
K0093	A	Rear zero pressure tire tube .....	.....	.....	.....	.....	.....
K0094	A	Wheel tire for power base .....	.....	.....	.....	.....	.....
K0095	A	Wheel tire tube each base .....	.....	.....	.....	.....	.....
K0096	A	Wheel assem powr base complt .....	.....	.....	.....	.....	.....
K0097	A	Wheel zero presure tire tube .....	.....	.....	.....	.....	.....
K0098	A	Drive belt power wheelchair .....	.....	.....	.....	.....	.....
K0099	A	Front caster power wheelchair .....	.....	.....	.....	.....	.....
K0100	A	Amputee adapter pair .....	.....	.....	.....	.....	.....
K0101	A	One-arm drive attachment .....	.....	.....	.....	.....	.....
K0102	A	Crutch and cane holder .....	.....	.....	.....	.....	.....
K0103	A	Transfer board < 25" .....	.....	.....	.....	.....	.....
K0104	A	Cylinder tank carrier .....	.....	.....	.....	.....	.....
K0105	A	Iv hanger .....	.....	.....	.....	.....	.....
K0106	A	Arm trough each .....	.....	.....	.....	.....	.....
K0107	A	Wheelchair tray .....	.....	.....	.....	.....	.....
K0108	A	Other accessories .....	.....	.....	.....	.....	.....
K0109	A	Customize whlchr base frame .....	.....	.....	.....	.....	.....
K0112	A	Trunk vest supprt innr frame .....	.....	.....	.....	.....	.....
K0113	A	Trunk vest suprt w/o innr frm .....	.....	.....	.....	.....	.....
K0114	A	Whlchr back suprt innr frame .....	.....	.....	.....	.....	.....
K0115	A	Back module orthotic system .....	.....	.....	.....	.....	.....
K0116	A	Back & seat modul orthot sys .....	.....	.....	.....	.....	.....
K0119	N	Azathioprine oral tab 50 MG .....	.....	.....	.....	.....	.....
K0120	N	Azathioprine prenlrl 100 MG .....	.....	.....	.....	.....	.....
K0121	N	Cyclosporine oral 25 MG .....	.....	.....	.....	.....	.....
K0122	N	Cyclosporine prenlrl 250 MG .....	.....	.....	.....	.....	.....
K0123	N	Imun/antitymocyt glob 250 MG .....	.....	.....	.....	.....	.....
K0137	A	Skin barrier liquid per oz .....	.....	.....	.....	.....	.....
K0138	A	Skin barrier paste per oz .....	.....	.....	.....	.....	.....
K0139	A	Skin barrier powder per oz .....	.....	.....	.....	.....	.....
K0168	A	Disposable nebulizer set .....	.....	.....	.....	.....	.....
K0169	A	Disposable nebulizer small .....	.....	.....	.....	.....	.....
K0170	A	Non disposable nebulizer set .....	.....	.....	.....	.....	.....
K0171	A	Filtered nebulizer set .....	.....	.....	.....	.....	.....
K0172	A	Disposable nebulizer unfill .....	.....	.....	.....	.....	.....
K0173	A	Disposable nebulizer prefill .....	.....	.....	.....	.....	.....
K0174	A	Reservoir bottle w nebulizer .....	.....	.....	.....	.....	.....
K0175	A	Disposable corrugated tubing .....	.....	.....	.....	.....	.....
K0176	A	Non dispos corrugated tubing .....	.....	.....	.....	.....	.....
K0177	A	Water collec dev w nebulizer .....	.....	.....	.....	.....	.....
K0178	A	Disposbl filter w compressor .....	.....	.....	.....	.....	.....
K0179	A	Non-dispos filter w/compress .....	.....	.....	.....	.....	.....
K0180	A	Aerosol mask with nebulizer .....	.....	.....	.....	.....	.....
K0181	A	Dome & mouthpiece w/ nebuliz .....	.....	.....	.....	.....	.....
K0182	A	Water distilled w/ nebulizer .....	.....	.....	.....	.....	.....
K0183	A	Nasal application with cpap .....	.....	.....	.....	.....	.....
K0184	A	Nasal pillows/seals pair					
K0185	A	Headgear with cpap device					
K0186	A	Chin strap with cpap device					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
K0187	A	Tubing with cpap device .....	.....	.....	.....	.....	.....
K0188	A	Filter disposable with cpap .....	.....	.....	.....	.....	.....
K0189	A	Filter non-disposable w/cpap .....	.....	.....	.....	.....	.....
K0190	A	Disposable canister w/pump .....	.....	.....	.....	.....	.....
K0191	A	Non-disposbl canister w/pump .....	.....	.....	.....	.....	.....
K0192	A	Tubing used w/ suction pump .....	.....	.....	.....	.....	.....
K0193	A	Airway pressure dev/w hmdfer .....	.....	.....	.....	.....	.....
K0194	A	Assist device w/humidifier .....	.....	.....	.....	.....	.....
K0195	A	Elevating whlchair leg rests .....	.....	.....	.....	.....	.....
K0268	A	Humidifier with cpap device .....	.....	.....	.....	.....	.....
K0269	A	Aerosol compressor cpap dev .....	.....	.....	.....	.....	.....
K0270	A	Ultrasonic generator w nebul .....	.....	.....	.....	.....	.....
K0277	A	Skin barrier solid 4x4 equiv .....	.....	.....	.....	.....	.....
K0278	A	Skin barrier with flange .....	.....	.....	.....	.....	.....
K0279	A	Skin barrier extended wear .....	.....	.....	.....	.....	.....
K0280	A	Extension drainage tubing .....	.....	.....	.....	.....	.....
K0281	A	Lubricant catheter insertion .....	.....	.....	.....	.....	.....
K0283	A	Saline solution dispenser .....	.....	.....	.....	.....	.....
K0284	A	External infusion pump reuse .....	.....	.....	.....	.....	.....
K0400	A	Skin support attachment each .....	.....	.....	.....	.....	.....
K0401	A	Diabetic deluxe shoe .....	.....	.....	.....	.....	.....
K0407	A	Urinary cath skin attachment .....	.....	.....	.....	.....	.....
K0408	A	Urinary cath leg strap .....	.....	.....	.....	.....	.....
K0409	A	Sterile H2O irrigation solut .....	.....	.....	.....	.....	.....
K0410	A	Male ext cath w/adh coating .....	.....	.....	.....	.....	.....
K0411	A	Male ext cath w/adh strip .....	.....	.....	.....	.....	.....
K0412	N	Mycophenolate mofetil 250 mg .....	.....	.....	.....	.....	.....
K0415	N	RX antiemetic drg. oral NOS .....	.....	.....	.....	.....	.....
K0416	N	Rx antiemetic drg.rectal NOS .....	.....	.....	.....	.....	.....
K0417	A	Mech infus pump sht trm drug .....	.....	.....	.....	.....	.....
K0418	N	Oral cyclosporin .....	.....	.....	.....	.....	.....
K0419	A	Drainable plstic pch w fcpl .....	.....	.....	.....	.....	.....
K0420	A	Drainable rubber pch w fcpl .....	.....	.....	.....	.....	.....
K0421	A	drainable plstic pch w/o fp .....	.....	.....	.....	.....	.....
K0422	A	Drainable rubber pch w/o fp .....	.....	.....	.....	.....	.....
K0423	A	Urinary plstic pouch w fcpl .....	.....	.....	.....	.....	.....
K0424	A	Urinary rubber pouch w fcpl .....	.....	.....	.....	.....	.....
K0425	A	Urinary plstic pouch w/o fp .....	.....	.....	.....	.....	.....
K0426	A	Urinary hvy plstc pch w/o fp .....	.....	.....	.....	.....	.....
K0427	A	Urinary rubber pouch w/o fp .....	.....	.....	.....	.....	.....
K0428	A	Ostomy faceplt/silicone ring .....	.....	.....	.....	.....	.....
K0429	A	Skin barrier solid ext wear .....	.....	.....	.....	.....	.....
K0430	A	Skin barrier w flang ex wear .....	.....	.....	.....	.....	.....
K0431	A	Closed pouch w st wear bar .....	.....	.....	.....	.....	.....
K0432	A	Drainable pch w ex wear bar .....	.....	.....	.....	.....	.....
K0433	A	Drainable pch w st wear bar .....	.....	.....	.....	.....	.....
K0434	A	Drainable pch ex wear convex .....	.....	.....	.....	.....	.....
K0435	A	Urinary pouch w ex wear bar .....	.....	.....	.....	.....	.....
K0436	A	Urinary pouch w st wear bar .....	.....	.....	.....	.....	.....
K0437	A	Urine pch w ex wear bar conv .....	.....	.....	.....	.....	.....
K0438	A	Ostomy pouch liq deodorant .....	.....	.....	.....	.....	.....
K0439	A	Ostomy pouch solid deodorant .....	.....	.....	.....	.....	.....
K0440	A	Nasal prosthesis .....	.....	.....	.....	.....	.....
K0441	A	Midfacial prosthesis .....	.....	.....	.....	.....	.....
K0442	A	Orbital prosthesis .....	.....	.....	.....	.....	.....
K0443	A	Upper facial prosthesis .....	.....	.....	.....	.....	.....
K0444	A	Hemi-facial prosthesis .....	.....	.....	.....	.....	.....
K0445	S	Auricular prosthesis	031	1.33	\$70.52	\$14.10	\$14.10
K0446	A	Partial facial prosthesis .....	.....	.....	.....	.....	.....
K0447	A	Nasal septal prosthesis .....	.....	.....	.....	.....	.....
K0448	A	Unspec maxillofacial prosth .....	.....	.....	.....	.....	.....
K0449	A	Repair maxillofacial prosth .....	.....	.....	.....	.....	.....
K0450	A	Liq adhes for facial prosth .....	.....	.....	.....	.....	.....
K0451	A	Adhesive remover wipes .....	.....	.....	.....	.....	.....
K0452	A	Wheelchair bearings .....	.....	.....	.....	.....	.....
K0453	N	Amphotericin B .....	.....	.....	.....	.....	.....
K0455	A	Pump uninterrupted infusion .....	.....	.....	.....	.....	.....
K0501	A	Aerosol compressor for svneb .....	.....	.....	.....	.....	.....
K0503	A	Acetylcysteine inh sol u d .....	.....	.....	.....	.....	.....
K0504	A	Albuterol inh sol con .....	.....	.....	.....	.....	.....
K0505	A	Albuterol inh sol u d .....	.....	.....	.....	.....	.....
K0506	A	Atropine inh sol con .....	.....	.....	.....	.....	.....
K0507	A	Atropine inh sol u d					
K0508	A	Bitolterol mes inh sol con					
K0509	A	Bitolterol mes inh sol u d					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
K0511	A	Cromolyn sodium inh sol u d .....	.....	.....	.....	.....	.....
K0512	A	Dexamethasone inh sol con .....	.....	.....	.....	.....	.....
K0513	A	Dexamethasone inh sol u d .....	.....	.....	.....	.....	.....
K0514	A	Dornase alpha inh sol u d .....	.....	.....	.....	.....	.....
K0515	A	Glycopyrrolate inh sol con .....	.....	.....	.....	.....	.....
K0516	A	Glycopyrrolate inh sol u d .....	.....	.....	.....	.....	.....
K0518	A	Ipratropium brom inh sol u d .....	.....	.....	.....	.....	.....
K0519	A	Isoetharine HCl inh sol con .....	.....	.....	.....	.....	.....
K0520	A	Isoetharine HCl inh sol u d .....	.....	.....	.....	.....	.....
K0521	A	IsoproterenolHCl inh sol con .....	.....	.....	.....	.....	.....
K0522	A	IsoproterenolHCl inh sol u d .....	.....	.....	.....	.....	.....
K0523	A	Metaproterenol inh sol con .....	.....	.....	.....	.....	.....
K0524	A	Metaproterenol inh sol u d .....	.....	.....	.....	.....	.....
K0525	A	Terbutaline SO4 inh sol con .....	.....	.....	.....	.....	.....
K0526	A	Terbutaline SO4 inh sol u d .....	.....	.....	.....	.....	.....
K0527	A	Triamcinolone inh sol con .....	.....	.....	.....	.....	.....
K0528	A	Triamcinolone inh sol u d .....	.....	.....	.....	.....	.....
K0529	A	Sterile H2O or nss w lv neb .....	.....	.....	.....	.....	.....
K0530	A	Nebulizer not used w oxygen .....	.....	.....	.....	.....	.....
L0100	A	Cerv craniosten helmet mold .....	.....	.....	.....	.....	.....
L0110	A	Cerv craniostenosis hel non- .....	.....	.....	.....	.....	.....
L0120	A	Cerv flexible non-adjustable .....	.....	.....	.....	.....	.....
L0130	A	Flex thermoplastic collar mo .....	.....	.....	.....	.....	.....
L0140	A	Cervical semi-rigid adjustab .....	.....	.....	.....	.....	.....
L0150	A	Cerv semi-rig adj molded chn .....	.....	.....	.....	.....	.....
L0160	A	Cerv semi-rig wire occ/mand .....	.....	.....	.....	.....	.....
L0170	A	Cervical collar molded to pt .....	.....	.....	.....	.....	.....
L0172	A	Cerv col thermplas foam 2 pi .....	.....	.....	.....	.....	.....
L0174	A	Cerv col foam 2 piece w thor .....	.....	.....	.....	.....	.....
L0180	A	Cer post col occ/man sup adj .....	.....	.....	.....	.....	.....
L0190	A	Cerv collar supp adj cerv ba .....	.....	.....	.....	.....	.....
L0200	A	Cerv col supp adj bar & thor .....	.....	.....	.....	.....	.....
L0210	A	Thoracic rib belt .....	.....	.....	.....	.....	.....
L0220	A	Thor rib belt custom fabrica .....	.....	.....	.....	.....	.....
L0300	A	TLSo flex surgical support .....	.....	.....	.....	.....	.....
L0310	A	Tlso flexible custom fabrica .....	.....	.....	.....	.....	.....
L0315	A	Tlso flex elas rigid post pa .....	.....	.....	.....	.....	.....
L0317	A	Tlso flex hypext elas post p .....	.....	.....	.....	.....	.....
L0320	A	Tlso a-p contrl w apron frnt .....	.....	.....	.....	.....	.....
L0330	A	Tlso ant-pos-lateral control .....	.....	.....	.....	.....	.....
L0340	A	Tlso a-p-l-rotary with apron .....	.....	.....	.....	.....	.....
L0350	A	Tlso flex compress jacket cu .....	.....	.....	.....	.....	.....
L0360	A	Tlso flex compress jacket mo .....	.....	.....	.....	.....	.....
L0370	A	Tlso a-p-l-rotary hyperexten .....	.....	.....	.....	.....	.....
L0380	A	Tlso a-p-l-rot w/ pos extens .....	.....	.....	.....	.....	.....
L0390	A	Tlso a-p-l control molded .....	.....	.....	.....	.....	.....
L0400	A	Tlso a-p-l w interface mater .....	.....	.....	.....	.....	.....
L0410	A	Tlso a-p-l two piece constr .....	.....	.....	.....	.....	.....
L0420	A	Tlso a-p-l 2 piece w interfa .....	.....	.....	.....	.....	.....
L0430	A	Tlso a-p-l w interface custm .....	.....	.....	.....	.....	.....
L0440	A	Tlso a-p-l overlap frnt cust .....	.....	.....	.....	.....	.....
L0500	A	Lso flex surgical support .....	.....	.....	.....	.....	.....
L0510	A	Lso flexible custom fabricat .....	.....	.....	.....	.....	.....
L0515	A	Lso flex elas w/ rig post pa .....	.....	.....	.....	.....	.....
L0520	A	Lso a-p-l control with apron .....	.....	.....	.....	.....	.....
L0530	A	Lso ant-pos control w apron .....	.....	.....	.....	.....	.....
L0540	A	Lso lumbar flexion a-p-l .....	.....	.....	.....	.....	.....
L0550	A	Lso a-p-l control molded .....	.....	.....	.....	.....	.....
L0560	A	Lso a-p-l w interface .....	.....	.....	.....	.....	.....
L0565	A	Lso a-p-l control custom .....	.....	.....	.....	.....	.....
L0600	A	Sacroiliac flex surg support .....	.....	.....	.....	.....	.....
L0610	A	Sacroiliac flexible custm fa .....	.....	.....	.....	.....	.....
L0620	A	Sacroiliac semi-rig w apron .....	.....	.....	.....	.....	.....
L0700	A	Ctlso a-p-l control molded .....	.....	.....	.....	.....	.....
L0710	A	Ctlso a-p-l control w/ inter .....	.....	.....	.....	.....	.....
L0810	A	Halo cervical into jckt vest .....	.....	.....	.....	.....	.....
L0820	A	Halo cervical into body jack .....	.....	.....	.....	.....	.....
L0830	A	Halo cerv into milwaukee typ .....	.....	.....	.....	.....	.....
L0860	A	Magnetic resonanc image comp .....	.....	.....	.....	.....	.....
L0900	A	Torso/ptosis support .....	.....	.....	.....	.....	.....
L0910	A	Torso & ptosis supp custm fa .....	.....	.....	.....	.....	.....
L0920	A	Torso/pendulous abd support .....	.....	.....	.....	.....	.....
L0930	A	Pendulous abdomen supp custm					
L0940	A	Torso/posturgical support					
L0950	A	Post surg support custom fab					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L0960	A	Post surgical support pads .....	.....	.....	.....	.....	.....
L0970	A	Tlso corset front .....	.....	.....	.....	.....	.....
L0972	A	Lso corset front .....	.....	.....	.....	.....	.....
L0974	A	Tlso full corset .....	.....	.....	.....	.....	.....
L0976	A	Lso full corset .....	.....	.....	.....	.....	.....
L0978	A	Axillary crutch extension .....	.....	.....	.....	.....	.....
L0980	A	Peroneal straps pair .....	.....	.....	.....	.....	.....
L0982	A	Stocking supp grips set of f .....	.....	.....	.....	.....	.....
L0984	A	Protective body sock each .....	.....	.....	.....	.....	.....
L0999	A	Add to spinal orthosis NOS .....	.....	.....	.....	.....	.....
L1000	A	Ctlso milwauke initial model .....	.....	.....	.....	.....	.....
L1010	A	Ctlso axilla sling .....	.....	.....	.....	.....	.....
L1020	A	Kyphosis pad .....	.....	.....	.....	.....	.....
L1025	A	Kyphosis pad floating .....	.....	.....	.....	.....	.....
L1030	A	Lumbar bolster pad .....	.....	.....	.....	.....	.....
L1040	A	Lumbar or lumbar rib pad .....	.....	.....	.....	.....	.....
L1050	A	Sternal pad .....	.....	.....	.....	.....	.....
L1060	A	Thoracic pad .....	.....	.....	.....	.....	.....
L1070	A	Trapezius sling .....	.....	.....	.....	.....	.....
L1080	A	Outrigger .....	.....	.....	.....	.....	.....
L1085	A	Outrigger bil w/ vert extens .....	.....	.....	.....	.....	.....
L1090	A	Lumbar sling .....	.....	.....	.....	.....	.....
L1100	A	Ring flange plastic/leather .....	.....	.....	.....	.....	.....
L1110	A	Ring flange plas/leather mol .....	.....	.....	.....	.....	.....
L1120	A	Covers for upright each .....	.....	.....	.....	.....	.....
L1200	A	Furnsh initial orthosis only .....	.....	.....	.....	.....	.....
L1210	A	Lateral thoracic extension .....	.....	.....	.....	.....	.....
L1220	A	Anterior thoracic extension .....	.....	.....	.....	.....	.....
L1230	A	Milwaukee type superstructur .....	.....	.....	.....	.....	.....
L1240	A	Lumbar derotation pad .....	.....	.....	.....	.....	.....
L1250	A	Anterior asis pad .....	.....	.....	.....	.....	.....
L1260	A	Anterior thoracic derotation .....	.....	.....	.....	.....	.....
L1270	A	Abdominal pad .....	.....	.....	.....	.....	.....
L1280	A	Rib gusset (elastic) each .....	.....	.....	.....	.....	.....
L1290	A	Lateral trochanteric pad .....	.....	.....	.....	.....	.....
L1300	A	Body jacket mold to patient .....	.....	.....	.....	.....	.....
L1310	A	Post-operative body jacket .....	.....	.....	.....	.....	.....
L1499	A	Spinal orthosis NOS .....	.....	.....	.....	.....	.....
L1500	A	Thkao mobility frame .....	.....	.....	.....	.....	.....
L1510	A	Thkao standing frame .....	.....	.....	.....	.....	.....
L1520	A	Thkao swivel walker .....	.....	.....	.....	.....	.....
L1600	A	Abduct hip flex frejka w cvr .....	.....	.....	.....	.....	.....
L1610	A	Abduct hip flex frejka covr .....	.....	.....	.....	.....	.....
L1620	A	Abduct hip flex pavlik harne .....	.....	.....	.....	.....	.....
L1630	A	Abduct control hip semi-flex .....	.....	.....	.....	.....	.....
L1640	A	Pelv band/spread bar thigh c .....	.....	.....	.....	.....	.....
L1650	A	HO abduction hip adjustable .....	.....	.....	.....	.....	.....
L1660	A	HO abduction static plastic .....	.....	.....	.....	.....	.....
L1680	A	Pelvic & hip control thigh c .....	.....	.....	.....	.....	.....
L1685	A	Post-op hip abduct custom fa .....	.....	.....	.....	.....	.....
L1686	A	HO post-op hip abduction .....	.....	.....	.....	.....	.....
L1700	A	Leg perthes orth toronto typ .....	.....	.....	.....	.....	.....
L1710	A	Legg perthes orth newington .....	.....	.....	.....	.....	.....
L1720	A	Legg perthes orthosis trilat .....	.....	.....	.....	.....	.....
L1730	A	Legg perthes orth scottish r .....	.....	.....	.....	.....	.....
L1750	A	Legg perthes sling .....	.....	.....	.....	.....	.....
L1755	A	Legg perthes patten bottom t .....	.....	.....	.....	.....	.....
L1800	A	Knee orthoses elas w stays .....	.....	.....	.....	.....	.....
L1810	A	Ko elastic with joints .....	.....	.....	.....	.....	.....
L1815	A	Elastic with condylar pads .....	.....	.....	.....	.....	.....
L1820	A	Ko elas w/ condyle pads & jo .....	.....	.....	.....	.....	.....
L1825	A	Ko elastic knee cap .....	.....	.....	.....	.....	.....
L1830	A	Ko immobilizer canvas longit .....	.....	.....	.....	.....	.....
L1832	A	KO adj jnt pos rigid support .....	.....	.....	.....	.....	.....
L1834	A	Ko w/0 joint rigid molded to .....	.....	.....	.....	.....	.....
L1840	A	Ko derot ant cruciate custom .....	.....	.....	.....	.....	.....
L1843	A	KO single upright custom fit .....	.....	.....	.....	.....	.....
L1844	A	Ko w/adj jt rot cntrl molded .....	.....	.....	.....	.....	.....
L1845	A	Ko w/ adj flex/ext rotat cus .....	.....	.....	.....	.....	.....
L1846	A	Ko w adj flex/ext rotat mold .....	.....	.....	.....	.....	.....
L1850	A	Ko swedish type .....	.....	.....	.....	.....	.....
L1855	A	Ko plas doub upright jnt mol .....	.....	.....	.....	.....	.....
L1858	A	Ko polycentric pneumatic pad .....	.....	.....	.....	.....	.....
L1860	A	Ko supracondylar socket mold					
L1870	A	Ko doub upright lacers molde					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS ²	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L1880	A	Ko doub upright cuffs/lacers .....	.....	.....	.....	.....	.....
L1885	A	Knee upright w/resistance .....	.....	.....	.....	.....	.....
L1900	A	Afo sprng wir drsfx calf bd .....	.....	.....	.....	.....	.....
L1902	A	Afo ankle gauntlet .....	.....	.....	.....	.....	.....
L1904	A	Afo molded ankle gauntlet .....	.....	.....	.....	.....	.....
L1906	A	Afo multiligamentous ankle su .....	.....	.....	.....	.....	.....
L1910	A	Afo sing bar clasp attach sh .....	.....	.....	.....	.....	.....
L1920	A	Afo sing upright w/ adjust s .....	.....	.....	.....	.....	.....
L1930	A	Afo plastic .....	.....	.....	.....	.....	.....
L1940	A	Afo molded to patient plasti .....	.....	.....	.....	.....	.....
L1945	A	Afo molded plas rig ant tib .....	.....	.....	.....	.....	.....
L1950	A	Afo spiral molded to pt plas .....	.....	.....	.....	.....	.....
L1960	A	Afo pos solid ank plastic mo .....	.....	.....	.....	.....	.....
L1970	A	Afo plastic molded w/ankle j .....	.....	.....	.....	.....	.....
L1980	A	Afo sing solid stirrup calf .....	.....	.....	.....	.....	.....
L1990	A	Afo doub solid stirrup calf .....	.....	.....	.....	.....	.....
L2000	A	Kafo sing fre stirr thi/calf .....	.....	.....	.....	.....	.....
L2010	A	Kafo sng solid stirrup w/o j .....	.....	.....	.....	.....	.....
L2020	A	Kafo dbl solid stirrup band/ .....	.....	.....	.....	.....	.....
L2030	A	Kafo dbl solid stirrup w/o j .....	.....	.....	.....	.....	.....
L2035	A	KAFO plastic pediatric size .....	.....	.....	.....	.....	.....
L2036	A	Kafo plas doub free knee mol .....	.....	.....	.....	.....	.....
L2037	A	Kafo plas sing free knee mol .....	.....	.....	.....	.....	.....
L2038	A	Kafo w/o joint multi-axis an .....	.....	.....	.....	.....	.....
L2039	A	KAFO, plstic, medlat rotat con .....	.....	.....	.....	.....	.....
L2040	A	Hkafo torsion bil rot straps .....	.....	.....	.....	.....	.....
L2050	A	Hkafo torsion cable hip pelv .....	.....	.....	.....	.....	.....
L2060	A	Hkafo torsion ball bearing j .....	.....	.....	.....	.....	.....
L2070	A	Hkafo torsion unilat rot str .....	.....	.....	.....	.....	.....
L2080	A	Hkafo unilat torsion cable .....	.....	.....	.....	.....	.....
L2090	A	Hkafo unilat torsion ball br .....	.....	.....	.....	.....	.....
L2102	A	Afo tibial fx cast plstr mol .....	.....	.....	.....	.....	.....
L2104	A	Afo tib fx cast synthetic mo .....	.....	.....	.....	.....	.....
L2106	A	Afo tib fx cast plaster mold .....	.....	.....	.....	.....	.....
L2108	A	Afo tib fx cast molded to pt .....	.....	.....	.....	.....	.....
L2112	A	Afo tibial fracture soft .....	.....	.....	.....	.....	.....
L2114	A	Afo tib fx semi-rigid .....	.....	.....	.....	.....	.....
L2116	A	Afo tibial fracture rigid .....	.....	.....	.....	.....	.....
L2122	A	Kafo fem fx cast plaster mol .....	.....	.....	.....	.....	.....
L2124	A	Kafo fem fx cast synthet mol .....	.....	.....	.....	.....	.....
L2126	A	Kafo fem fx cast thermoplas .....	.....	.....	.....	.....	.....
L2128	A	Kafo fem fx cast molded to p .....	.....	.....	.....	.....	.....
L2132	A	Kafo femoral fx cast soft .....	.....	.....	.....	.....	.....
L2134	A	Kafo fem fx cast semi-rigid .....	.....	.....	.....	.....	.....
L2136	A	Kafo femoral fx cast rigid .....	.....	.....	.....	.....	.....
L2180	A	Plas shoe insert w ank joint .....	.....	.....	.....	.....	.....
L2182	A	Drop lock knee .....	.....	.....	.....	.....	.....
L2184	A	Limited motion knee joint .....	.....	.....	.....	.....	.....
L2186	A	Adj motion knee jnt lerman t .....	.....	.....	.....	.....	.....
L2188	A	Quadrilateral brim .....	.....	.....	.....	.....	.....
L2190	A	Waist belt .....	.....	.....	.....	.....	.....
L2192	A	Pelvic band & belt thigh fla .....	.....	.....	.....	.....	.....
L2200	A	Limited ankle motion ea jnt .....	.....	.....	.....	.....	.....
L2210	A	Dorsiflexion assist each joi .....	.....	.....	.....	.....	.....
L2220	A	Dorsi & plantar flex ass/res .....	.....	.....	.....	.....	.....
L2230	A	Split flat caliper stirr & p .....	.....	.....	.....	.....	.....
L2240	A	Round caliper and plate atta .....	.....	.....	.....	.....	.....
L2250	A	Foot plate molded stirrup at .....	.....	.....	.....	.....	.....
L2260	A	Reinforced solid stirrup .....	.....	.....	.....	.....	.....
L2265	A	Long tongue stirrup .....	.....	.....	.....	.....	.....
L2270	A	Varus/valgus strap padded/li .....	.....	.....	.....	.....	.....
L2275	A	Plastic mod low ext pad/line .....	.....	.....	.....	.....	.....
L2280	A	Molded inner boot .....	.....	.....	.....	.....	.....
L2300	A	Abduction bar jointed adjust .....	.....	.....	.....	.....	.....
L2310	A	Abduction bar-straight .....	.....	.....	.....	.....	.....
L2320	A	Non-molded lacer .....	.....	.....	.....	.....	.....
L2330	A	Lacer molded to patient mode .....	.....	.....	.....	.....	.....
L2335	A	Anterior swing band .....	.....	.....	.....	.....	.....
L2340	A	Pre-tibial shell molded to p .....	.....	.....	.....	.....	.....
L2350	A	Prosthetic type socket molde .....	.....	.....	.....	.....	.....
L2360	A	Extended steel shank .....	.....	.....	.....	.....	.....
L2370	A	Patten bottom .....	.....	.....	.....	.....	.....
L2375	A	Torsion ank & half solid sti .....	.....	.....	.....	.....	.....
L2380	A	Torsion straight knee joint					
L2385	A	Straight knee joint heavy du					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L2390	A	Offset knee joint each .....	.....	.....	.....	.....	.....
L2395	A	Offset knee joint heavy duty .....	.....	.....	.....	.....	.....
L2397	A	Suspension sleeve lower ext .....	.....	.....	.....	.....	.....
L2405	A	Knee joint drop lock ea jnt .....	.....	.....	.....	.....	.....
L2415	A	Knee joint cam lock each joi .....	.....	.....	.....	.....	.....
L2425	A	Knee disc/dial lock/adj flex .....	.....	.....	.....	.....	.....
L2430	A	Knee jnt ratchet lock ea jnt .....	.....	.....	.....	.....	.....
L2435	A	Knee joint polycentric joint .....	.....	.....	.....	.....	.....
L2492	A	Knee lift loop drop lock rin .....	.....	.....	.....	.....	.....
L2500	A	Thi/glut/ischia wgt bearing .....	.....	.....	.....	.....	.....
L2510	A	Th/wght bear quad-lat brim m .....	.....	.....	.....	.....	.....
L2520	A	Th/wght bear quad-lat brim c .....	.....	.....	.....	.....	.....
L2525	A	Th/wght bear nar m-l brim mo .....	.....	.....	.....	.....	.....
L2526	A	Th/wght bear nar m-l brim cu .....	.....	.....	.....	.....	.....
L2530	A	Thigh/wght bear lacer non-mo .....	.....	.....	.....	.....	.....
L2540	A	Thigh/wght bear lacer molded .....	.....	.....	.....	.....	.....
L2550	A	Thigh/wght bear high roll cu .....	.....	.....	.....	.....	.....
L2570	A	Hip clevis type 2 posit jnt .....	.....	.....	.....	.....	.....
L2580	A	Pelvic control pelvic sling .....	.....	.....	.....	.....	.....
L2600	A	Hip clevis/thrust bearing fr .....	.....	.....	.....	.....	.....
L2610	A	Hip clevis/thrust bearing lo .....	.....	.....	.....	.....	.....
L2620	A	Pelvic control hip heavy dut .....	.....	.....	.....	.....	.....
L2622	A	Hip joint adjustable flexion .....	.....	.....	.....	.....	.....
L2624	A	Hip adj flex ext abduct cont .....	.....	.....	.....	.....	.....
L2627	A	Plastic mold recipro hip & c .....	.....	.....	.....	.....	.....
L2628	A	Metal frame recipro hip & ca .....	.....	.....	.....	.....	.....
L2630	A	Pelvic control band & belt u .....	.....	.....	.....	.....	.....
L2640	A	Pelvic control band & belt b .....	.....	.....	.....	.....	.....
L2650	A	Pelv & thor control gluteal .....	.....	.....	.....	.....	.....
L2660	A	Thoracic control thoracic ba .....	.....	.....	.....	.....	.....
L2670	A	Thorac cont paraspinal uprig .....	.....	.....	.....	.....	.....
L2680	A	Thorac cont lat support upri .....	.....	.....	.....	.....	.....
L2750	A	Plating chrome/nickel pr bar .....	.....	.....	.....	.....	.....
L2755	A	Carbon graphite lamination .....	.....	.....	.....	.....	.....
L2760	A	Extension per extension per .....	.....	.....	.....	.....	.....
L2770	A	Low ext orthosis per bar/jnt .....	.....	.....	.....	.....	.....
L2780	A	Non-corrosive finish .....	.....	.....	.....	.....	.....
L2785	A	Drop lock retainer each .....	.....	.....	.....	.....	.....
L2795	A	Knee control full kneecap .....	.....	.....	.....	.....	.....
L2800	A	Knee cap medial or lateral p .....	.....	.....	.....	.....	.....
L2810	A	Knee control condylar pad .....	.....	.....	.....	.....	.....
L2820	A	Soft interface below knee se .....	.....	.....	.....	.....	.....
L2830	A	Soft interface above knee se .....	.....	.....	.....	.....	.....
L2840	A	Tibial length sock fx or equ .....	.....	.....	.....	.....	.....
L2850	A	Femoral lgth sock fx or equa .....	.....	.....	.....	.....	.....
L2860	A	Torsion mechanism knee/ankle .....	.....	.....	.....	.....	.....
L2999	A	Lower extremity orthosis NOS .....	.....	.....	.....	.....	.....
L3000	A	Ft insert ucb berkeley shell .....	.....	.....	.....	.....	.....
L3001	A	Foot insert remov molded spe .....	.....	.....	.....	.....	.....
L3002	A	Foot insert plastazote or eq .....	.....	.....	.....	.....	.....
L3003	A	Foot insert silicone gel eac .....	.....	.....	.....	.....	.....
L3010	A	Foot longitudinal arch suppo .....	.....	.....	.....	.....	.....
L3020	A	Foot longitud/metatarsal sup .....	.....	.....	.....	.....	.....
L3030	A	Foot arch support remov prem .....	.....	.....	.....	.....	.....
L3040	A	Ft arch suprt premold longit .....	.....	.....	.....	.....	.....
L3050	A	Foot arch supp premold metat .....	.....	.....	.....	.....	.....
L3060	A	Foot arch supp longitud/meta .....	.....	.....	.....	.....	.....
L3070	A	Arch suprt att to sho longit .....	.....	.....	.....	.....	.....
L3080	A	Arch supp att to shoe metata .....	.....	.....	.....	.....	.....
L3090	A	Arch supp att to shoe long/m .....	.....	.....	.....	.....	.....
L3100	A	Hallus-valgus nght dynamic s .....	.....	.....	.....	.....	.....
L3140	A	Abduction rotation bar shoe .....	.....	.....	.....	.....	.....
L3150	A	Abduct rotation bar w/o shoe .....	.....	.....	.....	.....	.....
L3160	A	Shoe styled positioning dev .....	.....	.....	.....	.....	.....
L3170	A	Foot plastic heel stabilizer .....	.....	.....	.....	.....	.....
L3201	A	Oxford w supinat/pronat inf .....	.....	.....	.....	.....	.....
L3202	A	Oxford w/ supinat/pronator c .....	.....	.....	.....	.....	.....
L3203	A	Oxford w/ supinator/pronator .....	.....	.....	.....	.....	.....
L3204	A	Hightop w/ supp/pronator inf .....	.....	.....	.....	.....	.....
L3206	A	Hightop w/ supp/pronator chi .....	.....	.....	.....	.....	.....
L3207	A	Hightop w/ supp/pronator jun .....	.....	.....	.....	.....	.....
L3208	A	Surgical boot each infant .....	.....	.....	.....	.....	.....
L3209	A	Surgical boot each child					
L3211	A	Surgical boot each junior					
L3212	A	Benesch boot pair infant					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L3213	A	Benesch boot pair child .....	.....	.....	.....	.....	.....
L3214	A	Benesch boot pair junior .....	.....	.....	.....	.....	.....
L3215	A	Orthopedic ftwear ladies oxf .....	.....	.....	.....	.....	.....
L3216	A	Orthoped ladies shoes dpth i .....	.....	.....	.....	.....	.....
L3217	A	Ladies shoes hightop depth i .....	.....	.....	.....	.....	.....
L3218	A	Ladies surgical boot each .....	.....	.....	.....	.....	.....
L3219	A	Orthopedic mens shoes oxford .....	.....	.....	.....	.....	.....
L3221	A	Orthopedic mens shoes dpth i .....	.....	.....	.....	.....	.....
L3222	A	Mens shoes hightop depth inl .....	.....	.....	.....	.....	.....
L3223	A	Mens surgical boot each .....	.....	.....	.....	.....	.....
L3224	A	Woman's shoe oxford brace .....	.....	.....	.....	.....	.....
L3225	A	Man's shoe oxford brace .....	.....	.....	.....	.....	.....
L3230	A	Custom shoes depth inlay .....	.....	.....	.....	.....	.....
L3250	A	Custom mold shoe remov prost .....	.....	.....	.....	.....	.....
L3251	A	Shoe molded to pt silicone s .....	.....	.....	.....	.....	.....
L3252	A	Shoe molded plastazote cust .....	.....	.....	.....	.....	.....
L3253	A	Shoe molded plastazote cust .....	.....	.....	.....	.....	.....
L3254	A	Orth foot non-standard size/w .....	.....	.....	.....	.....	.....
L3255	A	Orth foot non-standard size/ .....	.....	.....	.....	.....	.....
L3257	A	Orth foot add charge split s .....	.....	.....	.....	.....	.....
L3260	A	Ambulatory surgical boot eac .....	.....	.....	.....	.....	.....
L3265	A	Plastazote sandal each .....	.....	.....	.....	.....	.....
L3300	A	Sho lift taper to metatarsal .....	.....	.....	.....	.....	.....
L3310	A	Shoe lift elev heel/sole neo .....	.....	.....	.....	.....	.....
L3320	A	Shoe lift elev heel/sole cor .....	.....	.....	.....	.....	.....
L3330	A	Lifts elevation metal extens .....	.....	.....	.....	.....	.....
L3332	A	Shoe lifts tapered to one-ha .....	.....	.....	.....	.....	.....
L3334	A	Shoe lifts elevation heel /i .....	.....	.....	.....	.....	.....
L3340	A	Shoe wedge sach .....	.....	.....	.....	.....	.....
L3350	A	Shoe heel wedge .....	.....	.....	.....	.....	.....
L3360	A	Shoe sole wedge outside sole .....	.....	.....	.....	.....	.....
L3370	A	Shoe sole wedge between sole .....	.....	.....	.....	.....	.....
L3380	A	Shoe clubfoot wedge .....	.....	.....	.....	.....	.....
L3390	A	Shoe outflare wedge .....	.....	.....	.....	.....	.....
L3400	A	Shoe metatarsal bar wedge ro .....	.....	.....	.....	.....	.....
L3410	A	Shoe metatarsal bar between .....	.....	.....	.....	.....	.....
L3420	A	Full sole/heel wedge btween .....	.....	.....	.....	.....	.....
L3430	A	Sho heel count plast reinfor .....	.....	.....	.....	.....	.....
L3440	A	Heel leather reinforced .....	.....	.....	.....	.....	.....
L3450	A	Shoe heel sach cushion type .....	.....	.....	.....	.....	.....
L3455	A	Shoe heel new leather standa .....	.....	.....	.....	.....	.....
L3460	A	Shoe heel new rubber standar .....	.....	.....	.....	.....	.....
L3465	A	Shoe heel thomas with wedge .....	.....	.....	.....	.....	.....
L3470	A	Shoe heel thomas extend to b .....	.....	.....	.....	.....	.....
L3480	A	Shoe heel pad & depress for .....	.....	.....	.....	.....	.....
L3485	A	Shoe heel pad removable for .....	.....	.....	.....	.....	.....
L3500	A	Shoe misc add insole leather .....	.....	.....	.....	.....	.....
L3510	A	Shoe misc addition insole ru .....	.....	.....	.....	.....	.....
L3520	A	Shoe insole felt cver w/ lea .....	.....	.....	.....	.....	.....
L3530	A	Shoe misc additions sole hal .....	.....	.....	.....	.....	.....
L3540	A	Shoe misc additions sole ful .....	.....	.....	.....	.....	.....
L3550	A	Shoe misc add toe tap standa .....	.....	.....	.....	.....	.....
L3560	A	Shoe misc add toe tap horses .....	.....	.....	.....	.....	.....
L3570	A	Shoe special extension to in .....	.....	.....	.....	.....	.....
L3580	A	Shoe convert instep velcro c .....	.....	.....	.....	.....	.....
L3590	A	Shoe convert firm to soft cn .....	.....	.....	.....	.....	.....
L3595	A	Shoe misc additions march ba .....	.....	.....	.....	.....	.....
L3600	A	Trans shoe calip plate exist .....	.....	.....	.....	.....	.....
L3610	A	Trans shoe caliper plate new .....	.....	.....	.....	.....	.....
L3620	A	Trans shoe solid stirrup exi .....	.....	.....	.....	.....	.....
L3630	A	Trans shoe solid stirrup new .....	.....	.....	.....	.....	.....
L3640	A	Shoe dennis browne splint bo .....	.....	.....	.....	.....	.....
L3649	A	Unlist proc orth shoe modif/ .....	.....	.....	.....	.....	.....
L3650	A	Shlder fig 8 abduct restrain .....	.....	.....	.....	.....	.....
L3660	A	Abduct restrainer canvas & web .....	.....	.....	.....	.....	.....
L3670	A	Acromio/clavicular canvas & we .....	.....	.....	.....	.....	.....
L3700	A	Elbow orthoses elas w stays .....	.....	.....	.....	.....	.....
L3710	A	Elbow elastic with metal joi .....	.....	.....	.....	.....	.....
L3720	A	Forearm/arm cuffs free motio .....	.....	.....	.....	.....	.....
L3730	A	Forearm/arm cuffs ext/flex a .....	.....	.....	.....	.....	.....
L3740	A	Cuffs adj lock w/ active con .....	.....	.....	.....	.....	.....
L3800	A	Whfo short opponen no attach .....	.....	.....	.....	.....	.....
L3805	A	Whfo long opponens no attach					
L3810	A	Whfo thumb abduction bar					
L3815	A	Whfo second m.p. abduction a					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L3820	A	Whfo ip ext asst w/ mp ext s .....	.....	.....	.....	.....	.....
L3825	A	Whfo m.p. extension stop .....	.....	.....	.....	.....	.....
L3830	A	Whfo m.p. extension assist .....	.....	.....	.....	.....	.....
L3835	A	Whfo m.p. spring extension a .....	.....	.....	.....	.....	.....
L3840	A	Whfo spring swivel thumb .....	.....	.....	.....	.....	.....
L3845	A	Whfo thumb ip ext ass w/ mp .....	.....	.....	.....	.....	.....
L3850	A	Action wrist w/ dorsiflex as .....	.....	.....	.....	.....	.....
L3855	A	Whfo adj m.p. flexion contro .....	.....	.....	.....	.....	.....
L3860	A	Whfo adj m.p. flex ctrl & i .....	.....	.....	.....	.....	.....
L3890	A	Torsion mechanism wrist/elbo .....	.....	.....	.....	.....	.....
L3900	A	Hinge extension/flex wrist/f .....	.....	.....	.....	.....	.....
L3901	A	Hinge ext/flex wrist finger .....	.....	.....	.....	.....	.....
L3902	A	Whfo ext power compress gas .....	.....	.....	.....	.....	.....
L3904	A	Whfo electric custom fitted .....	.....	.....	.....	.....	.....
L3906	A	Wrist gauntlet molded to pt .....	.....	.....	.....	.....	.....
L3907	A	Whfo wrst gauntlt thmb spica .....	.....	.....	.....	.....	.....
L3908	A	Wrist cock-up non-molded .....	.....	.....	.....	.....	.....
L3910	A	Whfo swanson design .....	.....	.....	.....	.....	.....
L3912	A	Flex glove w/elastic finger .....	.....	.....	.....	.....	.....
L3914	A	WHO wrist extension cock-up .....	.....	.....	.....	.....	.....
L3916	A	Whfo wrist extens w/ outrigg .....	.....	.....	.....	.....	.....
L3918	A	HFO knuckle bender .....	.....	.....	.....	.....	.....
L3920	A	Knuckle bender with outrigge .....	.....	.....	.....	.....	.....
L3922	A	Knuckle bend 2 seg to flex j .....	.....	.....	.....	.....	.....
L3924	A	Oppenheimer .....	.....	.....	.....	.....	.....
L3926	A	Thomas suspension .....	.....	.....	.....	.....	.....
L3928	A	Finger extension w/ clock sp .....	.....	.....	.....	.....	.....
L3930	A	Finger extension with wrist .....	.....	.....	.....	.....	.....
L3932	A	Safety pin spring wire .....	.....	.....	.....	.....	.....
L3934	A	Safety pin modified .....	.....	.....	.....	.....	.....
L3936	A	Palmer .....	.....	.....	.....	.....	.....
L3938	A	Dorsal wrist .....	.....	.....	.....	.....	.....
L3940	A	Dorsal wrist w/outrigger at .....	.....	.....	.....	.....	.....
L3942	A	Reverse knuckle bender .....	.....	.....	.....	.....	.....
L3944	A	Reverse knuckle bend w/ outr .....	.....	.....	.....	.....	.....
L3946	A	HFO composite elastic .....	.....	.....	.....	.....	.....
L3948	A	Finger knuckle bender .....	.....	.....	.....	.....	.....
L3950	A	Oppenheimer w/ knuckle bend .....	.....	.....	.....	.....	.....
L3952	A	Oppenheimer w/ rev knuckle 2 .....	.....	.....	.....	.....	.....
L3954	A	Spreading hand .....	.....	.....	.....	.....	.....
L3956	A	Add joint upper ext orthosis .....	.....	.....	.....	.....	.....
L3960	A	Sewho airplan desig abdu pos .....	.....	.....	.....	.....	.....
L3962	A	Sewho erbs palsey design abd .....	.....	.....	.....	.....	.....
L3963	A	Molded w/ articulating elbow .....	.....	.....	.....	.....	.....
L3964	A	Seo mobile arm sup att to wc .....	.....	.....	.....	.....	.....
L3965	A	Arm supp att to wc rancho ty .....	.....	.....	.....	.....	.....
L3966	A	Mobile arm supports reclinin .....	.....	.....	.....	.....	.....
L3968	A	Friction dampening arm supp .....	.....	.....	.....	.....	.....
L3969	A	Monosuspension arm/hand supp .....	.....	.....	.....	.....	.....
L3970	A	Elevat proximal arm support .....	.....	.....	.....	.....	.....
L3972	A	Offset/lat rocker arm w/ ela .....	.....	.....	.....	.....	.....
L3974	A	Mobile arm support supinator .....	.....	.....	.....	.....	.....
L3980	A	Upp ext fx orthosis humeral .....	.....	.....	.....	.....	.....
L3982	A	Upper ext fx orthosis rad/ul .....	.....	.....	.....	.....	.....
L3984	A	Upper ext fx orthosis wrist .....	.....	.....	.....	.....	.....
L3985	A	Forearm hand fx orth w/ wr h .....	.....	.....	.....	.....	.....
L3986	A	Humeral rad/ulna wrist fx or .....	.....	.....	.....	.....	.....
L3995	A	Sock fracture or equal each .....	.....	.....	.....	.....	.....
L3999	A	Upper limb orthosis NOS .....	.....	.....	.....	.....	.....
L4000	A	Repl girdle milwaukee orth .....	.....	.....	.....	.....	.....
L4010	A	Replace trilateral socket br .....	.....	.....	.....	.....	.....
L4020	A	Replace quadlat socket brim .....	.....	.....	.....	.....	.....
L4030	A	Replace socket brim cust fit .....	.....	.....	.....	.....	.....
L4040	A	Replace molded thigh lacer .....	.....	.....	.....	.....	.....
L4045	A	Replace non-molded thigh lac .....	.....	.....	.....	.....	.....
L4050	A	Replace molded calf lacer .....	.....	.....	.....	.....	.....
L4055	A	Replace non-molded calf lace .....	.....	.....	.....	.....	.....
L4060	A	Replace high roll cuff .....	.....	.....	.....	.....	.....
L4070	A	Replace prox & dist upright .....	.....	.....	.....	.....	.....
L4080	A	Repl met band kafo-afo prox .....	.....	.....	.....	.....	.....
L4090	A	Repl met band kafo-afo calf/ .....	.....	.....	.....	.....	.....
L4100	A	Repl leath cuff kafo prox th .....	.....	.....	.....	.....	.....
L4110	A	Repl leath cuff kafo-afo cal					
L4130	A	Replace pretibial shell					
L4205	A	Ortho dvc repair per 15 min					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L4210	A	Orth dev repair/repl minor p .....	.....	.....	.....	.....	.....
L4310	A	Multi-podus/eq orth prep mgmt .....	.....	.....	.....	.....	.....
L4320	A	Low ext mgmt sys ft pos afo .....	.....	.....	.....	.....	.....
L4350	A	Pneumatic ankle cntrl splint .....	.....	.....	.....	.....	.....
L4360	A	Pneumatic walking splint .....	.....	.....	.....	.....	.....
L4370	A	Pneumatic full leg splint .....	.....	.....	.....	.....	.....
L4380	A	Pneumatic knee splint .....	.....	.....	.....	.....	.....
L4390	A	Replace multi-podus splint .....	.....	.....	.....	.....	.....
L4392	A	Replace ankle contrac splint .....	.....	.....	.....	.....	.....
L4394	A	Replace foot drop splint .....	.....	.....	.....	.....	.....
L4396	A	Ankle contracture splint .....	.....	.....	.....	.....	.....
L4398	A	Foot drop splint recumbent .....	.....	.....	.....	.....	.....
L5000	A	Sho insert w arch toe filler .....	.....	.....	.....	.....	.....
L5010	A	Mold socket ank hgt w/ toe f .....	.....	.....	.....	.....	.....
L5020	A	Tibial tubercle hgt w/ toe f .....	.....	.....	.....	.....	.....
L5050	A	Ank symes mold sckt sach ft .....	.....	.....	.....	.....	.....
L5060	A	Symes met fr leath socket ar .....	.....	.....	.....	.....	.....
L5100	A	Molded socket shin sach foot .....	.....	.....	.....	.....	.....
L5105	A	Plast socket jts/thgh lacer .....	.....	.....	.....	.....	.....
L5150	A	Mold sckt ext knee shin sach .....	.....	.....	.....	.....	.....
L5160	A	Mold socket bent knee shin s .....	.....	.....	.....	.....	.....
L5200	A	Kne sing axis fric shin sach .....	.....	.....	.....	.....	.....
L5210	A	No knee/ankle joints w/ ft b .....	.....	.....	.....	.....	.....
L5220	A	No knee joint with artic ali .....	.....	.....	.....	.....	.....
L5230	A	Fem focal defic constant fri .....	.....	.....	.....	.....	.....
L5250	A	Hip canad sing axi cons fric .....	.....	.....	.....	.....	.....
L5270	A	Tilt table locking hip sing .....	.....	.....	.....	.....	.....
L5280	A	Hemipelvect canad sing axis .....	.....	.....	.....	.....	.....
L5300	A	Bk sach soft cover & finish .....	.....	.....	.....	.....	.....
L5310	A	Knee disart sach soft cv/fin .....	.....	.....	.....	.....	.....
L5320	A	Ak open end sach soft cv/fin .....	.....	.....	.....	.....	.....
L5330	A	Hip canadian sach sft cv/fin .....	.....	.....	.....	.....	.....
L5340	A	Hemipelvectomy canad cv/fin .....	.....	.....	.....	.....	.....
L5400	A	Postop dress & 1 cast chg bk .....	.....	.....	.....	.....	.....
L5410	A	Postop dsq bk ea add cast ch .....	.....	.....	.....	.....	.....
L5420	A	Postop dsq & 1 cast chg ak/d .....	.....	.....	.....	.....	.....
L5430	A	Postop dsq ak ea add cast ch .....	.....	.....	.....	.....	.....
L5450	A	Postop app non-wgt bear dsq .....	.....	.....	.....	.....	.....
L5460	A	Postop app non-wgt bear dsq .....	.....	.....	.....	.....	.....
L5500	A	Init bk ptb plaster direct .....	.....	.....	.....	.....	.....
L5505	A	Init ak ischal plstr direct .....	.....	.....	.....	.....	.....
L5510	A	Prep BK ptb plaster molded .....	.....	.....	.....	.....	.....
L5520	A	Prep BK ptb thermopls direct .....	.....	.....	.....	.....	.....
L5530	A	Prep BK ptb thermopls molded .....	.....	.....	.....	.....	.....
L5535	A	Prep BK ptb open end socket .....	.....	.....	.....	.....	.....
L5540	A	Prep BK ptb laminated socket .....	.....	.....	.....	.....	.....
L5560	A	Prep AK ischial plast molded .....	.....	.....	.....	.....	.....
L5570	A	Prep AK ischial direct form .....	.....	.....	.....	.....	.....
L5580	A	Prep AK ischial thermo mold .....	.....	.....	.....	.....	.....
L5585	A	Prep AK ischial open end .....	.....	.....	.....	.....	.....
L5590	A	Prep AK ischial laminated .....	.....	.....	.....	.....	.....
L5595	A	Hip disartic sach thermopls .....	.....	.....	.....	.....	.....
L5600	A	Hip disart sach laminat mold .....	.....	.....	.....	.....	.....
L5610	A	Above knee hydracadence .....	.....	.....	.....	.....	.....
L5611	A	Ak 4 bar link w/fric swing .....	.....	.....	.....	.....	.....
L5613	A	Ak 4 bar ling w/hydraul swig .....	.....	.....	.....	.....	.....
L5614	A	4-bar link above knee w/swng .....	.....	.....	.....	.....	.....
L5616	A	Ak univ multiplex sys frict .....	.....	.....	.....	.....	.....
L5617	A	AK/BK self-aligning unit ea .....	.....	.....	.....	.....	.....
L5618	A	Test socket symes .....	.....	.....	.....	.....	.....
L5620	A	Test socket below knee .....	.....	.....	.....	.....	.....
L5622	A	Test socket knee disarticula .....	.....	.....	.....	.....	.....
L5624	A	Test socket above knee .....	.....	.....	.....	.....	.....
L5626	A	Test socket hip disarticulat .....	.....	.....	.....	.....	.....
L5628	A	Test socket hemipelvectomy .....	.....	.....	.....	.....	.....
L5629	A	Below knee acrylic socket .....	.....	.....	.....	.....	.....
L5630	A	Syme typ expandabl wall sckt .....	.....	.....	.....	.....	.....
L5631	A	Ak/knee disartic acrylic soc .....	.....	.....	.....	.....	.....
L5632	A	Symes type ptb brim design s .....	.....	.....	.....	.....	.....
L5634	A	Symes type poster opening so .....	.....	.....	.....	.....	.....
L5636	A	Symes type medial opening so .....	.....	.....	.....	.....	.....
L5637	A	Below knee total contact .....	.....	.....	.....	.....	.....
L5638	A	Below knee leather socket					
L5639	A	Below knee wood socket					
L5640	A	Knee disarticulat leather so					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L5642	A	Above knee leather socket .....	.....	.....	.....	.....	.....
L5643	A	Hip flex inner socket ext fr .....	.....	.....	.....	.....	.....
L5644	A	Above knee wood socket .....	.....	.....	.....	.....	.....
L5645	A	Ak flexibl inner socket ext .....	.....	.....	.....	.....	.....
L5646	A	Below knee air cushion socke .....	.....	.....	.....	.....	.....
L5647	A	Below knee suction socket .....	.....	.....	.....	.....	.....
L5648	A	Above knee air cushion socke .....	.....	.....	.....	.....	.....
L5649	A	Isch containmt/narrow m-l so .....	.....	.....	.....	.....	.....
L5650	A	Tot contact ak/knee disart s .....	.....	.....	.....	.....	.....
L5651	A	Ak flex inner socket ext fra .....	.....	.....	.....	.....	.....
L5652	A	Suction susp ak/knee disart .....	.....	.....	.....	.....	.....
L5653	A	Knee disart expand wall sock .....	.....	.....	.....	.....	.....
L5654	A	Socket insert symes .....	.....	.....	.....	.....	.....
L5655	A	Socket insert below knee .....	.....	.....	.....	.....	.....
L5656	A	Socket insert knee articulata .....	.....	.....	.....	.....	.....
L5658	A	Socket insert above knee .....	.....	.....	.....	.....	.....
L5660	A	Sock insrt syme silicone gel .....	.....	.....	.....	.....	.....
L5661	A	Multi-durometer symes .....	.....	.....	.....	.....	.....
L5662	A	Socket insert bk silicone ge .....	.....	.....	.....	.....	.....
L5663	A	Sock knee disartic silicone .....	.....	.....	.....	.....	.....
L5664	A	Socket insert ak silicone ge .....	.....	.....	.....	.....	.....
L5665	A	Multi-durometer below knee .....	.....	.....	.....	.....	.....
L5666	A	Below knee cuff suspension .....	.....	.....	.....	.....	.....
L5667	A	Socket insert w lock lower .....	.....	.....	.....	.....	.....
L5668	A	Socket insert w/o lock lower .....	.....	.....	.....	.....	.....
L5669	A	Below knee socket w/o lock .....	.....	.....	.....	.....	.....
L5670	A	Bk molded supracondylar susp .....	.....	.....	.....	.....	.....
L5672	A	Bk removable medial brim sus .....	.....	.....	.....	.....	.....
L5674	A	Bk latex sleeve suspension/e .....	.....	.....	.....	.....	.....
L5675	A	Bk latex sleeve susp/eq hvy .....	.....	.....	.....	.....	.....
L5676	A	Bk knee joints single axis p .....	.....	.....	.....	.....	.....
L5677	A	Bk knee joints polycentric p .....	.....	.....	.....	.....	.....
L5678	A	Bk joint covers pair .....	.....	.....	.....	.....	.....
L5680	A	Bk thigh lacer non-molded .....	.....	.....	.....	.....	.....
L5682	A	Bk thigh lacer glut/ischia m .....	.....	.....	.....	.....	.....
L5684	A	Bk fork strap .....	.....	.....	.....	.....	.....
L5686	A	Bk back check .....	.....	.....	.....	.....	.....
L5688	A	Bk waist belt webbing .....	.....	.....	.....	.....	.....
L5690	A	Bk waist belt padded and lin .....	.....	.....	.....	.....	.....
L5692	A	Ak pelvic control belt light .....	.....	.....	.....	.....	.....
L5694	A	Ak pelvic control belt pad/l .....	.....	.....	.....	.....	.....
L5695	A	Ak sleeve susp neoprene/equa .....	.....	.....	.....	.....	.....
L5696	A	Ak/knee disartic pelvic join .....	.....	.....	.....	.....	.....
L5697	A	Ak/knee disartic pelvic band .....	.....	.....	.....	.....	.....
L5698	A	Ak/knee disartic silesian ba .....	.....	.....	.....	.....	.....
L5699	A	Shoulder harness .....	.....	.....	.....	.....	.....
L5700	A	Replace socket below knee .....	.....	.....	.....	.....	.....
L5701	A	Replace socket above knee .....	.....	.....	.....	.....	.....
L5702	A	Replace socket hip .....	.....	.....	.....	.....	.....
L5704	A	Custom shape covr below knee .....	.....	.....	.....	.....	.....
L5705	A	Custm shape cover above knee .....	.....	.....	.....	.....	.....
L5706	A	Custm shape cvr knee disart .....	.....	.....	.....	.....	.....
L5707	A	Custm shape cover hip disart .....	.....	.....	.....	.....	.....
L5710	A	Knee-shin exo sng axi mnl loc .....	.....	.....	.....	.....	.....
L5711	A	Knee-shin exo mnl lock ultra .....	.....	.....	.....	.....	.....
L5712	A	Knee-shin exo frict swg & st .....	.....	.....	.....	.....	.....
L5714	A	Knee-shin exo variable frict .....	.....	.....	.....	.....	.....
L5716	A	Knee-shin exo mech stance ph .....	.....	.....	.....	.....	.....
L5718	A	Knee-shin exo frct swg & sta .....	.....	.....	.....	.....	.....
L5722	A	Knee-shin pneum swg frct exo .....	.....	.....	.....	.....	.....
L5724	A	Knee-shin exo fluid swing ph .....	.....	.....	.....	.....	.....
L5726	A	Knee-shin ext jnts fld swg e .....	.....	.....	.....	.....	.....
L5728	A	Knee-shin fluid swg & stance .....	.....	.....	.....	.....	.....
L5780	A	Knee-shin pneum/hydra pneum .....	.....	.....	.....	.....	.....
L5785	A	Exoskeletal bk ultra-lt mater .....	.....	.....	.....	.....	.....
L5790	A	Exoskeletal ak ultra-light m .....	.....	.....	.....	.....	.....
L5795	A	Exoskel hip ultra-light mate .....	.....	.....	.....	.....	.....
L5810	A	Endoskel knee-shin mnl lock .....	.....	.....	.....	.....	.....
L5811	A	Endo knee-shin mnl lck ultra .....	.....	.....	.....	.....	.....
L5812	A	Endo knee-shin frct swg & st .....	.....	.....	.....	.....	.....
L5814	A	Endo knee-shin hydra swg ph .....	.....	.....	.....	.....	.....
L5816	A	Endo knee-shin polyc mch sta .....	.....	.....	.....	.....	.....
L5818	A	Endo knee-shin frct swg & st					
L5822	A	Endo knee-shin pneum swg frc					
L5824	A	Endo knee-shin fluid swing p					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT-1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L5826	A	Pediatric knee joint .....	.....	.....	.....	.....	.....
L5828	A	Endo knee-shin fluid swg/sta .....	.....	.....	.....	.....	.....
L5830	A	Endo knee-shin pneum/swg pha .....	.....	.....	.....	.....	.....
L5840	A	Multi-axial knee/shin system .....	.....	.....	.....	.....	.....
L5845	A	Knee-shin sys stance flexion .....	.....	.....	.....	.....	.....
L5846	A	Knee-shin sys microprocessor .....	.....	.....	.....	.....	.....
L5850	A	Endo ak/hip knee extens assi .....	.....	.....	.....	.....	.....
L5855	A	Mech hip extension assist .....	.....	.....	.....	.....	.....
L5910	A	Endo below knee alignable sy .....	.....	.....	.....	.....	.....
L5920	A	Endo ak/hip alignable system .....	.....	.....	.....	.....	.....
L5925	A	Above knee manual lock .....	.....	.....	.....	.....	.....
L5930	A	High activity knee frame .....	.....	.....	.....	.....	.....
L5940	A	Endo bk ultra-light material .....	.....	.....	.....	.....	.....
L5950	A	Endo ak ultra-light material .....	.....	.....	.....	.....	.....
L5960	A	Endo hip ultra-light materia .....	.....	.....	.....	.....	.....
L5962	A	Below knee flex cover system .....	.....	.....	.....	.....	.....
L5964	A	Above knee flex cover system .....	.....	.....	.....	.....	.....
L5966	A	Hip flexible cover system .....	.....	.....	.....	.....	.....
L5970	A	Foot external keel sach foot .....	.....	.....	.....	.....	.....
L5972	A	Flexible keel foot .....	.....	.....	.....	.....	.....
L5974	A	Foot single axis ankle/foot .....	.....	.....	.....	.....	.....
L5976	A	Energy storing foot .....	.....	.....	.....	.....	.....
L5978	A	Ft prosth multiaxial anl/ft .....	.....	.....	.....	.....	.....
L5979	A	Multi-axial ankle/ft prosth .....	.....	.....	.....	.....	.....
L5980	A	Flex foot system .....	.....	.....	.....	.....	.....
L5981	A	Flex-walk sys low ext prosth .....	.....	.....	.....	.....	.....
L5982	A	Exoskeletal axial rotation u .....	.....	.....	.....	.....	.....
L5984	A	Endoskeletal axial rotation .....	.....	.....	.....	.....	.....
L5985	A	Lwr ext dynamic prosth pylon .....	.....	.....	.....	.....	.....
L5986	A	Multi-axial rotation unit .....	.....	.....	.....	.....	.....
L5987	A	Shank ft w vert load pylon .....	.....	.....	.....	.....	.....
L5999	A	Lowr extremity prosthes NOS .....	.....	.....	.....	.....	.....
L6000	A	Par hand robin-aids thum rem .....	.....	.....	.....	.....	.....
L6010	A	Hand robin-aids little/ring .....	.....	.....	.....	.....	.....
L6020	A	Part hand robin-aids no fing .....	.....	.....	.....	.....	.....
L6050	A	Wrst Mld sock fix hng tri pad .....	.....	.....	.....	.....	.....
L6055	A	Wrst mold sock w/exp interfa .....	.....	.....	.....	.....	.....
L6100	A	Elb mold sock flex hinge pad .....	.....	.....	.....	.....	.....
L6110	A	Elbow mold sock suspension t .....	.....	.....	.....	.....	.....
L6120	A	Elbow mold doub splt soc ste .....	.....	.....	.....	.....	.....
L6130	A	Elbow stump activated lock h .....	.....	.....	.....	.....	.....
L6200	A	Elbow mold outsid lock hinge .....	.....	.....	.....	.....	.....
L6205	A	Elbow molded w/ expand inter .....	.....	.....	.....	.....	.....
L6250	A	Elbow inter loc elbow forarm .....	.....	.....	.....	.....	.....
L6300	A	Shldr disart int lock elbow .....	.....	.....	.....	.....	.....
L6310	A	Shoulder passive restor comp .....	.....	.....	.....	.....	.....
L6320	A	Shoulder passive restor cap .....	.....	.....	.....	.....	.....
L6350	A	Thoracic intern lock elbow .....	.....	.....	.....	.....	.....
L6360	A	Thoracic passive restor comp .....	.....	.....	.....	.....	.....
L6370	A	Thoracic passive restor cap .....	.....	.....	.....	.....	.....
L6380	A	Postop dsg cast chg wrst/elb .....	.....	.....	.....	.....	.....
L6382	A	Postop dsg cast chg elb dis/ .....	.....	.....	.....	.....	.....
L6384	A	Postop dsg cast chg shldr/t .....	.....	.....	.....	.....	.....
L6386	A	Postop ea cast chg & realign .....	.....	.....	.....	.....	.....
L6388	A	Postop applicat rigid dsg on .....	.....	.....	.....	.....	.....
L6400	A	Below elbow prosth tiss shap .....	.....	.....	.....	.....	.....
L6450	A	Elb disart prosth tiss shap .....	.....	.....	.....	.....	.....
L6500	A	Above elbow prosth tiss shap .....	.....	.....	.....	.....	.....
L6550	A	Shldr disart prosth tiss shap .....	.....	.....	.....	.....	.....
L6570	A	Scap thorac prosth tiss shap .....	.....	.....	.....	.....	.....
L6580	A	Wrist/elbow bowden cable mol .....	.....	.....	.....	.....	.....
L6582	A	Wrist/elbow bowden cbl dir f .....	.....	.....	.....	.....	.....
L6584	A	Elbow fair lead cable molded .....	.....	.....	.....	.....	.....
L6586	A	Elbow fair lead cable dir fo .....	.....	.....	.....	.....	.....
L6588	A	Shdr fair lead cable molded .....	.....	.....	.....	.....	.....
L6590	A	Shdr fair lead cable direct .....	.....	.....	.....	.....	.....
L6600	A	Polycentric hinge pair .....	.....	.....	.....	.....	.....
L6605	A	Single pivot hinge pair .....	.....	.....	.....	.....	.....
L6610	A	Flexible metal hinge pair .....	.....	.....	.....	.....	.....
L6615	A	Disconnect locking wrist uni .....	.....	.....	.....	.....	.....
L6616	A	Disconnect insert locking wr .....	.....	.....	.....	.....	.....
L6620	A	Flexion-friction wrist unit .....	.....	.....	.....	.....	.....
L6623	A	Spring-ass rot wrst w/ latch					
L6625	A	Rotation wrst w/ cable lock					
L6628	A	Quick disconn hook adapter o					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L6629	A	Lamination collar w/couplin .....	.....	.....	.....	.....	.....
L6630	A	Stainless steel any wrist .....	.....	.....	.....	.....	.....
L6632	A	Latex suspension sleeve each .....	.....	.....	.....	.....	.....
L6635	A	Lift assist for elbow .....	.....	.....	.....	.....	.....
L6637	A	Nudge control elbow lock .....	.....	.....	.....	.....	.....
L6640	A	Shoulder abduction joint pai .....	.....	.....	.....	.....	.....
L6641	A	Excursion amplifier pulley t .....	.....	.....	.....	.....	.....
L6642	A	Excursion amplifier lever ty .....	.....	.....	.....	.....	.....
L6645	A	Shoulder flexion-abduction j .....	.....	.....	.....	.....	.....
L6650	A	Shoulder universal joint .....	.....	.....	.....	.....	.....
L6655	A	Standard control cable extra .....	.....	.....	.....	.....	.....
L6660	A	Heavy duty control cable .....	.....	.....	.....	.....	.....
L6665	A	Teflon or equal cable lining .....	.....	.....	.....	.....	.....
L6670	A	Hook to hand cable adapter .....	.....	.....	.....	.....	.....
L6672	A	Harness chest/shlder saddle .....	.....	.....	.....	.....	.....
L6675	A	Harness figure of 8 sing con .....	.....	.....	.....	.....	.....
L6676	A	Harness figure of 8 dual con .....	.....	.....	.....	.....	.....
L6680	A	Test sock wrist disart/bel e .....	.....	.....	.....	.....	.....
L6682	A	Test sock elbw disart/above .....	.....	.....	.....	.....	.....
L6684	A	Test socket shldr disart/tho .....	.....	.....	.....	.....	.....
L6686	A	Suction socket .....	.....	.....	.....	.....	.....
L6687	A	Frame typ socket bel elbow/w .....	.....	.....	.....	.....	.....
L6688	A	Frame typ sock above elb/dis .....	.....	.....	.....	.....	.....
L6689	A	Frame typ socket shoulder di .....	.....	.....	.....	.....	.....
L6690	A	Frame typ sock interscap-tho .....	.....	.....	.....	.....	.....
L6691	A	Removable insert each .....	.....	.....	.....	.....	.....
L6692	A	Silicone gel insert or equal .....	.....	.....	.....	.....	.....
L6700	A	Terminal device model #3 .....	.....	.....	.....	.....	.....
L6705	A	Terminal device model #5 .....	.....	.....	.....	.....	.....
L6710	A	Terminal device model #5x .....	.....	.....	.....	.....	.....
L6715	A	Terminal device model #5xa .....	.....	.....	.....	.....	.....
L6720	A	Terminal device model #6 .....	.....	.....	.....	.....	.....
L6725	A	Terminal device model #7 .....	.....	.....	.....	.....	.....
L6730	A	Terminal device model #7lo .....	.....	.....	.....	.....	.....
L6735	A	Terminal device model #8 .....	.....	.....	.....	.....	.....
L6740	A	Terminal device model #8x .....	.....	.....	.....	.....	.....
L6745	A	Terminal device model #88x .....	.....	.....	.....	.....	.....
L6750	A	Terminal device model #10p .....	.....	.....	.....	.....	.....
L6755	A	Terminal device model #10x .....	.....	.....	.....	.....	.....
L6765	A	Terminal device model #12p .....	.....	.....	.....	.....	.....
L6770	A	Terminal device model #99x .....	.....	.....	.....	.....	.....
L6775	A	Terminal device model#555 .....	.....	.....	.....	.....	.....
L6780	A	Terminal device model #ss555 .....	.....	.....	.....	.....	.....
L6790	A	Hooks-accu hook or equal .....	.....	.....	.....	.....	.....
L6795	A	Hooks-2 load or equal .....	.....	.....	.....	.....	.....
L6800	A	Hooks-aprl vc or equal .....	.....	.....	.....	.....	.....
L6805	A	Modifier wrist flexion unit .....	.....	.....	.....	.....	.....
L6806	A	Trs grip vc or equal .....	.....	.....	.....	.....	.....
L6807	A	Term device grip1/2 or equal .....	.....	.....	.....	.....	.....
L6808	A	Term device infant or child .....	.....	.....	.....	.....	.....
L6809	A	Trs super sport passive .....	.....	.....	.....	.....	.....
L6810	A	Pincher tool otto bock or eq .....	.....	.....	.....	.....	.....
L6825	A	Hands dorrance vo .....	.....	.....	.....	.....	.....
L6830	A	Hand aprl vc .....	.....	.....	.....	.....	.....
L6835	A	Hand sierra vo .....	.....	.....	.....	.....	.....
L6840	A	Hand becker imperial .....	.....	.....	.....	.....	.....
L6845	A	Hand becker lock grip .....	.....	.....	.....	.....	.....
L6850	A	Term dvc-hand becker plylite .....	.....	.....	.....	.....	.....
L6855	A	Hand robin-aids vo .....	.....	.....	.....	.....	.....
L6860	A	Hand robin-aids vo soft .....	.....	.....	.....	.....	.....
L6865	A	Hand passive hand .....	.....	.....	.....	.....	.....
L6867	A	Hand detroit infant hand .....	.....	.....	.....	.....	.....
L6868	A	Passive inf hand steeper/hos .....	.....	.....	.....	.....	.....
L6870	A	Hand child mitt .....	.....	.....	.....	.....	.....
L6872	A	Hand nyu child hand .....	.....	.....	.....	.....	.....
L6873	A	Hand mech inf steeper or equ .....	.....	.....	.....	.....	.....
L6875	A	Hand bock vc .....	.....	.....	.....	.....	.....
L6880	A	Hand bock vo .....	.....	.....	.....	.....	.....
L6890	A	Production glove .....	.....	.....	.....	.....	.....
L6895	A	Custom glove .....	.....	.....	.....	.....	.....
L6900	A	Hand restorat thumb/1 finger .....	.....	.....	.....	.....	.....
L6905	A	Hand restoration multiple fi .....	.....	.....	.....	.....	.....
L6910	A	Hand restoration no fingers .....	.....	.....	.....	.....	.....
L6915	A	Hand restoration replacmnt g					
L6920	A	Wrist disarticul switch ctrl					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L6925	A	Wrist disart myoelectronic c .....	.....	.....	.....	.....	.....
L6930	A	Below elbow switch control .....	.....	.....	.....	.....	.....
L6935	A	Below elbow myoelectronic ct .....	.....	.....	.....	.....	.....
L6940	A	Elbow disarticulation switch .....	.....	.....	.....	.....	.....
L6945	A	Elbow disart myoelectronic c .....	.....	.....	.....	.....	.....
L6950	A	Above elbow switch control .....	.....	.....	.....	.....	.....
L6955	A	Above elbow myoelectronic ct .....	.....	.....	.....	.....	.....
L6960	A	Shldr disartic switch contro .....	.....	.....	.....	.....	.....
L6965	A	Shldr disartic myoelectronic .....	.....	.....	.....	.....	.....
L6970	A	Interscapular-thor switch ct .....	.....	.....	.....	.....	.....
L6975	A	Interscap-thor myoelectronic .....	.....	.....	.....	.....	.....
L7010	A	Hand otto back steeper/eq sw .....	.....	.....	.....	.....	.....
L7015	A	Hand sys teknik village swit .....	.....	.....	.....	.....	.....
L7020	A	Electronic greifer switch ct .....	.....	.....	.....	.....	.....
L7025	A	Electron hand myoelectronic .....	.....	.....	.....	.....	.....
L7030	A	Hand sys teknik vill myoelec .....	.....	.....	.....	.....	.....
L7035	A	Electron greifer myoelectro .....	.....	.....	.....	.....	.....
L7040	A	Prehensile actuator hosmer s .....	.....	.....	.....	.....	.....
L7045	A	Electron hook child michigan .....	.....	.....	.....	.....	.....
L7170	A	Electronic elbow hosmer swit .....	.....	.....	.....	.....	.....
L7180	A	Electronic elbow utah myoele .....	.....	.....	.....	.....	.....
L7185	A	Electron elbow adolescent sw .....	.....	.....	.....	.....	.....
L7186	A	Electron elbow child switch .....	.....	.....	.....	.....	.....
L7190	A	Elbow adolescent myoelectron .....	.....	.....	.....	.....	.....
L7191	A	Elbow child myoelectronic ct .....	.....	.....	.....	.....	.....
L7260	A	Electron wrist rotator otto .....	.....	.....	.....	.....	.....
L7261	A	Electron wrist rotator utah .....	.....	.....	.....	.....	.....
L7266	A	Servo control steeper or equ .....	.....	.....	.....	.....	.....
L7272	A	Analogue control unb or equa .....	.....	.....	.....	.....	.....
L7274	A	Proportional ctl 12 volt uta .....	.....	.....	.....	.....	.....
L7360	A	Six volt bat otto bock/eq ea .....	.....	.....	.....	.....	.....
L7362	A	Battery chrgr six volt otto .....	.....	.....	.....	.....	.....
L7364	A	Twelve volt battery utah/equ .....	.....	.....	.....	.....	.....
L7366	A	Battery chrgr 12 volt utah/e .....	.....	.....	.....	.....	.....
L7499	A	Upper extremity prosthes NOS .....	.....	.....	.....	.....	.....
L7500	A	Prosthetic dvc repair hourly .....	.....	.....	.....	.....	.....
L7510	A	Prosthetic device repair rep .....	.....	.....	.....	.....	.....
L7520	A	Repair prosthesis per 15 min .....	.....	.....	.....	.....	.....
L7900	A	Vacuum erection system .....	.....	.....	.....	.....	.....
L8000	A	Mastectomy bra .....	.....	.....	.....	.....	.....
L8010	A	Mastectomy sleeve .....	.....	.....	.....	.....	.....
L8020	A	Mastectomy form .....	.....	.....	.....	.....	.....
L8030	A	Breast prosthesis silicone/e .....	.....	.....	.....	.....	.....
L8039	A	Breast prosthesis NOS .....	.....	.....	.....	.....	.....
L8100	A	Elas suprt stock bk med wgt .....	.....	.....	.....	.....	.....
L8110	A	Elastic supp stocking bk hvy .....	.....	.....	.....	.....	.....
L8120	A	Elastic supp stockng bk surg .....	.....	.....	.....	.....	.....
L8130	A	Elastic supp stocking ak med .....	.....	.....	.....	.....	.....
L8140	A	Elastic supp stocking ak hvy .....	.....	.....	.....	.....	.....
L8150	A	Elastic supp stockng ak surg .....	.....	.....	.....	.....	.....
L8160	A	Supp stocking full lgth med .....	.....	.....	.....	.....	.....
L8170	A	Supp stocking full lgth hvy .....	.....	.....	.....	.....	.....
L8180	A	Supp stocking heavy surg wei .....	.....	.....	.....	.....	.....
L8190	A	Elas stocking leotards med w .....	.....	.....	.....	.....	.....
L8200	A	Elas stocking leotards surg .....	.....	.....	.....	.....	.....
L8210	A	Elastic stocking custom made .....	.....	.....	.....	.....	.....
L8220	A	Elastic stocking lymphedema .....	.....	.....	.....	.....	.....
L8230	A	Elastic stocking garter belt .....	.....	.....	.....	.....	.....
L8239	A	Elastic support NOS .....	.....	.....	.....	.....	.....
L8300	A	Truss single w/ standard pad .....	.....	.....	.....	.....	.....
L8310	A	Truss double w/ standard pad .....	.....	.....	.....	.....	.....
L8320	A	Truss addition to std pad wa .....	.....	.....	.....	.....	.....
L8330	A	Truss add to std pad scrotal .....	.....	.....	.....	.....	.....
L8400	A	Sheath below knee .....	.....	.....	.....	.....	.....
L8410	A	Sheath above knee .....	.....	.....	.....	.....	.....
L8415	A	Sheath upper limb .....	.....	.....	.....	.....	.....
L8417	A	Pros sheath/sock w gel cushn .....	.....	.....	.....	.....	.....
L8420	A	Sock wool below knee .....	.....	.....	.....	.....	.....
L8430	A	Sock wool above knee .....	.....	.....	.....	.....	.....
L8435	A	Sock wool upper limb .....	.....	.....	.....	.....	.....
L8440	A	Shrinker below knee .....	.....	.....	.....	.....	.....
L8460	A	Shrinker above knee .....	.....	.....	.....	.....	.....
L8465	A	Shrinker upper limb .....	.....	.....	.....	.....	.....
L8470	A	Stump sock single below knee					
L8480	A	Stump sock single above knee					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L8485	A	Stump sock fitting uppr limb					
L8490	A	Air seal suction reten systm					
L8499	A	Unlisted misc prosthetic ser					
L8500	A	Artificial larynx					
L8501	A	Tracheostomy speaking valve					
L8600	A	Implant breast silicone/eq					
L8603	A	Collagen imp urinary 2.5 CC					
L8610	A	Ocular implant					
L8612	A	Aqueous shunt prosthesis					
L8613	A	Ossicular implant					
L8614	A	Cochlear device/system					
L8619	A	Replace cochlear processor					
L8630	A	Metacarpophalangeal implant					
L8641	A	Metatarsal joint implant					
L8642	A	Hallux implant					
L8658	A	Interphalangeal joint implnt					
L8670	A	Vascular graft, synthetic					
L8699	A	Prosthetic implant NOS					
M0064	X	Visit for drug monitoring	090	0.85	\$45.05	\$12.43	\$9.01
M0075	E	Cellular therapy					
M0076	E	Prolotherapy					
M0100	E	Intragastric hypothermia					
M0101	E	Foot care hygienic/pm					
M0300	E	IV chelation therapy					
M0301	E	Fabric wrapping of aneurysm					
M0302	E	Assessment of cardiac output					
P2028	A	Cephalin flocculation test					
P2029	A	Congo red blood test					
P2031	E	Hair analysis					
P2033	A	Blood thymol turbidity					
P2038	A	Blood mucoprotein					
P3000	A	Screen pap by tech w md supv					
P3001	A	Screening pap smear by phys					
P7001	E	Culture bacterial urine					
P9010	N	Whole blood for transfusion					
P9011	N	Blood split unit					
P9012	N	Cryoprecipitate each unit					
P9013	N	Unit/s blood fibrinogen					
P9014	N	Gamma globulin 1 ML					
P9015	N	Rh immune globulin 1 ML					
P9016	N	Leukocyte poor blood, unit					
P9017	N	One donor fresh frozn plasma					
P9018	N	Plasma protein fract, unit					
P9019	N	Platelet concentrate unit					
P9020	N	Platelet rich plasma unit					
P9021	N	Red blood cells unit					
P9022	N	Washed red blood cells unit					
P9603	N	One-way allow prorated miles					
P9604	N	One-way allow prorated trip					
P9610	E	Urine specimen collect singl					
P9615	E	Urine specimen collect mult					
Q0034	X	Admin of influenza vaccine	901	0.07	\$3.92	\$2.49	\$7.78
Q0035	X	Cardiokymography	950	0.35	\$18.61	\$15.82	\$3.72
Q0068	T	Extracorporeal plasmapheresis	369	4.33	\$229.19	\$97.18	\$45.84
Q0081	X	Infusion ther other than che	906	1.46	\$77.38	\$42.49	\$15.48
Q0082	X	Activity therapy w/partial h					
Q0083	S	Chemo by other than infusion	987	0.65	\$34.28	\$13.33	\$6.86
Q0084	S	Chemotherapy by infusion	989	1.72	\$91.09	\$40.68	\$18.22
Q0085	S	Chemo by both infusion and o	989	1.72	\$91.09	\$40.68	\$18.22
Q0086	A	Physical therapy evaluation/					
Q0091	T	Obtaining screen pap smear	561	1.52	\$80.32	\$24.63	\$16.06
Q0092	N	Set up port xray equipment					
Q0111	A	Wet mounts/ w preparations					
Q0112	A	Potassium hydroxide preps					
Q0113	A	Pinworm examinations					
Q0114	A	Fern test					
Q0115	A	Post-coital mucous exam					
Q0132	A	Dispensing fee DME neb drug					
Q0136	N	Non esrd epoetin alpha inj					
Q0144	E	Azithromycin dihydrate, oral					
Q0156	N	Human albumin 5%					
Q0157	N	Human albumin 25%					
Q9920	A	Epoetin with hct <= 20					
Q9921	A	Epoetin with hct = 21					
Q9922	A	Epoetin with hct = 22					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
Q9923	A	Epoetin with hct = 23 .....	.....	.....	.....	.....	.....
Q9924	A	Epoetin with hct = 24 .....	.....	.....	.....	.....	.....
Q9925	A	Epoetin with hct = 25 .....	.....	.....	.....	.....	.....
Q9926	A	Epoetin with hct = 26 .....	.....	.....	.....	.....	.....
Q9927	A	Epoetin with hct = 27 .....	.....	.....	.....	.....	.....
Q9928	A	Epoetin with hct = 28 .....	.....	.....	.....	.....	.....
Q9929	A	Epoetin with hct = 29 .....	.....	.....	.....	.....	.....
Q9930	A	Epoetin with hct = 30 .....	.....	.....	.....	.....	.....
Q9931	A	Epoetin with hct = 31 .....	.....	.....	.....	.....	.....
Q9932	A	Epoetin with hct = 32 .....	.....	.....	.....	.....	.....
Q9933	A	Epoetin with hct = 33 .....	.....	.....	.....	.....	.....
Q9934	A	Epoetin with hct = 34 .....	.....	.....	.....	.....	.....
Q9935	A	Epoetin with hct = 35 .....	.....	.....	.....	.....	.....
Q9936	A	Epoetin with hct = 36 .....	.....	.....	.....	.....	.....
Q9937	A	Epoetin with hct = 37 .....	.....	.....	.....	.....	.....
Q9938	A	Epoetin with hct = 38 .....	.....	.....	.....	.....	.....
Q9939	A	Epoetin with hct = 39 .....	.....	.....	.....	.....	.....
Q9940	A	Epoetin with hct >= 40 .....	.....	.....	.....	.....	.....
R0070	N	Transport portable x-ray .....	.....	.....	.....	.....	.....
R0075	N	Transport port x-ray multipl .....	.....	.....	.....	.....	.....
R0076	N	Transport portable EKG .....	.....	.....	.....	.....	.....
V2020	A	Vision svcs frames purchases .....	.....	.....	.....	.....	.....
V2025	E	Eyeglasses delux frames .....	.....	.....	.....	.....	.....
V2100	A	Lens sphr single plano 4.00 .....	.....	.....	.....	.....	.....
V2101	A	Single visn sphere 4.12-7.00 .....	.....	.....	.....	.....	.....
V2102	A	Singl visn sphere 7.12-20.00 .....	.....	.....	.....	.....	.....
V2103	A	Sphero cylindr 4.00d/12-2.00d .....	.....	.....	.....	.....	.....
V2104	A	Sphero cylindr 4.00d/2.12-4d .....	.....	.....	.....	.....	.....
V2105	A	Sphero cylinder 4.00d/4.25-6d .....	.....	.....	.....	.....	.....
V2106	A	Sphero cylinder 4.00d/>6.00d .....	.....	.....	.....	.....	.....
V2107	A	Sphero cylinder 4.25d/12-2d .....	.....	.....	.....	.....	.....
V2108	A	Sphero cylinder 4.25d/2.12-4d .....	.....	.....	.....	.....	.....
V2109	A	Sphero cylinder 4.25d/4.25-6d .....	.....	.....	.....	.....	.....
V2110	A	Sphero cylinder 4.25d/over 6d .....	.....	.....	.....	.....	.....
V2111	A	Sphero cylindr 7.25d/.25-2.25 .....	.....	.....	.....	.....	.....
V2112	A	Sphero cylindr 7.25d/2.25-4d .....	.....	.....	.....	.....	.....
V2113	A	Sphero cylindr 7.25d/4.25-6d .....	.....	.....	.....	.....	.....
V2114	A	Sphero cylinder over 12.00d .....	.....	.....	.....	.....	.....
V2115	A	Lens lenticular bifocal .....	.....	.....	.....	.....	.....
V2116	A	Nonaspheric lens bifocal .....	.....	.....	.....	.....	.....
V2117	A	Aspheric lens bifocal .....	.....	.....	.....	.....	.....
V2118	A	Lens aniseikonic single .....	.....	.....	.....	.....	.....
V2199	A	Lens single vision not oth c .....	.....	.....	.....	.....	.....
V2200	A	Lens sphr bifoc plano 4.00d .....	.....	.....	.....	.....	.....
V2201	A	Lens sphere bifocal 4.12-7.0 .....	.....	.....	.....	.....	.....
V2202	A	Lens sphere bifocal 7.12-20 .....	.....	.....	.....	.....	.....
V2203	A	Lens sphcyl bifocal 4.00d/.1 .....	.....	.....	.....	.....	.....
V2204	A	Lens sphcy bifocal 4.00d/2.1 .....	.....	.....	.....	.....	.....
V2205	A	Lens sphcy bifocal 4.00d/4.2 .....	.....	.....	.....	.....	.....
V2206	A	Lens sphcy bifocal 4.00d/ove .....	.....	.....	.....	.....	.....
V2207	A	Lens sphcy bifocal 4.25-7d/ .....	.....	.....	.....	.....	.....
V2208	A	Lens sphcy bifocal 4.25-7/2 .....	.....	.....	.....	.....	.....
V2209	A	Lens sphcy bifocal 4.25-7/4 .....	.....	.....	.....	.....	.....
V2210	A	Lens sphcy bifocal 4.25-7/ov .....	.....	.....	.....	.....	.....
V2211	A	Lens sphcy bifo 7.25-12/.25- .....	.....	.....	.....	.....	.....
V2212	A	Lens sphcyl bifo 7.25-12/2.2 .....	.....	.....	.....	.....	.....
V2213	A	Lens sphcyl bifo 7.25-12/4.2 .....	.....	.....	.....	.....	.....
V2214	A	Lens sphcyl bifocal over 12 .....	.....	.....	.....	.....	.....
V2215	A	Lens lenticular bifocal .....	.....	.....	.....	.....	.....
V2216	A	Lens lenticular nonaspheric .....	.....	.....	.....	.....	.....
V2217	A	Lens lenticular aspheric bif .....	.....	.....	.....	.....	.....
V2218	A	Lens aniseikonic bifocal .....	.....	.....	.....	.....	.....
V2219	A	Lens bifocal seg width over .....	.....	.....	.....	.....	.....
V2220	A	Lens bifocal add over 3.25d .....	.....	.....	.....	.....	.....
V2299	A	Lens bifocal speciality .....	.....	.....	.....	.....	.....
V2300	A	Lens sphere trifocal 4.00d .....	.....	.....	.....	.....	.....
V2301	A	Lens sphere trifocal 4.12-7 .....	.....	.....	.....	.....	.....
V2302	A	Lens sphere trifocal 7.12-20 .....	.....	.....	.....	.....	.....
V2303	A	Lens sphcy trifocal 4.0/12- .....	.....	.....	.....	.....	.....
V2304	A	Lens sphcy trifocal 4.0/2.25 .....	.....	.....	.....	.....	.....
V2305	A	Lens sphcy trifocal 4.0/4.25 .....	.....	.....	.....	.....	.....
V2306	A	Lens sphcyl trifocal 4.00/>6 .....	.....	.....	.....	.....	.....
V2307	A	Lens sphcy trifocal 4.25-7/					
V2308	A	Lens sphc trifocal 4.25-7/2					
V2309	A	Lens sphc trifocal 4.25-7/4					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
V2310	A	Lens sphc trifocal 4.25–7/>>6 .....	.....	.....	.....	.....	.....
V2311	A	Lens sphc trifo 7.25–12/25– .....	.....	.....	.....	.....	.....
V2312	A	Lens sphc trifo 7.25–12/2.25 .....	.....	.....	.....	.....	.....
V2313	A	Lens sphc trifo 7.25–12/4.25 .....	.....	.....	.....	.....	.....
V2314	A	Lens sphcyl trifocal over 12 .....	.....	.....	.....	.....	.....
V2315	A	Lens lenticular trifocal .....	.....	.....	.....	.....	.....
V2316	A	Lens lenticular nonaspheric .....	.....	.....	.....	.....	.....
V2317	A	Lens lenticular aspheric tri .....	.....	.....	.....	.....	.....
V2318	A	Lens aniseikonic trifocal .....	.....	.....	.....	.....	.....
V2319	A	Lens trifocal seg width > 28 .....	.....	.....	.....	.....	.....
V2320	A	Lens trifocal add over 3.25d .....	.....	.....	.....	.....	.....
V2399	A	Lens trifocal speciality .....	.....	.....	.....	.....	.....
V2410	A	Lens variab asphericity sing .....	.....	.....	.....	.....	.....
V2430	A	Lens variable asphericity bi .....	.....	.....	.....	.....	.....
V2499	A	Variable asphericity lens .....	.....	.....	.....	.....	.....
V2500	A	Contact lens pmma spherical .....	.....	.....	.....	.....	.....
V2501	A	Cntct lens pmma-toric/prism .....	.....	.....	.....	.....	.....
V2502	A	Contact lens pmma bifocal .....	.....	.....	.....	.....	.....
V2503	A	Cntct lens pmma color vision .....	.....	.....	.....	.....	.....
V2510	A	Cntct gas permeable sphericl .....	.....	.....	.....	.....	.....
V2511	A	Cntct toric prism ballast .....	.....	.....	.....	.....	.....
V2512	A	Cntct lens gas permbl bifocl .....	.....	.....	.....	.....	.....
V2513	A	Contact lens extended wear .....	.....	.....	.....	.....	.....
V2520	A	Contact lens hydrophilic .....	.....	.....	.....	.....	.....
V2521	A	Cntct lens hydrophilic toric .....	.....	.....	.....	.....	.....
V2522	A	Cntct lens hydrophil bifocl .....	.....	.....	.....	.....	.....
V2523	A	Cntct lens hydrophil extend .....	.....	.....	.....	.....	.....
V2530	A	Contact lens gas impermeable .....	.....	.....	.....	.....	.....
V2531	A	Contact lens gas permeable .....	.....	.....	.....	.....	.....
V2599	A	Contact lens/es other type .....	.....	.....	.....	.....	.....
V2600	A	Hand held low vision aids .....	.....	.....	.....	.....	.....
V2610	A	Single lens spectacle mount .....	.....	.....	.....	.....	.....
V2615	A	Telescop/othr compound lens .....	.....	.....	.....	.....	.....
V2623	A	Plastic eye prosth custom .....	.....	.....	.....	.....	.....
V2624	A	Polishing artifical eye .....	.....	.....	.....	.....	.....
V2625	A	Enlargemnt of eye prosthesis .....	.....	.....	.....	.....	.....
V2626	A	Reduction of eye prosthesis .....	.....	.....	.....	.....	.....
V2627	A	Scleral cover shell .....	.....	.....	.....	.....	.....
V2628	A	Fabrication & fitting .....	.....	.....	.....	.....	.....
V2629	A	Prosthetic eye other type .....	.....	.....	.....	.....	.....
V2630	N	Anter chamber intraocul lens .....	.....	.....	.....	.....	.....
V2631	N	Iris support intraoclr lens .....	.....	.....	.....	.....	.....
V2632	N	Post chmbr intraocular lens .....	.....	.....	.....	.....	.....
V2700	A	Balance lens .....	.....	.....	.....	.....	.....
V2710	A	Glass/plastic slab off prism .....	.....	.....	.....	.....	.....
V2715	A	Prism lens/es .....	.....	.....	.....	.....	.....
V2718	A	Fresnell prism press-on lens .....	.....	.....	.....	.....	.....
V2730	A	Special base curve .....	.....	.....	.....	.....	.....
V2740	A	Rose tint plastic .....	.....	.....	.....	.....	.....
V2741	A	Non-rose tint plastic .....	.....	.....	.....	.....	.....
V2742	A	Rose tint glass .....	.....	.....	.....	.....	.....
V2743	A	Non-rose tint glass .....	.....	.....	.....	.....	.....
V2744	A	Tint photochromatic lens/es .....	.....	.....	.....	.....	.....
V2750	A	Anti-reflective coating .....	.....	.....	.....	.....	.....
V2755	A	UV lens/es .....	.....	.....	.....	.....	.....
V2760	A	Scratch resistant coating .....	.....	.....	.....	.....	.....
V2770	A	Occluder lens/es .....	.....	.....	.....	.....	.....
V2780	A	Oversize lens/es .....	.....	.....	.....	.....	.....
V2781	A	Progressive lens per lens .....	.....	.....	.....	.....	.....
V2785	N	Corneal tissue processing .....	.....	.....	.....	.....	.....
V2799	A	Miscellaneous vision service .....	.....	.....	.....	.....	.....
V5008	E	Hearing screening .....	.....	.....	.....	.....	.....
V5010	E	Assessment for hearing aid .....	.....	.....	.....	.....	.....
V5011	E	Hearing aid fitting/checking .....	.....	.....	.....	.....	.....
V5014	E	Hearing aid repair/modifying .....	.....	.....	.....	.....	.....
V5020	E	Conformity evaluation .....	.....	.....	.....	.....	.....
V5030	E	Body-worn hearing aid air .....	.....	.....	.....	.....	.....
V5040	E	Body-worn hearing aid bone .....	.....	.....	.....	.....	.....
V5050	E	Body-worn hearing aid in ear .....	.....	.....	.....	.....	.....
V5060	E	Behind ear hearing aid .....	.....	.....	.....	.....	.....
V5070	E	Glasses air conduction .....	.....	.....	.....	.....	.....
V5080	E	Glasses bone conduction .....	.....	.....	.....	.....	.....
V5090	E	Hearing aid dispensing fee					
V5100	E	Body-worn bilat hearing aid					
V5110	E	Hearing aid dispensing fee					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT ¹ / HCPCS ²	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
V5120	E	Body-worn binaur hearing aid .....	.....	.....	.....	.....	.....
V5130	E	In ear binaural hearing aid .....	.....	.....	.....	.....	.....
V5140	E	Behind ear binaur hearing ai .....	.....	.....	.....	.....	.....
V5150	E	Glasses binaural hearing aid .....	.....	.....	.....	.....	.....
V5160	E	Dispensing fee binaural .....	.....	.....	.....	.....	.....
V5170	E	Within ear cros hearing aid .....	.....	.....	.....	.....	.....
V5180	E	Behind ear cros hearing aid .....	.....	.....	.....	.....	.....
V5190	E	Glasses cros hearing aid .....	.....	.....	.....	.....	.....
V5200	E	Cros hearing aid dispens fee .....	.....	.....	.....	.....	.....
V5210	E	In ear bicros hearing aid .....	.....	.....	.....	.....	.....
V5220	E	Behind ear bicros hearing ai .....	.....	.....	.....	.....	.....
V5230	E	Glasses bicros hearing aid .....	.....	.....	.....	.....	.....
V5240	E	Dispensing fee bicros .....	.....	.....	.....	.....	.....
V5299	A	Hearing service .....	.....	.....	.....	.....	.....
V5336	E	Repair communication device .....	.....	.....	.....	.....	.....
V5362	A	Speech screening .....	.....	.....	.....	.....	.....
V5363	A	Language screening .....	.....	.....	.....	.....	.....
V5364	A	Dysphagia screening .....	.....	.....	.....	.....	.....

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
031	Dental procedures		S	1.34	\$67.90	\$13.58	\$13.58
031	D0150	Comprehensive oral evaluation					
031	D0240	Intraoral occlusal film					
031	D0250	Extraoral first film					
031	D0260	Extraoral ea additional film					
031	D0270	Dental bitewing single film					
031	D0272	Dental bitewings two films					
031	D0274	Dental bitewings four films					
031	D0460	Pulp vitality test					
031	D0471	Diagnostic photographs					
031	D0501	Histopathologic examinations					
031	D0502	Other oral pathology procedure					
031	D0999	Unspecified diagnostic procedure					
031	D1510	Space maintainer fxd unilat					
031	D1515	Fixed bilat space maintainer					
031	D1520	Remove unilat space maintain					
031	D1525	Remove bilat space maintain					
031	D1550	Recement space maintainer					
031	D2970	Temporary- fractured tooth					
031	D2999	Dental unspec restorative pr					
031	D3460	Endodontic endosseous implan					
031	D3999	Endodontic procedure					
031	D4250	Mucogingival surg per quadra					
031	D4260	Osseous surgery per quadrant					
031	D4263	Bone replce graft first site					
031	D4264	Bone replce graft each add					
031	D4270	Pedicle soft tissue graft pr					
031	D4271	Free soft tissue graft proc					
031	D4273	Subepithelial tissue graft					
031	D4355	Full mouth debridement					
031	D4381	Localized chemo delivery					
031	D5911	Facial moulage sectional					
031	D5912	Facial moulage complete					
031	D5983	Radiation applicator					
031	D5984	Radiation shield					
031	D5985	Radiation cone locator					
031	D5987	Commissure splint					
031	D6920	Dental connector bar					
031	D7110	Oral surgery single tooth					
031	D7120	Each add tooth extraction					
031	D7130	Tooth root removal					
031	D7210	Rem imp tooth w mucoper flap					
031	D7220	Impact tooth remov soft tiss					
031	D7230	Impact tooth remov part bony					
031	D7240	Impact tooth remov comp bony					
031	D7241	Impact tooth rem bony w/comp					
031	D7250	Tooth root removal					
031	D7260	Oral antral fistula closure					
031	D7291	Transseptal fiberotomy					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
031	D7940	Reshaping bone orthognathic					
031	D9630	Other drugs/medicaments					
031	D9930	Treatment of complications					
031	D9940	Dental occlusal guard					
031	D9950	Occlusion analysis					
031	D9951	Limited occlusal adjustment					
031	D9952	Complete occlusal adjustment					
031	K0445	Auricular prosthesis					
061	Level I	Chemotherapeutic agents	X	1.04	\$52.70	\$36.61	\$10.54
061	J8610	Methotrexate oral 2.5 MG					
061	J8999	Oral prescription drug chemo					
061	J9015	Aldesleukin/single use vial					
061	J9070	Cyclophosphamide 100 MG inj					
061	J9080	Cyclophosphamide 200 MG inj					
061	J9090	Cyclophosphamide 500 MG inj					
061	J9093	Cyclophosphamide lyophilized					
061	J9094	Cyclophosphamide lyophilized					
061	J9095	Cyclophosphamide lyophilized					
061	J9100	Cytarabine hcl 100 MG inj					
061	J9110	Cytarabine hcl 500 MG inj					
061	J9120	Dactinomycin actinomycin d					
061	J9130	Dacarbazine 10 MG inj					
061	J9140	Dacarbazine 200 MG inj					
061	J9165	Diethylstilbestrol injection					
061	J9170	Docetaxel					
061	J9181	Etoposide 10 MG inj					
061	J9190	Fluorouracil injection					
061	J9201	Gemcitabine HCl					
061	J9206	Irinotecan injection					
061	J9214	Interferon alfa-2b inj					
061	J9215	Interferon alfa-n3 inj					
061	J9218	Leuprolide acetate injection					
061	J9230	Mechlorethamine hcl inj					
061	J9250	Methotrexate sodium inj					
061	J9260	Methotrexate sodium inj					
061	J9266	Pegaspargase/singl dose vial					
061	J9350	Topotecan					
061	J9360	Vinblastine sulfate inj					
061	J9390	Vinorelbine tartrate/10 mg					
061	J9600	Porfimer sodium					
061	J9999	Chemotherapy drug					
062	Level II	Chemotherapeutic agents	X	1.69	\$85.63	\$36.61	\$17.13
062	J9000	Doxorubic hcl 10 MG v1 chemo					
062	J9020	Asparaginase injection					
062	J9060	Cisplatin 10 MG injection					
062	J9065	Inj cladribine per 1 MG					
062	J9091	Cyclophosphamide 1.0 grm inj					
062	J9092	Cyclophosphamide 2.0 grm inj					
062	J9096	Cyclophosphamide lyophilized					
062	J9097	Cyclophosphamide lyophilized					
062	J9150	Daunorubicin					
062	J9211	Idarubicin hcl injection					
062	J9213	Interferon alfa-2a inj					
062	J9265	Paclitaxel injection					
062	J9268	Pentostatin injection					
062	J9370	Vincristine sulfate 1 MG inj					
063	Level III	Chemotherapeutic agents	X	2.89	\$146.43	\$110.97	\$29.29
063	J9031	Bcg live intravesical vac					
063	J9040	Bleomycin sulfate injection					
063	J9045	Carboplatin injection					
063	J9050	Carmus bischl nitro inj					
063	J9062	Cisplatin 50 MG injection					
063	J9182	Etoposide 100 MG inj					
063	J9185	Fludarabine phosphate inj					
063	J9200	Floxuridine injection					
063	J9202	Goserelin acetate implant					
063	J9208	Ifosfomide injection					
063	J9209	Mesna injection					
063	J9216	Interferon gamma 1-b inj					
063	J9270	Plicamycin (mithramycin) inj					
063	J9280	Mitomycin 5 MG inj					
063	J9320	Streptozocin injection					
063	J9340	Thiotepa injection					
063	J9375	Vincristine sulfate 2 MG inj					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
063	J9380	Vincristine sulfate 5 MG inj					
064	Level IV	Chemotherapeutic agents	X	4.17	\$211.29	\$140.12	\$42.26
064	J0640	Leucovorin calcium injection					
064	J9217	Leuprolide acetate suspnsion					
064	J9245	Inj melphalan hydrochl 50 MG					
064	J9290	Mitomycin 20 MG inj					
064	J9291	Mitomycin 40 MG inj					
064	J9293	Mitoxantrone hydrochl / 5 MG					
089	Neuropsychological	Testing	X	2.54	\$128.7	\$37.29	\$25.74
089	96100	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF PERSONALITY, PSYCHOPATHOLOGY, EMOTIONALITY, INTELLECTUAL ABILITIES, EG, WAIS-R, RORSCHACH, MMPI) WITH INTERPRETATION AND REPORT, PER HOUR					
089	96105	ASSESSMENT OF APHASIA (INCLUDES ASSESSMENT OF EXPRESSIVE AND RECEPTIVE SPEECH AND LANGUAGE FUNCTION, LANGUAGE COMPREHENSION, SPEECH PRODUCTION ABILITY, READING, SPELLING, WRITING, EG, BY BOSTON DIAGNOSTIC APHASIA EXAMINATION) WITH INTERPRETATION AND REPORT					
089	96110	DEVELOPMENTAL TESTING; LIMITED (EG, DEVELOPMENTAL SCREENING TEST II, EARLY LANGUAGE MILESTONE SCREEN), WITH INTERPRETATION AND REPORT					
089	96111	DEVELOPMENTAL TESTING; EXTENDED (INCLUDES ASSESSMENT OF MOTOR, LANGUAGE, SOCIAL, ADAPTIVE AND/OR COGNITIVE FUNCTIONING BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS, EG, BAYLEY SCALES OF INFANT DEVELOPMENT) WITH INTERPRETATION AND REPORT, PER HOUR					
089	96115	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, MEMORY, VISUAL SPATIAL ABILITIES, LANGUAGE FUNCTIONS, PLANNING) WITH INTERPRETATION AND REPORT, PER HOUR					
089	96117	NEUROPSYCHOLOGICAL TESTING BATTERY (EG, HALSTEAD-REITAN, LURIA, WAIS-R) WITH INTERPRETATION AND REPORT, PER HOUR					
090	Monitoring	psychiatric drugs	X	0.85	\$43.07	\$12.43	\$8.61
090	90862	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION, USE, AND REVIEW OF MEDICATION WITH NO MORE THAN MINIMAL MEDICAL PSYCHOTHERAPY					
090	M0064	Visit for drug monitoring					
091	Brief Individual	Psychotherapy	S	1.09	\$55.23	\$14.01	\$11.05
091	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;					
091	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					
091	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;					
091	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 M					
091	90899	UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE					
092	Extended Individual	Psychotherapy	S	1.57	\$79.55	\$21.92	\$15.91
092	90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION					
092	90802	INTERACTIVE PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF COMMUNICATION					
092	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;					
092	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 SERVICES					
092	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;					
092	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					
092	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;					
092	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 M					
092	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;					
092	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 M					
092	90845	PSYCHOANALYSIS					
092	90865	NARCOSYNTHESIS FOR PSYCHIATRIC DIAGNOSTIC AND THERAPEUTIC PURPOSES (EG, SODIUM AMOBARBITAL (AMYTAL) INTERVIEW					
092	90880	HYPNOTHERAPY					
093	Family	Psychotherapy	S	1.54	\$78.03	\$20.11	\$15.61

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
093	90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)					
093	90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)					
094	Group Psychotherapy		S	1.24	\$62.83	\$20.11	\$12.57
094	90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY					
094	90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)					
094	90857	INTERACTIVE GROUP PSYCHOTHERAPY					
121	Level I needle biopsy/aspiration		T	0.67	\$33.95	\$20.91	\$6.79
121	17999	UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND SUBCUTANEOUS TISSUE					
121	19000	PUNCTURE ASPIRATION OF CYST OF BREAST;					
121	19001	PUNCTURE ASPIRATION OF CYST OF BREAST; EACH ADDITIONAL CYST					
121	20615	ASPIRATION AND INJECTION FOR TREATMENT OF BONE CYST					
121	55000	PUNCTURE ASPIRATION OF HYDROCELE, TUNICA VAGINALIS, WITH OR WITHOUT INJECTION OF MEDICATION					
121	60001	ASPIRATION AND/OR INJECTION, THYROID CYST					
121	60699	UNLISTED PROCEDURE, ENDOCRINE SYSTEM					
121	85095	BONE MARROW; ASPIRATION ONLY					
121	85102	BONE MARROW BIOPSY, NEEDLE OR TROCAR					
121	88170	FINE NEEDLE ASPIRATION WITH OR WITHOUT PREPARATION OF SMEARS; SUPERFICIAL TISSUE (EG, THYROID, BREAST, PROSTATE					
121	88171	FINE NEEDLE ASPIRATION WITH OR WITHOUT PREPARATION OF SMEARS; DEEP TISSUE UNDER RADIOLOGIC GUIDANCE					
122	Level II needle biopsy/aspiration		T	4.87	\$246.76	\$115.03	\$49.35
122	19100	BIOPSY OF BREAST; NEEDLE CORE (SEPARATE PROCEDURE)					
122	20206	BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE					
122	32400	BIOPSY, PLEURA; PERCUTANEOUS NEEDLE					
122	32405	BIOPSY, LUNG OR MEDIASTINUM, PERCUTANEOUS NEEDLE					
122	38505	BIOPSY OR EXCISION OF LYMPH NODE(S); BY NEEDLE, SUPERFICIAL (EG, CERVICAL, INGUINAL, AXILLARY)					
122	42400	BIOPSY OF SALIVARY GLAND; NEEDLE					
122	47000	BIOPSY OF LIVER, NEEDLE; PERCUTANEOUS					
122	47399	UNLISTED PROCEDURE, LIVER					
122	48102	BIOPSY OF PANCREAS, PERCUTANEOUS NEEDLE					
122	48999	UNLISTED PROCEDURE, PANCREAS					
122	49180	BIOPSY, ABDOMINAL OR RETROPERITONEAL MASS, PERCUTANEOUS NEEDLE					
122	50200	RENAL BIOPSY; PERCUTANEOUS, BY TROCAR OR NEEDLE					
122	50390	ASPIRATION AND/OR INJECTION OF RENAL CYST OR PELVIS BY NEEDLE, PERCUTANEOUS					
122	54500	BIOPSY OF TESTIS, NEEDLE (SEPARATE PROCEDURE)					
122	54800	BIOPSY OF EPIDIDYMISS, NEEDLE					
122	60100	BIOPSY THYROID, PERCUTANEOUS CORE NEEDLE					
122	62269	BIOPSY OF SPINAL CORD, PERCUTANEOUS NEEDLE					
122	67415	FINE NEEDLE ASPIRATION OF ORBITAL CONTENTS					
131	Level I incision & drainage		T	1.94	\$98.30	\$36.61	\$19.66
131	10040	ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF MULTIPLE MILIA, COMEDONES, CYSTS, PUSTULES)					
131	10060	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTANEOUS OR SUBCUTANEOUS ABSCESS, CYST, FURUNCLE, OR PARONYCHIA); SIMPLE OR SINGLE					
131	10061	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTANEOUS OR SUBCUTANEOUS ABSCESS, CYST, FURUNCLE, OR PARONYCHIA); COMPLICATED OR MULTIPLE					
131	10080	INCISION AND DRAINAGE OF PILONIDAL CYST; SIMPLE					
131	10081	INCISION AND DRAINAGE OF PILONIDAL CYST; COMPLICATED					
131	10120	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; SIMPLE					
131	10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION					
131	10160	PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST					
131	10180	INCISION AND DRAINAGE, COMPLEX, POSTOPERATIVE WOUND INFECTION					
131	11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES					
131	20000	INCISION OF SOFT TISSUE ABSCESS (EG, SECONDARY TO OSTEOMYELITIS); SUPERFICIAL					
131	26010	DRAINAGE OF FINGER ABSCESS; SIMPLE					
131	26011	DRAINAGE OF FINGER ABSCESS; COMPLICATED (EG, FELON)					
131	69000	DRAINAGE EXTERNAL EAR, ABSCESS OR HEMATOMA; SIMPLE					
131	69005	DRAINAGE EXTERNAL EAR, ABSCESS OR HEMATOMA; COMPLICATED					
131	69020	DRAINAGE EXTERNAL AUDITORY CANAL, ABSCESS					
132	Level II incision & drainage		T	6.04	\$306.04	\$134.13	\$61.21
132	19020	MASTOTOMY WITH EXPLORATION OR DRAINAGE OF ABSCESS, DEEP					
132	20950	MONITORING OF INTERSTITIAL FLUID PRESSURE (INCLUDES INSERTION OF DEVICE, EG, WICK CATHETER TECHNIQUE, NEEDLE MANOMETER TECHNIQUE) IN DETECTION OF MUSCLE COMPARTMENT SYNDROME					
132	21501	INCISION AND DRAINAGE, DEEP ABSCESS OR HEMATOMA, SOFT TISSUES OF NECK OR THORAX;					
132	21700	DIVISION OF SCALENUS ANTICUS; WITHOUT RESECTION OF CERVICAL RIB					
132	21720	DIVISION OF STERNOCLEIDOMASTOID FOR TORTICOLLIS, OPEN OPERATION; WITHOUT CAST APPLICATION					
132	21725	DIVISION OF STERNOCLEIDOMASTOID FOR TORTICOLLIS, OPEN OPERATION; WITH CAST APPLICATION					
132	23030	INCISION AND DRAINAGE, SHOULDER AREA; DEEP ABSCESS OR HEMATOMA					
132	23031	INCISION AND DRAINAGE, SHOULDER AREA; INFECTED BURSA					
132	23930	INCISION AND DRAINAGE, UPPER ARM OR ELBOW AREA; DEEP ABSCESS OR HEMATOMA					
132	23931	INCISION AND DRAINAGE, UPPER ARM OR ELBOW AREA; INFECTED BURSA					
132	27301	INCISION AND DRAINAGE OF DEEP ABSCESS, INFECTED BURSA, OR HEMATOMA, THIGH OR KNEE REGION					
132	27603	INCISION AND DRAINAGE, LEG OR ANKLE; DEEP ABSCESS OR HEMATOMA					
132	28001	INCISION AND DRAINAGE, INFECTED BURSA, FOOT					
132	38300	DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS; SIMPLE					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
132	38305	DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS; EXTENSIVE					
132	38999	UNLISTED PROCEDURE, HEMIC OR LYMPHATIC SYSTEM					
132	51080	DRAINAGE OF PERIVESICAL OR PREVESICAL SPACE ABSCESS					
132	54015	INCISION AND DRAINAGE OF PENIS, DEEP					
132	54115	REMOVAL FOREIGN BODY FROM DEEP PENILE TISSUE (EG, PLASTIC IMPLANT)					
132	55100	DRAINAGE OF SCROTAL WALL ABSCESS					
137	Nail procedures		T	0.46	\$23.31	\$4.66	\$4.66
137	11719	TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER					
137	11720	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); ONE TO FIVE					
137	11721	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); SIX OR MORE					
137	11740	EVACUATION OF SUBUNGUAL HEMATOMA					
137	11755	BIOPSY OF NAIL UNIT, ANY METHOD (EG, PLATE, BED, MATRIX, HYPONYCHIIUM, PROXIMAL AND LATERAL NAIL FOLDS) (SEPARATE PROCEDURE)					
141	Level I Destruction of lesion		T	0.59	\$29.90	\$9.49	\$5.98
141	17000	DESTRUCTION BY ANY METHOD, INCLUDING LASER, WITH OR WITHOUT SURGICAL CURETTMENT, ALL BENIGN OR PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES) OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS, INCLUDING LOCAL ANESTHESIA; FIRST LESION					
141	17003	DESTRUCTION BY ANY METHOD, INCLUDING LASER, WITH OR WITHOUT SURGICAL CURETTMENT, ALL BENIGN OR PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES) OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS, INCLUDING LOCAL ANESTHESIA; SECOND THROUGH 14 LE					
141	17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM					
141	17110	DESTRUCTION BY ANY METHOD OF FLAT WARTS, MOLLUSCUM CONTAGIOSUM, OR MILIA; UP TO 14 LESIONS					
142	Level II Destruction of lesion		T	3.77	\$191.02	\$73.00	\$38.20
142	17004	DESTRUCTION BY ANY METHOD, INCLUDING LASER, WITH OR WITHOUT SURGICAL CURETTMENT, ALL BENIGN OR PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES) OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS, INCLUDING LOCAL ANESTHESIA; 15 OR MORE LESIONS					
142	17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0–50.0 SQ CM					
142	17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50.0 SQ CM					
142	17111	DESTRUCTION BY ANY METHOD OF FLAT WARTS, MOLLUSCUM CONTAGIOSUM, OR MILIA; 15 OR MORE LESIONS					
151	Level I debridement/destruction		T	1.74	\$88.16	\$35.71	\$17.63
151	11000	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF BODY SURFACE					
151	11001	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; EACH ADDITIONAL 10% OF THE BODY SURFACE					
151	11040	DEBRIDEMENT; SKIN, PARTIAL THICKNESS					
151	11041	DEBRIDEMENT; SKIN, FULL THICKNESS					
151	11042	DEBRIDEMENT; SKIN, AND SUBCUTANEOUS TISSUE					
151	11055	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); SINGLE LESION					
151	11056	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); TWO TO FOUR LESIONS					
151	11057	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); MORE THAN FOUR LESIONS					
151	11200	REMOVAL OF SKIN TAGS, MULTIPLE FIBROSCUTANEOUS TAGS, ANY AREA; UP TO AND INCLUDING 15 LESIONS					
151	11201	REMOVAL OF SKIN TAGS, MULTIPLE FIBROSCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL TEN LESIONS					
151	11300	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
151	11301	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
151	11302	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
151	11303	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER OVER 2.0 CM					
151	11305	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
151	11306	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
151	11307	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
151	11308	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 2.0 CM					
151	11310	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.5 CM OR LESS					
151	11311	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM					
151	11312	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM					
151	11313	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER OVER 2.0 CM					
151	11730	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; SINGLE					
151	11731	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; SECOND NAIL PLATE					
151	11732	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; EACH ADDITIONAL NAIL PLATE					
151	11765	WEDGE EXCISION OF SKIN OF NAIL FOLD (EG, FOR INGROWN TOENAIL)					
151	11900	INJECTION, INTRALESIONAL; UP TO AND INCLUDING SEVEN LESIONS					
151	11901	INJECTION, INTRALESIONAL; MORE THAN SEVEN LESIONS					
151	15783	DERMABRASION; SUPERFICIAL, ANY SITE, (EG, TATTOO REMOVAL)					
151	15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)					
151	15787	ABRASION; EACH ADDITIONAL FOUR LESIONS OR LESS					
151	15788	CHEMICAL PEEL, FACIAL; EPIDERMAL					
151	15789	CHEMICAL PEEL, FACIAL; DERMAL					
151	15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL					
151	15793	CHEMICAL PEEL, NONFACIAL; DERMAL					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
151	15810	SALABRASION; 20 SQ CM OR LESS					
151	15850	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER THAN LOCAL), SAME SURGEON					
151	15851	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER THAN LOCAL), OTHER SURGEON					
151	15852	DRESSING CHANGE (FOR OTHER THAN BURNS) UNDER ANESTHESIA (OTHER THAN LOCAL)					
151	16000	INITIAL TREATMENT, FIRST DEGREE BURN, WHEN NO MORE THAN LOCAL TREATMENT IS REQUIRED					
151	16020	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; WITHOUT ANESTHESIA, OFFICE OR HOSPITAL, SMALL					
151	16025	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; WITHOUT ANESTHESIA, MEDIUM (EG, WHOLE FACE OR WHOLE EX- TREMITY)					
151	16030	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; WITHOUT ANESTHESIA, LARGE (EG, MORE THAN ONE EXTREMITY)					
151	17250	CHEMICAL CAUTERIZATION OF GRANULATION TISSUE (PROUD FLESH, SINUS OR FISTULA)					
151	17260	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
151	17261	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
151	17262	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
151	17263	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 2.1 TO 3.0 CM					
151	17264	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 3.1 TO 4.0 CM					
151	17266	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER OVER 4.0 CM					
151	17270	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
151	17271	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
151	17272	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
151	17273	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 2.1 TO 3.0 CM					
151	17274	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 3.1 TO 4.0 CM					
151	17276	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 4.0 CM					
151	17280	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.5 CM OR LESS					
151	17281	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM					
151	17282	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM					
151	17283	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 2.1 TO 3.0 CM					
151	17284	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 3.1 TO 4.0 CM					
151	17286	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER OVER 4.0 CM					
151	17340	CRYOTHERAPY (CO2 SLUSH, LIQUID N2) FOR ACNE					
151	17360	CHEMICAL EXFOLIATION FOR ACNE (EG, ACNE PASTE, ACID)					
151	17380	ELECTROLYSIS EPILATION, EACH 1/2 HOUR					
151	42809	REMOVAL OF FOREIGN BODY FROM PHARYNX					
151	69220	DEBRIDEMENT, MASTOIDECTOMY CAVITY, SIMPLE (EG, ROUTINE CLEANING)					
152	Level II debridement/destruction		T	10.43	\$528.48	\$261.71	\$105.7
152	16010	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; UNDER ANESTHESIA, SMALL					
152	16015	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; UNDER ANESTHESIA, MEDIUM OR LARGE, OR WITH MAJOR DEBRIDEMENT					
152	46900	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CHEMICAL					
152	46910	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; ELECTRODESICCATION					
152	46916	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CRYOSURGERY					
152	46917	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; LASER SURGERY					
152	46922	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; SUR- GICAL EXCISION					
152	46924	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), EXTENSIVE, ANY METHOD					
152	54050	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CHEMICAL					
152	54055	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; ELECTRODESICCATION					
152	54056	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CRYOSURGERY					
152	54057	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; LASER SURGERY					
152	54060	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; SUR- GICAL EXCISION					
152	54065	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), EXTENSIVE, ANY METHOD					
152	56501	DESTRUCTION OF LESION(S), VULVA; SIMPLE, ANY METHOD					
152	56515	DESTRUCTION OF LESION(S), VULVA; EXTENSIVE, ANY METHOD					
161	Level I excision/biopsy		T	3.50	\$177.34	\$75.48	\$35.47
161	11100	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE (INCLUDING SIMPLE CLOSURE), UNLESS OTHERWISE LIST- ED (SEPARATE PROCEDURE); SINGLE LESION					
161	11101	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE (INCLUDING SIMPLE CLOSURE), UNLESS OTHERWISE LIST- ED (SEPARATE PROCEDURE); EACH SEPARATE/ADDITIONAL LESION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
161	11400	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
161	11401	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
161	11402	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
161	11403	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 2.1 TO 3.0 CM					
161	11420	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
161	11421	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
161	11422	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
161	11423	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 2.1 TO 3.0 CM					
161	11440	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.5 CM OR LESS					
161	11441	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM					
161	11442	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM					
161	11443	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 2.1 TO 3.0 CM					
161	11600	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
161	11601	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
161	11602	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
161	11603	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 2.1 TO 3.0 CM					
161	11620	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
161	11621	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
161	11622	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
161	11623	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 2.1 TO 3.0 CM					
161	11640	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 0.5 CM OR LESS					
161	11641	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 0.6 TO 1.0 CM					
161	11642	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 1.1 TO 2.0 CM					
161	11643	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 2.1 TO 3.0 CM					
161	11750	EXCISION OF NAIL AND NAIL MATRIX, PARTIAL OR COMPLETE, (EG, INGROWN OR DEFORMED NAIL) FOR PERMANENT REMOVAL;					
161	20520	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH; SIMPLE					
161	21550	BIOPSY, SOFT TISSUE OF NECK OR THORAX					
161	21920	BIOPSY, SOFT TISSUE OF BACK OR FLANK; SUPERFICIAL					
161	23065	BIOPSY, SOFT TISSUE OF SHOULDER AREA; SUPERFICIAL					
161	24065	BIOPSY, SOFT TISSUE OF UPPER ARM OR ELBOW AREA; SUPERFICIAL					
161	24200	REMOVAL OF FOREIGN BODY, UPPER ARM OR ELBOW AREA; SUBCUTANEOUS					
161	25065	BIOPSY, SOFT TISSUE OF FOREARM AND/OR WRIST; SUPERFICIAL					
161	27613	BIOPSY, SOFT TISSUE OF LEG OR ANKLE AREA; SUPERFICIAL					
161	28190	REMOVAL OF FOREIGN BODY, FOOT; SUBCUTANEOUS					
161	56605	BIOPSY OF VULVA OR PERINEUM (SEPARATE PROCEDURE); ONE LESION					
161	56606	BIOPSY OF VULVA OR PERINEUM (SEPARATE PROCEDURE); EACH SEPARATE ADDITIONAL LESION					
161	58999	UNLISTED PROCEDURE, FEMALE GENITAL SYSTEM (NONOBSTETRICAL)					
161	69100	BIOPSY EXTERNAL EAR					
161	69105	BIOPSY EXTERNAL AUDITORY CANAL					
162	Level II excision/biopsy		T	5.67	\$287.30	\$125.43	\$57.46
162	11043	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE					
162	11044	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, MUSCLE, AND BONE					
162	11404	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 3.1 TO 4.0 CM					
162	11424	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 3.1 TO 4.0 CM					
162	11444	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 3.1 TO 4.0 CM					
162	11604	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 3.1 TO 4.0 CM					
162	11770	EXCISION OF PILONIDAL CYST OR SINUS; SIMPLE					
162	16035	ESCHAROTOMY					
162	16040	EXCISION BURN WOUND, WITHOUT SKIN GRAFTING, EMPLOYING ALLOPLASTIC DRESSING (EG, SYNTHETIC MESH), ANY ANATOMIC SITE; UP TO ONE PERCENT TOTAL BODY SURFACE AREA					
162	16041	EXCISION BURN WOUND, WITHOUT SKIN GRAFTING, EMPLOYING ALLOPLASTIC DRESSING (EG, SYNTHETIC MESH), ANY ANATOMIC SITE; GREATER THAN ONE PERCENT AND UP TO NINE PERCENT TOTAL BODY SURFACE AREA					
162	16042	EXCISION BURN WOUND, WITHOUT SKIN GRAFTING, EMPLOYING ALLOPLASTIC DRESSING (EG, SYNTHETIC MESH), ANY ANATOMIC SITE; EACH ADDITIONAL NINE PERCENT TOTAL BODY SURFACE AREA, OR PART THEREOF					
162	17304	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; FI					
162	17305	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; SE					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
162	17306	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; TH					
162	17307	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; AD					
162	17310	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; MO					
162	20200	BIOPSY, MUSCLE; SUPERFICIAL					
162	20205	BIOPSY, MUSCLE; DEEP					
162	20220	BIOPSY, BONE, TROCAR, OR NEEDLE; SUPERFICIAL (EG, ILIUM, STERNUM, SPINOUS PROCESS, RIBS)					
162	20225	BIOPSY, BONE, TROCAR, OR NEEDLE; DEEP (VERTEBRAL BODY, FEMUR)					
162	20670	REMOVAL OF IMPLANT; SUPERFICIAL, (EG, BURIED WIRE, PIN OR ROD) (SEPARATE PROCEDURE)					
162	23000	REMOVAL OF SUBDELTOID (OR INTRATENDINOUS) CALCAREOUS DEPOSITS, OPEN METHOD					
162	23075	EXCISION, TUMOR, SHOULDER AREA; SUBCUTANEOUS					
162	24075	EXCISION, TUMOR, UPPER ARM OR ELBOW AREA; SUBCUTANEOUS					
162	25075	EXCISION, TUMOR, FOREARM AND/OR WRIST AREA; SUBCUTANEOUS					
162	27040	BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; SUPERFICIAL					
162	27323	BIOPSY, SOFT TISSUE OF THIGH OR KNEE AREA; SUPERFICIAL					
162	28043	EXCISION, TUMOR, FOOT; SUBCUTANEOUS					
162	37609	LIGATION OR BIOPSY, TEMPORAL ARTERY					
162	37799	UNLISTED PROCEDURE, VASCULAR SURGERY					
162	54100	BIOPSY OF PENIS; CUTANEOUS (SEPARATE PROCEDURE)					
162	54105	BIOPSY OF PENIS; DEEP STRUCTURES					
162	67350	BIOPSY OF EXTRAOCULAR MUSCLE					
162	67399	UNLISTED PROCEDURE, OCULAR MUSCLE					
162	68100	BIOPSY OF CONJUNCTIVA					
162	68110	EXCISION OF LESION, CONJUNCTIVA; UP TO 1 CM					
162	68115	EXCISION OF LESION, CONJUNCTIVA; OVER 1 CM					
162	68135	DESTRUCTION OF LESION, CONJUNCTIVA					
162	68399	UNLISTED PROCEDURE, CONJUNCTIVA					
163	Level III excision/biopsy		T	10.69	\$541.66	\$264.65	\$108.33
163	10121	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATED					
163	11010	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH OPEN FRACTURE(S) AND/OR DISLOCATION(S); SKIN AND SUBCUTANEOUS TISSUES					
163	11011	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH OPEN FRACTURE(S) AND/OR DISLOCATION(S); SKIN, SUBCUTANEOUS TISSUE, MUSCLE FASCIA, AND MUSCLE					
163	11012	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH OPEN FRACTURE(S) AND/OR DISLOCATION(S); SKIN, SUBCUTANEOUS TISSUE, MUSCLE FASCIA, MUSCLE, AND BONE					
163	11406	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER OVER					
163	11426	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 4.0 CM					
163	11446	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER OVER 4.0 CM					
163	11450	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, AXILLARY; WITH SIMPLE OR INTERMEDIATE REPAIR					
163	11451	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, AXILLARY; WITH COMPLEX REPAIR					
163	11462	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, INGUINAL; WITH SIMPLE OR INTERMEDIATE REPAIR					
163	11463	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, INGUINAL; WITH COMPLEX REPAIR					
163	11470	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, PERIANAL, PERINEAL, OR UMBILICAL; WITH SIMPLE OR INTERMEDIATE REPAIR					
163	11471	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, PERIANAL, PERINEAL, OR UMBILICAL; WITH COMPLEX REPAIR					
163	11606	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER OVER 4.0 CM					
163	11624	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 3.1 TO 4.0 CM					
163	11626	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 4.0 CM					
163	11644	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 3.1 TO 4.0 CM					
163	11646	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER OVER 4.0 CM					
163	11752	EXCISION OF NAIL AND NAIL MATRIX, PARTIAL OR COMPLETE, (EG, INGROWN OR DEFORMED NAIL) FOR PERMANENT REMOVAL; WITH AMPUTATION OF TUFT OF DISTAL PHALANX					
163	11771	EXCISION OF PILONIDAL CYST OR SINUS; EXTENSIVE					
163	11772	EXCISION OF PILONIDAL CYST OR SINUS; COMPLICATED					
163	11971	REMOVAL OF TISSUE EXPANDER(S) WITHOUT INSERTION OF PROSTHESIS					
163	15780	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS)					
163	15781	DERMABRASION; SEGMENTAL, FACE					
163	15782	DERMABRASION; REGIONAL, OTHER THAN FACE					
163	15811	SALABRASION; OVER 20 SQ CM					
163	15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); SUBMENTAL FAT PAD					
163	15920	EXCISION, COCCYGEAL PRESSURE ULCER, WITH COCCYGECTOMY; WITH PRIMARY SUTURE					
163	15931	EXCISION, SACRAL PRESSURE ULCER, WITH PRIMARY SUTURE;					
163	15933	EXCISION, SACRAL PRESSURE ULCER, WITH PRIMARY SUTURE; WITH OSTECTOMY					
163	15940	EXCISION, ISCHIAL PRESSURE ULCER, WITH PRIMARY SUTURE;					
163	15941	EXCISION, ISCHIAL PRESSURE ULCER, WITH PRIMARY SUTURE; WITH OSTECTOMY (ISCHIECTOMY)					
163	15950	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH PRIMARY SUTURE;					
163	15951	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH PRIMARY SUTURE; WITH OSTECTOMY					
163	15999	UNLISTED PROCEDURE, EXCISION PRESSURE ULCER					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
163	20240	BIOPSY, EXCISIONAL; SUPERFICIAL (EG, ILIUM, STERNUM, SPINOUS PROCESS, RIBS, TROCHANTER OF FEMUR)					
163	20245	BIOPSY, EXCISIONAL; DEEP (EG, HUMERUS, ISCHIUM, FEMUR)					
163	20525	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH; DEEP OR COMPLICATED					
163	20680	REMOVAL OF IMPLANT; DEEP (EG, BURIED WIRE, PIN, SCREW, METAL BAND, NAIL, ROD OR PLATE)					
163	21555	EXCISION TUMOR, SOFT TISSUE OF NECK OR THORAX; SUBCUTANEOUS					
163	21556	EXCISION TUMOR, SOFT TISSUE OF NECK OR THORAX; DEEP, SUBFASCIAL, INTRAMUSCULAR					
163	21925	BIOPSY, SOFT TISSUE OF BACK OR FLANK; DEEP					
163	21930	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK					
163	21935	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF BACK OR FLANK					
163	22900	EXCISION, ABDOMINAL WALL TUMOR, SUBFASCIAL (EG, DESMOID)					
163	22999	UNLISTED PROCEDURE, ABDOMEN, MUSCULOSKELETAL SYSTEM					
163	23066	BIOPSY, SOFT TISSUE OF SHOULDER AREA; DEEP					
163	23076	EXCISION, TUMOR, SHOULDER AREA; DEEP, SUBFASCIAL, OR INTRAMUSCULAR					
163	23077	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF SHOULDER AREA					
163	23330	REMOVAL OF FOREIGN BODY, SHOULDER; SUBCUTANEOUS					
163	23331	REMOVAL OF FOREIGN BODY, SHOULDER; DEEP (EG, NEER PROSTHESIS REMOVAL)					
163	24066	BIOPSY, SOFT TISSUE OF UPPER ARM OR ELBOW AREA; DEEP					
163	24076	EXCISION, TUMOR, UPPER ARM OR ELBOW AREA; DEEP, SUBFASCIAL OR INTRAMUSCULAR					
163	24077	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF UPPER ARM OR ELBOW AREA					
163	24201	REMOVAL OF FOREIGN BODY, UPPER ARM OR ELBOW AREA; DEEP					
163	25066	BIOPSY, SOFT TISSUE OF FOREARM AND/OR WRIST; DEEP					
163	25076	EXCISION, TUMOR, FOREARM AND/OR WRIST AREA; DEEP, SUBFASCIAL OR INTRAMUSCULAR					
163	25077	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF FOREARM AND/OR WRIST AREA					
163	26115	EXCISION, TUMOR OR VASCULAR MALFORMATION, HAND OR FINGER; SUBCUTANEOUS					
163	26116	EXCISION, TUMOR OR VASCULAR MALFORMATION, HAND OR FINGER; DEEP, SUBFASCIAL, INTRAMUSCULAR					
163	26117	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF HAND OR FINGER					
163	26320	REMOVAL OF IMPLANT FROM FINGER OR HAND					
163	27041	BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; DEEP					
163	27047	EXCISION, TUMOR, PELVIS AND HIP AREA; SUBCUTANEOUS					
163	27048	EXCISION, TUMOR, PELVIS AND HIP AREA; DEEP, SUBFASCIAL, INTRAMUSCULAR					
163	27049	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF PELVIS AND HIP AREA					
163	27324	BIOPSY, SOFT TISSUE OF THIGH OR KNEE AREA; DEEP					
163	27327	EXCISION, TUMOR, THIGH OR KNEE AREA; SUBCUTANEOUS					
163	27328	EXCISION, TUMOR, THIGH OR KNEE AREA; DEEP, SUBFASCIAL, OR INTRAMUSCULAR					
163	27329	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF THIGH OR KNEE AREA					
163	27372	REMOVAL OF FOREIGN BODY, DEEP, THIGH REGION OR KNEE AREA					
163	27614	BIOPSY, SOFT TISSUE OF LEG OR ANKLE AREA; DEEP					
163	27618	EXCISION, TUMOR, LEG OR ANKLE AREA; SUBCUTANEOUS					
163	27619	EXCISION, TUMOR, LEG OR ANKLE AREA; DEEP, SUBFASCIAL OR INTRAMUSCULAR					
163	28192	REMOVAL OF FOREIGN BODY, FOOT; DEEP					
163	28193	REMOVAL OF FOREIGN BODY, FOOT; COMPLICATED					
163	69110	EXCISION EXTERNAL EAR; PARTIAL, SIMPLE REPAIR					
163	69145	EXCISION SOFT TISSUE LESION, EXTERNAL AUDITORY CANAL					
163	69205	REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL; WITH GENERAL ANESTHESIA					
181	Level I skin repair		T	2.19	\$110.97	\$43.84	\$22.19
181	11760	REPAIR OF NAIL BED					
181	11762	RECONSTRUCTION OF NAIL BED WITH GRAFT					
181	11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.0 SQ CM OR LESS					
181	11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.1 TO 20.0 SQ CM					
181	11922	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; EACH ADDITIONAL 20.0 SQ CM					
181	11950	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); 1 CC OR LESS					
181	11951	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC					
181	11952	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC					
181	11954	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); OVER 10.0 CC					
181	12001	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 2.5 CM OR LESS					
181	12002	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 2.6 CM TO 7.5 CM					
181	12004	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 7.6 CM TO 12.5 CM					
181	12005	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 12.6 CM TO 20.0 CM					
181	12006	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 20.1 CM TO 30.0 CM					
181	12007	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); OVER 30.0 CM					
181	12011	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS					
181	12013	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.6 CM TO 5.0 CM					
181	12014	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 5.1 CM TO 7.5 CM					
181	12015	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 7.6 CM TO 12.5 CM					
181	12016	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 12.6 CM TO 20.0 CM					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
181	12017	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 20.1 CM TO 30.0 CM					
181	12018	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; OVER 30.0 CM					
181	12020	TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; SIMPLE CLOSURE					
181	12021	TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; WITH PACKING					
181	12031	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 2.5 CM OR LESS					
181	12032	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 2.6 CM TO 7.5 CM					
181	12034	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 7.6 CM TO 12.5 CM					
181	12035	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 12.6 CM TO 20.0 CM					
181	12036	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 20.1 CM TO 30.0 CM					
181	12041	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 2.5 CM OR LESS					
181	12042	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 2.6 CM TO 7.5 CM					
181	12044	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 7.6 CM TO 12.5 CM					
181	12045	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 12.6 CM TO 20.0 CM					
181	12046	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 20.1 CM TO 30.0 CM					
181	12051	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS					
181	12052	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.6 CM TO 5.0 CM					
181	12053	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 5.1 CM TO 7.5 CM					
181	12054	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 7.6 CM TO 12.5 CM					
181	12055	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 12.6 CM TO 20.0 CM					
181	12056	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 20.1 CM TO 30.0 CM					
181	20500	INJECTION OF SINUS TRACT; THERAPEUTIC (SEPARATE PROCEDURE)					
182	Level II skin repair		T	4.	\$202.68	\$84.98	\$40.54
182	13100	REPAIR, COMPLEX, TRUNK; 1.1 CM TO 2.5 CM					
182	13101	REPAIR, COMPLEX, TRUNK; 2.6 CM TO 7.5 CM					
182	13120	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 1.1 CM TO 2.5 CM					
182	13121	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 2.6 CM TO 7.5 CM					
182	13131	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 1.1 CM TO 2.5 CM					
182	13132	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 2.6 CM TO 7.5 CM					
182	13150	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.0 CM OR LESS					
182	13151	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.1 CM TO 2.5 CM					
182	13152	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 2.6 CM TO 7.5 CM					
182	13160	SECONDARY CLOSURE OF SURGICAL WOUND OR DEHISCENCE, EXTENSIVE OR COMPLICATED					
182	13300	REPAIR, UNUSUAL, COMPLICATED, OVER 7.5 CM, ANY AREA					
182	43870	CLOSURE OF GASTROSTOMY, SURGICAL					
183	Level III skin repair		T	11.17	\$565.98	\$286.46	\$113.20
183	11960	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUENT EXPANSION					
183	11970	REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT PROSTHESIS					
183	12037	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); OVER 30.0 CM					
183	12047	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; OVER 30.0 CM					
183	12057	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; OVER 30.0 CM					
183	14000	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; DEFECT 10 SQ CM OR LESS					
183	14001	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14020	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/OR LEGS; DEFECT 10 SQ CM OR LESS					
183	14021	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/OR LEGS; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14040	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; DEFECT 10 SQ CM OR LESS					
183	14041	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14060	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10 SQ CM OR LESS					
183	14061	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14300	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, MORE THAN 30 SQ CM, UNUSUAL OR COMPLICATED, ANY AREA					
183	14350	FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF RECIPIENT SITE					
183	15000	EXCISIONAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF ESSENTIALLY INTACT SKIN (INCLUDING SUBCUTANEOUS TISSUES), SCAR, OR OTHER LESION PRIOR TO REPAIR WITH FREE SKIN GRAFT (LIST AS SEPARATE SERVICE IN ADDITION TO SKIN GRAFT)					
183	15050	PINCH GRAFT, SINGLE OR MULTIPLE, TO COVER SMALL ULCER, TIP OF DIGIT, OR OTHER MINIMAL OPEN AREA (EXCEPT ON FACE), UP TO DEFECT SIZE 2 CM DIAMETER					
183	15100	SPLIT GRAFT, TRUNK, SCALP, ARMS, LEGS, HANDS, AND/OR FEET (EXCEPT MULTIPLE DIGITS); 100 SQ CM OR LESS, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN (EXCEPT 15050)					
183	15101	SPLIT GRAFT, TRUNK, SCALP, ARMS, LEGS, HANDS, AND/OR FEET (EXCEPT MULTIPLE DIGITS); EACH ADDITIONAL 100 SQ CM, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF					
183	15120	SPLIT GRAFT, FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, AND/OR MULTIPLE DIGITS; 100 SQ CM OR LESS, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN (EXCEPT 15050)					
183	15121	SPLIT GRAFT, FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF					
183	15200	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, TRUNK; 20 SQ CM OR LESS					
183	15201	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, TRUNK; EACH ADDITIONAL 20 SQ CM					
183	15220	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, SCALP, ARMS, AND/OR LEGS; 20 SQ CM OR LESS					
183	15221	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 20 SQ CM					
183	15240	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS, AND/OR FEET; 20 SQ CM OR LESS					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
183	15241	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS, AND/OR FEET; EACH ADDITIONAL 20 SQ CM					
183	15260	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, NOSE, EARS, EYELIDS, AND/OR LIPS; 20 SQ CM OR LESS					
183	15261	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, NOSE, EARS, EYELIDS, AND/OR LIPS; EACH ADDITIONAL 20 SQ CM					
183	15350	APPLICATION OF ALLOGRAFT, SKIN					
183	15400	APPLICATION OF XENOGRFT, SKIN					
183	15570	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; TRUNK					
183	15572	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; SCALP, ARMS, OR LEGS					
183	15574	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS OR FEET					
183	15576	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; EYELIDS, NOSE, EARS, LIPS, OR INTRAORAL					
183	15580	CROSS FINGER FLAP, INCLUDING FREE GRAFT TO DONOR SITE					
183	15600	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT TRUNK					
183	15610	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT SCALP, ARMS, OR LEGS					
183	15620	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT FOREHEAD, CHEEKS, CHIN, NECK, AXILLAE, GENITALIA, HANDS (EXCEPT 15625), OR FEET					
183	15625	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); SECTION PEDICLE OF CROSS FINGER FLAP					
183	15630	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT EYELIDS, NOSE, EARS, OR LIPS					
183	15650	TRANSFER, INTERMEDIATE, OF ANY PEDICLE FLAP (EG, ABDOMEN TO WRIST, "WALKING" TUBE), ANY LOCATION					
183	15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS					
183	15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS					
183	15819	CERVICOPLASTY					
183	15820	BLEPHAROPLASTY, LOWER EYELID					
183	15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD					
183	15822	BLEPHAROPLASTY, UPPER EYELID					
183	15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID					
183	15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, "P-FLAP")					
183	15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP					
183	15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); BUTTOCK					
183	20910	CARTILAGE GRAFT; COSTOCHONDRAL					
183	20912	CARTILAGE GRAFT; NASAL SEPTUM					
183	20920	FASCIA LATA GRAFT; BY STRIPPER					
183	20922	FASCIA LATA GRAFT; BY INCISION AND AREA EXPOSURE, COMPLEX OR SHEET					
183	20926	TISSUE GRAFTS, OTHER (EG, PARATENON, FAT, DERMIS)					
183	23921	DISARTICULATION OF SHOULDER; SECONDARY CLOSURE OR SCAR REVISION					
183	25929	TRANSMETACARPAL AMPUTATION; SECONDARY CLOSURE OR SCAR REVISION					
183	44312	REVISION OF ILEOSTOMY; SIMPLE (RELEASE OF SUPERFICIAL SCAR) (SEPARATE PROCEDURE)					
183	44340	REVISION OF COLOSTOMY; SIMPLE (RELEASE OF SUPERFICIAL SCAR) (SEPARATE PROCEDURE)					
183	65270	REPAIR OF LACERATION; CONJUNCTIVA, WITH OR WITHOUT NONPERFORATING LACERATION SCLERA, DIRECT CLOSURE					
184	Level IV skin repair		T	15.17	\$768.66	\$396.40	\$153.73
184	15732	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; HEAD AND NECK (EG, TEMPORALIS, MASSETER, STERNOCLEIDOMASTOID, LEVATOR SCAPULAE)					
184	15734	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; TRUNK					
184	15736	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; UPPER EXTREMITY					
184	15738	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; LOWER EXTREMITY					
184	15740	FLAP; ISLAND PEDICLE					
184	15750	FLAP; NEUROVASCULAR PEDICLE					
184	15760	GRAFT; COMPOSITE (EG, FULL THICKNESS OF EXTERNAL EAR OR NASAL ALA), INCLUDING PRIMARY CLOSURE, DONOR AREA					
184	15770	GRAFT; DERMA-FAT-FASCIA					
184	15824	RHYTIDECTOMY; FOREHEAD					
184	15826	RHYTIDECTOMY; GLABELLAR FROWN LINES					
184	15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK					
184	15831	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); ABDOMEN (ABDOMINOPLASTY)					
184	15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); THIGH					
184	15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); LEG					
184	15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); HIP					
184	15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); ARM					
184	15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); FOREARM OR HAND					
184	15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); OTHER AREA					
184	15840	GRAFT FOR FACIAL NERVE PARALYSIS; FREE FASCIA GRAFT (INCLUDING OBTAINING FASCIA)					
184	15841	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE GRAFT (INCLUDING OBTAINING GRAFT)					
184	15842	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE GRAFT BY MICROSURGICAL TECHNIQUE					
184	15845	GRAFT FOR FACIAL NERVE PARALYSIS; REGIONAL MUSCLE TRANSFER					
184	15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK					
184	15877	SUCTION ASSISTED LIPECTOMY; TRUNK					
184	15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY					
184	15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY					
184	15922	EXCISION, COCCYGEAL PRESSURE ULCER, WITH COCCYGECTOMY; WITH FLAP CLOSURE					
184	15934	EXCISION, SACRAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE					
184	15935	EXCISION, SACRAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE; WITH OSTECTOMY					
184	15936	EXCISION, SACRAL PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE					
184	15937	EXCISION, SACRAL PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE; WITH OSTECTOMY					
184	15944	EXCISION, ISCHIAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
184	15945	EXCISION, ISCHIAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE; WITH OSTECTOMY					
184	15946	EXCISION, ISCHIAL PRESSURE ULCER, WITH OSTECTOMY, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE					
184	15952	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH SKIN FLAP CLOSURE					
184	15953	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH SKIN FLAP CLOSURE; WITH OSTECTOMY					
184	15956	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE					
184	15958	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE; WITH OSTECTOMY					
197	Incision/excision breast		T	12.13	\$614.62	\$310.75	\$122.92
197	19101	BIOPSY OF BREAST; INCISIONAL					
197	19110	NIPPLE EXPLORATION, WITH OR WITHOUT EXCISION OF A SOLITARY LACTIFEROUS DUCT OR A PAPILLOMA LACTIFEROUS DUCT					
197	19112	EXCISION OF LACTIFEROUS DUCT FISTULA					
197	19120	EXCISION OF CYST, FIBROADENOMA, OR OTHER BENIGN OR MALIGNANT TUMOR ABERRANT BREAST TISSUE, DUCT LESION, NIPPLE OR AREOLAR LESION (EXCEPT 19140), MALE OR FEMALE, ONE OR MORE LESIONS					
197	19125	EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE PLACEMENT OF RADIOLOGICAL MARKER; SINGLE LESION					
197	19126	EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE PLACEMENT OF RADIOLOGICAL MARKER; EACH ADDITIONAL LESION SEPARATELY IDENTIFIED BY A RADIOLOGICAL MARKER					
197	19140	MASTECTOMY FOR GYNECOMASTIA					
197	19290	PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST					
197	19291	PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST; EACH ADDITIONAL LESION					
197	19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT					
197	19499	UNLISTED PROCEDURE, BREAST					
198	Breast reconstruction/mastectomy		T	19.17	\$971.33	\$530.20	\$194.27
198	19160	MASTECTOMY, PARTIAL;					
198	19162	MASTECTOMY, PARTIAL; WITH AXILLARY LYMPHADENECTOMY					
198	19180	MASTECTOMY, SIMPLE, COMPLETE					
198	19182	MASTECTOMY, SUBCUTANEOUS					
198	19316	MASTOPEXY					
198	19318	REDUCTION MAMMAPLASTY					
198	19324	MAMMAPLASTY, AUGMENTATION; WITHOUT PROSTHETIC IMPLANT					
198	19325	MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT					
198	19328	REMOVAL OF INTACT MAMMARY IMPLANT					
198	19330	REMOVAL OF MAMMARY IMPLANT MATERIAL					
198	19340	IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION					
198	19342	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION					
198	19350	NIPPLE/AREOLA RECONSTRUCTION					
198	19355	CORRECTION OF INVERTED NIPPLES					
198	19357	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION					
198	19366	BREAST RECONSTRUCTION WITH OTHER TECHNIQUE					
198	19370	OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST					
198	19371	PERIPROSTHETIC CAPSULECTOMY, BREAST					
198	19380	REVISION OF RECONSTRUCTED BREAST					
200	Arthrocentesis & Ligament/Tendon Injection		T	1.89	\$95.77	\$39.10	\$19.15
200	20550	INJECTION, TENDON SHEATH, LIGAMENT, TRIGGER POINTS OR GANGLION CYST					
200	20600	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; SMALL JOINT, BURSA OR GANGLION CYST (EG, FINGERS, TOES)					
200	20605	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; INTERMEDIATE JOINT, BURSA OR GANGLION CYST (EG, TEMPOROMANDIBULAR, ACROMIOCLAVICULAR, WRIST, ELBOW OR ANKLE, OLECRANON BURSA)					
200	20610	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; MAJOR JOINT OR BURSA (EG, SHOULDER, HIP, KNEE JOINT, SUBACROMIAL BURSA)					
207	Closed treatment fracture finger/toe/trunk		T	1.70	\$86.14	\$31.64	\$17.23
207	21800	CLOSED TREATMENT OF RIB FRACTURE, UNCOMPLICATED, EACH					
207	21820	CLOSED TREATMENT OF STERNUM FRACTURE					
207	21899	UNLISTED PROCEDURE, NECK OR THORAX					
207	22305	CLOSED TREATMENT OF VERTEBRAL PROCESS FRACTURE(S)					
207	22310	CLOSED TREATMENT OF VERTEBRAL BODY FRACTURE(S), WITHOUT MANIPULATION, REQUIRING AND INCLUDING CASTING OR BRACING					
207	22315	CLOSED TREATMENT OF VERTEBRAL FRACTURE(S) AND/OR DISLOCATION(S) REQUIRING CASTING OR BRACING, WITH AND INCLUDING CASTING AND/OR BRACING, WITH OR WITHOUT ANESTHESIA, BY MANIPULATION OR TRACTION					
207	22899	UNLISTED PROCEDURE, SPINE					
207	23500	CLOSED TREATMENT OF CLAVICULAR FRACTURE; WITHOUT MANIPULATION					
207	23505	CLOSED TREATMENT OF CLAVICULAR FRACTURE; WITH MANIPULATION					
207	23520	CLOSED TREATMENT OF STERNOCLAVICULAR DISLOCATION; WITHOUT MANIPULATION					
207	23525	WITH MANIPULATION					
207	23540	CLOSED TREATMENT OF ACROMIOCLAVICULAR DISLOCATION; WITHOUT MANIPULATION					
207	23545	CLOSED TREATMENT OF ACROMIOCLAVICULAR DISLOCATION; WITH MANIPULATION					
207	23570	CLOSED TREATMENT OF SCAPULAR FRACTURE; WITHOUT MANIPULATION					
207	23575	CLOSED TREATMENT OF SCAPULAR FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION (WITH OR WITHOUT SHOULDER JOINT INVOLVEMENT)					
207	23650	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH MANIPULATION; WITHOUT ANESTHESIA					
207	23929	UNLISTED PROCEDURE, SHOULDER					
207	26700	CLOSED TREATMENT OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH MANIPULATION; WITHOUT ANESTHESIA					
207	26720	CLOSED TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB; WITHOUT MANIPULATION, EACH					
207	26725	CLOSED TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION, EACH					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
207	26740	CLOSED TREATMENT OF ARTICULAR FRACTURE, INVOLVING METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT; WITHOUT MANIPULATION, EACH					
207	26750	CLOSED TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB; WITHOUT MANIPULATION, EACH					
207	26755	CLOSED TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB; WITH MANIPULATION, EACH					
207	26770	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, SINGLE, WITH MANIPULATION; WITHOUT ANESTHESIA					
207	26989	UNLISTED PROCEDURE, HANDS OR FINGERS					
207	27200	CLOSED TREATMENT OF COCCYGEAL FRACTURE					
207	27299	UNLISTED PROCEDURE, PELVIS OR HIP JOINT					
207	28490	CLOSED TREATMENT OF FRACTURE GREAT TOE, PHALANX OR PHALANGES; WITHOUT MANIPULATION					
207	28495	CLOSED TREATMENT OF FRACTURE GREAT TOE, PHALANX OR PHALANGES; WITH MANIPULATION					
207	28510	CLOSED TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER THAN GREAT TOE; WITHOUT MANIPULATION, EACH					
207	28515	CLOSED TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER THAN GREAT TOE; WITH MANIPULATION, EACH					
207	28630	CLOSED TREATMENT OF METATARSOPHALANGEAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
207	28660	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
207	28899	UNLISTED PROCEDURE, FOOT OR TOES					
207	31585	TREATMENT OF CLOSED LARYNGEAL FRACTURE; WITHOUT MANIPULATION					
207	31599	UNLISTED PROCEDURE, LARYNX					
209	Closed treatment fracture/dislocation/except finger/toe/trunk		T	1.94	\$98.30	\$37.29	\$19.66
209	23600	CLOSED TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE; WITHOUT MANIPULATION					
209	23605	CLOSED TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION					
209	23620	CLOSED TREATMENT OF GREATER TUBEROSITY FRACTURE; WITHOUT MANIPULATION					
209	23625	CLOSED TREATMENT OF GREATER TUBEROSITY FRACTURE; WITH MANIPULATION					
209	23665	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH FRACTURE OF GREATER TUBEROSITY, WITH MANIPULATION					
209	23675	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH SURGICAL OR ANATOMICAL NECK FRACTURE, WITH MANIPULATION					
209	24500	CLOSED TREATMENT OF HUMERAL SHAFT FRACTURE; WITHOUT MANIPULATION					
209	24505	CLOSED TREATMENT OF HUMERAL SHAFT FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION					
209	24530	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR HUMERAL FRACTURE, WITH OR WITHOUT INTERCONDYLAR EXTENSION; WITHOUT MANIPULATION					
209	24535	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR HUMERAL FRACTURE, WITH OR WITHOUT INTERCONDYLAR EXTENSION; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	24560	CLOSED TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL; WITHOUT MANIPULATION					
209	24565	CLOSED TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL; WITH MANIPULATION					
209	24576	CLOSED TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL; WITHOUT MANIPULATION					
209	24577	CLOSED TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL; WITH MANIPULATION					
209	24600	TREATMENT OF CLOSED ELBOW DISLOCATION; WITHOUT ANESTHESIA					
209	24620	CLOSED TREATMENT OF MONTEGGIA TYPE OF FRACTURE DISLOCATION AT ELBOW (FRACTURE PROXIMAL END OF ULNA WITH DISLOCATION OF RADIAL HEAD), WITH MANIPULATION					
209	24640	CLOSED TREATMENT OF RADIAL HEAD SUBLUXATION IN CHILD, "NURSEMAID ELBOW", WITH MANIPULATION					
209	24650	CLOSED TREATMENT OF RADIAL HEAD OR NECK FRACTURE; WITHOUT MANIPULATION					
209	24655	CLOSED TREATMENT OF RADIAL HEAD OR NECK FRACTURE; WITH MANIPULATION					
209	24670	CLOSED TREATMENT OF ULNAR FRACTURE, PROXIMAL END (OLECRANON PROCESS); WITHOUT MANIPULATION					
209	24675	CLOSED TREATMENT OF ULNAR FRACTURE, PROXIMAL END (OLECRANON PROCESS); WITH MANIPULATION					
209	24999	UNLISTED PROCEDURE, HUMERUS OR ELBOW					
209	25500	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE; WITHOUT MANIPULATION					
209	25505	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE; WITH MANIPULATION					
209	25520	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE, WITH DISLOCATION OF DISTAL RADIO-ULNAR JOINT (GALEAZZI FRACTURE/DISLOCATION)					
209	25530	CLOSED TREATMENT OF ULNAR SHAFT FRACTURE; WITHOUT MANIPULATION					
209	25535	CLOSED TREATMENT OF ULNAR SHAFT FRACTURE; WITH MANIPULATION					
209	25560	CLOSED TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES; WITHOUT MANIPULATION					
209	25565	CLOSED TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES; WITH MANIPULATION					
209	25600	CLOSED TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID; WITHOUT MANIPULATION					
209	25605	CLOSED TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID; WITH MANIPULATION					
209	25622	CLOSED TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE; WITHOUT MANIPULATION					
209	25624	CLOSED TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE; WITH MANIPULATION					
209	25630	CLOSED TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING CARPAL SCAPHOID (NAVICULAR)); WITHOUT MANIPULATION, EACH BONE					
209	25635	CLOSED TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING CARPAL SCAPHOID (NAVICULAR)); WITH MANIPULATION, EACH BONE					
209	25650	CLOSED TREATMENT OF ULNAR STYLOID FRACTURE					
209	25660	CLOSED TREATMENT OF RADIOCARPAL OR INTERCARPAL DISLOCATION, ONE OR MORE BONES, WITH MANIPULATION					
209	25675	CLOSED TREATMENT OF DISTAL RADIOULNAR DISLOCATION WITH MANIPULATION					
209	25680	CLOSED TREATMENT OF TRANS-SCAPHOPERILUNAR TYPE OF FRACTURE DISLOCATION, WITH MANIPULATION					
209	25690	CLOSED TREATMENT OF LUNATE DISLOCATION, WITH MANIPULATION					
209	25999	UNLISTED PROCEDURE, FOREARM OR WRIST					
209	26600	CLOSED TREATMENT OF METACARPAL FRACTURE, SINGLE; WITHOUT MANIPULATION, EACH BONE					
209	26605	CLOSED TREATMENT OF METACARPAL FRACTURE, SINGLE; WITH MANIPULATION, EACH BONE					
209	26607	CLOSED TREATMENT OF METACARPAL FRACTURE, WITH MANIPULATION, WITH INTERNAL OR EXTERNAL FIXATION, EACH BONE					
209	26641	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, THUMB, WITH MANIPULATION					
209	26645	CLOSED TREATMENT OF CARPOMETACARPAL FRACTURE DISLOCATION, THUMB (BENNETT FRACTURE), WITH MANIPULATION					
209	26670	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE), SINGLE, WITH MANIPULATION; WITHOUT ANESTHESIA					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT 1/ HCPCS 2	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
209	26706	PERCUTANEOUS SKELETAL FIXATION OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH MANIPULATION					
209	26742	CLOSED TREATMENT OF ARTICULAR FRACTURE, INVOLVING METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT; WITH MANIPULATION, EACH					
209	27193	CLOSED TREATMENT OF PELVIC RING FRACTURE, DISLOCATION, DIASTASIS OR SUBLUXATION; WITHOUT MANIPULATION					
209	27220	CLOSED TREATMENT OF ACETABULUM (HIP SOCKET) FRACTURE(S); WITHOUT MANIPULATION					
209	27230	CLOSED TREATMENT OF FEMORAL FRACTURE, PROXIMAL END, NECK; WITHOUT MANIPULATION					
209	27238	CLOSED TREATMENT OF INTERTROCHANTERIC, PERTROCHANTERIC, OR SUBTROCHANTERIC FEMORAL FRACTURE; WITHOUT MANIPULATION					
209	27246	CLOSED TREATMENT OF GREATER TROCHANTERIC FRACTURE, WITHOUT MANIPULATION					
209	27250	CLOSED TREATMENT OF HIP DISLOCATION, TRAUMATIC; WITHOUT ANESTHESIA					
209	27256	TREATMENT OF SPONTANEOUS HIP DISLOCATION (DEVELOPMENTAL, INCLUDING CONGENITAL OR PATHOLOGICAL), BY ABDUCTION, SPLINT OR TRACTION; WITHOUT ANESTHESIA, WITHOUT MANIPULATION					
209	27265	CLOSED TREATMENT OF POST HIP ARTHROPLASTY DISLOCATION; WITHOUT ANESTHESIA					
209	27500	CLOSED TREATMENT OF FEMORAL SHAFT FRACTURE, WITHOUT MANIPULATION					
209	27501	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR FEMORAL FRACTURE WITH OR WITHOUT INTERCONDYLAR EXTENSION, WITHOUT MANIPULATION					
209	27502	CLOSED TREATMENT OF FEMORAL SHAFT FRACTURE, WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27503	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR FEMORAL FRACTURE WITH OR WITHOUT INTERCONDYLAR EXTENSION, WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27508	CLOSED TREATMENT OF FEMORAL FRACTURE, DISTAL END, MEDIAL OR LATERAL CONDYLE, WITHOUT MANIPULATION					
209	27510	CLOSED TREATMENT OF FEMORAL FRACTURE, DISTAL END, MEDIAL OR LATERAL CONDYLE, WITH MANIPULATION					
209	27516	CLOSED TREATMENT OF DISTAL FEMORAL EPIPHYSEAL SEPARATION; WITHOUT MANIPULATION					
209	27517	CLOSED TREATMENT OF DISTAL FEMORAL EPIPHYSEAL SEPARATION; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27520	CLOSED TREATMENT OF PATELLAR FRACTURE, WITHOUT MANIPULATION					
209	27530	CLOSED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); WITHOUT MANIPULATION					
209	27532	CLOSED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); WITH OR WITHOUT MANIPULATION, WITH SKELETAL TRACTION					
209	27538	CLOSED TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR TUBEROSITY FRACTURE(S) OF KNEE, WITH OR WITHOUT MANIPULATION					
209	27550	CLOSED TREATMENT OF KNEE DISLOCATION; WITHOUT ANESTHESIA					
209	27560	CLOSED TREATMENT OF PATELLAR DISLOCATION; WITHOUT ANESTHESIA					
209	27599	UNLISTED PROCEDURE, FEMUR OR KNEE					
209	27750	CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE); WITHOUT MANIPULATION					
209	27752	CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE); WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION					
209	27760	CLOSED TREATMENT OF MEDIAL MALLEOLUS FRACTURE; WITHOUT MANIPULATION					
209	27762	CLOSED TREATMENT OF MEDIAL MALLEOLUS FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27780	CLOSED TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE; WITHOUT MANIPULATION					
209	27781	CLOSED TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE; WITH MANIPULATION					
209	27786	CLOSED TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS); WITHOUT MANIPULATION					
209	27788	CLOSED TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS); WITH MANIPULATION					
209	27808	CLOSED TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, (INCLUDING POTTS); WITHOUT MANIPULATION					
209	27810	CLOSED TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, (INCLUDING POTTS); WITH MANIPULATION					
209	27816	CLOSED TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE; WITHOUT MANIPULATION					
209	27818	CLOSED TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE; WITH MANIPULATION					
209	27824	CLOSED TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH OR WITHOUT ANESTHESIA; WITHOUT MANIPULATION					
209	27825	CLOSED TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH OR WITHOUT ANESTHESIA; WITH SKELETAL TRACTION AND/OR REQUIRING MANIPULATION					
209	27830	CLOSED TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT DISLOCATION; WITHOUT ANESTHESIA					
209	27840	CLOSED TREATMENT OF ANKLE DISLOCATION; WITHOUT ANESTHESIA					
209	27899	UNLISTED PROCEDURE, LEG OR ANKLE					
209	28400	CLOSED TREATMENT OF CALCANEAL FRACTURE; WITHOUT MANIPULATION					
209	28405	CLOSED TREATMENT OF CALCANEAL FRACTURE; WITH MANIPULATION					
209	28430	CLOSED TREATMENT OF TALUS FRACTURE; WITHOUT MANIPULATION					
209	28435	CLOSED TREATMENT OF TALUS FRACTURE; WITH MANIPULATION					
209	28450	TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS); WITHOUT MANIPULATION, EACH					
209	28455	TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS); WITH MANIPULATION, EACH					
209	28470	CLOSED TREATMENT OF METATARSAL FRACTURE; WITHOUT MANIPULATION, EACH					
209	28475	CLOSED TREATMENT OF METATARSAL FRACTURE; WITH MANIPULATION, EACH					
209	28530	CLOSED TREATMENT OF SESAMOID FRACTURE					
209	28540	CLOSED TREATMENT OF TARSAL BONE DISLOCATION, OTHER THAN TALOTARSAL; WITHOUT ANESTHESIA					
209	28570	CLOSED TREATMENT OF TALOTARSAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
209	28600	CLOSED TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
209	31586	TREATMENT OF CLOSED LARYNGEAL FRACTURE; WITH CLOSED MANIPULATIVE REDUCTION					
210	Bone/joint manipulation under anesthesia		T	10.46	\$530.00	\$283.40	\$106.00
210	22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION					
210	23655	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH MANIPULATION; REQUIRING ANESTHESIA					
210	23700	MANIPULATION UNDER ANESTHESIA, SHOULDER JOINT, INCLUDING APPLICATION OF FIXATION APPARATUS (DISLOCATION EXCLUDED)					
210	24605	TREATMENT OF CLOSED ELBOW DISLOCATION; REQUIRING ANESTHESIA					
210	26675	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE), SINGLE, WITH MANIPULATION; REQUIRING ANESTHESIA					
210	26705	CLOSED TREATMENT OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH MANIPULATION; REQUIRING ANESTHESIA					
210	26775	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, SINGLE, WITH MANIPULATION; REQUIRING ANESTHESIA					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT-1/ HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
210	27194	CLOSED TREATMENT OF PELVIC RING FRACTURE, DISLOCATION, DIASTASIS OR SUBLUXATION; WITH MANIPULATION, REQUIRING MORE THAN LOCAL ANESTHESIA					
210	27252	CLOSED TREATMENT OF HIP DISLOCATION, TRAUMATIC; REQUIRING ANESTHESIA					
210	27257	TREATMENT OF SPONTANEOUS HIP DISLOCATION (DEVELOPMENTAL, INCLUDING CONGENITAL OR PATHOLOGICAL), BY ABDUCTION, SPLINT OR TRACTION; WITH MANIPULATION, REQUIRING ANESTHESIA					
210	27275	MANIPULATION, HIP JOINT, REQUIRING GENERAL ANESTHESIA					
210	27552	CLOSED TREATMENT OF KNEE DISLOCATION; REQUIRING ANESTHESIA					
210	27562	CLOSED TREATMENT OF PATELLAR DISLOCATION; REQUIRING ANESTHESIA					
210	27570	MANIPULATION OF KNEE JOINT UNDER GENERAL ANESTHESIA (INCLUDES APPLICATION OF TRACTION OR OTHER FIXATION DEVICES)					
210	27831	CLOSED TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	27842	CLOSED TREATMENT OF ANKLE DISLOCATION; REQUIRING ANESTHESIA, WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION					
210	27860	MANIPULATION OF ANKLE UNDER GENERAL ANESTHESIA (INCLUDES APPLICATION OF TRACTION OR OTHER FIXATION APPARATUS)					
210	28545	CLOSED TREATMENT OF TARSAL BONE DISLOCATION, OTHER THAN TALOTARSAL; REQUIRING ANESTHESIA					
210	28575	CLOSED TREATMENT OF TALOTARSAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	28605	CLOSED TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	28635	CLOSED TREATMENT OF METATARSOPHALANGEAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	28665	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
216	Open/percutaneous treatment fracture or dislocation		T	20.13	\$1,019.98	\$520.82	\$204.00
216	21336	OPEN TREATMENT OF NASAL SEPTAL FRACTURE, WITH OR WITHOUT STABILIZATION					
216	21805	OPEN TREATMENT OF RIB FRACTURE WITHOUT FIXATION, EACH					
216	23515	OPEN TREATMENT OF CLAVICULAR FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	23530	OPEN TREATMENT OF STERNOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC;					
216	23532	OPEN TREATMENT OF STERNOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC; WITH FASCIAL GRAFT (INCLUDES OBTAINING GRAFT)					
216	23550	OPEN TREATMENT OF ACROMIOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC;					
216	23552	OPEN TREATMENT OF ACROMIOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC; WITH FASCIAL GRAFT (INCLUDES OBTAINING GRAFT)					
216	23585	OPEN TREATMENT OF SCAPULAR FRACTURE (BODY, GLENOID OR ACROMION) WITH OR WITHOUT INTERNAL FIXATION					
216	23615	OPEN TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, WITH OR WITHOUT REPAIR OF TUBEROSITY(-IES);					
216	23616	OPEN TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, WITH OR WITHOUT REPAIR OF TUBEROSITY(-IES); WITH PROXIMAL HUMERAL PROSTHETIC REPLACEMENT					
216	23630	OPEN TREATMENT OF GREATER TUBEROSITY FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	23660	OPEN TREATMENT OF ACUTE SHOULDER DISLOCATION					
216	23670	OPEN TREATMENT OF SHOULDER DISLOCATION, WITH FRACTURE OF GREATER TUBEROSITY, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	23680	OPEN TREATMENT OF SHOULDER DISLOCATION, WITH SURGICAL OR ANATOMICAL NECK FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24515	OPEN TREATMENT OF HUMERAL SHAFT FRACTURE WITH PLATE/SCREWS, WITH OR WITHOUT CERCLAGE					
216	24516	OPEN TREATMENT OF HUMERAL SHAFT FRACTURE, WITH INSERTION OF INTRAMEDULLARY IMPLANT, WITH OR WITHOUT CERCLAGE AND/OR LOCKING SCREWS					
216	24538	PERCUTANEOUS SKELETAL FIXATION OF SUPRACONDYLAR OR TRANSCONDYLAR HUMERAL FRACTURE, WITH OR WITHOUT INTERCONDYLAR EXTENSION					
216	24545	OPEN TREATMENT OF HUMERAL SUPRACONDYLAR OR TRANSCONDYLAR FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITHOUT INTERCONDYLAR EXTENSION					
216	24546	OPEN TREATMENT OF HUMERAL SUPRACONDYLAR OR TRANSCONDYLAR FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITH INTERCONDYLAR EXTENSION					
216	24566	PERCUTANEOUS SKELETAL FIXATION OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH MANIPULATION					
216	24575	OPEN TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24579	OPEN TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24582	PERCUTANEOUS SKELETAL FIXATION OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH MANIPULATION					
216	24586	OPEN TREATMENT OF PERIARTICULAR FRACTURE AND/OR DISLOCATION OF THE ELBOW (FRACTURE DISTAL HUMERUS AND PROXIMAL ULNA AND/ OR PROXIMAL RADIUS);					
216	24587	OPEN TREATMENT OF PERIARTICULAR FRACTURE AND/OR DISLOCATION OF THE ELBOW (FRACTURE DISTAL HUMERUS AND PROXIMAL ULNA AND/ OR PROXIMAL RADIUS); WITH IMPLANT ARTHROPLASTY					
216	24615	OPEN TREATMENT OF ACUTE OR CHRONIC ELBOW DISLOCATION					
216	24635	OPEN TREATMENT OF MONTEGGIA TYPE OF FRACTURE DISLOCATION AT ELBOW (FRACTURE PROXIMAL END OF ULNA WITH DISLOCATION OF RADIAL HEAD), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24665	OPEN TREATMENT OF RADIAL HEAD OR NECK FRACTURE, WITH OR WITHOUT INTERNAL FIXATION OR RADIAL HEAD EXCISION;					
216	24666	OPEN TREATMENT OF RADIAL HEAD OR NECK FRACTURE, WITH OR WITHOUT INTERNAL FIXATION OR RADIAL HEAD EXCISION; WITH RADIAL HEAD PROSTHETIC REPLACEMENT					
216	24685	OPEN TREATMENT OF ULNAR FRACTURE PROXIMAL END (OLECRANON PROCESS), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25515	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25525	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH INTERNAL AND/ OR EXTERNAL FIXATION AND CLOSED TREATMENT OF DISLOCATION OF DISTAL RADIO-ULNAR JOINT (GALEAZZI FRACTURE/DISLOCATION), WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION					
216	25526	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH INTERNAL AND/ OR EXTERNAL FIXATION AND OPEN TREATMENT, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION OF DISTAL RADIO-ULNAR JOINT (GALEAZZI FRACTURE/DISLOCATION), INCLUDES REPAIR OF TRIANGULAR CARTILAGE					
216	25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25574	OPEN TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES, WITH INTERNAL OR EXTERNAL FIXATION; OF RADIUS OR ULNA					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
216	25575	OPEN TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES, WITH INTERNAL OR EXTERNAL FIXATION; OF RADIUS AND ULNA					
216	25611	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID, REQUIRING MANIPULATION, WITH OR WITHOUT EXTERNAL FIXATION					
216	25620	OPEN TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25628	OPEN TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25645	OPEN TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING CARPAL SCAPHOID (NAVICULAR)), EACH BONE					
216	25670	OPEN TREATMENT OF RADIOCARPAL OR INTERCARPAL DISLOCATION, ONE OR MORE BONES					
216	25676	OPEN TREATMENT OF DISTAL RADIOULNAR DISLOCATION, ACUTE OR CHRONIC					
216	25685	OPEN TREATMENT OF TRANS-SCAPHOPERILUNAR TYPE OF FRACTURE DISLOCATION					
216	25695	OPEN TREATMENT OF LUNATE DISLOCATION					
216	26608	PERCUTANEOUS SKELETAL FIXATION OF METACARPAL FRACTURE, EACH BONE					
216	26615	OPEN TREATMENT OF METACARPAL FRACTURE, SINGLE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH BONE					
216	26650	PERCUTANEOUS SKELETAL FIXATION OF CARPOMETACARPAL FRACTURE DISLOCATION, THUMB (BENNETT FRACTURE), WITH MANIPULATION, WITH OR WITHOUT EXTERNAL FIXATION					
216	26665	OPEN TREATMENT OF CARPOMETACARPAL FRACTURE DISLOCATION, THUMB (BENNETT FRACTURE), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	26676	PERCUTANEOUS SKELETAL FIXATION OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE), SINGLE, WITH MANIPULATION					
216	26685	OPEN TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE); SINGLE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	26686	OPEN TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE); COMPLEX, MULTIPLE OR DELAYED REDUCTION					
216	26715	OPEN TREATMENT OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	26727	PERCUTANEOUS SKELETAL FIXATION OF UNSTABLE PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB, WITH MANIPULATION, EACH					
216	26735	OPEN TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	26746	OPEN TREATMENT OF ARTICULAR FRACTURE, INVOLVING METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	26756	PERCUTANEOUS SKELETAL FIXATION OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB, EACH					
216	26765	OPEN TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	26776	PERCUTANEOUS SKELETAL FIXATION OF INTERPHALANGEAL JOINT DISLOCATION, SINGLE, WITH MANIPULATION					
216	26785	OPEN TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, SINGLE					
216	27202	OPEN TREATMENT OF COCCYGEAL FRACTURE					
216	27509	PERCUTANEOUS SKELETAL FIXATION OF FEMORAL FRACTURE, DISTAL END, MEDIAL OR LATERAL CONDYLE, OR SUPRACONDYLAR OR TRANSCONDYLAR, WITH OR WITHOUT INTERCONDYLAR EXTENSION, OR DISTAL FEMORAL EPIPHYSEAL SEPARATION					
216	27556	OPEN TREATMENT OF KNEE DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITHOUT PRIMARY LIGAMENTOUS REPAIR OR AUGMENTATION/RECONSTRUCTION					
216	27566	OPEN TREATMENT OF PATELLAR DISLOCATION, WITH OR WITHOUT PARTIAL OR TOTAL PATELLECTOMY					
216	27615	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF LEG OR ANKLE AREA					
216	27756	PERCUTANEOUS SKELETAL FIXATION OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE) (EG, PINS OR SCREWS)					
216	27758	OPEN TREATMENT OF TIBIAL SHAFT FRACTURE, (WITH OR WITHOUT FIBULAR FRACTURE) WITH PLATE/SCREWS, WITH OR WITHOUT CERCLAGE					
216	27759	OPEN TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE) BY INTRAMEDULLARY IMPLANT, WITH OR WITHOUT INTERLOCKING SCREWS AND/OR CERCLAGE					
216	27766	OPEN TREATMENT OF MEDIAL MALLEOLUS FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27784	OPEN TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27792	OPEN TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27814	OPEN TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27822	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, MEDIAL AND/OR LATERAL MALLEOLUS; WITHOUT FIXATION OF POSTERIOR LIP					
216	27823	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, MEDIAL AND/OR LATERAL MALLEOLUS; WITH FIXATION OF POSTERIOR LIP					
216	27826	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR SURFACE/ PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH INTERNAL OR EXTERNAL FIXATION; OF FIBULA ONLY					
216	27827	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR SURFACE/ PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH INTERNAL OR EXTERNAL FIXATION; OF TIBIA ONLY					
216	27828	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR SURFACE/ PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH INTERNAL OR EXTERNAL FIXATION; OF BOTH TIBIA AND FIBULA					
216	27829	OPEN TREATMENT OF DISTAL TIBIOFIBULAR JOINT (SYNDESOSIS) DISRUPTION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27832	OPEN TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, OR WITH EXCISION OF PROXIMAL FIBULA					
216	27846	OPEN TREATMENT OF ANKLE DISLOCATION, WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION; WITHOUT REPAIR OR INTERNAL FIXATION					
216	27848	OPEN TREATMENT OF ANKLE DISLOCATION, WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION; WITH REPAIR OR INTERNAL OR EXTERNAL FIXATION					
216	28406	PERCUTANEOUS SKELETAL FIXATION OF CALCANEAL FRACTURE, WITH MANIPULATION					
216	28415	OPEN TREATMENT OF CALCANEAL FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION;					
216	28420	OPEN TREATMENT OF CALCANEAL FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITH PRIMARY ILIAC OR OTHER AUTOGENOUS BONE GRAFT (INCLUDES OBTAINING GRAFT)					
216	28436	PERCUTANEOUS SKELETAL FIXATION OF TALUS FRACTURE, WITH MANIPULATION					
216	28445	OPEN TREATMENT OF TALUS FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28456	PERCUTANEOUS SKELETAL FIXATION OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS), WITH MANIPULATION, EACH					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
216	28465	OPEN TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	28476	PERCUTANEOUS SKELETAL FIXATION OF METATARSAL FRACTURE, WITH MANIPULATION, EACH					
216	28485	OPEN TREATMENT OF METATARSAL FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	28496	PERCUTANEOUS SKELETAL FIXATION OF FRACTURE GREAT TOE, PHALANX OR PHALANGES, WITH MANIPULATION					
216	28505	OPEN TREATMENT OF FRACTURE GREAT TOE, PHALANX OR PHALANGES, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28525	OPEN TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER THAN GREAT TOE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	28531	OPEN TREATMENT OF SESAMOID FRACTURE, WITH OR WITHOUT INTERNAL FIXATION					
216	28546	PERCUTANEOUS SKELETAL FIXATION OF TARSAL BONE DISLOCATION, OTHER THAN TALOTARSAL, WITH MANIPULATION					
216	28555	OPEN TREATMENT OF TARSAL BONE DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28576	PERCUTANEOUS SKELETAL FIXATION OF TALOTARSAL JOINT DISLOCATION, WITH MANIPULATION					
216	28585	OPEN TREATMENT OF TALOTARSAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28606	PERCUTANEOUS SKELETAL FIXATION OF TARSOMETATARSAL JOINT DISLOCATION, WITH MANIPULATION					
216	28615	OPEN TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28636	PERCUTANEOUS SKELETAL FIXATION OF METATARSOPHALANGEAL JOINT DISLOCATION, WITH MANIPULATION					
216	28645	OPEN TREATMENT OF METATARSOPHALANGEAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28666	PERCUTANEOUS SKELETAL FIXATION OF INTERPHALANGEAL JOINT DISLOCATION, WITH MANIPULATION					
216	28675	OPEN TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
217	Arthroplasty		T	20.48	\$1,037.71	\$526.81	\$207.54
217	24360	ARTHROPLASTY, ELBOW; WITH MEMBRANE					
217	24365	ARTHROPLASTY, RADIAL HEAD;					
217	25332	ARTHROPLASTY, WRIST, WITH OR WITHOUT INTERPOSITION, WITH OR WITHOUT EXTERNAL OR INTERNAL FIXATION					
217	25447	INTERPOSITION ARTHROPLASTY, INTERCARPAL OR CARPOMETACARPAL JOINTS					
217	25449	REVISION OF ARTHROPLASTY, INCLUDING REMOVAL OF IMPLANT, WRIST JOINT					
217	26530	ARTHROPLASTY, METACARPOPHALANGEAL JOINT; SINGLE, EACH					
217	26535	ARTHROPLASTY INTERPHALANGEAL JOINT; SINGLE, EACH					
217	27266	CLOSED TREATMENT OF POST HIP ARTHROPLASTY DISLOCATION; REQUIRING REGIONAL OR GENERAL ANESTHESIA					
217	27437	ARTHROPLASTY, PATELLA; WITHOUT PROSTHESIS					
217	27440	ARTHROPLASTY, KNEE, TIBIAL PLATEAU;					
217	27441	ARTHROPLASTY, KNEE, TIBIAL PLATEAU; WITH DEBRIDEMENT AND PARTIAL SYNOVECTOMY					
217	27442	ARTHROPLASTY, KNEE, FEMORAL CONDYLES OR TIBIAL PLATEAUS;					
217	27443	ARTHROPLASTY, KNEE, FEMORAL CONDYLES OR TIBIAL PLATEAUS; WITH DEBRIDEMENT AND PARTIAL SYNOVECTOMY					
217	27700	ARTHROPLASTY, ANKLE;					
218	Arthroplasty with prosthesis		T	27.49	\$1,392.90	\$715.52	\$278.58
218	21243	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC JOINT REPLACEMENT					
218	24361	ARTHROPLASTY, ELBOW; WITH DISTAL HUMERAL PROSTHETIC REPLACEMENT					
218	24362	ARTHROPLASTY, ELBOW; WITH IMPLANT AND FASCIA LATA LIGAMENT RECONSTRUCTION					
218	24363	ARTHROPLASTY, ELBOW; WITH DISTAL HUMERUS AND PROXIMAL ULNAR PROSTHETIC REPLACEMENT ("TOTAL ELBOW")					
218	24366	ARTHROPLASTY, RADIAL HEAD; WITH IMPLANT					
218	25441	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS					
218	25442	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL ULNA					
218	25443	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; SCAPHOID (NAVICULAR)					
218	25444	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; LUNATE					
218	25445	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; TRAPEZIUM					
218	25446	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS AND PARTIAL OR ENTIRE CARPUS ("TOTAL WRIST")					
218	26531	ARTHROPLASTY, METACARPOPHALANGEAL JOINT; WITH PROSTHETIC IMPLANT, SINGLE, EACH					
218	26536	ARTHROPLASTY INTERPHALANGEAL JOINT; WITH PROSTHETIC IMPLANT, SINGLE, EACH					
218	27438	ARTHROPLASTY, PATELLA; WITH PROSTHESIS					
226	Maxillofacial prostheses		T	1.59	\$80.56	\$21.92	\$16.11
226	21076	IMPRESSION AND CUSTOM PREPARATION; SURGICAL OBTURATOR PROSTHESIS					
226	21077	IMPRESSION AND CUSTOM PREPARATION; ORBITAL PROSTHESIS					
226	21079	IMPRESSION AND CUSTOM PREPARATION; INTERIM OBTURATOR PROSTHESIS					
226	21080	IMPRESSION AND CUSTOM PREPARATION; DEFINITIVE OBTURATOR PROSTHESIS					
226	21081	IMPRESSION AND CUSTOM PREPARATION; MANDIBULAR RESECTION PROSTHESIS					
226	21082	IMPRESSION AND CUSTOM PREPARATION; PALATAL AUGMENTATION PROSTHESIS					
226	21083	IMPRESSION AND CUSTOM PREPARATION; PALATAL LIFT PROSTHESIS					
226	21084	IMPRESSION AND CUSTOM PREPARATION; SPEECH AID PROSTHESIS					
226	21086	IMPRESSION AND CUSTOM PREPARATION; AURICULAR PROSTHESIS					
226	21087	IMPRESSION AND CUSTOM PREPARATION; NASAL PROSTHESIS					
226	21088	IMPRESSION AND CUSTOM PREPARATION; FACIAL PROSTHESIS					
226	21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE					
231	Level I skull and facial bone procedures		T	12.02	\$609.05	\$299.9	\$121.81
231	21015	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF FACE OR SCALP					
231	21025	EXCISION OF BONE (EG, FOR OSTEOMYELITIS OR BONE ABSCESS); MANDIBLE					
231	21026	EXCISION OF BONE (EG, FOR OSTEOMYELITIS OR BONE ABSCESS); FACIAL BONE(S)					
231	21029	REMOVAL BY CONTOURING OF BENIGN TUMOR OF FACIAL BONE (EG, FIBROUS DYSPLASIA)					
231	21030	EXCISION OF BENIGN TUMOR OR CYST OF FACIAL BONE OTHER THAN MANDIBLE					
231	21031	EXCISION OF TORUS MANDIBULARIS					
231	21032	EXCISION OF MAXILLARY TORUS PALATINUS					
231	21040	EXCISION OF BENIGN CYST OR TUMOR OF MANDIBLE; SIMPLE					
231	21041	EXCISION OF BENIGN CYST OR TUMOR OF MANDIBLE; COMPLEX					
231	21100	APPLICATION OF HALO TYPE APPLIANCE FOR MAXILLOFACIAL FIXATION, INCLUDES REMOVAL (SEPARATE PROCEDURE)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
231	21110	APPLICATION OF INTERDENTAL FIXATION DEVICE FOR CONDITIONS OTHER THAN FRACTURE OR DISLOCATION, INCLUDES					
231	21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)					
231	21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL					
231	21280	MEDIAL CANTHOPEXY (SEPARATE PROCEDURE)					
231	21282	LATERAL CANTHOPEXY					
231	21295	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); EXTRAORAL AP- PROACH					
231	21296	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); INTRAORAL AP- PROACH					
231	21299	UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE					
231	21300	CLOSED TREATMENT OF SKULL FRACTURE WITHOUT OPERATION					
231	21310	CLOSED TREATMENT OF NASAL BONE FRACTURE WITHOUT MANIPULATION					
231	21315	CLOSED TREATMENT OF NASAL BONE FRACTURE; WITHOUT STABILIZATION					
231	21320	CLOSED TREATMENT OF NASAL BONE FRACTURE; WITH STABILIZATION					
231	21325	OPEN TREATMENT OF NASAL FRACTURE; UNCOMPLICATED					
231	21337	CLOSED TREATMENT OF NASAL SEPTAL FRACTURE, WITH OR WITHOUT STABILIZATION					
231	21355	PERCUTANEOUS TREATMENT OF FRACTURE OF MALAR AREA, INCLUDING ZYGOMATIC ARCH AND MALAR TRIPOD, WITH MANIPULA- TION					
231	21400	CLOSED TREATMENT OF FRACTURE OF ORBIT, EXCEPT "BLOWOUT"; WITHOUT MANIPULATION					
231	21401	CLOSED TREATMENT OF FRACTURE OF ORBIT, EXCEPT "BLOWOUT"; WITH MANIPULATION					
231	21440	CLOSED TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR RIDGE FRACTURE (SEPARATE PROCEDURE)					
231	21451	CLOSED TREATMENT OF MANDIBULAR FRACTURE; WITH MANIPULATION					
231	21480	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; INITIAL OR SUBSEQUENT					
231	21485	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; COMPLICATED (EG, RECURRENT REQUIRING INTERMAXILLARY FIXA- TION OR SPLINTING), INITIAL OR SUBSEQUENT					
231	21493	CLOSED TREATMENT OF HYOID FRACTURE; WITHOUT MANIPULATION					
231	21494	CLOSED TREATMENT OF HYOID FRACTURE; WITH MANIPULATION					
231	21497	INTERDENTAL WIRING, FOR CONDITION OTHER THAN FRACTURE					
231	21499	UNLISTED MUSCULOSKELETAL PROCEDURE, HEAD					
231	41822	EXCISION OF FIBROUS TUBEROSITIES, DENTOALVEOLAR STRUCTURES					
231	41823	EXCISION OF OSSEOUS TUBEROSITIES, DENTOALVEOLAR STRUCTURES					
232	Level II skull and facial bone procedures		T	23.93	\$1,212.52	\$639.35	\$242.50
232	21010	ARTHROTOMY, TEMPOROMANDIBULAR JOINT					
232	21034	EXCISION OF MALIGNANT TUMOR OF FACIAL BONE OTHER THAN MANDIBLE					
232	21044	EXCISION OF MALIGNANT TUMOR OF MANDIBLE					
232	21050	CONDYLECTOMY, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)					
232	21060	MENISCECTOMY, PARTIAL OR COMPLETE, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)					
232	21070	CORONOIDECTOMY (SEPARATE PROCEDURE)					
232	21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE					
232	21122	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)					
232	21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)					
232	21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)					
232	21181	RECONSTRUCTION BY CONTOURING OF BENIGN TUMOR OF CRANIAL BONES (EG, FIBROUS DYSPLASIA), EXTRACRANIAL					
232	21206	OSTEOTOMY, MAXILLA, SEGMENTAL (EG, WASSMUND OR SCHUCHARD)					
232	21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT)					
232	21209	OSTEOPLASTY, FACIAL BONES; REDUCTION					
232	21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES OBTAINING GRAFT)					
232	21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)					
232	21230	GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE, CHIN, NOSE OR EAR (INCLUDES OBTAINING GRAFT)					
232	21235	GRAFT; EAR CARTILAGE, AUTOGENOUS, TO NOSE OR EAR (INCLUDES OBTAINING GRAFT)					
232	21240	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH OR WITHOUT AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
232	21242	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH ALLOGRAFT					
232	21244	RECONSTRUCTION OF MANDIBLE, EXTRAORAL, WITH TRANSOSTEAL BONE PLATE (EG, MANDIBULAR STAPLE BONE PLATE)					
232	21245	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; PARTIAL					
232	21246	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; COMPLETE					
232	21248	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); PARTIAL					
232	21249	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); COMPLETE					
232	21260	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH BONE GRAFTS; EXTRACRANIAL APPROACH					
232	21267	ORBITAL REPOSITIONING, PERIORBITAL OSTEOTOMIES, UNILATERAL, WITH BONE GRAFTS; EXTRACRANIAL APPROACH					
232	21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL					
232	21275	SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION					
232	21330	OPEN TREATMENT OF NASAL FRACTURE; COMPLICATED, WITH INTERNAL AND/OR EXTERNAL SKELETAL FIXATION					
232	21335	OPEN TREATMENT OF NASAL FRACTURE; WITH CONCOMITANT OPEN TREATMENT OF FRACTURED SEPTUM					
232	21338	OPEN TREATMENT OF NASOETHMOID FRACTURE; WITHOUT EXTERNAL FIXATION					
232	21339	OPEN TREATMENT OF NASOETHMOID FRACTURE; WITH EXTERNAL FIXATION					
232	21340	PERCUTANEOUS TREATMENT OF NASOETHMOID COMPLEX FRACTURE, WITH SPLINT, WIRE OR HEADCAP FIXATION, INCLUDING RE- PAIR OF CANTHAL LIGAMENTS AND/OR THE NASOLACRIMAL APPARATUS					
232	21343	OPEN TREATMENT OF DEPRESSED FRONTAL SINUS FRACTURE					
232	21345	CLOSED TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE (LEFORT II TYPE), WITH INTERDENTAL WIRE FIXATION OR FIXATION OF DENTURE OR SPLINT					
232	21421	CLOSED TREATMENT OF PALATAL OR MAXILLARY FRACTURE (LEFORT I TYPE), WITH INTERDENTAL WIRE FIXATION OR FIXATION OF DENTURE OR SPLINT					
232	21445	OPEN TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR RIDGE FRACTURE (SEPARATE PROCEDURE)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
232	21450	CLOSED TREATMENT OF MANDIBULAR FRACTURE; WITHOUT MANIPULATION					
232	21452	PERCUTANEOUS TREATMENT OF MANDIBULAR FRACTURE, WITH EXTERNAL FIXATION					
232	21453	CLOSED TREATMENT OF MANDIBULAR FRACTURE WITH INTERDENTAL FIXATION					
232	21454	OPEN TREATMENT OF MANDIBULAR FRACTURE WITH EXTERNAL FIXATION					
232	21461	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITHOUT INTERDENTAL FIXATION					
232	21462	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITH INTERDENTAL FIXATION					
232	21465	OPEN TREATMENT OF MANDIBULAR CONDYLAR FRACTURE					
232	21490	OPEN TREATMENT OF TEMPOROMANDIBULAR DISLOCATION					
232	67420	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); WITH REMOVAL OF LESION					
232	67430	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); WITH REMOVAL OF FOREIGN BODY					
232	67440	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); WITH DRAINAGE					
232	67450	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); FOR EXPLORATION, WITH OR WITHOUT BI- OPSY					
251	Level I musculoskeletal procedures		T	14.26	\$722.55	\$366.12	\$144.51
251	20005	INCISION OF SOFT TISSUE ABSCESS (EG, SECONDARY TO OSTEOMYELITIS); DEEP OR COMPLICATED					
251	20250	BIOPSY, VERTEBRAL BODY, OPEN; THORACIC					
251	20251	BIOPSY, VERTEBRAL BODY, OPEN; LUMBAR OR CERVICAL					
251	20650	INSERTION OF WIRE OR PIN WITH APPLICATION OF SKELETAL TRACTION, INCLUDING REMOVAL (SEPARATE PROCEDURE)					
251	20693	ADJUSTMENT OR REVISION OF EXTERNAL FIXATION SYSTEM REQUIRING ANESTHESIA (EG, NEW PIN(S) OR WIRE(S) AND/OR NEW RING(S) OR BAR(S))					
251	20694	REMOVAL, UNDER ANESTHESIA, OF EXTERNAL FIXATION SYSTEM					
251	20975	ELECTRICAL STIMULATION TO AID BONE HEALING; INVASIVE (OPERATIVE)					
251	23100	ARTHROTOMY WITH BIOPSY, GLENOHUMERAL JOINT					
251	23140	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CLAVICLE OR SCAPULA;					
251	23935	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), HUMERUS OR ELBOW					
251	24100	ARTHROTOMY, ELBOW; WITH SYNOVIAL BIOPSY ONLY					
251	24105	EXCISION, OLECRANON BURSA					
251	24110	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, HUMERUS;					
251	24120	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF HEAD OR NECK OF RADIUS OR OLECRANON PROCESS;					
251	24310	TENOTOMY, OPEN, ELBOW TO SHOULDER, SINGLE, EACH					
251	24925	AMPUTATION, ARM THROUGH HUMERUS; SECONDARY CLOSURE OR SCAR REVISION					
251	25000	TENDON SHEATH INCISION; AT RADIAL STYLOID (EG, FOR DEQUERVAIN'S DISEASE)					
251	25020	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST; FLEXOR OR EXTENSOR COMPARTMENT					
251	25028	INCISION AND DRAINAGE, FOREARM AND/OR WRIST; DEEP ABSCESS OR HEMATOMA					
251	25031	INCISION AND DRAINAGE, FOREARM AND/OR WRIST; INFECTED BURSA					
251	25035	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), FOREARM AND/OR WRIST					
251	25085	CAPSULOTOMY, WRIST (EG, FOR CONTRACTURE)					
251	25100	ARTHROTOMY, WRIST JOINT; WITH BIOPSY					
251	25110	EXCISION, LESION OF TENDON SHEATH, FOREARM AND/OR WRIST					
251	25115	RADICAL EXCISION OF BURSA, SYNOVIA OF WRIST, OR FOREARM TENDON SHEATHS (EG, TENOSYNOVITIS, FUNGUS, TBC, OR OTHER GRANULOMAS, RHEUMATOID ARTHRITIS); FLEXORS					
251	25116	RADICAL EXCISION OF BURSA, SYNOVIA OF WRIST, OR FOREARM TENDON SHEATHS (EG, TENOSYNOVITIS, FUNGUS, TBC, OR OTHER GRANULOMAS, RHEUMATOID ARTHRITIS); EXTENSORS, WITH OR WITHOUT TRANSPOSITION OF DORSAL RETINACULUM					
251	25248	EXPLORATION WITH REMOVAL OF DEEP FOREIGN BODY, FOREARM OR WRIST					
251	25295	TENOLYSIS, FLEXOR OR EXTENSOR TENDON, FOREARM AND/OR WRIST, SINGLE, EACH TENDON					
251	25907	AMPUTATION, FOREARM, THROUGH RADIUS AND ULNA; SECONDARY CLOSURE OR SCAR REVISION					
251	25922	DISARTICULATION THROUGH WRIST; SECONDARY CLOSURE OR SCAR REVISION					
251	26990	INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; DEEP ABSCESS OR HEMATOMA					
251	26991	INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; INFECTED BURSA					
251	27000	TENOTOMY, ADDUCTOR OF HIP, SUBCUTANEOUS, CLOSED (SEPARATE PROCEDURE)					
251	27050	ARTHROTOMY, WITH BIOPSY; SACROILIAC JOINT					
251	27052	ARTHROTOMY, WITH BIOPSY; HIP JOINT					
251	27060	EXCISION; ISCHIAL BURSA					
251	27062	EXCISION; TROCHANTERIC BURSA OR CALCIFICATION					
251	27065	EXCISION OF BONE CYST OR BENIGN TUMOR; SUPERFICIAL (WING OF ILIUM, SYMPHYSIS PUBIS, OR GREATER TROCHANTER OF FEMUR) WITH OR WITHOUT AUTOGRAFT					
251	27086	REMOVAL OF FOREIGN BODY, PELVIS OR HIP; SUBCUTANEOUS TISSUE					
251	27087	REMOVAL OF FOREIGN BODY, PELVIS OR HIP; DEEP					
251	27305	FASCIOTOMY, ILIOTIBIAL (TENOTOMY), OPEN					
251	27306	TENOTOMY, SUBCUTANEOUS, CLOSED, ADDUCTOR OR HAMSTRING, (SEPARATE PROCEDURE); SINGLE					
251	27307	TENOTOMY, SUBCUTANEOUS, CLOSED, ADDUCTOR OR HAMSTRING, (SEPARATE PROCEDURE); MULTIPLE					
251	27340	EXCISION, PREPATELLAR BURSA					
251	27345	EXCISION OF SYNOVIAL CYST OF POPLITEAL SPACE (BAKER'S CYST)					
251	27380	SUTURE OF INFRAPATELLAR TENDON; PRIMARY					
251	27381	SUTURE OF INFRAPATELLAR TENDON; SECONDARY RECONSTRUCTION, INCLUDING FASCIAL OR TENDON GRAFT					
251	27385	SUTURE OF QUADRICEPS OR HAMSTRING MUSCLE RUPTURE; PRIMARY					
251	27386	SUTURE OF QUADRICEPS OR HAMSTRING MUSCLE RUPTURE; SECONDARY RECONSTRUCTION, INCLUDING FASCIAL OR TENDON GRAFT					
251	27390	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; SINGLE					
251	27391	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; MULTIPLE, ONE LEG					
251	27392	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; MULTIPLE, BILATERAL					
251	27496	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, ONE COMPARTMENT (FLEXOR OR EXTENSOR OR ADDUCTOR);					
251	27497	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, ONE COMPARTMENT (FLEXOR OR EXTENSOR OR ADDUCTOR); WITH DEBRIDEMENT OF NONVIALB MUSCLE AND/OR NERVE					
251	27498	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, MULTIPLE COMPARTMENTS;					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
251	27499	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, MULTIPLE COMPARTMENTS; WITH DEBRIDEMENT OF NONVIALE MUSCLE AND/OR NERVE					
251	27594	AMPUTATION, THIGH, THROUGH FEMUR, ANY LEVEL; SECONDARY CLOSURE OR SCAR REVISION					
251	27600	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL COMPARTMENTS ONLY					
251	27601	DECOMPRESSION FASCIOTOMY, LEG; POSTERIOR COMPARTMENT(S) ONLY					
251	27602	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL, AND POSTERIOR COMPARTMENT(S)					
251	27604	INCISION AND DRAINAGE, LEG OR ANKLE; INFECTED BURSA					
251	27606	TENOTOMY, ACHILLES TENDON, SUBCUTANEOUS (SEPARATE PROCEDURE); GENERAL ANESTHESIA					
251	27607	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), LEG OR ANKLE					
251	27630	EXCISION OF LESION OF TENDON SHEATH OR CAPSULE (EG, CYST OR GANGLION), LEG AND/OR ANKLE					
251	27656	REPAIR, FASCIAL DEFECT OF LEG					
251	27658	REPAIR OR SUTURE OF FLEXOR TENDON OF LEG; PRIMARY, WITHOUT GRAFT, SINGLE, EACH					
251	27659	REPAIR OR SUTURE OF FLEXOR TENDON OF LEG; SECONDARY WITH OR WITHOUT GRAFT, SINGLE TENDON, EACH					
251	27664	REPAIR OR SUTURE OF EXTENSOR TENDON OF LEG; PRIMARY, WITHOUT GRAFT, SINGLE, EACH					
251	27675	REPAIR FOR DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR OSTEOTOMY					
251	27704	REMOVAL OF ANKLE IMPLANT					
251	27707	OSTEOTOMY; FIBULA					
251	27884	AMPUTATION, LEG, THROUGH TIBIA AND FIBULA; SECONDARY CLOSURE OR SCAR REVISION					
251	27892	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL COMPARTMENTS ONLY, WITH DEBRIDEMENT OF NONVIALE MUSCLE AND/OR NERVE					
251	27893	DECOMPRESSION FASCIOTOMY, LEG; POSTERIOR COMPARTMENT(S) ONLY, WITH DEBRIDEMENT OF NONVIALE MUSCLE AND/OR NERVE					
251	27894	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL, AND POSTERIOR COMPARTMENT(S), WITH DEBRIDEMENT OF NONVIALE MUSCLE AND/OR NERVE					
251	28002	DEEP DISSECTION BELOW FASCIA, FOR DEEP INFECTION OF FOOT, WITH OR WITHOUT TENDON SHEATH INVOLVEMENT; SINGLE BURSAL SPACE, SPECIFY					
251	28003	DEEP DISSECTION BELOW FASCIA, FOR DEEP INFECTION OF FOOT, WITH OR WITHOUT TENDON SHEATH INVOLVEMENT; MULTIPLE AREAS					
252	Level II Musculoskeletal Procedures		T	19.39	\$982.48	\$509.18	\$196.5
252	20690	APPLICATION OF A UNIPLANE (PINS OR WIRES IN ONE PLANE), UNILATERAL, EXTERNAL FIXATION SYSTEM					
252	20692	APPLICATION OF A MULTIPLANE (PINS OR WIRES IN MORE THAN ONE PLANE), UNILATERAL, EXTERNAL FIXATION SYSTEM (EG, ILIZAROV, MONTICELLI TYPE)					
252	20900	BONE GRAFT, ANY DONOR AREA; MINOR OR SMALL (EG, DOWEL OR BUTTON)					
252	20902	BONE GRAFT, ANY DONOR AREA; MAJOR OR LARGE					
252	20924	TENDON GRAFT, FROM A DISTANCE (EG, PALMARIS, TOE EXTENSOR, PLANTARIS)					
252	21502	INCISION AND DRAINAGE, DEEP ABSCESS OR HEMATOMA, SOFT TISSUES OF NECK OR THORAX; WITH PARTIAL RIB OSTEOTOMY					
252	21600	EXCISION OF RIB, PARTIAL					
252	21610	COSTOTRANSVERSECTOMY (SEPARATE PROCEDURE)					
252	23040	ARTHROTOMY, GLENOHUMERAL JOINT, FOR INFECTION, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	23044	ARTHROTOMY, ACROMIOCLAVICULAR, STERNOCLAVICULAR JOINT, FOR INFECTION, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	23101	ARTHROTOMY WITH BIOPSY, OR WITH EXCISION OF TORN CARTILAGE, ACROMIOCLAVICULAR, STERNOCLAVICULAR JOINT					
252	23105	ARTHROTOMY WITH SYNOVECTOMY; GLENOHUMERAL JOINT					
252	23106	ARTHROTOMY WITH SYNOVECTOMY; STERNOCLAVICULAR JOINT					
252	23107	ARTHROTOMY, GLENOHUMERAL JOINT, WITH JOINT EXPLORATION, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	23145	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CLAVICLE OR SCAPULA; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	23146	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CLAVICLE OR SCAPULA; WITH ALLOGRAFT					
252	23150	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL HUMERUS;					
252	23155	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	23156	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL HUMERUS; WITH ALLOGRAFT					
252	23170	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), CLAVICLE					
252	23172	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), SCAPULA					
252	23174	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), HUMERAL HEAD TO SURGICAL NECK					
252	23180	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), CLAVICLE					
252	23182	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), SCAPULA					
252	23184	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), PROXIMAL HUMERUS					
252	23190	OSTECTOMY OF SCAPULA, PARTIAL (EG, SUPERIOR MEDIAL ANGLE)					
252	23405	TENOMYOTOMY, SHOULDER AREA; SINGLE					
252	23406	TENOMYOTOMY, SHOULDER AREA; MULTIPLE THROUGH SAME INCISION					
252	24000	ARTHROTOMY, ELBOW, FOR INFECTION, WITH EXPLORATION, DRAINAGE OR REMOVAL OF FOREIGN BODY					
252	24006	ARTHROTOMY OF THE ELBOW, WITH CAPSULAR EXCISION FOR CAPSULAR RELEASE (SEPARATE PROCEDURE)					
252	24101	ARTHROTOMY, ELBOW; WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	24102	ARTHROTOMY, ELBOW; WITH SYNOVECTOMY					
252	24115	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	24116	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, HUMERUS; WITH ALLOGRAFT					
252	24125	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF HEAD OR NECK OF RADIUS OR OLECRANON PROCESS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	24126	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF HEAD OR NECK OF RADIUS OR OLECRANON PROCESS; WITH ALLOGRAFT					
252	24130	EXCISION, RADIAL HEAD					
252	24134	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), SHAFT OR DISTAL HUMERUS					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
252	24136	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), RADIAL HEAD OR NECK					
252	24138	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), OLECRANON PROCESS					
252	24140	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), HUMERUS					
252	24145	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), RADIAL HEAD OR NECK					
252	24147	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), OLECRANON PROCESS					
252	24160	IMPLANT REMOVAL; ELBOW JOINT					
252	24164	IMPLANT REMOVAL; RADIAL HEAD					
252	24301	MUSCLE OR TENDON TRANSFER, ANY TYPE, UPPER ARM OR ELBOW, SINGLE (EXCLUDING 24320-24331)					
252	24305	TENDON LENGTHENING, UPPER ARM OR ELBOW, SINGLE, EACH					
252	24350	FASCIOTOMY, LATERAL OR MEDIAL (EG, "TENNIS ELBOW" OR EPICONDYLITIS);					
252	24351	FASCIOTOMY, LATERAL OR MEDIAL (EG, "TENNIS ELBOW" OR EPICONDYLITIS); WITH EXTENSOR ORIGIN DETACHMENT					
252	24352	FASCIOTOMY, LATERAL OR MEDIAL (EG, "TENNIS ELBOW" OR EPICONDYLITIS); WITH ANNULAR LIGAMENT RESECTION					
252	24354	FASCIOTOMY, LATERAL OR MEDIAL (EG, "TENNIS ELBOW" OR EPICONDYLITIS); WITH STRIPPING					
252	24356	FASCIOTOMY, LATERAL OR MEDIAL (EG, "TENNIS ELBOW" OR EPICONDYLITIS); WITH PARTIAL OSTECTOMY					
252	24400	OSTEOTOMY, HUMERUS, WITH OR WITHOUT INTERNAL FIXATION					
252	24410	MULTIPLE OSTEOTOMIES WITH REALIGNMENT ON INTRAMEDULLARY ROD, HUMERAL SHAFT (SOFIELD TYPE PROCEDURE)					
252	24495	DECOMPRESSION FASCIOTOMY, FOREARM, WITH BRACHIAL ARTERY EXPLORATION					
252	25023	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST; WITH DEBRIDEMENT OF NONVIALBLE MUSCLE AND/OR NERVE					
252	25040	ARTHROTOMY, RADIOCARPAL OR MIDCARPAL JOINT, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	25101	ARTHROTOMY, WRIST JOINT; WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	25105	ARTHROTOMY, WRIST JOINT; WITH SYNOVECTOMY					
252	25107	ARTHROTOMY, DISTAL RADIOULNAR JOINT FOR REPAIR OF TRIANGULAR CARTILAGE COMPLEX					
252	25118	SYNOVECTOMY, EXTENSOR TENDON SHEATH, WRIST, SINGLE COMPARTMENT;					
252	25119	SYNOVECTOMY, EXTENSOR TENDON SHEATH, WRIST, SINGLE COMPARTMENT; WITH RESECTION OF DISTAL ULNA					
252	25120	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF RADIUS OR ULNA (EXCLUDING HEAD OR NECK OF RADIUS AND OLECRANON PROCESS);					
252	25125	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF RADIUS OR ULNA (EXCLUDING HEAD OR NECK OF RADIUS AND OLECRANON PROCESS); WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	25126	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF RADIUS OR ULNA (EXCLUDING HEAD OR NECK OF RADIUS AND OLECRANON PROCESS); WITH ALLOGRAFT					
252	25130	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CARPAL BONES;					
252	25135	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CARPAL BONES; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	25136	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CARPAL BONES; WITH ALLOGRAFT					
252	25145	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), FOREARM AND/OR WRIST					
252	25150	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); ULNA					
252	25151	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); RADIUS					
252	25230	RADIAL STYLOIDECTOMY (SEPARATE PROCEDURE)					
252	25240	EXCISION DISTAL ULNA PARTIAL OR COMPLETE (EG, DARRACH TYPE OR MATCHED RESECTION)					
252	25250	REMOVAL OF WRIST PROSTHESIS; (SEPARATE PROCEDURE)					
252	25251	REMOVAL OF WRIST PROSTHESIS; COMPLICATED, INCLUDING "TOTAL WRIST"					
252	25260	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST; PRIMARY, SINGLE, EACH TENDON OR MUSCLE					
252	25263	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST; SECONDARY, SINGLE, EACH TENDON OR MUSCLE					
252	25265	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST; SECONDARY, WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON OR MUSCLE					
252	25270	REPAIR, TENDON OR MUSCLE, EXTENSOR, FOREARM AND/OR WRIST; PRIMARY, SINGLE, EACH TENDON OR MUSCLE					
252	25272	REPAIR, TENDON OR MUSCLE, EXTENSOR, FOREARM AND/OR WRIST; SECONDARY, SINGLE, EACH TENDON OR MUSCLE					
252	25274	REPAIR, TENDON OR MUSCLE, EXTENSOR, SECONDARY, WITH TENDON GRAFT (INCLUDES OBTAINING GRAFT), FOREARM AND/OR WRIST, EACH TENDON OR MUSCLE					
252	25280	LENGTHENING OR SHORTENING OF FLEXOR OR EXTENSOR TENDON, FOREARM AND/OR WRIST, SINGLE, EACH TENDON					
252	25290	TENOTOMY, OPEN, FLEXOR OR EXTENSOR TENDON, FOREARM AND/OR WRIST, SINGLE, EACH TENDON					
252	25300	TENODESIS AT WRIST; FLEXORS OF FINGERS					
252	25301	TENODESIS AT WRIST; EXTENSORS OF FINGERS					
252	25360	OSTEOTOMY; ULNA					
252	25365	OSTEOTOMY; RADIUS AND ULNA					
252	25400	REPAIR OF NONUNION OR MALUNION, RADIUS OR ULNA; WITHOUT GRAFT (EG, COMPRESSION TECHNIQUE)					
252	25415	REPAIR OF NONUNION OR MALUNION, RADIUS AND ULNA; WITHOUT GRAFT (EG, COMPRESSION TECHNIQUE)					
252	27001	TENOTOMY, ADDUCTOR OF HIP, SUBCUTANEOUS, OPEN					
252	27003	TENOTOMY, ADDUCTOR, SUBCUTANEOUS, OPEN, WITH OBTURATOR NEURECTOMY					
252	27066	EXCISION OF BONE CYST OR BENIGN TUMOR; DEEP, WITH OR WITHOUT AUTOGRAFT					
252	27067	EXCISION OF BONE CYST OR BENIGN TUMOR; WITH AUTOGRAFT REQUIRING SEPARATE INCISION					
252	27080	COCCYGECTOMY, PRIMARY					
252	27097	HAMSTRING RESECTION, PROXIMAL					
252	27098	ADDUCTOR TRANSFER TO ISCHIUM					
252	27310	ARTHROTOMY, KNEE, FOR INFECTION, WITH EXPLORATION, DRAINAGE OR REMOVAL OF FOREIGN BODY					
252	27330	ARTHROTOMY, KNEE; WITH SYNOVIAL BIOPSY ONLY					
252	27331	ARTHROTOMY, KNEE; WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODIES					
252	27332	ARTHROTOMY, KNEE, WITH EXCISION OF SEMILUNAR CARTILAGE (MENISCECTOMY); MEDIAL OR LATERAL					
252	27333	ARTHROTOMY, KNEE, WITH EXCISION OF SEMILUNAR CARTILAGE (MENISCECTOMY); MEDIAL AND LATERAL					
252	27334	ARTHROTOMY, KNEE, WITH SYNOVECTOMY; ANTERIOR OR POSTERIOR					
252	27335	ARTHROTOMY, KNEE, WITH SYNOVECTOMY; ANTERIOR AND POSTERIOR INCLUDING POPLITEAL AREA					
252	27350	PATELLECTOMY OR HEMIPATELLECTOMY					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT 1/ HCPCS 2	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
252	27355	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR;					
252	27356	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR; WITH ALLOGRAFT					
252	27357	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	27358	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR; WITH INTERNAL FIXATION (LIST IN ADDITION TO 27355, 27356, OR 27357)					
252	27360	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), FEMUR, PROXIMAL TIBIA AND/OR FIBULA					
252	27393	LENGTHENING OF HAMSTRING TENDON; SINGLE					
252	27394	LENGTHENING OF HAMSTRING TENDON; MULTIPLE, ONE LEG					
252	27396	TRANSPLANT, HAMSTRING TENDON TO PATELLA; SINGLE					
252	27403	ARTHROTOMY WITH OPEN MENISCUS REPAIR					
252	27425	LATERAL RETINACULAR RELEASE (ANY METHOD)					
252	27610	ARTHROTOMY, ANKLE, FOR INFECTION, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	27612	ARTHROTOMY, ANKLE, POSTERIOR CAPSULAR RELEASE, WITH OR WITHOUT ACHILLES TENDON LENGTHENING					
252	27620	ARTHROTOMY, ANKLE, WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	27625	ARTHROTOMY, ANKLE, WITH SYNOVECTOMY;					
252	27626	ARTHROTOMY, ANKLE, WITH SYNOVECTOMY; INCLUDING TENOSYNOVECTOMY					
252	27635	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA OR FIBULA;					
252	27637	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA OR FIBULA; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	27638	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA OR FIBULA; WITH ALLOGRAFT					
252	27641	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR EXOSTOSIS); FIBULA					
252	27665	REPAIR OR SUTURE OF EXTENSOR TENDON OF LEG; SECONDARY WITH OR WITHOUT GRAFT, SINGLE TENDON, EACH					
252	27676	REPAIR FOR DISLOCATING PERONEAL TENDONS; WITH FIBULAR OSTEOATOMY					
252	27680	TENOLYSIS, INCLUDING TIBIA, FIBULA, AND ANKLE FLEXOR; SINGLE					
252	27681	TENOLYSIS, INCLUDING TIBIA, FIBULA, AND ANKLE FLEXOR; MULTIPLE (THROUGH SAME INCISION), EACH					
252	27685	LENGTHENING OR SHORTENING OF TENDON, LEG OR ANKLE; SINGLE (SEPARATE PROCEDURE)					
252	27686	LENGTHENING OR SHORTENING OF TENDON, LEG OR ANKLE; MULTIPLE (THROUGH SAME INCISION), EACH					
252	27687	GASTROCNEMIUS RESECTION (EG, STRAYER PROCEDURE)					
252	27695	SUTURE, PRIMARY, TORN, RUPTURED OR SEVERED LIGAMENT, ANKLE; COLLATERAL					
252	27696	SUTURE, PRIMARY, TORN, RUPTURED OR SEVERED LIGAMENT, ANKLE; BOTH COLLATERAL LIGAMENTS					
252	27698	SUTURE, SECONDARY REPAIR, TORN, RUPTURED OR SEVERED LIGAMENT, ANKLE, COLLATERAL (EG, WATSON-JONES PROCEDURE)					
252	27709	OSTEOTOMY; TIBIA AND FIBULA					
252	27730	EPIPHYSEAL ARREST BY EPIPHYSEODESIS OR STAPLING; DISTAL TIBIA					
252	27732	EPIPHYSEAL ARREST BY EPIPHYSEODESIS OR STAPLING; DISTAL FIBULA					
252	27734	EPIPHYSEAL ARREST BY EPIPHYSEODESIS OR STAPLING; DISTAL TIBIA AND FIBULA					
252	27740	EPIPHYSEAL ARREST BY EPIPHYSEODESIS OR STAPLING, COMBINED, PROXIMAL AND DISTAL TIBIA AND FIBULA;					
252	27889	ANKLE DISARTICULATION					
253	Level III Musculoskeletal Procedures		T	26.33	\$1,334.13	\$699.24	\$266.83
253	23020	CAPSULAR CONTRACTURE RELEASE (SEVER TYPE PROCEDURE)					
253	23120	CLAVICULECTOMY; PARTIAL					
253	23130	ACROMIOPLASTY OR ACROMIONECTOMY, PARTIAL					
253	23415	CORACACROMIAL LIGAMENT RELEASE, WITH OR WITHOUT ACROMIOPLASTY					
253	23480	OSTEOTOMY, CLAVICLE, WITH OR WITHOUT INTERNAL FIXATION;					
253	23485	OSTEOTOMY, CLAVICLE, WITH OR WITHOUT INTERNAL FIXATION; WITH BONE GRAFT FOR NONUNION OR MALUNION (INCLUDES OBTAINING GRAFT AND/OR NECESSARY FIXATION)					
253	23490	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; CLAVICLE					
253	23491	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; PROXIMAL HUMERUS AND HUMERAL HEAD					
253	23800	ARTHRODESIS, SHOULDER JOINT; WITH OR WITHOUT LOCAL BONE GRAFT					
253	23802	ARTHRODESIS, SHOULDER JOINT; WITH PRIMARY AUTOGENOUS GRAFT (INCLUDES OBTAINING GRAFT)					
253	24155	RESECTION OF ELBOW JOINT (ARTHRECTOMY)					
253	24320	TENOPLASTY, WITH MUSCLE TRANSFER, WITH OR WITHOUT FREE GRAFT, ELBOW TO SHOULDER, SINGLE (SEDDON-BROOKES TYPE PROCEDURE)					
253	24330	FLEXOR-PLASTY, ELBOW (EG, STEINDLER TYPE ADVANCEMENT);					
253	24331	FLEXOR-PLASTY, ELBOW (EG, STEINDLER TYPE ADVANCEMENT); WITH EXTENSOR ADVANCEMENT					
253	24340	TENODESIS OF BICEPS TENDON AT ELBOW (SEPARATE PROCEDURE)					
253	24341	REPAIR, TENDON OR MUSCLE, UPPER ARM OR ELBOW, EACH TENDON OR MUSCLE, PRIMARY OR SECONDARY (EXCLUDES ROTATOR CUFF)					
253	24342	REINSERTION OF RUPTURED BICEPS OR TRICEPS TENDON, DISTAL, WITH OR WITHOUT TENDON GRAFT					
253	24420	OSTEOPLASTY, HUMERUS (EG, SHORTENING OR LENGTHENING) (EXCLUDING 64876)					
253	24430	REPAIR OF NONUNION OR MALUNION, HUMERUS; WITHOUT GRAFT (EG, COMPRESSION TECHNIQUE)					
253	24435	REPAIR OF NONUNION OR MALUNION, HUMERUS; WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
253	24470	HEMIEPIPHYSEAL ARREST (EG, FOR CUBITUS VARUS OR VALGUS, DISTAL HUMERUS)					
253	24498	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING), WITH OR WITHOUT METHYLMETHACRYLATE, HUMERUS					
253	24800	ARTHRODESIS, ELBOW JOINT; WITH OR WITHOUT LOCAL AUTOGRAFT OR ALLOGRAFT					
253	24802	ARTHRODESIS, ELBOW JOINT; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT OTHER THAN LOCALLY OBTAINED)					
253	25310	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR, FOREARM AND/OR WRIST, SINGLE; EACH TENDON					
253	25312	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR, FOREARM AND/OR WRIST, SINGLE; WITH TENDON GRAFT(S) (INCLUDES OBTAINING GRAFT), EACH TENDON					
253	25315	FLEXOR ORIGIN SLIDE (EG, FOR CEREBRAL PALSY, VOLKMANN CONTRACTURE), FOREARM AND/OR WRIST;					
253	25316	FLEXOR ORIGIN SLIDE (EG, FOR CEREBRAL PALSY, VOLKMANN CONTRACTURE), FOREARM AND/OR WRIST; WITH TENDON(S) TRANSFER					
253	25320	CAPSULORRHAPHY OR RECONSTRUCTION, WRIST, ANY METHOD (EG, CAPSULODESIS, LIGAMENT REPAIR, TENDON TRANSFER OR GRAFT) (INCLUDES SYNOVECTOMY, CAPSULOTOMY AND OPEN REDUCTION) FOR CARPAL INSTABILITY					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
253	25335	CENTRALIZATION OF WRIST ON ULNA (EG, RADIAL CLUB HAND)					
253	25337	RECONSTRUCTION FOR STABILIZATION OF UNSTABLE DISTAL ULNA OR DISTAL RADIOULNAR JOINT, SECONDARY BY SOFT TISSUE STABILIZATION (EG, TENDON TRANSFER, TENDON GRAFT OR WEAVE, OR TENODESIS) WITH OR WITHOUT OPEN REDUCTION OF DISTAL RADIOULNAR JOINT					
253	25350	OSTEOTOMY, RADIUS; DISTAL THIRD					
253	25355	OSTEOTOMY, RADIUS; MIDDLE OR PROXIMAL THIRD					
253	25370	MULTIPLE OSTEOTOMIES, WITH REALIGNMENT ON INTRAMEDULLARY ROD (SOFIELD TYPE PROCEDURE); RADIUS OR ULNA					
253	25375	MULTIPLE OSTEOTOMIES, WITH REALIGNMENT ON INTRAMEDULLARY ROD (SOFIELD TYPE PROCEDURE); RADIUS AND ULNA					
253	25425	REPAIR OF DEFECT WITH AUTOGRAFT; RADIUS OR ULNA					
253	25426	REPAIR OF DEFECT WITH AUTOGRAFT; RADIUS AND ULNA					
253	25440	REPAIR OF NONUNION, SCAPHOID (NAVICULAR) BONE, WITH OR WITHOUT RADIAL STYLOIDECTOMY (INCLUDES OBTAINING GRAFT AND NECESSARY FIXATION)					
253	25450	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL RADIUS OR ULNA					
253	25455	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL RADIUS AND ULNA					
253	25490	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; RADIUS					
253	25491	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; ULNA					
253	25492	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; RADIUS AND ULNA					
253	25800	ARTHRODESIS, WRIST JOINT (INCLUDING RADIOCARPAL AND/OR ULNOCARPAL FUSION); WITHOUT BONE GRAFT					
253	25805	ARTHRODESIS, WRIST JOINT (INCLUDING RADIOCARPAL AND/OR ULNOCARPAL FUSION); WITH SLIDING GRAFT					
253	25810	ARTHRODESIS, WRIST JOINT (INCLUDING RADIOCARPAL AND/OR ULNOCARPAL FUSION); WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
253	25830	DISTAL RADIOULNAR JOINT ARTHRODESIS AND SEGMENTAL RESECTION OF ULNA (EG, SAUVE-KAPANDJI PROCEDURE), WITH OR WITHOUT BONE GRAFT					
253	27033	ARTHROTOMY, HIP, WITH EXPLORATION OR REMOVAL OF LOOSE OR FOREIGN BODY					
253	27100	TRANSFER EXTERNAL OBLIQUE MUSCLE TO GREATER TROCHANTER INCLUDING FASCIAL OR TENDON EXTENSION (GRAFT)					
253	27105	TRANSFER PARASPINAL MUSCLE TO HIP (INCLUDES FASCIAL OR TENDON EXTENSION GRAFT)					
253	27110	TRANSFER ILIOPSOAS; TO GREATER TROCHANTER					
253	27111	TRANSFER ILIOPSOAS; TO FEMORAL NECK					
253	27395	LENGTHENING OF HAMSTRING TENDON; MULTIPLE, BILATERAL					
253	27397	TRANSPLANT, HAMSTRING TENDON TO PATELLA; MULTIPLE					
253	27400	TENDON OR MUSCLE TRANSFER, HAMSTRINGS TO FEMUR (EGGERS TYPE PROCEDURE)					
253	27405	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE; COLLATERAL					
253	27407	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE; CRUCIATE					
253	27409	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE; COLLATERAL AND CRUCIATE LIGAMENTS					
253	27418	ANTERIOR TIBIAL TUBERCLEPLASTY (EG, FOR CHONDROMALACIA PATELLAE)					
253	27420	RECONSTRUCTION FOR RECURRENT DISLOCATING PATELLA; (HAUSER TYPE PROCEDURE)					
253	27422	RECONSTRUCTION FOR RECURRENT DISLOCATING PATELLA; WITH EXTENSOR REALIGNMENT AND/OR MUSCLE ADVANCEMENT OR RELEASE (CAMPBELL, GOLDWAITE TYPE PROCEDURE)					
253	27424	RECONSTRUCTION FOR RECURRENT DISLOCATING PATELLA; WITH PATELLECTOMY					
253	27430	QUADRICEPSPLASTY (BENNETT OR THOMPSON TYPE)					
253	27435	CAPSULOTOMY, KNEE, POSTERIOR CAPSULAR RELEASE					
253	27640	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR EXOSTOSIS); TIBIA					
253	27647	RADICAL RESECTION OF TUMOR, BONE; TALUS OR CALCANEUS					
253	27650	REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES TENDON;					
253	27652	REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES TENDON; WITH GRAFT (INCLUDES OBTAINING GRAFT)					
253	27654	REPAIR, SECONDARY, RUPTURED ACHILLES TENDON, WITH OR WITHOUT GRAFT					
253	27690	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); SUPERFICIAL (EG, ANTERIOR TIBIAL EXTENSORS INTO MIDFOOT)					
253	27691	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); DEEP (EG, ANTERIOR TIBIAL OR POSTERIOR TIBIAL THROUGH INTEROSSEOUS SPACE, FLEXOR DIGITORUM LONGUS, FLEXOR HALLUCIS LONGUS, OR PERONEAL TENDON TO MIDFOOT OR HINDFOOT)					
253	27692	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); EACH ADDITIONAL TENDON					
253	27705	OSTEOTOMY; TIBIA					
253	27742	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING, COMBINED, PROXIMAL AND DISTAL TIBIA AND FIBULA; AND DISTAL FEMUR					
253	27745	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE, TIBIA					
253	27870	ARTHRODESIS, ANKLE, ANY METHOD					
253	27871	ARTHRODESIS, TIBIOFIBULAR JOINT, PROXIMAL OR DISTAL					
254	Level IV Musculoskeletal Procedures		T	34.37	\$1,741.51	\$937.11	\$348.30
254	23410	REPAIR OF RUPTURED MUSCULOTENDINOUS CUFF (EG, ROTATOR CUFF); ACUTE					
254	23412	REPAIR OF RUPTURED MUSCULOTENDINOUS CUFF (EG, ROTATOR CUFF); CHRONIC					
254	23420	REPAIR OF COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)					
254	23430	TENODESIS OF LONG TENDON OF BICEPS					
254	23450	CAPSULORRHAPHY, ANTERIOR; PUTTI-PLATT PROCEDURE OR MAGNUSON TYPE OPERATION					
254	23455	CAPSULORRHAPHY, ANTERIOR; BANKART TYPE OPERATION WITH OR WITHOUT STAPLING					
254	23460	CAPSULORRHAPHY, ANTERIOR, ANY TYPE; WITH BONE BLOCK					
254	23462	CAPSULORRHAPHY, ANTERIOR, ANY TYPE; WITH CORACOID PROCESS TRANSFER					
254	23465	CAPSULORRHAPHY FOR RECURRENT DISLOCATION, POSTERIOR, WITH OR WITHOUT BONE BLOCK					
254	23466	CAPSULORRHAPHY WITH ANY TYPE MULTI-DIRECTIONAL INSTABILITY					
254	27427	LIGAMENOUS RECONSTRUCTION (AUGMENTATION), KNEE; EXTRA-ARTICULAR					
254	27428	LIGAMENOUS RECONSTRUCTION (AUGMENTATION), KNEE; INTRA-ARTICULAR (OPEN)					
254	27429	LIGAMENOUS RECONSTRUCTION (AUGMENTATION), KNEE; INTRA-ARTICULAR (OPEN) AND EXTRA-ARTICULAR					
261	Level I Hand Musculoskeletal Procedures		T	10.54	\$534.06	\$261.48	\$106.81
261	25111	EXCISION OF GANGLION, WRIST (DORSAL OR VOLAR); PRIMARY					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT 1/ HCPCS 2	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
261	25112	EXCISION OF GANGLION, WRIST (DORSAL OR VOLAR); RECURRENT					
261	25820	INTERCARPAL FUSION; WITHOUT BONE GRAFT					
261	26020	DRAINAGE OF TENDON SHEATH, ONE DIGIT AND/OR PALM					
261	26025	DRAINAGE OF PALMAR BURSA; SINGLE, ULNAR OR RADIAL					
261	26030	DRAINAGE OF PALMAR BURSA; MULTIPLE OR COMPLICATED					
261	26034	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), HAND OR FINGER					
261	26035	DECOMPRESSION FINGERS AND/OR HAND, INJECTION INJURY (EG, GREASE GUN)					
261	26037	DECOMPRESSIVE FASCIOTOMY, HAND (EXCLUDES 26035)					
261	26055	TENDON SHEATH INCISION (EG, FOR TRIGGER FINGER)					
261	26060	TENOTOMY, PERCUTANEOUS, SINGLE, EACH DIGIT					
261	26070	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY; CARPOMETACARPAL JOINT					
261	26075	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY; METACARPOPHALANGEAL JOINT					
261	26080	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY; INTERPHALANGEAL JOINT, EACH					
261	26100	ARTHROTOMY WITH SYNOVIAL BIOPSY; CARPOMETACARPAL JOINT					
261	26105	ARTHROTOMY WITH SYNOVIAL BIOPSY; METACARPOPHALANGEAL JOINT					
261	26110	ARTHROTOMY WITH SYNOVIAL BIOPSY; INTERPHALANGEAL JOINT, EACH					
261	26130	SYNOVECTOMY, CARPOMETACARPAL JOINT					
261	26140	SYNOVECTOMY, PROXIMAL INTERPHALANGEAL JOINT, INCLUDING EXTENSOR RECONSTRUCTION, EACH INTERPHALANGEAL					
261	26145	SYNOVECTOMY TENDON SHEATH, RADICAL (TENOSYNOVECTOMY), FLEXOR, PALM OR FINGER, SINGLE, EACH DIGIT					
261	26160	EXCISION OF LESION OF TENDON SHEATH OR CAPSULE (EG, CYST, MUCOUS CYST, OR GANGLION), HAND OR FINGER					
261	26170	EXCISION OF TENDON, PALM, FLEXOR, SINGLE (SEPARATE PROCEDURE), EACH					
261	26180	EXCISION OF TENDON, FINGER, FLEXOR (SEPARATE PROCEDURE)					
261	26185	SESAMOIDECTOMY, THUMB OR FINGER (SEPARATE PROCEDURE)					
261	26200	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF METACARPAL;					
261	26210	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL, MIDDLE, OR DISTAL PHALANX OF FINGER;					
261	26215	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL, MIDDLE, OR DISTAL PHALANX OF FINGER; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
261	26230	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); METACARPAL					
261	26235	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); PROXIMAL OR MIDDLE PHALANX OF FINGER					
261	26236	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); DISTAL PHALANX OF FINGER					
261	26250	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, METACARPAL;					
261	26260	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, PROXIMAL OR MIDDLE PHALANX OF FINGER;					
261	26261	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, PROXIMAL OR MIDDLE PHALANX OF FINGER; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
261	26262	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, DISTAL PHALANX OF FINGER					
261	26410	EXTENSOR TENDON REPAIR, DORSUM OF HAND, SINGLE, PRIMARY OR SECONDARY; WITHOUT FREE GRAFT, EACH TENDON					
261	26418	EXTENSOR TENDON REPAIR, DORSUM OF FINGER, SINGLE, PRIMARY OR SECONDARY; WITHOUT FREE GRAFT, EACH TENDON					
261	26432	EXTENSOR TENDON REPAIR, DISTAL INSERTION ("Mallet Finger"), CLOSED, SPLINTING WITH OR WITHOUT PERCUTANEOUS PINNING					
261	26433	EXTENSOR TENDON REPAIR, DISTAL INSERTION ("Mallet Finger"), OPEN, PRIMARY OR SECONDARY REPAIR; WITHOUT GRAFT					
261	26437	EXTENSOR TENDON REALIGNMENT, HAND					
261	26440	TENOLYSIS, SIMPLE, FLEXOR TENDON; PALM OR FINGER, SINGLE, EACH TENDON					
261	26445	TENOLYSIS, EXTENSOR TENDON, DORSUM OF HAND OR FINGER; EACH TENDON					
261	26450	TENOTOMY, FLEXOR, SINGLE, PALM, OPEN, EACH					
261	26455	TENOTOMY, FLEXOR, SINGLE, FINGER, OPEN, EACH					
261	26460	TENOTOMY, EXTENSOR, HAND OR FINGER, SINGLE, OPEN, EACH					
261	26471	TENODESIS; FOR PROXIMAL INTERPHALANGEAL JOINT STABILIZATION					
261	26474	TENODESIS; FOR DISTAL JOINT STABILIZATION					
261	26476	TENDON LENGTHENING, EXTENSOR, HAND OR FINGER, SINGLE, EACH					
261	26477	TENDON SHORTENING, EXTENSOR, HAND OR FINGER, SINGLE, EACH					
261	26478	TENDON LENGTHENING, FLEXOR, HAND OR FINGER, SINGLE, EACH					
261	26479	TENDON SHORTENING, FLEXOR, HAND OR FINGER, SINGLE, EACH					
261	26500	TENDON PULLEY RECONSTRUCTION; WITH LOCAL TISSUES (SEPARATE PROCEDURE)					
261	26508	THENAR MUSCLE RELEASE FOR THUMB CONTRACTURE					
261	26520	CAPSULECTOMY OR CAPSULOTOMY FOR CONTRACTURE; METACARPOPHALANGEAL JOINT, SINGLE, EACH					
261	26525	CAPSULECTOMY OR CAPSULOTOMY FOR CONTRACTURE; INTERPHALANGEAL JOINT, SINGLE, EACH					
261	26540	REPAIR OF COLLATERAL LIGAMENT, METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT					
261	26542	RECONSTRUCTION, COLLATERAL LIGAMENT, METACARPOPHALANGEAL JOINT, SINGLE; WITH LOCAL TISSUE (EG, ADDUCTOR ADVANCEMENT)					
261	26560	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; WITH SKIN FLAPS					
261	26587	RECONSTRUCTION OF SUPERNUMERARY DIGIT, SOFT TISSUE AND BONE					
261	26593	RELEASE, INTRINSIC MUSCLES OF HAND (SPECIFY)					
261	26951	AMPUTATION, FINGER OR THUMB, PRIMARY OR SECONDARY, ANY JOINT OR PHALANX, SINGLE, INCLUDING NEURECTOMIES; WITH DIRECT CLOSURE					
261	26952	AMPUTATION, FINGER OR THUMB, PRIMARY OR SECONDARY, ANY JOINT OR PHALANX, SINGLE, INCLUDING NEURECTOMIES; WITH LOCAL ADVANCEMENT FLAPS (V-Y, HOOD)					
262	Level II Hand Musculoskeletal Procedures		T	18.35	\$929.78	\$480.82	\$185.96
262	25210	CARPECTOMY; ONE BONE					
262	25215	CARPECTOMY; ALL BONES OF PROXIMAL ROW					
262	25825	INTERCARPAL FUSION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26040	FASCIOTOMY, PALMAR, FOR DUPUYTREN'S CONTRACTURE; PERCUTANEOUS					
262	26045	FASCIOTOMY, PALMAR, FOR DUPUYTREN'S CONTRACTURE; OPEN, PARTIAL					
262	26121	FASCIECTOMY, PALM ONLY, WITH OR WITHOUT Z-PLASTY, OTHER LOCAL TISSUE REARRANGEMENT, OR SKIN GRAFTING (INCLUDES OBTAINING GRAFT)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
262	26123	FASCIECTOMY, PARTIAL PALMAR WITH RELEASE OF SINGLE DIGIT INCLUDING PROXIMAL INTERPHALANGEAL JOINT, WITH OR WITHOUT Z-PLASTY, OTHER LOCAL TISSUE REARRANGEMENT, OR SKIN GRAFTING (INCLUDES OBTAINING GRAFT);					
262	26125	FASCIECTOMY, PARTIAL PALMAR WITH RELEASE OF SINGLE DIGIT INCLUDING PROXIMAL INTERPHALANGEAL JOINT, WITH OR WITHOUT Z-PLASTY, OTHER LOCAL TISSUE REARRANGEMENT, OR SKIN GRAFTING (INCLUDES OBTAINING GRAFT); EACH ADDITIONAL DIGIT (LIST SEPARATELY IN ADDITION					
262	26135	SYNOVECTOMY, METACARPOPHALANGEAL JOINT INCLUDING INTRINSIC RELEASE AND EXTENSOR HOOD RECONSTRUCTION, EACH DIGIT					
262	26205	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF METACARPAL; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26255	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, METACARPAL; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26350	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, NOT IN "NO MAN'S LAND"; PRIMARY OR SECONDARY WITHOUT FREE GRAFT, EACH TENDON					
262	26352	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, NOT IN "NO MAN'S LAND"; SECONDARY WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26356	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, IN "NO MAN'S LAND"; PRIMARY, EACH TENDON					
262	26357	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, IN "NO MAN'S LAND"; SECONDARY, EACH TENDON					
262	26358	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, IN "NO MAN'S LAND"; SECONDARY WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26370	PROFUNDUS TENDON REPAIR OR ADVANCEMENT, WITH INTACT SUBLIMIS; PRIMARY					
262	26372	PROFUNDUS TENDON REPAIR OR ADVANCEMENT, WITH INTACT SUBLIMIS; SECONDARY WITH FREE GRAFT (INCLUDES OBTAINING GRAFT)					
262	26373	PROFUNDUS TENDON REPAIR OR ADVANCEMENT, WITH INTACT SUBLIMIS; SECONDARY WITHOUT FREE GRAFT					
262	26390	FLEXOR TENDON EXCISION, IMPLANTATION OF PLASTIC TUBE OR ROD FOR DELAYED TENDON GRAFT, HAND OR FINGER					
262	26392	REMOVAL OF TUBE OR ROD AND INSERTION OF FLEXOR TENDON GRAFT (INCLUDES OBTAINING GRAFT), HAND OR FINGER					
262	26412	EXTENSOR TENDON REPAIR, DORSUM OF HAND, SINGLE, PRIMARY OR SECONDARY; WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26415	EXTENSOR TENDON EXCISION, IMPLANTATION OF PLASTIC TUBE OR ROD FOR DELAYED EXTENSOR TENDON GRAFT, HAND OR FINGER					
262	26416	REMOVAL OF TUBE OR ROD AND INSERTION OF EXTENSOR TENDON GRAFT (INCLUDES OBTAINING GRAFT), HAND OR FINGER					
262	26420	EXTENSOR TENDON REPAIR, DORSUM OF FINGER, SINGLE, PRIMARY OR SECONDARY; WITH FREE GRAFT (INCLUDES OBTAINING GRAFT) EACH TENDON					
262	26426	EXTENSOR TENDON REPAIR, CENTRAL SLIP REPAIR, SECONDARY (BOUTONNIERE DEFORMITY); USING LOCAL TISSUES					
262	26428	EXTENSOR TENDON REPAIR, CENTRAL SLIP REPAIR, SECONDARY (BOUTONNIERE DEFORMITY); WITH FREE GRAFT (INCLUDES OBTAINING GRAFT)					
262	26434	EXTENSOR TENDON REPAIR, DISTAL INSERTION ("Mallet Finger"), OPEN, PRIMARY OR SECONDARY REPAIR; WITH FREE GRAFT (INCLUDES OBTAINING GRAFT)					
262	26442	TENOLYSIS, SIMPLE, FLEXOR TENDON; PALM AND FINGER, EACH TENDON					
262	26449	TENOLYSIS, COMPLEX, EXTENSOR TENDON, DORSUM OF HAND OR FINGER, INCLUDING HAND AND FOREARM					
262	26480	TENDON TRANSFER OR TRANSPLANT, CARPOMETACARPAL AREA OR DORSUM OF HAND, SINGLE; WITHOUT FREE GRAFT, EACH					
262	26483	TENDON TRANSFER OR TRANSPLANT, CARPOMETACARPAL AREA OR DORSUM OF HAND, SINGLE; WITH FREE TENDON GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26485	TENDON TRANSFER OR TRANSPLANT, PALMAR, SINGLE, EACH TENDON; WITHOUT FREE TENDON GRAFT					
262	26489	TENDON TRANSFER OR TRANSPLANT, PALMAR, SINGLE, EACH TENDON; WITH FREE TENDON GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26490	OPPONENSPLASTY; SUBLIMIS TENDON TRANSFER TYPE					
262	26492	OPPONENSPLASTY; TENDON TRANSFER WITH GRAFT (INCLUDES OBTAINING GRAFT)					
262	26494	OPPONENSPLASTY; HYPOTHENAR MUSCLE TRANSFER					
262	26496	OPPONENSPLASTY; OTHER METHODS					
262	26497	TENDON TRANSFER TO RESTORE INTRINSIC FUNCTION; RING AND SMALL FINGER					
262	26498	TENDON TRANSFER TO RESTORE INTRINSIC FUNCTION; ALL FOUR FINGERS					
262	26499	CORRECTION CLAW FINGER, OTHER METHODS					
262	26502	TENDON PULLEY RECONSTRUCTION; WITH TENDON OR FASCIAL GRAFT (INCLUDES OBTAINING GRAFT) (SEPARATE PROCEDURE)					
262	26504	TENDON PULLEY RECONSTRUCTION; WITH TENDON PROSTHESIS (SEPARATE PROCEDURE)					
262	26510	CROSS INTRINSIC TRANSFER					
262	26516	CAPSULODESIS FOR M-P JOINT STABILIZATION; SINGLE DIGIT					
262	26517	CAPSULODESIS FOR M-P JOINT STABILIZATION; TWO DIGITS					
262	26518	CAPSULODESIS FOR M-P JOINT STABILIZATION; THREE OR FOUR DIGITS					
262	26541	RECONSTRUCTION, COLLATERAL LIGAMENT, METACARPOPHALANGEAL JOINT, SINGLE; WITH TENDON OR FASCIAL GRAFT (INCLUDES OBTAINING GRAFT)					
262	26545	RECONSTRUCTION, COLLATERAL LIGAMENT, INTERPHALANGEAL JOINT, SINGLE, INCLUDING GRAFT, EACH JOINT					
262	26546	REPAIR NON-UNION, METACARPAL OR PHALANX, (INCLUDES OBTAINING BONE GRAFT WITH OR WITHOUT EXTERNAL OR INTERNAL FIXATION)					
262	26548	REPAIR AND RECONSTRUCTION, FINGER, VOLAR PLATE, INTERPHALANGEAL JOINT					
262	26550	POLLICIZATION OF A DIGIT					
262	26555	POSITIONAL CHANGE OF OTHER FINGER					
262	26561	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; WITH SKIN FLAPS AND GRAFTS					
262	26562	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; COMPLEX (EG, INVOLVING BONE, NAILS)					
262	26565	OSTEOTOMY FOR CORRECTION OF DEFORMITY; METACARPAL					
262	26567	OSTEOTOMY FOR CORRECTION OF DEFORMITY; PHALANX OF FINGER					
262	26568	OSTEOPLASTY FOR LENGTHENING OF METACARPAL OR PHALANX					
262	26580	REPAIR CLEFT HAND					
262	26585	REPAIR BIFID DIGIT					
262	26590	REPAIR MACRODACTYLIA					
262	26591	REPAIR, INTRINSIC MUSCLES OF HAND (SPECIFY)					
262	26596	EXCISION OF CONSTRICTING RING OF FINGER, WITH MULTIPLE Z-PLASTIES					
262	26597	RELEASE OF SCAR CONTRACTURE, FLEXOR OR EXTENSOR, WITH SKIN GRAFTS, REARRANGEMENT FLAPS, OR Z-PLASTIES, HAND AND/OR FINGER					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT 1/ HCPCS 2	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
262	26820	FUSION IN OPPOSITION, THUMB, WITH AUTOGENOUS GRAFT (INCLUDES OBTAINING GRAFT)					
262	26841	ARTHRODESIS, CARPOMETACARPAL JOINT, THUMB, WITH OR WITHOUT INTERNAL FIXATION;					
262	26842	ARTHRODESIS, CARPOMETACARPAL JOINT, THUMB, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26843	ARTHRODESIS, CARPOMETACARPAL JOINT, DIGITS, OTHER THAN THUMB;					
262	26844	ARTHRODESIS, CARPOMETACARPAL JOINT, DIGITS, OTHER THAN THUMB; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26850	ARTHRODESIS, METACARPOPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION;					
262	26852	ARTHRODESIS, METACARPOPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26860	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION;					
262	26861	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; EACH ADDITIONAL INTERPHALANGEAL JOINT					
262	26862	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26863	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT), EACH ADDITIONAL JOINT					
262	26910	AMPUTATION, METACARPAL, WITH FINGER OR THUMB (RAY AMPUTATION), SINGLE, WITH OR WITHOUT INTEROSSEOUS TRANSFER					
271	Level I Foot Musculoskeletal Procedures		T	14.41	\$730.15	\$368.38	\$146.03
271	27605	TENOTOMY, ACHILLES TENDON, SUBCUTANEOUS (SEPARATE PROCEDURE); *LOCAL ANESTHESIA					
271	28005	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), FOOT					
271	28008	FASCIOTOMY, FOOT AND/OR TOE					
271	28010	TENOTOMY, SUBCUTANEOUS, TOE; SINGLE					
271	28011	TENOTOMY, SUBCUTANEOUS, TOE; MULTIPLE					
271	28020	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF LOOSE OR FOREIGN BODY; INTERTARSAL OR TARSOMETATARSAL JOINT					
271	28022	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF LOOSE OR FOREIGN BODY; METATARSOPHALANGEAL JOINT					
271	28024	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF LOOSE OR FOREIGN BODY; INTERPHALANGEAL JOINT					
271	28045	EXCISION, TUMOR, FOOT; DEEP, SUBFASCIAL, INTRAMUSCULAR					
271	28046	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF FOOT					
271	28050	ARTHROTOMY FOR SYNOVIAL BIOPSY; INTERTARSAL OR TARSOMETATARSAL JOINT					
271	28052	ARTHROTOMY FOR SYNOVIAL BIOPSY; METATARSOPHALANGEAL JOINT					
271	28054	ARTHROTOMY FOR SYNOVIAL BIOPSY; INTERPHALANGEAL JOINT					
271	28080	EXCISION OF INTERDIGITAL (MORTON) NEUROMA, SINGLE, EACH					
271	28086	SYNOVECTOMY, TENDON SHEATH, FOOT; FLEXOR					
271	28088	SYNOVECTOMY, TENDON SHEATH, FOOT; EXTENSOR					
271	28090	EXCISION OF LESION OF TENDON OR FIBROUS SHEATH OR CAPSULE (INCLUDING SYNOVECTOMY) (CYST OR GANGLION); FOOT					
271	28092	EXCISION OF LESION OF TENDON OR FIBROUS SHEATH OR CAPSULE (INCLUDING SYNOVECTOMY) (CYST OR GANGLION); TOES					
271	28100	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TALUS OR CALCANEUS;					
271	28104	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TARSAL OR METATARSAL BONES, EXCEPT TALUS OR CALCANEUS;					
271	28108	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, PHALANGES OF FOOT					
271	28111	OSTECTOMY, COMPLETE EXCISION; FIRST METATARSAL HEAD					
271	28112	OSTECTOMY, COMPLETE EXCISION; OTHER METATARSAL HEAD (SECOND, THIRD OR FOURTH)					
271	28113	OSTECTOMY, COMPLETE EXCISION; FIFTH METATARSAL HEAD					
271	28114	OSTECTOMY, COMPLETE EXCISION; ALL METATARSAL HEADS, WITH PARTIAL PROXIMAL PHALANGECTOMY, EXCLUDING FIRST METATARSAL (CLAYTON TYPE PROCEDURE)					
271	28116	OSTECTOMY, EXCISION OF TARSAL COALITION					
271	28118	OSTECTOMY, CALCANEUS;					
271	28119	OSTECTOMY, CALCANEUS; FOR SPUR, WITH OR WITHOUT PLANTAR FASCIAL RELEASE					
271	28120	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, SEQUESTRECTOMY, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR TALAR BOSSING), TALUS OR CALCANEUS					
271	28122	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR TARSAL BOSSING), TARSAL OR METATARSAL BONE, EXCEPT TALUS OR CALCANEUS					
271	28124	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR DORSAL BOSSING), PHALANX OF TOE					
271	28126	RESECTION, PARTIAL OR COMPLETE, PHALANGEAL BASE, SINGLE TOE, EACH					
271	28130	TALECTOMY (ASTRAGALECTOMY)					
271	28140	METATARSECTOMY					
271	28150	PHALANGECTOMY OF TOE, SINGLE, EACH					
271	28153	RESECTION, HEAD OF PHALANX, TOE					
271	28160	HEMIPHALANGECTOMY OR INTERPHALANGEAL JOINT EXCISION, TOE, SINGLE, EACH					
271	28171	RADICAL RESECTION OF TUMOR, BONE; TARSAL (EXCEPT TALUS OR CALCANEUS)					
271	28173	RADICAL RESECTION OF TUMOR, BONE; METATARSAL					
271	28175	RADICAL RESECTION OF TUMOR, BONE; PHALANX OF TOE					
271	28200	REPAIR OR SUTURE OF TENDON, FOOT, FLEXOR, SINGLE; PRIMARY OR SECONDARY, WITHOUT FREE GRAFT, EACH TENDON					
271	28208	REPAIR OR SUTURE OF TENDON, FOOT, EXTENSOR, SINGLE; PRIMARY OR SECONDARY, EACH TENDON					
271	28210	REPAIR OR SUTURE OF TENDON, FOOT, EXTENSOR, SINGLE; SECONDARY WITH FREE GRAFT, EACH TENDON (INCLUDES OBTAINING GRAFT)					
271	28220	TENOLYSIS, FLEXOR, FOOT; SINGLE					
271	28222	TENOLYSIS, FLEXOR, FOOT; MULTIPLE (THROUGH SAME INCISION)					
271	28225	TENOLYSIS, EXTENSOR, FOOT; SINGLE					
271	28226	TENOLYSIS, EXTENSOR, FOOT; MULTIPLE (THROUGH SAME INCISION)					
271	28230	TENOTOMY, OPEN, FLEXOR; FOOT, SINGLE OR MULTIPLE (SEPARATE PROCEDURE)					
271	28232	TENOTOMY, OPEN, FLEXOR; TOE, SINGLE (SEPARATE PROCEDURE)					
271	28234	TENOTOMY, OPEN, EXTENSOR, FOOT OR TOE					
271	28240	TENOTOMY, LENGTHENING, OR RELEASE, ABDUCTOR HALLUCIS MUSCLE					
271	28270	CAPSULOTOMY; METATARSOPHALANGEAL JOINT, WITH OR WITHOUT TENORRHAPHY, SINGLE, EACH JOINT (SEPARATE PROCEDURE)					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
271	28272	CAPSULOTOMY; INTERPHALANGEAL JOINT, SINGLE, EACH JOINT (SEPARATE PROCEDURE)					
271	28280	WEBBING OPERATION (CREATE SYNDACTYLISM OF TOES) (KELIKIAN TYPE PROCEDURE)					
271	28285	HAMMERTOE OPERATION, ONE TOE (EG, INTERPHALANGEAL FUSION, FILLETING, PHALANGECTOMY)					
271	28286	COCK-UP FIFTH TOE OPERATION WITH PLASTIC SKIN CLOSURE (RUIZ-MORA TYPE PROCEDURE)					
271	28310	OSTEOTOMY FOR SHORTENING, ANGULAR OR ROTATIONAL CORRECTION; PROXIMAL PHALANX, FIRST TOE (SEPARATE PROCEDURE)					
271	28312	OSTEOTOMY FOR SHORTENING, ANGULAR OR ROTATIONAL CORRECTION; OTHER PHALANGES, ANY TOE					
271	28313	RECONSTRUCTION, ANGULAR DEFORMITY OF TOE (OVERLAPPING SECOND TOE, FIFTH TOE, CURLY TOES), SOFT TISSUE PROCEDURES ONLY					
271	28315	SESAMOIDECTOMY, FIRST TOE (SEPARATE PROCEDURE)					
271	28340	RECONSTRUCTION, TOE, MACRODACTYLY; SOFT TISSUE RESECTION					
271	28341	RECONSTRUCTION, TOE, MACRODACTYLY; REQUIRING BONE RESECTION					
271	28737	ARTHRODESIS, MIDTARSAL NAVICULAR-CUNEIFORM, WITH TENDON LENGTHENING AND ADVANCEMENT (MILLER TYPE PROCEDURE)					
271	28750	ARTHRODESIS, GREAT TOE; METATARSOPHALANGEAL JOINT					
271	28755	ARTHRODESIS, GREAT TOE; INTERPHALANGEAL JOINT					
271	28810	AMPUTATION, METATARSAL, WITH TOE, SINGLE					
271	28820	AMPUTATION, TOE; METATARSOPHALANGEAL JOINT					
271	28825	AMPUTATION, TOE; INTERPHALANGEAL JOINT					
271	29893	ENDOSCOPIC PLANTAR FASCIOTOMY					
272	Level II Foot Musculoskeletal Procedures		T	16.56	\$839.09	\$409.74	\$167.82
272	28060	FASCIECTOMY, EXCISION OF PLANTAR FASCIA; PARTIAL (SEPARATE PROCEDURE)					
272	28062	FASCIECTOMY, EXCISION OF PLANTAR FASCIA; RADICAL (SEPARATE PROCEDURE)					
272	28070	SYNOVECTOMY; INTERTARSAL OR TARSOMETATARSAL JOINT, EACH					
272	28072	SYNOVECTOMY; METATARSOPHALANGEAL JOINT, EACH					
272	28102	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TALUS OR CALCANEUS; WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
272	28103	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TALUS OR CALCANEUS; WITH ALLOGRAFT					
272	28106	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TARSAL OR METATARSAL BONES, EXCEPT TALUS OR CALCANEUS; WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
272	28107	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TARSAL OR METATARSAL BONES, EXCEPT TALUS OR CALCANEUS; WITH ALLOGRAFT					
272	28202	REPAIR OR SUTURE OF TENDON, FOOT, FLEXOR, SINGLE; SECONDARY WITH FREE GRAFT, EACH TENDON (INCLUDES OBTAINING GRAFT)					
272	28238	ADVANCEMENT OF POSTERIOR TIBIAL TENDON WITH EXCISION OF ACCESSORY NAVICULAR BONE (KIDNER TYPE PROCEDURE)					
272	28250	DIVISION OF PLANTAR FASCIA AND MUSCLE ("STEINDLER STRIPPING") (SEPARATE PROCEDURE)					
272	28260	CAPSULOTOMY, MIDFOOT; MEDIAL RELEASE ONLY (SEPARATE PROCEDURE)					
272	28261	CAPSULOTOMY, MIDFOOT; WITH TENDON LENGTHENING					
272	28262	CAPSULOTOMY, MIDFOOT; EXTENSIVE, INCLUDING POSTERIOR TALOTIBIAL CAPSULOTOMY AND TENDON(S) LENGTHENING AS FOR RESISTANT CLUBFOOT DEFORMITY					
272	28264	CAPSULOTOMY, MIDTARSAL (HEYMAN TYPE PROCEDURE)					
272	28288	OSTECTOMY, PARTIAL, EXOSTECTOMY OR CONDYLECTOMY, SINGLE, METATARSAL HEAD, FIRST THROUGH FIFTH, EACH METATARSAL HEAD					
272	28300	OSTEOTOMY; CALCANEUS (DWYER OR CHAMBERS TYPE PROCEDURE), WITH OR WITHOUT INTERNAL FIXATION					
272	28302	OSTEOTOMY; TALUS					
272	28304	OSTEOTOMY, MIDTARSAL BONES, OTHER THAN CALCANEUS OR TALUS;					
272	28305	OSTEOTOMY, MIDTARSAL BONES, OTHER THAN CALCANEUS OR TALUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT) (FOWLER TYPE)					
272	28306	OSTEOTOMY, METATARSAL, BASE OR SHAFT, SINGLE, WITH OR WITHOUT LENGTHENING, FOR SHORTENING OR ANGULAR CORRECTION; FIRST METATARSAL					
272	28307	OSTEOTOMY, METATARSAL, BASE OR SHAFT, SINGLE, WITH OR WITHOUT LENGTHENING, FOR SHORTENING OR ANGULAR CORRECTION; FIRST METATARSAL WITH AUTOGRAFT					
272	28308	OSTEOTOMY, METATARSAL, BASE OR SHAFT, SINGLE, WITH OR WITHOUT LENGTHENING, FOR SHORTENING OR ANGULAR CORRECTION; OTHER THAN FIRST METATARSAL					
272	28309	OSTEOTOMY, METATARSALS, MULTIPLE, FOR CAVUS FOOT (SWANSON TYPE PROCEDURE)					
272	28320	REPAIR OF NONUNION OR MALUNION; TARSAL BONES (EG, CALCANEUS, TALUS)					
272	28322	REPAIR OF NONUNION OR MALUNION; METATARSAL, WITH OR WITHOUT BONE GRAFT (INCLUDES OBTAINING GRAFT)					
272	28344	RECONSTRUCTION, TOE(S); POLYDACTYLY					
272	28345	RECONSTRUCTION, TOE(S); SYNDACTYLY, WITH OR WITHOUT SKIN GRAFT(S), EACH WEB					
272	28360	RECONSTRUCTION, CLEFT FOOT					
272	28705	PANTALAR ARTHRODESIS					
272	28715	TRIPLE ARTHRODESIS					
272	28725	SUBTALAR ARTHRODESIS					
272	28730	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, MULTIPLE OR TRANSVERSE;					
272	28735	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, MULTIPLE OR TRANSVERSE; WITH OSTEOTOMY AS FOR FLATFOOT CORRECTION					
272	28740	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, SINGLE JOINT					
272	28760	ARTHRODESIS, GREAT TOE, INTERPHALANGEAL JOINT, WITH EXTENSOR HALLUCIS LONGUS TRANSFER TO FIRST METATARSAL NECK (JONES TYPE PROCEDURE)					
276	Bunion Procedures		T	19.19	\$972.35	\$500.14	\$194.47
276	28110	OSTECTOMY, PARTIAL EXCISION, FIFTH METATARSAL HEAD (BUNIONETTE) (SEPARATE PROCEDURE)					
276	28290	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; SIMPLE EXOSTECTOMY (SILVER TYPE PROCEDURE)					
276	28292	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; KELLER, MCBRIDE, OR MAYO TYPE PROCEDURE					
276	28293	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; RESECTION OF JOINT WITH IMPLANT					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
276	28294	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; WITH TENDON TRANSPLANTS (JOPLIN TYPE PROCEDURE)					
276	28296	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; WITH METATARSAL OSTEOTOMY (EG, MITCHELL, CHEVRON, OR CONCENTRIC TYPE PROCEDURES)					
276	28297	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; LAPIDUS TYPE PROCEDURE					
276	28298	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; BY PHALANX OSTEOTOMY					
276	28299	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; BY OTHER METHODS (EG, DOUBLE OSTEOTOMY)					
280	Diagnostic Arthroscopy		T	22.2	\$1,124.86	\$581.72	\$224.97
280	29800	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29815	ARTHROSCOPY, SHOULDER, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29830	ARTHROSCOPY, ELBOW, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29840	ARTHROSCOPY, WRIST, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29870	ARTHROSCOPY, KNEE, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29909	UNLISTED PROCEDURE, ARTHROSCOPY					
281	Level I Surgical Arthroscopy		T	22.65	\$1,147.66	\$590.20	\$229.53
281	29804	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, SURGICAL					
281	29819	ARTHROSCOPY, SHOULDER, SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29820	ARTHROSCOPY, SHOULDER, SURGICAL; SYNOVECTOMY, PARTIAL					
281	29821	ARTHROSCOPY, SHOULDER, SURGICAL; SYNOVECTOMY, COMPLETE					
281	29822	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED					
281	29823	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, EXTENSIVE					
281	29825	ARTHROSCOPY, SHOULDER, SURGICAL; WITH LYSIS AND RESECTION OF ADHESIONS, WITH OR WITHOUT MANIPULATION					
281	29826	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION OF SUBACROMIAL SPACE WITH PARTIAL ACROMIOPLASTY, WITH OR WITHOUT CORACOACROMIAL RELEASE					
281	29834	ARTHROSCOPY, ELBOW, SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29835	ARTHROSCOPY, ELBOW, SURGICAL; SYNOVECTOMY, PARTIAL					
281	29836	ARTHROSCOPY, ELBOW, SURGICAL; SYNOVECTOMY, COMPLETE					
281	29837	ARTHROSCOPY, ELBOW, SURGICAL; DEBRIDEMENT, LIMITED					
281	29838	ARTHROSCOPY, ELBOW, SURGICAL; DEBRIDEMENT, EXTENSIVE					
281	29843	ARTHROSCOPY, WRIST, SURGICAL; FOR INFECTION, LAVAGE AND DRAINAGE					
281	29844	ARTHROSCOPY, WRIST, SURGICAL; SYNOVECTOMY, PARTIAL					
281	29845	ARTHROSCOPY, WRIST, SURGICAL; SYNOVECTOMY, COMPLETE					
281	29846	ARTHROSCOPY, WRIST, SURGICAL; EXCISION AND/OR REPAIR OF TRIANGULAR FIBROCARILAGE AND/OR JOINT DEBRIDEMENT					
281	29847	ARTHROSCOPY, WRIST, SURGICAL; INTERNAL FIXATION FOR FRACTURE OR INSTABILITY					
281	29848	ARTHROSCOPY, WRIST, SURGICAL; WITH RELEASE OF TRANSVERSE CARPAL LIGAMENT					
281	29860	ARTHROSCOPY, HIP, DIAGNOSTIC WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
281	29861	ARTHROSCOPY, HIP, SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29862	ARTHROSCOPY, HIP, SURGICAL; WITH DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY), ABRASION ARTHROPLASTY, AND/OR RESECTION OF LABRUM					
281	29863	ARTHROSCOPY, HIP, SURGICAL; WITH SYNOVECTOMY					
281	29874	ARTHROSCOPY, KNEE, SURGICAL; FOR REMOVAL OF LOOSE BODY OR FOREIGN BODY (EG, OSTEOCHONDritis DISSECANS FRAGMENTATION, CHONDRAL FRAGMENTATION)					
281	29875	ARTHROSCOPY, KNEE, SURGICAL; SYNOVECTOMY, LIMITED (EG, PLICA OR SHELF RESECTION) (SEPARATE PROCEDURE)					
281	29877	ARTHROSCOPY, KNEE, SURGICAL; DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY)					
281	29879	ARTHROSCOPY, KNEE, SURGICAL; ABRASION ARTHROPLASTY (INCLUDES CHONDROPLASTY WHERE NECESSARY) OR MULTIPLE DRILLING					
281	29880	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL AND LATERAL, INCLUDING ANY MENISCAL SHAVING)					
281	29881	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL OR LATERAL, INCLUDING ANY MENISCAL SHAVING)					
281	29884	ARTHROSCOPY, KNEE, SURGICAL; WITH LYSIS OF ADHESIONS, WITH OR WITHOUT MANIPULATION (SEPARATE PROCEDURE)					
281	29886	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR INTACT OSTEOCHONDritis DISSECANS LESION					
281	29894	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29895	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; SYNOVECTOMY, PARTIAL					
281	29897	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; DEBRIDEMENT, LIMITED					
281	29898	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; DEBRIDEMENT, EXTENSIVE					
282	Level II Surgical Arthroscopy		T	23.94	\$1,213.03	\$614.04	\$242.61
282	29871	ARTHROSCOPY, KNEE, SURGICAL; FOR INFECTION, LAVAGE AND DRAINAGE					
282	29876	ARTHROSCOPY, KNEE, SURGICAL; SYNOVECTOMY, MAJOR, TWO OR MORE COMPARTMENTS (EG, MEDIAL OR LATERAL)					
282	29882	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCUS REPAIR (MEDIAL OR LATERAL)					
282	29883	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCUS REPAIR (MEDIAL AND LATERAL)					
282	29885	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR OSTEOCHONDritis DISSECANS WITH BONE GRAFTING, WITH OR WITHOUT INTERNAL FIXATION (INCLUDING DEBRIDEMENT OF BASE OF LESION)					
282	29887	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR INTACT OSTEOCHONDritis DISSECANS LESION WITH INTERNAL FIXATION					
282	29891	ARTHROSCOPY, ANKLE, SURGICAL; EXCISION OF OSTEOCHONDRAL DEFECT OF TALUS AND/OR TIBIA, INCLUDING DRILLING OF THE DEFECT					
286	Arthroscopically-Aided Procedures		T	26.76	\$1,355.91	\$802.41	\$271.18
286	29850	ARTHROSCOPICALLY AIDED TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR TUBEROSITY FRACTURE(S) OF THE KNEE, WITH OR WITHOUT MANIPULATION; WITHOUT INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
286	29851	ARTHROSCOPICALLY AIDED TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR TUBEROSITY FRACTURE(S) OF THE KNEE, WITH OR WITHOUT MANIPULATION; WITH INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
286	29855	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); UNICONDYLAR, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
286	29856	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); BICONDYLAR, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
286	29888	ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT REPAIR/AUGMENTATION OR RECONSTRUCTION					
286	29889	ARTHROSCOPICALLY AIDED POSTERIOR CRUCIATE LIGAMENT REPAIR/ AUGMENTATION OR RECONSTRUCTION					
286	29892	ARTHROSCOPICALLY AIDED REPAIR OF LARGE OSTEOCHONDritis DISSECANS LESION, TALAR DOME FRACTURE, OR TIBIAL PLAFOND FRACTURE, WITH OR WITHOUT INTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
311	Level I ENT Procedures		T	1.43	\$72.46	\$20.57	\$14.49
311	30000	DRAINAGE ABSCESS OR HEMATOMA, NASAL, INTERNAL APPROACH					
311	30020	DRAINAGE ABSCESS OR HEMATOMA, NASAL SEPTUM					
311	30100	BIOPSY, INTRANASAL					
311	30110	EXCISION, NASAL POLYP(S), SIMPLE					
311	30117	EXCISION OR DESTRUCTION, ANY METHOD (INCLUDING LASER), INTRANASAL LESION; INTERNAL APPROACH					
311	30124	EXCISION DERMOID CYST, NOSE; SIMPLE, SKIN, SUBCUTANEOUS					
311	30210	DISPLACEMENT THERAPY (PROETZ TYPE)					
311	30220	INSERTION, NASAL SEPTAL PROSTHESIS (BUTTON)					
311	30300	REMOVAL FOREIGN BODY, INTRANASAL; OFFICE TYPE PROCEDURE					
311	30560	LYSIS INTRANASAL SYNECHIA					
311	31000	LAVAGE BY CANNULATION; MAXILLARY SINUS (ANTRUM PUNCTURE OR NATURAL OSTIUM)					
311	31002	LAVAGE BY CANNULATION; SPHENOID SINUS					
311	31603	TRACHEOSTOMY, EMERGENCY PROCEDURE; TRANSTRACHEAL					
311	31605	TRACHEOSTOMY, EMERGENCY PROCEDURE; CRICOTHYROID MEMBRANE					
311	40490	BIOPSY OF LIP					
311	40799	UNLISTED PROCEDURE, LIPS					
311	40800	DRAINAGE OF ABSCESS, CYST, HEMATOMA, VESTIBULE OF MOUTH; SIMPLE					
311	40801	DRAINAGE OF ABSCESS, CYST, HEMATOMA, VESTIBULE OF MOUTH; COMPLICATED					
311	40804	REMOVAL OF EMBEDDED FOREIGN BODY, VESTIBULE OF MOUTH; SIMPLE					
311	40805	REMOVAL OF EMBEDDED FOREIGN BODY, VESTIBULE OF MOUTH; COMPLICATED					
311	40806	INCISION OF LABIAL FRENUM (FRENOTOMY)					
311	40808	BIOPSY, VESTIBULE OF MOUTH					
311	40810	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; WITHOUT REPAIR					
311	40812	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; WITH SIMPLE REPAIR					
311	40820	DESTRUCTION OF LESION OR SCAR OF VESTIBULE OF MOUTH BY PHYSICAL METHODS (EG, LASER, THERMAL, CRYO, CHEMICAL)					
311	40899	UNLISTED PROCEDURE, VESTIBULE OF MOUTH					
311	41000	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; LINGUAL					
311	41005	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBLINGUAL, SUPERFICIAL					
311	41100	BIOPSY OF TONGUE; ANTERIOR TWO-THIRDS					
311	41105	BIOPSY OF TONGUE; POSTERIOR ONE-THIRD					
311	41108	BIOPSY OF FLOOR OF MOUTH					
311	41110	EXCISION OF LESION OF TONGUE WITHOUT CLOSURE					
311	41115	EXCISION OF LINGUAL FRENUM (FRENECTOMY)					
311	41599	UNLISTED PROCEDURE, TONGUE, FLOOR OF MOUTH					
311	41805	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR STRUCTURES; SOFT TISSUES					
311	41806	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR STRUCTURES; BONE					
311	41820	GINGIVECTOMY, EXCISION GINGIVA, EACH QUADRANT					
311	41821	OPERCULECTOMY, EXCISION PERICORONAL TISSUES					
311	41825	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE), DENTOALVEOLAR STRUCTURES; WITHOUT REPAIR					
311	41826	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE), DENTOALVEOLAR STRUCTURES; WITH SIMPLE REPAIR					
311	41828	EXCISION OF HYPERPLASTIC ALVEOLAR MUCOSA, EACH QUADRANT (SPECIFY)					
311	41830	ALVEOLECTOMY, INCLUDING CURETTAGE OF OSTEITIS OR SEQUESTRECTOMY					
311	41850	DESTRUCTION OF LESION (EXCEPT EXCISION), DENTOALVEOLAR STRUCTURES					
311	41870	PERIODONTAL MUCOSAL GRAFTING					
311	41872	GINGIVOPLASTY, EACH QUADRANT (SPECIFY)					
311	41874	ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)					
311	41899	UNLISTED PROCEDURE, DENTOALVEOLAR STRUCTURES					
311	42000	DRAINAGE OF ABSCESS OF PALATE, UVULA					
311	42100	BIOPSY OF PALATE, UVULA					
311	42104	EXCISION, LESION OF PALATE, UVULA; WITHOUT CLOSURE					
311	42106	EXCISION, LESION OF PALATE, UVULA; WITH SIMPLE PRIMARY CLOSURE					
311	42140	UVULECTOMY, EXCISION OF UVULA					
311	42160	DESTRUCTION OF LESION, PALATE OR UVULA (THERMAL, CRYO OR CHEMICAL)					
311	42280	MAXILLARY IMPRESSION FOR PALATAL PROSTHESIS					
311	42281	INSERTION OF PIN-RETAINED PALATAL PROSTHESIS					
311	42299	UNLISTED PROCEDURE, PALATE, UVULA					
311	42330	SIALOLITHOTOMY; SUBMANDIBULAR (SUBMAXILLARY), SUBLINGUAL OR PAROTID, UNCOMPLICATED, INTRAORAL					
311	42335	SIALOLITHOTOMY; SUBMANDIBULAR (SUBMAXILLARY), COMPLICATED, INTRAORAL					
311	42650	DILATION SALIVARY DUCT					
311	42660	DILATION AND CATHETERIZATION OF SALIVARY DUCT, WITH OR WITHOUT INJECTION					
311	42665	LIGATION SALIVARY DUCT, INTRAORAL					
311	42699	UNLISTED PROCEDURE, SALIVARY GLANDS OR DUCTS					
311	69200	REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL; WITHOUT GENERAL ANESTHESIA					
311	69210	REMOVAL IMPACTED CERUMEN (SEPARATE PROCEDURE), ONE OR BOTH EARS					
311	69222	DEBRIDEMENT, MASTOIDECTOMY CAVITY, COMPLEX (EG, WITH ANESTHESIA OR MORE THAN ROUTINE CLEANING)					
311	69399	UNLISTED PROCEDURE, EXTERNAL EAR					
311	69400	EUSTACHIAN TUBE INFLATION, TRANSNASAL; WITH CATHETERIZATION					
311	69405	EUSTACHIAN TUBE CATHETERIZATION, TRANSTYMPANIC					
311	69410	FOCAL APPLICATION OF PHASE CONTROL SUBSTANCE, MIDDLE EAR (BAFFLE TECHNIQUE)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
311	69420	MYRINGOTOMY INCLUDING ASPIRATION AND/OR EUSTACHIAN TUBE INFLATION					
311	69424	VENTILATING TUBE REMOVAL WHEN ORIGINALLY INSERTED BY ANOTHER PHYSICIAN					
311	69540	EXCISION AURAL POLYP					
311	69610	TYMPANIC MEMBRANE REPAIR, WITH OR WITHOUT SITE PREPARATION OR PERFORATION FOR CLOSURE, WITH OR WITHOUT PATCH					
311	69799	UNLISTED PROCEDURE, MIDDLE EAR					
311	92502	OTOLARYNGOLOGIC EXAMINATION UNDER GENERAL ANESTHESIA					
312	Level II ENT Procedures		T	7.26	\$367.86	\$178.31	\$73.57
312	30801	CAUTERIZATION AND/OR ABLATION, MUCOSA OF TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD, (SEPARATE PROCEDURE); SUPERFICIAL					
312	30802	CAUTERIZATION AND/OR ABLATION, MUCOSA OF TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD, (SEPARATE PROCEDURE); INTRAMURAL					
312	30930	FRACTURE NASAL TURBINATE(S), THERAPEUTIC					
312	31612	TRACHEAL PUNCTURE, PERCUTANEOUS WITH TRANSTRACHEAL ASPIRATION AND/OR INJECTION					
12	40830	CLOSURE OF LACERATION, VESTIBULE OF MOUTH; 2.5 CM OR LESS					
312	40831	CLOSURE OF LACERATION, VESTIBULE OF MOUTH; OVER 2.5 CM OR COMPLEX					
312	41250	REPAIR OF LACERATION 2.5 CM OR LESS; FLOOR OF MOUTH AND/OR ANTERIOR TWO-THIRDS OF TONGUE					
312	41251	REPAIR OF LACERATION 2.5 CM OR LESS; POSTERIOR ONE-THIRD OF TONGUE					
312	41252	REPAIR OF LACERATION OF TONGUE, FLOOR OF MOUTH, OVER 2.6 CM OR COMPLEX					
312	41500	FIXATION OF TONGUE, MECHANICAL, OTHER THAN SUTURE (EG, K-WIRE)					
312	41510	SUTURE OF TONGUE TO LIP FOR MICROGNATHIA (DOUGLAS TYPE PROCEDURE)					
312	41800	DRAINAGE OF ABSCESS, CYST, HEMATOMA FROM DENTOALVEOLAR STRUCTURES					
312	42300	DRAINAGE OF ABSCESS; PAROTID, SIMPLE					
312	42305	DRAINAGE OF ABSCESS; PAROTID, COMPLICATED					
312	42310	DRAINAGE OF ABSCESS; SUBMAXILLARY OR SUBLINGUAL, INTRAORAL					
312	42320	DRAINAGE OF ABSCESS; SUBMAXILLARY, EXTERNAL					
312	42405	BIOPSY OF SALIVARY GLAND; INCISIONAL					
312	42700	INCISION AND DRAINAGE ABSCESS; PERITONSILLAR					
312	42720	INCISION AND DRAINAGE ABSCESS; RETROPHARYNGEAL OR PARAPHARYNGEAL, INTRAORAL APPROACH					
312	42800	BIOPSY; OROPHARYNX					
312	42802	BIOPSY; HYPOPHARYNX					
312	42804	BIOPSY; NASOPHARYNX, VISIBLE LESION, SIMPLE					
312	42806	BIOPSY; NASOPHARYNX, SURVEY FOR UNKNOWN PRIMARY LESION					
312	42808	EXCISION OR DESTRUCTION OF LESION OF PHARYNX, ANY METHOD					
312	60000	INCISION AND DRAINAGE OF THYROGLOSSAL CYST, INFECTED					
312	69421	MYRINGOTOMY INCLUDING ASPIRATION AND/OR EUSTACHIAN TUBE INFLATION REQUIRING GENERAL ANESTHESIA					
312	69433	TYMPANOSTOMY (REQUIRING INSERTION OF VENTILATING TUBE), LOCAL OR TOPICAL ANESTHESIA					
312	69436	TYMPANOSTOMY (REQUIRING INSERTION OF VENTILATING TUBE), GENERAL ANESTHESIA					
313	Level III ENT Procedures		T	15.81	\$801.08	\$411.09	\$160.22
313	30115	EXCISION, NASAL POLYP(S), EXTENSIVE					
313	30118	EXCISION OR DESTRUCTION, ANY METHOD (INCLUDING LASER), INTRANASAL LESION; EXTERNAL APPROACH (LATERAL RHINOTOMY)					
313	30120	EXCISION OR SURGICAL PLANING OF SKIN OF NOSE FOR RHINOPHYMA					
313	30125	EXCISION DERMOID CYST, NOSE; COMPLEX, UNDER BONE OR CARTILAGE					
313	30130	EXCISION TURBINATE, PARTIAL OR COMPLETE					
313	30140	SUBMUCOUS RESECTION TURBINATE, PARTIAL OR COMPLETE					
313	30150	RHINECTOMY; PARTIAL					
313	30160	RHINECTOMY; TOTAL					
313	30310	REMOVAL FOREIGN BODY, INTRANASAL; REQUIRING GENERAL ANESTHESIA					
313	30320	REMOVAL FOREIGN BODY, INTRANASAL; BY LATERAL RHINOTOMY					
313	30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)					
313	30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING, CONTOURING OR REPLACEMENT WITH GRAFT					
313	30540	REPAIR CHOANAL ATRESIA; INTRANASAL					
313	30580	REPAIR FISTULA; OROMAXILLARY (COMBINE WITH 31030 IF ANTROTOMY IS INCLUDED)					
313	30600	REPAIR FISTULA; ORONASAL					
313	30620	SEPTAL OR OTHER INTRANASAL DERMATOPLASTY (DOES NOT INCLUDE OBTAINING GRAFT)					
313	30630	REPAIR NASAL SEPTAL PERFORATIONS					
313	31020	SINUSOTOMY, MAXILLARY (ANTROTOMY); INTRANASAL					
313	31030	SINUSOTOMY, MAXILLARY (ANTROTOMY); RADICAL (CALDWELL-LUC) WITHOUT REMOVAL OF ANTROCHOANAL POLYPS					
313	31032	SINUSOTOMY, MAXILLARY (ANTROTOMY); RADICAL (CALDWELL-LUC) WITH REMOVAL OF ANTROCHOANAL POLYPS					
313	31050	SINUSOTOMY, SPHENOID, WITH OR WITHOUT BIOPSY;					
313	31051	SINUSOTOMY, SPHENOID, WITH OR WITHOUT BIOPSY; WITH MUCOSAL STRIPPING OR REMOVAL OF POLYP(S)					
313	31070	SINUSOTOMY FRONTAL; EXTERNAL, SIMPLE (TREPHINE OPERATION)					
313	31200	ETHMOIDECTOMY; INTRANASAL, ANTERIOR					
313	31320	LARYNGOTOMY (THYROTOMY, LARYNGOFISSURE); DIAGNOSTIC					
313	31595	SECTION RECURRENT LARYNGEAL NERVE, THERAPEUTIC (SEPARATE PROCEDURE), UNILATERAL					
313	31611	CONSTRUCTION OF TRACHEOESOPHAGEAL FISTULA AND SUBSEQUENT INSERTION OF AN ALARYNGEAL SPEECH PROSTHESIS (EG, VOICE BUTTON, BLOM-SINGER PROSTHESIS)					
313	31613	TRACHEOSTOMA REVISION; SIMPLE, WITHOUT FLAP ROTATION					
313	31614	TRACHEOSTOMA REVISION; COMPLEX, WITH FLAP ROTATION					
313	31820	SURGICAL CLOSURE TRACHEOSTOMY OR FISTULA; WITHOUT PLASTIC REPAIR					
313	31825	SURGICAL CLOSURE TRACHEOSTOMY OR FISTULA; WITH PLASTIC REPAIR					
313	31830	REVISION OF TRACHEOSTOMY SCAR					
313	40500	VERMILIONECTOMY (LIP SHAVE), WITH MUCOSAL ADVANCEMENT					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
313	40510	EXCISION OF LIP; TRANSVERSE WEDGE EXCISION WITH PRIMARY CLOSURE					
313	40520	EXCISION OF LIP; V-EXCISION WITH PRIMARY DIRECT LINEAR CLOSURE					
313	40525	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH LOCAL FLAP (EG, ESTLANDER OR FAN)					
313	40527	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH CROSS LIP FLAP (ABBE-ESTLANDER)					
313	40530	RESECTION OF LIP, MORE THAN ONE-FOURTH, WITHOUT RECONSTRUCTION					
313	40650	REPAIR LIP, FULL THICKNESS; VERMILION ONLY					
313	40652	REPAIR LIP, FULL THICKNESS; UP TO HALF VERTICAL HEIGHT					
313	40654	REPAIR LIP, FULL THICKNESS; OVER ONE-HALF VERTICAL HEIGHT, OR COMPLEX					
313	40814	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; WITH COMPLEX REPAIR					
313	40816	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; COMPLEX, WITH EXCISION OF UNDERLYING MUSCLE					
313	40818	EXCISION OF MUCOSA OF VESTIBULE OF MOUTH AS DONOR GRAFT					
313	40819	EXCISION OF FRENUM, LABIAL OR BUCCAL (FRENUMECTOMY, FRENULECTOMY, FRENECTOMY)					
313	40840	VESTIBULOPLASTY; ANTERIOR					
313	40842	VESTIBULOPLASTY; POSTERIOR, UNILATERAL					
313	41006	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBLINGUAL, DEEP, SUPRAPHARYNGEAL					
313	41007	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBMENTAL SPACE					
313	41008	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBMANDIBULAR					
313	41009	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; MASTICATOR SPACE					
313	41010	INCISION OF LINGUAL FRENUM (FRENOTOMY)					
313	41015	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; SUBLINGUAL					
313	41016	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; SUBMENTAL					
313	41017	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; SUBMANDIBULAR					
313	41018	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; MASTICATOR SPACE					
313	41112	EXCISION OF LESION OF TONGUE WITH CLOSURE; ANTERIOR TWO-THIRDS					
313	41113	EXCISION OF LESION OF TONGUE WITH CLOSURE; POSTERIOR ONE-THIRD					
313	41114	EXCISION OF LESION OF TONGUE WITH CLOSURE; WITH LOCAL TONGUE FLAP					
313	41116	EXCISION, LESION OF FLOOR OF MOUTH					
313	41120	GLOSSECTOMY; LESS THAN ONE-HALF TONGUE					
313	41520	FRENOPLASTY (SURGICAL REVISION OF FRENUM, EG, WITH Z-PLASTY)					
313	41827	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE), DENTOALVEOLAR STRUCTURES; WITH COMPLEX REPAIR					
313	42107	EXCISION, LESION OF PALATE, UVULA; WITH LOCAL FLAP CLOSURE					
313	42120	RESECTION OF PALATE OR EXTENSIVE RESECTION OF LESION					
313	42180	REPAIR, LACERATION OF PALATE; UP TO 2 CM					
313	42182	REPAIR, LACERATION OF PALATE; OVER 2 CM OR COMPLEX					
313	42200	PALATOPLASTY FOR CLEFT PALATE, SOFT AND/OR HARD PALATE ONLY					
313	42205	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR RIDGE; SOFT TISSUE ONLY					
313	42215	PALATOPLASTY FOR CLEFT PALATE; MAJOR REVISION					
313	42220	PALATOPLASTY FOR CLEFT PALATE; SECONDARY LENGTHENING PROCEDURE					
313	42235	REPAIR OF ANTERIOR PALATE, INCLUDING VOMER FLAP					
313	42260	REPAIR OF NASOLABIAL FISTULA					
313	42325	FISTULIZATION OF SUBLINGUAL SALIVARY CYST (RANULA);					
313	42326	FISTULIZATION OF SUBLINGUAL SALIVARY CYST (RANULA); WITH PROSTHESIS					
313	42340	SIALOLITHOTOMY; PAROTID, EXTRAORAL OR COMPLICATED INTRAORAL					
313	42408	EXCISION OF SUBLINGUAL SALIVARY CYST (RANULA)					
313	42409	MARSUPIALIZATION OF SUBLINGUAL SALIVARY CYST (RANULA)					
313	42410	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; LATERAL LOBE, WITHOUT NERVE DISSECTION					
313	42440	EXCISION OF SUBMANDIBULAR (SUBMAXILLARY) GLAND					
313	42450	EXCISION OF SUBLINGUAL GLAND					
313	42500	PLASTIC REPAIR OF SALIVARY DUCT, SIALODOCHOPLASTY; PRIMARY OR SIMPLE					
313	42505	PLASTIC REPAIR OF SALIVARY DUCT, SIALODOCHOPLASTY; SECONDARY OR COMPLICATED					
313	42507	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE);					
313	42508	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE); WITH EXCISION OF ONE SUBMANDIBULAR GLAND					
313	42510	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE); WITH LIGATION OF BOTH SUBMANDIBULAR (WHARTON'S) DUCTS					
313	42600	CLOSURE SALIVARY FISTULA					
313	42725	INCISION AND DRAINAGE ABSCESS; RETROPHARYNGEAL OR PARAPHARYNGEAL, EXTERNAL APPROACH					
313	42810	EXCISION BRANCHIAL CLEFT CYST OR VESTIGE, CONFINED TO SKIN AND SUBCUTANEOUS TISSUES					
313	42815	EXCISION BRANCHIAL CLEFT CYST, VESTIGE, OR FISTULA, EXTENDING BENEATH SUBCUTANEOUS TISSUES AND/OR INTO PHARYNX					
313	42900	SUTURE PHARYNX FOR WOUND OR INJURY					
313	42950	PHARYNGOPLASTY (PLASTIC OR RECONSTRUCTIVE OPERATION ON PHARYNX)					
313	42955	PHARYNGOSTOMY (FISTULIZATION OF PHARYNX, EXTERNAL FOR FEEDING)					
313	42962	CONTROL OROPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POST-TONSILLECTOMY); WITH SECONDARY SURGICAL INTERVENTION					
313	42972	CONTROL OF NASOPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POSTADENOIDECTOMY); WITH SECONDARY SURGICAL INTERVENTION					
313	43020	ESOPHAGOTOMY, CERVICAL APPROACH, WITH REMOVAL OF FOREIGN BODY					
313	43030	CRICOPHARYNGEAL MYOTOMY					
313	69120	EXCISION EXTERNAL EAR; COMPLETE AMPUTATION					
313	69140	EXCISION EXOSTOSIS(ES), EXTERNAL AUDITORY CANAL					
313	69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION					
313	69440	MIDDLE EAR EXPLORATION THROUGH POSTAURICULAR OR EAR CANAL INCISION					
313	69450	TYMPANOLYSIS, TRANSCANAL					
313	69620	MYRINGOPLASTY (SURGERY CONFINED TO DRUMHEAD AND DONOR AREA)					
314	Level IV ENT Procedures		T	25.65	\$1,299.67	\$693.37	\$259.93
314	30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
314	30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP					
314	30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR					
314	30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)					
314	30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)					
314	30460	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP ONLY					
314	30462	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP, SEPTUM, OSTEOTOMIES					
314	30545	REPAIR CHOANAL ATRESIA; TRANSPALATINE					
314	31040	PTERYGOMAXILLARY FOSSA SURGERY, ANY APPROACH					
314	31075	SINUSOTOMY FRONTAL; TRANSORBITAL, UNILATERAL (FOR MUCOCELE OR OSTEOMA, LYNCH TYPE)					
314	31080	SINUSOTOMY FRONTAL; OBLITERATIVE WITHOUT OSTEOPLASTIC FLAP, BROW INCISION (INCLUDES ABLATION)					
314	31081	SINUSOTOMY FRONTAL; OBLITERATIVE, WITHOUT OSTEOPLASTIC FLAP, CORONAL INCISION (INCLUDES ABLATION)					
314	31084	SINUSOTOMY FRONTAL; OBLITERATIVE, WITH OSTEOPLASTIC FLAP, BROW INCISION					
314	31085	SINUSOTOMY FRONTAL; OBLITERATIVE, WITH OSTEOPLASTIC FLAP, CORONAL INCISION					
314	31086	SINUSOTOMY FRONTAL; NONOBLITERATIVE, WITH OSTEOPLASTIC FLAP, BROW INCISION					
314	31087	SINUSOTOMY FRONTAL; NONOBLITERATIVE, WITH OSTEOPLASTIC FLAP, CORONAL INCISION					
314	31090	SINUSOTOMY COMBINED, THREE OR MORE SINUSES (UNILATERAL)					
314	31201	ETHMOIDECTOMY; INTRANASAL, TOTAL					
314	31205	ETHMOIDECTOMY; EXTRANASAL, TOTAL					
314	31300	LARYNGOTOMY (THYROTOMY, LARYNGOFISSURE); WITH REMOVAL OF TUMOR OR LARYNGOCELE, CORDECTOMY					
314	31400	ARYTENOIDECTOMY OR ARYTENOIDOPEXY, EXTERNAL APPROACH					
314	31420	EPIGLOTTIDECTOMY					
314	31588	LARYNGOPLASTY, NOT OTHERWISE SPECIFIED (EG, FOR BURNS, RECONSTRUCTION AFTER PARTIAL LARYNGECTOMY)					
314	31590	LARYNGEAL REINNERVATION BY NEUROMUSCULAR PEDICLE					
314	31750	TRACHEOPLASTY; CERVICAL					
314	31755	TRACHEOPLASTY; TRACHEOPHARYNGEAL FISTULIZATION, EACH STAGE					
314	40700	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY, PARTIAL OR COMPLETE, UNILATERAL					
314	40701	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY BILATERAL, ONE STAGE PROCEDURE					
314	40702	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY BILATERAL, ONE OF TWO STAGES					
314	40720	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; SECONDARY, BY RECREATION OF DEFECT AND RECLOSURE					
314	40761	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; WITH CROSS LIP PEDICLE FLAP (ABBE-ESTLANDER TYPE), INCLUDING SECTIONING AND INSERTING OF PEDICLE					
314	40843	VESTIBULOPLASTY; POSTERIOR, BILATERAL					
314	40844	VESTIBULOPLASTY; ENTIRE ARCH					
314	40845	VESTIBULOPLASTY; COMPLEX (INCLUDING RIDGE EXTENSION, MUSCLE REPOSITIONING)					
314	42210	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR RIDGE; WITH BONE GRAFT TO ALVEOLAR RIDGE (INCLUDES OBTAINING GRAFT)					
314	42225	PALATOPLASTY FOR CLEFT PALATE; ATTACHMENT PHARYNGEAL FLAP					
314	42226	LENGTHENING OF PALATE, AND PHARYNGEAL FLAP					
314	42227	LENGTHENING OF PALATE, WITH ISLAND FLAP					
314	42415	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; LATERAL LOBE, WITH DISSECTION AND PRESERVATION OF FACIAL NERVE					
314	42420	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; TOTAL, WITH DISSECTION AND PRESERVATION OF FACIAL NERVE					
314	42425	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; TOTAL, EN BLOC REMOVAL WITH SACRIFICE OF FACIAL NERVE					
314	42509	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE); WITH EXCISION OF BOTH SUBMANDIBULAR GLANDS					
314	42842	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR RETROMOLAR TRIGONE; WITHOUT CLOSURE					
314	42844	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR RETROMOLAR TRIGONE; CLOSURE WITH LOCAL FLAP (EG, TONGUE, BUCCAL)					
314	42890	LIMITED PHARYNGECTOMY					
314	42892	RESECTION OF LATERAL PHARYNGEAL WALL OR PYRIFORM SINUS, DIRECT CLOSURE BY ADVANCEMENT OF LATERAL AND POSTERIOR PHARYNGEAL WALLS					
314	69150	RADICAL EXCISION EXTERNAL AUDITORY CANAL LESION; WITHOUT NECK DISSECTION					
314	69310	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL (MEATOPLASTY) (EG, FOR STENOSIS DUE TO TRAUMA, INFECTION) (SEPARATE PROCEDURE)					
314	69320	RECONSTRUCTION EXTERNAL AUDITORY CANAL FOR CONGENITAL ATRESIA, SINGLE STAGE					
314	69501	TRANSMASTOID ANTROSTOMY ("SIMPLE" MASTOIDECTOMY)					
314	69502	MASTOIDECTOMY; COMPLETE					
314	69505	MASTOIDECTOMY; MODIFIED RADICAL					
314	69511	MASTOIDECTOMY; RADICAL					
314	69530	PETROUS APECTOMY INCLUDING RADICAL MASTOIDECTOMY					
314	69550	EXCISION AURAL GLOMUS TUMOR; TRANSCANAL					
314	69552	EXCISION AURAL GLOMUS TUMOR; TRANSMASTOID					
314	69601	REVISION MASTOIDECTOMY; RESULTING IN COMPLETE MASTOIDECTOMY					
314	69602	REVISION MASTOIDECTOMY; RESULTING IN MODIFIED RADICAL MASTOIDECTOMY					
314	69603	REVISION MASTOIDECTOMY; RESULTING IN RADICAL MASTOIDECTOMY					
314	69604	REVISION MASTOIDECTOMY; RESULTING IN TYMPANOPLASTY					
314	69605	REVISION MASTOIDECTOMY; WITH APECTOMY					
314	69631	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69632	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITH OSSICULAR CHAIN RECONSTRUCTION (EG, POSTFENESTRATION)					
314	69633	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITH OSSICULAR CHAIN RECONSTRUCTION AND SYNTHETIC PROSTHESIS (EG, PARTIAL OSSICULAR REPLACEMENT PROSTHESIS (PORP), TOTAL OSSICULAR REPLACEMENT PROSTHESIS (PORP), TOTAL OSSICULAR REPLACEMENT PROSTHESIS (PORP))					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
314	69635	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69636	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69637	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION AND SYNTHETIC PROSTHESIS (EG, PARTIAL OSSICULAR REPLACEMENT PROSTHESIS (PORP), TOTAL					
314	69641	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69642	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69643	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH INTACT OR RECONSTRUCTED WALL, WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69644	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH INTACT OR RECONSTRUCTED CANAL WALL, WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69645	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); RADICAL OR COMPLETE, WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69646	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); RADICAL OR COMPLETE, WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69650	STAPES MOBILIZATION					
314	69660	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF OSSICULAR CONTINUITY, WITH OR WITHOUT USE OF FOREIGN MATERIAL;					
314	69661	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF OSSICULAR CONTINUITY, WITH OR WITHOUT USE OF FOREIGN MATERIAL; WITH FOOTPLATE DRILL OUT					
314	69662	REVISION OF STAPEDECTOMY OR STAPEDOTOMY					
314	69666	REPAIR OVAL WINDOW FISTULA					
314	69667	REPAIR ROUND WINDOW FISTULA					
314	69670	MASTOID OBLITERATION (SEPARATE PROCEDURE)					
314	69676	TYMPANIC NEURECTOMY					
314	69700	CLOSURE POSTAURICULAR FISTULA, MASTOID (SEPARATE PROCEDURE)					
314	69711	REMOVAL OR REPAIR OF ELECTROMAGNETIC BONE CONDUCTION HEARING DEVICE IN TEMPORAL BONE					
314	69720	DECOMPRESSION FACIAL NERVE, INTRATEMPORAL; LATERAL TO GENICULATE GANGLION					
314	69725	DECOMPRESSION FACIAL NERVE, INTRATEMPORAL; INCLUDING MEDIAL TO GENICULATE GANGLION					
314	69740	SUTURE FACIAL NERVE, INTRATEMPORAL, WITH OR WITHOUT GRAFT OR DECOMPRESSION; LATERAL TO GENICULATE GANGLION					
314	69745	SUTURE FACIAL NERVE, INTRATEMPORAL, WITH OR WITHOUT GRAFT OR DECOMPRESSION; INCLUDING MEDIAL TO GENICULATE GANGLION					
314	69801	LABYRINTHOTOMY, WITH OR WITHOUT CRYOSURGERY INCLUDING OTHER NONEXCISIONAL DESTRUCTIVE PROCEDURES OR PERFUSION OF VESTIBULOACTIVE DRUGS (SINGLE OR MULTIPLE PERFUSIONS); TRANSCANAL					
314	69802	LABYRINTHOTOMY, WITH OR WITHOUT CRYOSURGERY INCLUDING OTHER NONEXCISIONAL DESTRUCTIVE PROCEDURES OR PERFUSION OF VESTIBULOACTIVE DRUGS (SINGLE OR MULTIPLE PERFUSIONS); WITH MASTOIDECTOMY					
314	69805	ENDOLYMPHATIC SAC OPERATION; WITHOUT SHUNT					
314	69806	ENDOLYMPHATIC SAC OPERATION; WITH SHUNT					
314	69820	FENESTRATION SEMICIRCULAR CANAL					
314	69840	REVISION FENESTRATION OPERATION					
314	69905	LABYRINTHECTOMY; TRANSCANAL					
314	69910	LABYRINTHECTOMY; WITH MASTOIDECTOMY					
314	69915	VESTIBULAR NERVE SECTION, TRANSLABYRINTHINE APPROACH					
314	69949	UNLISTED PROCEDURE, INNER EAR					
317	Implantation of Cochlear Device		T				
317	69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT MASTOIDECTOMY					
318	Nasal Cauterization/Packing		T	2.07	\$104.89	\$38.65	\$20.98
318	30901	CONTROL NASAL HEMORRHAGE, ANTERIOR, SIMPLE (LIMITED CAUTERY AND/OR PACKING) ANY METHOD					
318	30903	CONTROL NASAL HEMORRHAGE, ANTERIOR, COMPLEX (EXTENSIVE CAUTERY AND/OR PACKING) ANY METHOD					
318	30905	CONTROL NASAL HEMORRHAGE, POSTERIOR, WITH POSTERIOR NASAL PACKS AND/OR CAUTERIZATION, ANY METHOD; INITIAL					
318	30906	CONTROL NASAL HEMORRHAGE, POSTERIOR, WITH POSTERIOR NASAL PACKS AND/OR CAUTERIZATION, ANY METHOD;					
318	30999	UNLISTED PROCEDURE, NOSE					
318	42960	CONTROL OROPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POST-TONSILLECTOMY); SIMPLE					
318	42970	CONTROL OF NASOPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POSTADENOIDECTOMY); SIMPLE, WITH POSTERIOR NASAL PACKS, WITH OR WITHOUT ANTERIOR PACKS AND/OR CAUTERIZATION					
318	42999	UNLISTED PROCEDURE, PHARYNX, ADENOIDS, OR TONSILS					
319	Tonsil/Adenoid Procedures		T	17.30	\$876.58	\$480.02	\$175.32
319	42820	TONSILLECTOMY AND ADENOIDECTOMY; UNDER AGE 12					
319	42821	TONSILLECTOMY AND ADENOIDECTOMY; AGE 12 OR OVER					
319	42825	TONSILLECTOMY, PRIMARY OR SECONDARY; UNDER AGE 12					
319	42826	TONSILLECTOMY, PRIMARY OR SECONDARY; AGE 12 OR OVER					
319	42830	ADENOIDECTOMY, PRIMARY; UNDER AGE 12					
319	42831	ADENOIDECTOMY, PRIMARY; AGE 12 OR OVER					
319	42835	ADENOIDECTOMY, SECONDARY; UNDER AGE 12					
319	42836	ADENOIDECTOMY, SECONDARY; AGE 12 OR OVER					
319	42860	EXCISION OF TONSIL TAGS					
319	42870	EXCISION OR DESTRUCTION LINGUAL TONSIL, ANY METHOD (SEPARATE PROCEDURE)					
320	Thoracentesis/Lavage Procedures		T	3.17	\$160.62	\$79.33	\$32.12
320	32000	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION, INITIAL OR SUBSEQUENT					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
320	32002	THORACENTESIS WITH INSERTION OF TUBE WITH OR WITHOUT WATER SEAL (EG, FOR PNEUMOTHORAX) (SEPARATE					
320	32020	TUBE THORACOSTOMY WITH OR WITHOUT WATER SEAL (EG, FOR ABSCESS, HEMOTHORAX, EMPYEMA) (SEPARATE PROCEDURE)					
320	32420	PNEUMONOCENTESIS, PUNCTURE OF LUNG FOR ASPIRATION					
320	32960	PNEUMOTHORAX, THERAPEUTIC, INTRAPLEURAL INJECTION OF AIR					
320	32999	UNLISTED PROCEDURE, LUNGS AND PLEURA					
320	33010	PERICARDIOCENTESIS; INITIAL					
320	33011	PERICARDIOCENTESIS; SUBSEQUENT					
320	33999	UNLISTED PROCEDURE, CARDIAC SURGERY					
320	49080	PERITONEOCENTESIS, ABDOMINAL PARACENTESIS, OR PERITONEAL LAVAGE (DIAGNOSTIC OR THERAPEUTIC); INITIAL					
320	49081	PERITONEOCENTESIS, ABDOMINAL PARACENTESIS, OR PERITONEAL LAVAGE (DIAGNOSTIC OR THERAPEUTIC); SUBSEQUENT					
331	Level I Endoscopy Upper Airway		T	0.69	\$34.96	\$14.01	\$6.99
331	31231	NASAL/SINUS ENDOSCOPY, DIAGNOSTIC, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)					
331	31299	UNLISTED PROCEDURE, ACCESSORY SINUSES					
331	31505	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); DIAGNOSTIC					
331	31575	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; DIAGNOSTIC					
331	31579	LARYNGOSCOPY, FLEXIBLE OR RIGID FIBEROPTIC, WITH STROBOSCOPY					
331	92511	NASOPHARYNGOSCOPY WITH ENDOSCOPE (SEPARATE PROCEDURE)					
332	Level II Endoscopy Upper Airway		T	9.74	\$493.52	\$244.98	\$98.70
332	31233	NASAL/SINUS ENDOSCOPY, DIAGNOSTIC WITH MAXILLARY SINUSOSCOPY (VIA INFERIOR MEATUS OR CANINE FOSSA PUNCTURE)					
332	31235	NASAL/SINUS ENDOSCOPY, DIAGNOSTIC WITH SPHENOID SINUSOSCOPY (VIA PUNCTURE OF SPHENOIDAL FACE OR CANNULATION OF OSTIUM)					
332	31237	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH BIOPSY, POLYPECTOMY OR DEBRIDEMENT (SEPARATE PROCEDURE)					
332	31238	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH CONTROL OF EPISTAXIS					
332	31240	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH CONCHA BULLOSA RESECTION					
332	31510	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH BIOPSY					
332	31511	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH REMOVAL OF FOREIGN BODY					
332	31512	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH REMOVAL OF LESION					
332	31513	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH VOCAL CORD INJECTION					
332	31515	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; FOR ASPIRATION					
332	31520	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; DIAGNOSTIC, NEWBORN					
332	31525	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; DIAGNOSTIC, EXCEPT NEWBORN					
332	31526	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; DIAGNOSTIC, WITH OPERATING MICROSCOPE					
332	31528	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; WITH DILATATION, INITIAL					
332	31529	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; WITH DILATATION, SUBSEQUENT					
332	31576	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH BIOPSY					
332	31577	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH REMOVAL OF FOREIGN BODY					
332	31578	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH REMOVAL OF LESION					
332	31700	CATHETERIZATION, TRANSGLOTTIC (SEPARATE PROCEDURE)					
332	31717	CATHETERIZATION WITH BRONCHIAL BRUSH BIOPSY					
332	31720	CATHETER ASPIRATION (SEPARATE PROCEDURE); NASOTRACHEAL					
332	31730	TRANSTRACHEAL (PERCUTANEOUS) INTRODUCTION OF NEEDLE WIRE DILATOR/ STENT OR INDWELLING TUBE FOR OXYGEN					
333	Level III Endoscopy Upper Airway		T	17.24	\$873.54	\$464.20	\$174.71
333	31239	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DACRYOCYSTORHINOSTOMY					
333	31254	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, PARTIAL (ANTERIOR)					
333	31255	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, TOTAL (ANTERIOR AND POSTERIOR)					
333	31256	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH MAXILLARY ANTROSTOMY;					
333	31267	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH MAXILLARY ANTROSTOMY; WITH REMOVAL OF TISSUE FROM MAXILLARY SINUS					
333	31276	NASAL/SINUS ENDOSCOPY, SURGICAL WITH FRONTAL SINUS EXPLORATION, WITH OR WITHOUT REMOVAL OF TISSUE FROM FRONTAL SINUS					
333	31287	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH SPHENOIDOTOMY;					
333	31288	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH SPHENOIDOTOMY; WITH REMOVAL OF TISSUE FROM THE SPHENOID SINUS					
333	31527	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; WITH INSERTION OF OBTURATOR					
333	31530	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH FOREIGN BODY REMOVAL;					
333	31531	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH FOREIGN BODY REMOVAL; WITH OPERATING MICROSCOPE					
333	31535	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH BIOPSY;					
333	31536	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH BIOPSY; WITH OPERATING MICROSCOPE					
333	31540	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH EXCISION OF TUMOR AND/OR STRIPPING OF VOCAL CORDS OR EPIGLOTTIS;					
333	31541	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH EXCISION OF TUMOR AND/OR STRIPPING OF VOCAL CORDS OR EPIGLOTTIS; WITH OPERATING MICROSCOPE					
333	31560	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH ARYTENOIDECTOMY;					
333	31561	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH ARYTENOIDECTOMY; WITH OPERATING MICROSCOPE					
333	31570	LARYNGOSCOPY, DIRECT, WITH INJECTION INTO VOCAL CORD(S), THERAPEUTIC;					
333	31571	LARYNGOSCOPY, DIRECT, WITH INJECTION INTO VOCAL CORD(S), THERAPEUTIC; WITH OPERATING MICROSCOPE					
336	Endoscopy Lower Airway		T	7.44	\$376.98	\$197.98	\$75.40
336	31615	TRACHEOBRONCHOSCOPY THROUGH ESTABLISHED TRACHEOSTOMY INCISION					
336	31622	BRONCHOSCOPY; DIAGNOSTIC, (FLEXIBLE OR RIGID), WITH OR WITHOUT CELL WASHING OR BRUSHING					
336	31625	BRONCHOSCOPY; WITH BIOPSY					
336	31628	BRONCHOSCOPY; WITH TRANSBRONCHIAL LUNG BIOPSY, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE					
336	31629	BRONCHOSCOPY; WITH TRANSBRONCHIAL NEEDLE ASPIRATION BIOPSY					
336	31630	BRONCHOSCOPY; WITH TRACHEAL OR BRONCHIAL DILATION OR CLOSED REDUCTION OF FRACTURE					
336	31631	BRONCHOSCOPY; WITH TRACHEAL DILATION AND PLACEMENT OF TRACHEAL STENT					
336	31635	BRONCHOSCOPY; WITH REMOVAL OF FOREIGN BODY					
336	31640	BRONCHOSCOPY; WITH EXCISION OF TUMOR					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
336	31641	BRONCHOSCOPY; WITH DESTRUCTION OF TUMOR OR RELIEF OF STENOSIS BY ANY METHOD OTHER THAN EXCISION (EG, LASER)					
336	31645	BRONCHOSCOPY; WITH THERAPEUTIC ASPIRATION OF TRACHEOBRONCHIAL TREE, INITIAL (EG, DRAINAGE OF LUNG ABSCESS)					
336	31646	BRONCHOSCOPY; WITH THERAPEUTIC ASPIRATION OF TRACHEOBRONCHIAL TREE, SUBSEQUENT					
336	31656	BRONCHOSCOPY; WITH INJECTION OF CONTRAST MATERIAL FOR SEGMENTAL BRONCHOGRAPHY (FIBERSCOPE ONLY)					
336	31899	UNLISTED PROCEDURE, TRACHEA, BRONCHI					
339	Injection of Sclerosing Solution		T	1.02	\$51.68	\$19.66	\$10.34
339	36468	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS (TELANGIECTASIA); LIMB OR TRUNK					
339	36469	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS (TELANGIECTASIA); FACE					
339	36470	INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN					
339	36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG					
339	45520	PERIRECTAL INJECTION OF SCLEROSING SOLUTION FOR PROLAPSE					
341	Level I Needle and Catheter Placement		T	.13	\$6.59	\$2.94	\$1.32
341	36410	VENIPUNCTURE, CHILD OVER AGE 3 YEARS OR ADULT, NECESSITATING PHYSICIAN'S SKILL (SEPARATE PROCEDURE), FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES. NOT TO BE USED FOR ROUTINE VENIPUNCTURE.					
341	36420	VENIPUNCTURE, CUTDOWN; UNDER AGE 1 YEAR					
341	36425	VENIPUNCTURE, CUTDOWN; AGE 1 OR OVER					
342	Level II Needle and Catheter Placement		T	3.20	\$162.14	\$80.23	\$32.43
342	36010	INTRODUCTION OF CATHETER, SUPERIOR OR INFERIOR VENA CAVA					
342	36011	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; FIRST ORDER BRANCH (EG, RENAL VEIN, JUGULAR VEIN)					
342	36012	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; SECOND ORDER, OR MORE SELECTIVE, BRANCH (EG, LEFT ADRENAL VEIN, PETROSAL SINUS)					
342	36013	INTRODUCTION OF CATHETER, RIGHT HEART OR MAIN PULMONARY ARTERY					
342	36014	SELECTIVE CATHETER PLACEMENT, LEFT OR RIGHT PULMONARY ARTERY					
342	36015	SELECTIVE CATHETER PLACEMENT, SEGMENTAL OR SUBSEGMENTAL PULMONARY ARTERY					
342	36100	INTRODUCTION OF NEEDLE OR INTRACATHETER, CAROTID OR VERTEBRAL ARTERY					
342	36120	INTRODUCTION OF NEEDLE OR INTRACATHETER; RETROGRADE BRACHIAL ARTERY					
342	36140	INTRODUCTION OF NEEDLE OR INTRACATHETER; EXTREMITY ARTERY					
342	36160	INTRODUCTION OF NEEDLE OR INTRACATHETER, AORTIC, TRANSLUMBAR					
342	36200	INTRODUCTION OF CATHETER, AORTA					
342	36500	VENOUS CATHETERIZATION FOR SELECTIVE ORGAN BLOOD SAMPLING					
342	36620	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING, MONITORING OR TRANSFUSION (SEPARATE PROCEDURE); PERCUTANEOUS					
342	36625	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING, MONITORING OR TRANSFUSION (SEPARATE PROCEDURE); CUTDOWN					
342	38794	CANNULATION, THORACIC DUCT					
343	Level III Needle and Catheter Placement		T	9.52	\$482.37	\$224.87	\$96.47
343	36215	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY					
343	36216	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY					
343	36217	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY					
343	36218	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL SECOND ORDER, THIRD ORDER, AND BEYOND, THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY (USE IN ADDITION TO 36216 OR 36217 AS APPROPRIATE)					
343	36245	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY					
343	36246	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY					
343	36247	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY					
343	36248	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL SECOND ORDER, THIRD ORDER, AND BEYOND, ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (USE IN ADDITION TO 36246 OR 36247 AS APPROPRIATE)					
343	36481	PERCUTANEOUS PORTAL VEIN CATHETERIZATION BY ANY METHOD					
343	93508	CATHETER PLACEMENT IN CORONARY ARTERY(S), ARTERIAL CORONARY CONDUIT(S), AND/OR VENOUS CORONARY BYPASS GRAFT(S) FOR CORONARY ANGIOGRAPHY WITHOUT CONCOMITANT LEFT HEART CATHETERIZATION					
346	Placement Transvenous Caths/Cutdown		T	4.83	\$244.73	\$120.23	\$48.95
346	36488	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); PERCUTANEOUS, AGE 2 YEARS OR UNDER					
346	36489	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); PERCUTANEOUS, OVER AGE 2					
346	36490	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); CUTDOWN, AGE 2 YEARS OR UNDER					
346	36491	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); CUTDOWN, OVER AGE 2					
346	36493	REPOSITIONING OF PREVIOUSLY PLACED CENTRAL VENOUS CATHETER UNDER FLUOROSCOPIC GUIDANCE					
346	36640	ARTERIAL CATHETERIZATION FOR PROLONGED INFUSION THERAPY (CHEMOTHERAPY), CUTDOWN					
347	Injection Procedures for Interventional Radiology		T	2.93	\$148.46	\$62.15	\$29.69
347	19030	INJECTION PROCEDURE ONLY FOR MAMMARY DUCTOGRAM OR GALACTOGRAM					
347	20501	INJECTION OF SINUS TRACT; DIAGNOSTIC (SINOGRAM)					
347	21116	INJECTION PROCEDURE FOR TEMPOROMANDIBULAR JOINT ARTHROGRAPHY					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT 1/ HCPCS 2	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
347	23350	INJECTION PROCEDURE FOR SHOULDER ARTHROGRAPHY					
347	24220	INJECTION PROCEDURE FOR ELBOW ARTHROGRAPHY					
347	25246	INJECTION PROCEDURE FOR WRIST ARTHROGRAPHY					
347	27093	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITHOUT ANESTHESIA					
347	27095	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITH ANESTHESIA					
347	27370	INJECTION PROCEDURE FOR KNEE ARTHROGRAPHY					
347	27648	INJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY					
347	30200	INJECTION INTO TURBinate(S), THERAPEUTIC					
347	31708	INSTILLATION OF CONTRAST MATERIAL FOR LARYNGOGRAPHY OR BRONCHOGRAPHY, WITHOUT CATHETERIZATION					
347	31710	CATHETERIZATION FOR BRONCHOGRAPHY, WITH OR WITHOUT INSTILLATION OF CONTRAST MATERIAL					
347	31715	TRANSTRACHEAL INJECTION FOR BRONCHOGRAPHY					
347	36005	INJECTION PROCEDURE FOR CONTRAST VENOGRAPHY (INCLUDING INTRODUCTION OF NEEDLE OR INTRACATHETER)					
347	38200	INJECTION PROCEDURE FOR SPLENOPORTOGRAPHY					
347	38790	INJECTION PROCEDURE FOR LYMPHANGIOGRAPHY					
347	42550	INJECTION PROCEDURE FOR SIALOGRAPHY					
347	47500	INJECTION PROCEDURE FOR PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAPHY					
347	47505	INJECTION PROCEDURE FOR CHOLANGIOGRAPHY THROUGH AN EXISTING CATHETER (EG, PERCUTANEOUS TRANSHEPATIC OR T-TUBE)					
347	49400	INJECTION OF AIR OR CONTRAST INTO PERITONEAL CAVITY (SEPARATE PROCEDURE)					
347	49424	CONTRAST INJECTION FOR ASSESSMENT OF ABSCESS OR CYST VIA PREVIOUSLY PLACED CATHETER (SEPARATE PROCEDURE)					
347	49427	INJECTION PROCEDURE (EG, CONTRAST MEDIA) FOR EVALUATION OF PREVIOUSLY PLACED PERITONEAL-VEIN SHUNT					
347	50392	INTRODUCTION OF INTRACATHETER OR CATHETER INTO RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS					
347	50393	INTRODUCTION OF URETERAL CATHETER OR STENT INTO URETER THROUGH RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS					
347	50394	INJECTION PROCEDURE FOR PYELOGRAPHY (AS NEPHROSTOGRAM, PYELOSTOGRAM, ANTEGRADE PYELOURETEROGRAMS) THROUGH NEPHROSTOMY OR PYELOSTOMY TUBE, OR INDWELLING URETERAL CATHETER					
347	50395	INTRODUCTION OF GUIDE INTO RENAL PELVIS AND/OR URETER WITH DILATION TO ESTABLISH NEPHROSTOMY TRACT, PERCUTANEOUS					
347	50684	INJECTION PROCEDURE FOR URETEROGRAPHY OR URETEROPYELOGRAPHY THROUGH URETEROSTOMY OR INDWELLING URETERAL CATHETER					
347	50690	INJECTION PROCEDURE FOR VISUALIZATION OF ILEAL CONDUIT AND/OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE					
347	51600	INJECTION PROCEDURE FOR CYSTOGRAPHY OR VOIDING URETHROCYSTOGRAPHY					
347	51605	INJECTION PROCEDURE AND PLACEMENT OF CHAIN FOR CONTRAST AND/OR CHAIN URETHROCYSTOGRAPHY					
347	51610	INJECTION PROCEDURE FOR RETROGRADE URETHROCYSTOGRAPHY					
347	54230	INJECTION PROCEDURE FOR CORPORA CAVERNOSOGRAHY					
347	55300	VASOTOMY FOR VASOGRAMS, SEMINAL VESICULOGRAMS, OR EPIDIDYMOGRAMS, UNILATERAL OR BILATERAL					
347	58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR HYSTEROSONOGRAPHY OR HYSTEROSALPINGOGRAPHY					
347	62284	INJECTION PROCEDURE FOR MYELOGRAPHY AND/OR COMPUTERIZED AXIAL TOMOGRAPHY, SPINAL (OTHER THAN C1-C2 AND POSTERIOR FOSSA)					
347	62290	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL; LUMBAR					
347	62291	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL; CERVICAL					
347	68850	INJECTION OF CONTRAST MEDIUM FOR DACRYOCYSTOGRAPHY					
360	Removal/Revision, Pacemaker/Vascular Device		T	6.09	\$308.58	\$140.12	\$61.72
360	33222	REVISION OR RELOCATION OF SKIN POCKET FOR PACEMAKER					
360	33223	REVISION OR RELOCATION OF SKIN POCKET FOR IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR					
360	36261	REVISION OF IMPLANTED INTRA-ARTERIAL INFUSION PUMP					
360	36262	REMOVAL OF IMPLANTED INTRA-ARTERIAL INFUSION PUMP					
360	36299	UNLISTED PROCEDURE, VASCULAR INJECTION					
360	36531	REVISION OF IMPLANTABLE INTRAVENOUS INFUSION PUMP					
360	36532	REMOVAL OF IMPLANTABLE INTRAVENOUS INFUSION PUMP					
360	36534	REVISION OF IMPLANTABLE VENOUS ACCESS PORT AND/OR SUBCUTANEOUS RESERVOIR					
419	44377	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND PORTION OF DUODENUM, INCLUDING ILEUM; WITH BIOPSY, SINGLE OR MULTIPLE					
419	44378	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND PORTION OF DUODENUM, INCLUDING ILEUM; WITH CONTROL OF BLEEDING, ANY METHOD					
419	44799	UNLISTED PROCEDURE, INTESTINE					
426	Diagnostic Lower GI Endoscopy		T	6.85	\$347.09	\$187.81	\$69.42
426	44380	ILEOSCOPY, THROUGH STOMA; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
426	44382	ILEOSCOPY, THROUGH STOMA; WITH BIOPSY, SINGLE OR MULTIPLE					
426	44385	ENDOSCOPIC EVALUATION OF SMALL INTESTINAL (ABDOMINAL OR PELVIC) POUCH; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
426	44386	ENDOSCOPIC EVALUATION OF SMALL INTESTINAL (ABDOMINAL OR PELVIC) POUCH; WITH BIOPSY, SINGLE OR MULTIPLE					
426	44388	COLONOSCOPY THROUGH STOMA; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
426	44389	COLONOSCOPY THROUGH STOMA; WITH BIOPSY, SINGLE OR MULTIPLE					
426	45378	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING, WITH OR WITHOUT COLON DECOMPRESSION (SEPARATE PROCEDURE)					
426	45380	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH BIOPSY, SINGLE OR MULTIPLE					
426	G0105	Colorectal Ca screening, pt at high risk					
427	Therapeutic Lower GI Endoscopy		T	8.22	\$416.5	\$224.19	\$83.3
427	44390	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF FOREIGN BODY					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
427	44391	COLONOSCOPY THROUGH STOMA; WITH CONTROL OF BLEEDING, ANY METHOD					
427	44392	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY HOT BIOPSY FORCEPS OR BI-POLAR CAUTERY					
427	44394	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY SNARE TECHNIQUE					
427	45355	COLONOSCOPY, RIGID OR FLEXIBLE, TRANSABDOMINAL VIA COLOTOMY, SINGLE OR MULTIPLE					
427	45379	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF FOREIGN BODY					
427	45382	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH CONTROL OF BLEEDING, ANY METHOD					
427	45384	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
427	45385	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY SNARE TECHNIQUE					
437	Therapeutic Anoscopy		T	2.91	\$147.45	\$76.61	\$29.49
437	46608	ANOSCOPY; WITH REMOVAL OF FOREIGN BODY					
437	46610	ANOSCOPY; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
437	46611	ANOSCOPY; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY SNARE TECHNIQUE					
437	46612	ANOSCOPY; WITH REMOVAL OF MULTIPLE TUMORS, POLYPS, OR OTHER LESIONS BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
437	46614	ANOSCOPY; WITH CONTROL OF BLEEDING, ANY METHOD					
437	46615	ANOSCOPY; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
446	Diagnostic Sigmoidoscopy		T	2.59	\$131.23	\$65.09	\$26.25
446	45300	PROCTOSIGMOIDOSCOPY, RIGID; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
446	45305	PROCTOSIGMOIDOSCOPY, RIGID; WITH BIOPSY, SINGLE OR MULTIPLE					
446	45330	SIGMOIDOSCOPY, FLEXIBLE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
446	45331	SIGMOIDOSCOPY, FLEXIBLE; WITH BIOPSY, SINGLE OR MULTIPLE					
446	G0104	Colorectal Ca screening					
447	Therapeutic Proctosigmoidoscopy		T	6.87	\$348.10	\$184.76	\$69.62
447	45303	PROCTOSIGMOIDOSCOPY, RIGID; WITH DILATION, ANY METHOD					
447	45307	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF FOREIGN BODY					
447	45308	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
447	45309	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY SNARE TECHNIQUE					
447	45315	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF MULTIPLE TUMORS, POLYPS, OR OTHER LESIONS BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
447	45317	PROCTOSIGMOIDOSCOPY, RIGID; WITH CONTROL OF BLEEDING, ANY METHOD					
447	45320	PROCTOSIGMOIDOSCOPY, RIGID; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE (EG, LASER)					
447	45321	PROCTOSIGMOIDOSCOPY, RIGID; WITH DECOMPRESSION OF VOLVULUS					
448	Therapeutic Flexible Sigmoidoscopy		T	5.37	\$272.09	\$141.25	\$54.42
448	45332	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF FOREIGN BODY					
448	45333	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
448	45334	SIGMOIDOSCOPY, FLEXIBLE; WITH CONTROL OF BLEEDING, ANY METHOD					
448	45337	SIGMOIDOSCOPY, FLEXIBLE; WITH DECOMPRESSION OF VOLVULUS, ANY METHOD					
448	45338	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY SNARE TECHNIQUE					
449	Complex GI Endoscopy		T	7.8	\$395.22	\$215.38	\$79.04
449	43219	ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH INSERTION OF PLASTIC TUBE OR STENT					
449	43228	ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S), NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	43258	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	43259	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; WITH ENDOSCOPIC ULTRASOUND EXAMINATION					
449	43272	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	44369	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND PORTION OF DUODENUM, NOT INCLUDING ILEUM; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	44393	COLONOSCOPY THROUGH STOMA; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	45339	SIGMOIDOSCOPY, FLEXIBLE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	45383	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
451	Level I Anal/Rectal Procedures		T	2.56	\$129.71	\$54.24	\$25.94
451	46070	INCISION, ANAL SEPTUM (INFANT)					
451	46083	INCISION OF THROMBOSED HEMORRHOID, EXTERNAL					
451	46220	PAPILLECTOMY OR EXCISION OF SINGLE TAG, ANUS (SEPARATE PROCEDURE)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
451	46221	HEMORRHOIDECTOMY, BY SIMPLE LIGATURE (EG, RUBBER BAND)					
451	46230	EXCISION OF EXTERNAL HEMORRHOID TAGS AND/OR MULTIPLE PAPILLAE					
451	46320	ENUCLEATION OR EXCISION OF EXTERNAL THROMBOTIC HEMORRHOID					
451	46500	INJECTION OF SCLEROSING SOLUTION, HEMORRHOIDS					
451	46934	DESTRUCTION OF HEMORRHOIDS, ANY METHOD; INTERNAL					
451	46935	DESTRUCTION OF HEMORRHOIDS, ANY METHOD; EXTERNAL					
451	46936	DESTRUCTION OF HEMORRHOIDS, ANY METHOD; INTERNAL AND EXTERNAL					
451	46940	CURETTAGE OR CAUTERIZATION OF ANAL FISSURE, INCLUDING DILATION OF ANAL SPHINCTER (SEPARATE PROCEDURE); INITIAL					
451	46942	CURETTAGE OR CAUTERIZATION OF ANAL FISSURE, INCLUDING DILATION OF ANAL SPHINCTER (SEPARATE PROCEDURE); SUBSE- QUENT					
451	46945	LIGATION OF INTERNAL HEMORRHOIDS; SINGLE PROCEDURE					
451	46946	LIGATION OF INTERNAL HEMORRHOIDS; MULTIPLE PROCEDURES					
452	Level II Anal/Rectal Procedures		T	4.82	\$244.23	\$109.61	\$48.85
452	45000	TRANSRECTAL DRAINAGE OF PELVIC ABSCESS					
452	45005	INCISION AND DRAINAGE OF SUBMUCOSAL ABSCESS, RECTUM					
452	45020	INCISION AND DRAINAGE OF DEEP SUPRALEVATOR, PELVIRECTAL, OR RETRORECTAL ABSCESS					
452	45100	BIOPSY OF ANORECTAL WALL, ANAL APPROACH (EG, CONGENITAL MEGACOLON)					
452	45900	REDUCTION OF PROCDENTIA (SEPARATE PROCEDURE) UNDER ANESTHESIA					
452	45905	DILATION OF ANAL SPHINCTER (SEPARATE PROCEDURE) UNDER ANESTHESIA OTHER THAN LOCAL					
452	45910	DILATION OF RECTAL STRICTURE (SEPARATE PROCEDURE) UNDER ANESTHESIA OTHER THAN LOCAL					
452	45915	REMOVAL OF FECAL IMPACTION OR FOREIGN BODY (SEPARATE PROCEDURE) UNDER ANESTHESIA					
452	45999	UNLISTED PROCEDURE, RECTUM					
452	46030	REMOVAL OF ANAL SETON, OTHER MARKER					
452	46040	INCISION AND DRAINAGE OF ISCHIORECTAL AND/OR PERIRECTAL ABSCESS (SEPARATE PROCEDURE)					
452	46050	INCISION AND DRAINAGE, PERIANAL ABSCESS, SUPERFICIAL					
452	46080	SPHINCTEROTOMY, ANAL, DIVISION OF SPHINCTER (SEPARATE PROCEDURE)					
452	46210	CRYPTECTOMY; SINGLE					
452	46754	REMOVAL OF THIERSCH WIRE OR SUTURE, ANAL CANAL					
452	46999	UNLISTED PROCEDURE, ANUS					
453	Level III Anal/Rectal Procedures		T	16.87	\$854.79	\$445.22	\$170.96
453	45108	ANORECTAL MYOMECTOMY					
453	45150	DIVISION OF STRICTURE OF RECTUM					
453	45160	EXCISION OF RECTAL TUMOR BY PROCTOTOMY, TRANSACRAL OR TRANSOCOCYGEAL APPROACH					
453	45170	EXCISION OF RECTAL TUMOR, TRANSANAL APPROACH					
453	45190	DESTRUCTION OF RECTAL TUMOR, ANY METHOD (EG, ELECTRODESICCATION) TRANSANAL APPROACH					
453	45500	PROCTOPLASTY; FOR STENOSIS					
453	45505	PROCTOPLASTY; FOR PROLAPSE OF MUCOUS MEMBRANE					
453	45560	REPAIR OF RECTOCELE (SEPARATE PROCEDURE)					
453	46045	INCISION AND DRAINAGE OF INTRAMURAL, INTRAMUSCULAR, OR SUBMUCOSAL ABSCESS, TRANSANAL, UNDER ANESTHESIA					
453	46060	INCISION AND DRAINAGE OF ISCHIORECTAL OR INTRAMURAL ABSCESS, WITH FISTULECTOMY OR FISTULOTOMY, SUBMUSCULAR, WITH OR WITHOUT PLACEMENT OF SETON					
453	46200	FISSURECTOMY, WITH OR WITHOUT SPHINCTEROTOMY					
453	46211	CRYPTECTOMY; MULTIPLE (SEPARATE PROCEDURE)					
453	46250	HEMORRHOIDECTOMY, EXTERNAL, COMPLETE					
453	46255	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE;					
453	46257	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE; WITH FISSURECTOMY					
453	46258	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE; WITH FISTULECTOMY, WITH OR WITHOUT FISSURECTOMY					
453	46260	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR EXTENSIVE;					
453	46261	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR EXTENSIVE; WITH FISSURECTOMY					
453	46262	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR EXTENSIVE; WITH FISTULECTOMY, WITH OR WITHOUT FISSURECTOMY					
453	46270	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); SUBCUTANEOUS					
453	46275	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); SUBMUSCULAR					
453	46280	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); COMPLEX OR MULTIPLE, WITH OR WITHOUT PLACEMENT OF SETON					
453	46285	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); SECOND STAGE					
453	46288	CLOSURE OF ANAL FISTULA WITH RECTAL ADVANCEMENT FLAP					
453	46700	ANOPLASTY, PLASTIC OPERATION FOR STRICTURE; ADULT					
453	46750	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE OR PROLAPSE; ADULT					
453	46753	GRAFT (THIERSCH OPERATION) FOR RECTAL INCONTINENCE AND/OR PROLAPSE					
453	46760	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; MUSCLE TRANSPLANT					
453	46761	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; LEVATOR MUSCLE IMBRICATION (PARK POSTERIOR ANAL REPAIR)					
453	46762	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; IMPLANTATION ARTIFICIAL SPHINCTER					
453	46937	CRYOSURGERY OF RECTAL TUMOR; BENIGN					
453	46938	CRYOSURGERY OF RECTAL TUMOR; MALIGNANT					
456	Endoscopic Retrograde Cholangiopancreatography (ERCP)		T	9.78	\$495.55	\$257.19	\$99.11
456	43260	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECI- MEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
456	43261	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH BIOPSY, SINGLE OR MULTIPLE					
456	43262	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH SPHINCTEROTOMY/PAPILLOTOMY					
456	43263	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH PRESSURE MEASUREMENT OF SPHINCTER OF ODDI (PANCREATIC DUCT OR COMMON BILE DUCT)					
456	43264	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE REMOVAL OF STONE(S) FROM BILIARY AND/OR PANCREATIC DUCTS					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
456	43265	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE DESTRUCTION, LITHOTRIPSY OF STONE(S), ANY METHOD					
456	43267	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE INSERTION OF NASOBILIARY OR NASOPANCREATIC DRAINAGE TUBE					
456	43268	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE INSERTION OF TUBE OR STENT INTO BILE OR PANCREATIC DUCT					
456	43269	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE REMOVAL OF FOREIGN BODY AND/OR CHANGE OF TUBE OR STENT					
456	43271	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE BALLOON DILATION OF AMPULLA, BILIARY AND/OR PANCREATIC DUCT(S)					
458	Percutaneous Biliary Endoscopic Procedures		T	7.23	\$366.34	\$181.59	\$73.27
458	47510	INTRODUCTION OF PERCUTANEOUS TRANSHEPATIC CATHETER FOR BILIARY DRAINAGE					
458	47511	INTRODUCTION OF PERCUTANEOUS TRANSHEPATIC STENT FOR INTERNAL AND EXTERNAL BILIARY DRAINAGE					
458	47552	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING AND/OR WASHING (SEPARATE PROCEDURE)					
458	47553	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH BIOPSY, SINGLE OR MULTIPLE					
458	47554	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH REMOVAL OF STONE(S)					
458	47555	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH DILATION OF BILIARY DUCT STRICTURE(S) WITHOUT STENT					
458	47556	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH DILATION OF BILIARY DUCT STRICTURE(S) WITH STENT					
458	47630	BILIARY DUCT STONE EXTRACTION, PERCUTANEOUS VIA T-TUBE TRACT, BASKET, OR SNARE (EG, BURHENNE TECHNIQUE)					
459	Peritoneal and Abdominal Procedures		T	18.06	\$915.09	\$496.52	\$183.02
459	49085	REMOVAL OF PERITONEAL FOREIGN BODY FROM PERITONEAL CAVITY					
459	49250	UMBILECTOMY, OMPHALECTOMY, EXCISION OF UMBILICUS (SEPARATE PROCEDURE)					
459	49420	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER FOR DRAINAGE OR DIALYSIS; TEMPORARY					
459	49421	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER FOR DRAINAGE OR DIALYSIS; PERMANENT					
459	49423	EXCHANGE OF PREVIOUSLY PLACED ABSCESS OR CYST DRAINAGE CATHETER UNDER RADIOLOGICAL GUIDANCE (SEPARATE PROCEDURE)					
459	49426	REVISION OF PERITONEAL-VENOUS SHUNT					
466	Hernia/Hydrocele Procedures		T	21.43	\$1,085.85	\$562.97	\$217.17
466	49495	REPAIR INITIAL INGUINAL HERNIA, UNDER AGE 6 MONTHS, WITH OR WITHOUT HYDROCELECTOMY; REDUCIBLE					
466	49496	REPAIR INITIAL INGUINAL HERNIA, UNDER AGE 6 MONTHS, WITH OR WITHOUT HYDROCELECTOMY; INCARCERATED OR STRANGULATED					
466	49500	REPAIR INITIAL INGUINAL HERNIA, AGE 6 MONTHS TO UNDER 5 YEARS, WITH OR WITHOUT HYDROCELECTOMY; REDUCIBLE					
466	49501	REPAIR INITIAL INGUINAL HERNIA, AGE 6 MONTHS TO UNDER 5 YEARS, WITH OR WITHOUT HYDROCELECTOMY; INCARCERATED OR STRANGULATED					
466	49505	REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE					
466	49507	REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED OR STRANGULATED					
466	49520	REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; REDUCIBLE					
466	49521	REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; INCARCERATED OR STRANGULATED					
466	49525	REPAIR INGUINAL HERNIA, SLIDING, ANY AGE					
466	49540	REPAIR LUMBAR HERNIA					
466	49550	REPAIR INITIAL FEMORAL HERNIA, ANY AGE, REDUCIBLE;					
466	49553	REPAIR INITIAL FEMORAL HERNIA, ANY AGE, REDUCIBLE; INCARCERATED OR STRANGULATED					
466	49555	REPAIR RECURRENT FEMORAL HERNIA; REDUCIBLE					
466	49557	REPAIR RECURRENT FEMORAL HERNIA; INCARCERATED OR STRANGULATED					
466	49560	REPAIR INITIAL INCISIONAL OR VENTRAL HERNIA; REDUCIBLE					
466	49561	REPAIR INITIAL INCISIONAL OR VENTRAL HERNIA; INCARCERATED OR STRANGULATED					
466	49565	REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; REDUCIBLE					
466	49566	REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; INCARCERATED OR STRANGULATED					
466	49568	IMPLANTATION OF MESH OR OTHER PROSTHESIS FOR INCISIONAL OR VENTRAL HERNIA REPAIR (LIST SEPARATELY IN ADDITION TO CODE FOR THE INCISIONAL OR VENTRAL HERNIA REPAIR)					
466	49570	REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); REDUCIBLE (SEPARATE PROCEDURE)					
466	49572	REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); INCARCERATED OR STRANGULATED					
466	49580	REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE					
466	49582	REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED OR STRANGULATED					
466	49585	REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE					
466	49587	REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED OR STRANGULATED					
466	49590	REPAIR SPIGELIAN HERNIA					
466	49600	REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE					
466	51500	EXCISION OF URACHAL CYST OR SINUS, WITH OR WITHOUT UMBILICAL HERNIA REPAIR					
466	55040	EXCISION OF HYDROCELE; UNILATERAL					
466	55041	EXCISION OF HYDROCELE; BILATERAL					
470	Tube Procedures		T	2.22	\$112.49	\$54.92	\$22.50
470	31502	TRACHEOTOMY TUBE CHANGE PRIOR TO ESTABLISHMENT OF FISTULA TRACT					
470	43760	CHANGE OF GASTROSTOMY TUBE					
470	43761	REPOSITIONING OF THE GASTRIC FEEDING TUBE THROUGH THE DUODENUM FOR ENTERIC NUTRITION					
470	43999	UNLISTED PROCEDURE, STOMACH					
470	47525	CHANGE OF PERCUTANEOUS BILIARY DRAINAGE CATHETER					
470	47530	REVISION AND/OR REINSERTION OF TRANSHEPATIC TUBE					
470	47999	UNLISTED PROCEDURE, BILIARY TRACT					
470	49422	REMOVAL OF PERMANENT INTRAPERITONEAL CANNULA OR CATHETER					
470	49429	REMOVAL OF PERITONEAL-VENOUS SHUNT					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
470	49999	UNLISTED PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM					
470	50688	CHANGE OF URETEROSTOMY TUBE					
470	51705	CHANGE OF CYSTOSTOMY TUBE; SIMPLE					
470	51710	CHANGE OF CYSTOSTOMY TUBE; COMPLICATED					
521	Level I Cystourethroscopy and other Genitourinary Procedures		T	5.06	\$256.39	\$112.10	\$51.28
521	50398	CHANGE OF NEPHROSTOMY OR PYELOSTOMY TUBE					
521	52000	CYSTOURETHROSCOPY (SEPARATE PROCEDURE)					
521	52265	CYSTOURETHROSCOPY, WITH DILATION OF BLADDER FOR INTERSTITIAL CYSTITIS; LOCAL ANESTHESIA					
522	Level II Cystourethroscopy and other Genitourinary Procedures		T	10.46	\$530.00	\$262.39	\$106.00
522	50551	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE;					
522	50553	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH URETERAL CATHETERIZATION, WITH OR WITHOUT DILATION OF URETER					
522	50555	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH BIOPSY					
522	50557	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH FULGURATION AND/OR INCISION, WITH OR WITHOUT BIOPSY					
522	50559	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH INSERTION OF RADIOACTIVE SUBSTANCE WITH OR WITHOUT BIOPSY AND/OR FULGURATION					
522	50561	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH REMOVAL OF FOREIGN BODY OR CALCULUS					
522	52005	CYSTOURETHROSCOPY, WITH URETERAL CATHETERIZATION, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE;					
522	52007	CYSTOURETHROSCOPY, WITH URETERAL CATHETERIZATION, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH BRUSH BIOPSY OF URETER AND/OR RENAL PELVIS					
522	52010	CYSTOURETHROSCOPY, WITH EJACULATORY DUCT CATHETERIZATION, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR DUCT RADIOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE					
522	52204	CYSTOURETHROSCOPY, WITH BIOPSY					
522	52214	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) OF TRIGONE, BLADDER NECK, PROSTATIC FOSSA, URETHRA, OR PERIURETHRAL GLANDS					
522	52224	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) OR TREATMENT OF MINOR (LESS THAN 0.5 CM) LESION(S) WITH OR WITHOUT BIOPSY					
522	52260	CYSTOURETHROSCOPY, WITH DILATION OF BLADDER FOR INTERSTITIAL CYSTITIS; GENERAL OR CONDUCTION (SPINAL) ANESTHESIA					
522	52270	CYSTOURETHROSCOPY, WITH INTERNAL URETHROTOMY; FEMALE					
522	52275	CYSTOURETHROSCOPY, WITH INTERNAL URETHROTOMY; MALE					
522	52276	CYSTOURETHROSCOPY WITH DIRECT VISION INTERNAL URETHROTOMY					
522	52281	CYSTOURETHROSCOPY, WITH CALIBRATION AND/OR DILATION OF URETHRAL STRICTURE OR STENOSIS, WITH OR WITHOUT MEATOTOMY, WITH OR WITHOUT INJECTION PROCEDURE FOR CYSTOGRAPHY, MALE OR FEMALE					
522	52283	CYSTOURETHROSCOPY, WITH STEROID INJECTION INTO STRICTURE					
522	52285	CYSTOURETHROSCOPY FOR TREATMENT OF THE FEMALE URETHRAL SYNDROME WITH ANY OR ALL OF THE FOLLOWING: URETHRAL MEATOTOMY, URETHRAL DILATION, INTERNAL URETHROTOMY, LYSIS OF URETHROVAGINAL SEPTAL FIBROSIS, LATERAL INCISIONS OF THE BLADDER NECK, AND FULGURATION					
522	52290	CYSTOURETHROSCOPY; WITH URETERAL MEATOTOMY, UNILATERAL OR BILATERAL					
522	52300	CYSTOURETHROSCOPY; WITH RESECTION OR FULGURATION OF ORTHOTOPIC URETEROCELE(S), UNILATERAL OR BILATERAL					
522	52301	CYSTOURETHROSCOPY; WITH RESECTION OR FULGURATION OF ECTOPIC URETEROCELE(S), UNILATERAL OR BILATERAL					
522	52305	CYSTOURETHROSCOPY; WITH INCISION OR RESECTION OF ORIFICE OF BLADDER DIVERTICULUM, SINGLE OR MULTIPLE					
522	52310	CYSTOURETHROSCOPY, WITH REMOVAL OF FOREIGN BODY, CALCULUS, OR URETERAL STENT FROM URETHRA OR BLADDER (SEPARATE PROCEDURE); SIMPLE					
522	52315	CYSTOURETHROSCOPY, WITH REMOVAL OF FOREIGN BODY, CALCULUS, OR URETERAL STENT FROM URETHRA OR BLADDER (SEPARATE PROCEDURE); COMPLICATED					
522	52327	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH SUBURETERIC INJECTION OF IMPLANT MATERIAL					
522	52510	TRANSURETHRAL BALLOON DILATION OF THE PROSTATIC URETHRA, ANY METHOD					
522	53605	DILATION OF URETHRAL STRICTURE OR VESICAL NECK BY PASSAGE OF SOUND OR URETHRAL DILATOR, MALE, GENERAL OR CONDUCTION (SPINAL) ANESTHESIA					
523	Level III Cystourethroscopy and other Genitourinary Procedures		T	16.87	\$854.79	\$447.03	\$170.96
523	50951	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE;					
523	50953	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH URETERAL CATHETERIZATION, WITH OR WITHOUT DILATION OF URETER					
523	50955	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH BIOPSY					
523	50957	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH FULGURATION AND/OR INCISION, WITH OR WITHOUT BIOPSY					
523	50959	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH INSERTION OF RADIOACTIVE SUBSTANCE, WITH OR WITHOUT BIOPSY AND/OR FULGURATION (NOT INCLUDING PROVIS)					
523	50961	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH REMOVAL OF FOREIGN BODY OR CALCULUS					
523	51020	CYSTOTOMY OR CYSTOSTOMY; WITH FULGURATION AND/OR INSERTION OF RADIOACTIVE MATERIAL					
523	51030	CYSTOTOMY OR CYSTOSTOMY; WITH CRYOSURGICAL DESTRUCTION OF INTRAVESICAL LESION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
523	51040	CYSTOSTOMY, CYSTOTOMY WITH DRAINAGE					
523	51045	CYSTOTOMY, WITH INSERTION OF URETERAL CATHETER OR STENT (SEPARATE PROCEDURE)					
523	51050	CYSTOLITHOTOMY, CYSTOTOMY WITH REMOVAL OF CALCULUS, WITHOUT VESICAL NECK RESECTION					
523	51065	CYSTOTOMY, WITH STONE BASKET EXTRACTION AND/OR ULTRASONIC OR ELECTROHYDRAULIC FRAGMENTATION OF URETERAL CALCULUS					
523	51520	CYSTOTOMY; FOR SIMPLE EXCISION OF VESICAL NECK (SEPARATE PROCEDURE)					
523	51880	CLOSURE OF CYSTOSTOMY (SEPARATE PROCEDURE)					
523	52234	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) AND/OR RESECTION OF; SMALL BLADDER TUMOR(S) (0.5 TO 2.0 CM)					
523	52235	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) AND/OR RESECTION OF; MEDIUM BLADDER TUMOR(S) (2.0 TO 5.0 CM)					
523	52240	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) AND/OR RESECTION OF; LARGE BLADDER TUMOR(S)					
523	52250	CYSTOURETHROSCOPY WITH INSERTION OF RADIOACTIVE SUBSTANCE, WITH OR WITHOUT BIOPSY OR FULGURATION					
523	52277	CYSTOURETHROSCOPY, WITH RESECTION OF EXTERNAL SPHINCTER (SPHINCTEROTOMY)					
523	52282	CYSTOURETHROSCOPY, WITH INSERTION OF URETHRAL STENT					
523	52317	LITHOLAPAXY: CRUSHING OR FRAGMENTATION OF CALCULUS BY ANY MEANS IN BLADDER AND REMOVAL OF FRAGMENTS; SIMPLE OR SMALL (LESS THAN 2.5 CM)					
523	52318	LITHOLAPAXY: CRUSHING OR FRAGMENTATION OF CALCULUS BY ANY MEANS IN BLADDER AND REMOVAL OF FRAGMENTS; COMPLICATED OR LARGE (OVER 2.5 CM)					
523	52320	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH REMOVAL OF URETERAL CALCULUS					
523	52325	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH FRAGMENTATION OF URETERAL CALCULUS (EG, ULTRASONIC OR ELECTRO-HYDRAULIC TECHNIQUE)					
523	52330	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH MANIPULATION, WITHOUT REMOVAL OF URETERAL CALCULUS					
523	52332	CYSTOURETHROSCOPY, WITH INSERTION OF INDWELLING URETERAL STENT (EG, GIBBONS OR DOUBLE-J TYPE)					
523	52334	CYSTOURETHROSCOPY WITH INSERTION OF URETERAL GUIDE WIRE THROUGH KIDNEY TO ESTABLISH A PERCUTANEOUS NEPHROSTOMY, RETROGRADE					
523	52335	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD);					
523	52336	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH REMOVAL OR MANIPULATION OF CALCULUS (URETERAL CATHETERIZATION IS INCLUDED)					
523	52338	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH BIOPSY AND/OR FULGURATION OF LESION					
523	52339	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH RESECTION OF TUMOR					
523	52340	CYSTOURETHROSCOPY WITH INCISION, FULGURATION, OR RESECTION OF CONGENITAL POSTERIOR URETHRAL VALVES, OR CONGENITAL OBSTRUCTIVE HYPERTROPHIC MUCOSAL FOLDS					
523	52450	TRANSURETHRAL INCISION OF PROSTATE					
523	52500	TRANSURETHRAL RESECTION OF BLADDER NECK (SEPARATE PROCEDURE)					
523	52606	TRANSURETHRAL FULGURATION FOR POSTOPERATIVE BLEEDING OCCURRING AFTER THE USUAL FOLLOW-UP TIME					
523	52640	TRANSURETHRAL RESECTION; OF POSTOPERATIVE BLADDER NECK CONTRACTURE					
523	52700	TRANSURETHRAL DRAINAGE OF PROSTATIC ABSCESS					
523	55720	PROSTATOTOMY, EXTERNAL DRAINAGE OF PROSTATIC ABSCESS, ANY APPROACH; SIMPLE					
523	55725	PROSTATOTOMY, EXTERNAL DRAINAGE OF PROSTATIC ABSCESS, ANY APPROACH; COMPLICATED					
523	55859	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE FOR INTERSTITIAL RADIOELEMENT APPLICATION, WITH OR WITHOUT CYSTOSCOPY					
524	Level IV Cystourethroscopy and other Genitourinary Procedures		T	28.89	\$1,463.84	\$833.38	\$292.77
524	52337	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH LITHOTRIPSY (URETERAL CATHETERIZATION IS INCLUDED)					
524	52601	TRANSURETHRAL ELECTROSURGICAL RESECTION OF PROSTATE, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED)					
524	52612	TRANSURETHRAL RESECTION OF PROSTATE; FIRST STAGE OF TWO-STAGE RESECTION (PARTIAL RESECTION)					
524	52614	TRANSURETHRAL RESECTION OF PROSTATE; SECOND STAGE OF TWO-STAGE RESECTION (RESECTION COMPLETED)					
524	52620	TRANSURETHRAL RESECTION; OF RESIDUAL OBSTRUCTIVE TISSUE AFTER 90 DAYS POSTOPERATIVE					
524	52630	TRANSURETHRAL RESECTION; OF REGROWTH OF OBSTRUCTIVE TISSUE LONGER THAN ONE YEAR POSTOPERATIVE					
524	52647	NON-CONTACT LASER COAGULATION OF PROSTATE, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED)					
524	52648	CONTACT LASER VAPORIZATION WITH OR WITHOUT TRANSURETHRAL RESECTION OF PROSTATE, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED)					
524	53850	TRANSURETHRAL DESTRUCTION OF PROSTATE TISSUE; BY MICROWAVE THERMOTHERAPY					
524	53852	TRANSURETHRAL DESTRUCTION OF PROSTATE TISSUE; BY RADIOFREQUENCY THERMOTHERAPY					
527	Lithotripsy		T	51.56	\$2,612.52	\$1,372.95	\$522.5
527	50590	LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE					
529	Simple Urinary Studies and Procedures		T	2.5	\$126.67	\$63.05	\$25.33
529	50396	MANOMETRIC STUDIES THROUGH NEPHROSTOMY OR PYELOSOTOMY TUBE, OR INDWELLING URETERAL CATHETER					
529	50686	MANOMETRIC STUDIES THROUGH URETEROSTOMY OR INDWELLING URETERAL CATHETER					
529	51725	SIMPLE CYSTOMETROGRAM (CMG) (EG, SPINAL MANOMETER)					
529	51726	COMPLEX CYSTOMETROGRAM (EG, CALIBRATED ELECTRONIC EQUIPMENT)					
529	51736	SIMPLE UROFLOWMETRY (UFR) (EG, STOP-WATCH FLOW RATE, MECHANICAL UROFLOWMETER)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
529	51741	COMPLEX UROFLOWMETRY (EG, CALIBRATED ELECTRONIC EQUIPMENT)					
529	51772	URETHRAL PRESSURE PROFILE STUDIES (UPP) (URETHRAL CLOSURE PRESSURE PROFILE), ANY TECHNIQUE					
529	51784	ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR URETHRAL SPHINCTER, OTHER THAN NEEDLE, ANY TECHNIQUE					
529	51785	NEEDLE ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR URETHRAL SPHINCTER, ANY TECHNIQUE					
529	51792	STIMULUS EVOKED RESPONSE (EG, MEASUREMENT OF BULBOCAVERNOSUS REFLEX LATENCY TIME)					
529	51795	VOIDING PRESSURE STUDIES (VP); BLADDER VOIDING PRESSURE, ANY TECHNIQUE					
529	51797	VOIDING PRESSURE STUDIES (VP); INTRA-ABDOMINAL VOIDING PRESSURE (AP) (RECTAL, GASTRIC, INTRAPERITONEAL)					
529	54240	PENILE PLETHYSMOGRAPHY					
529	54250	NOCTURNAL PENILE TUMESCENCE AND/OR RIGIDITY TEST					
530	Genitourinary Procedures		T	2.52	\$127.69	\$54.69	\$25.54
530	51000	ASPIRATION OF BLADDER BY NEEDLE					
530	51005	ASPIRATION OF BLADDER; BY TROCAR OR INTRACATHETER					
530	51010	ASPIRATION OF BLADDER; WITH INSERTION OF SUPRAPUBIC CATHETER					
530	51700	BLADDER IRRIGATION, SIMPLE, LAVAGE AND/OR INSTILLATION					
530	51720	BLADDER INSTILLATION OF ANTICARCINOGENIC AGENT (INCLUDING DETENTION TIME)					
530	53600	DILATION OF URETHRAL STRICTURE BY PASSAGE OF SOUND OR URETHRAL DILATOR, MALE; INITIAL					
530	53601	DILATION OF URETHRAL STRICTURE BY PASSAGE OF SOUND OR URETHRAL DILATOR, MALE; SUBSEQUENT					
530	53620	DILATION OF URETHRAL STRICTURE BY PASSAGE OF FILIFORM AND FOLLOWER, MALE; INITIAL					
530	53621	DILATION OF URETHRAL STRICTURE BY PASSAGE OF FILIFORM AND FOLLOWER, MALE; SUBSEQUENT					
530	53660	DILATION OF FEMALE URETHRA INCLUDING SUPPOSITORY AND/OR INSTILLATION; INITIAL					
530	53661	DILATION OF FEMALE URETHRA INCLUDING SUPPOSITORY AND/OR INSTILLATION; SUBSEQUENT					
530	53675	CATHETERIZATION, URETHRA; COMPLICATED (MAY INCLUDE DIFFICULT REMOVAL OF BALLOON CATHETER)					
530	53899	UNLISTED PROCEDURE, URINARY SYSTEM					
530	54200	INJECTION PROCEDURE FOR PEYRONIE DISEASE;					
530	54220	IRRIGATION OF CORPORA CAVERNOSA FOR PRIAPISM					
530	54231	DYNAMIC CAVERNOSOMETRY, INCLUDING INTRACAVERNOSAL INJECTION OF VASOACTIVE DRUGS (EG, PAPAVERINE, PHENTOL-AMINE)					
530	54235	INJECTION OF CORPORA CAVERNOSA WITH PHARMACOLOGIC AGENT(S) (EG, PAPAVERINE, PHENTOLAMINE)					
530	54450	FORESKIN MANIPULATION INCLUDING LYSIS OF PREPUTIAL ADHESIONS AND STRETCHING					
530	55899	UNLISTED PROCEDURE, MALE GENITAL SYSTEM					
531	Level I Urethral Procedures		T	18.94	\$959.68	\$527.26	\$191.94
531	51715	ENDOSCOPIC INJECTION OF IMPLANT MATERIAL INTO THE SUBMUCOSAL TISSUES OF THE URETHRA AND/OR BLADDER NECK					
531	53000	URETHROTOMY OR URETHROSTOMY, EXTERNAL (SEPARATE PROCEDURE); PENDULOUS URETHRA					
531	53010	URETHROTOMY OR URETHROSTOMY, EXTERNAL (SEPARATE PROCEDURE); PERINEAL URETHRA, EXTERNAL					
531	53020	MEATOTOMY, CUTTING OF MEATUS (SEPARATE PROCEDURE); EXCEPT INFANT					
531	53025	MEATOTOMY, CUTTING OF MEATUS (SEPARATE PROCEDURE); INFANT					
531	53040	DRAINAGE OF DEEP PERIURETHRAL ABSCESS					
531	53060	DRAINAGE OF SKENE'S GLAND ABSCESS OR CYST					
531	53080	DRAINAGE OF PERINEAL URINARY EXTRAVASATION; UNCOMPLICATED (SEPARATE PROCEDURE)					
531	53200	BIOPSY OF URETHRA					
531	53250	EXCISION OF BULBOURETHRAL GLAND (COWPER'S GLAND)					
531	53260	EXCISION OR FULGURATION; URETHRAL POLYP(S), DISTAL URETHRA					
531	53265	EXCISION OR FULGURATION; URETHRAL CARUNCLE					
531	53270	EXCISION OR FULGURATION; SKENE'S GLANDS					
531	53275	EXCISION OR FULGURATION; URETHRAL PROLAPSE					
531	53442	REMOVAL OF PERINEAL PROSTHESIS INTRODUCED FOR CONTINENCE					
531	53502	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY, FEMALE					
531	53505	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY; PENILE					
531	53510	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY; PERINEAL					
531	53665	DILATION OF FEMALE URETHRA, GENERAL OR CONDUCTION (SPINAL) ANESTHESIA					
531	54000	SLITTING OF PREPUCE, DORSAL OR LATERAL (SEPARATE PROCEDURE); NEWBORN					
531	54001	SLITTING OF PREPUCE, DORSAL OR LATERAL (SEPARATE PROCEDURE); EXCEPT NEWBORN					
532	Level II Urethral Procedures		T	25.5	\$1,292.07	\$602.18	\$258.41
532	53210	URETHRECTOMY, TOTAL, INCLUDING CYSTOSTOMY; FEMALE					
532	53215	URETHRECTOMY, TOTAL, INCLUDING CYSTOSTOMY; MALE					
532	53220	EXCISION OR FULGURATION OF CARCINOMA OF URETHRA					
532	53230	EXCISION OF URETHRAL DIVERTICULUM (SEPARATE PROCEDURE); FEMALE					
532	53235	EXCISION OF URETHRAL DIVERTICULUM (SEPARATE PROCEDURE); MALE					
532	53240	MARSUPIALIZATION OF URETHRAL DIVERTICULUM, MALE OR FEMALE					
532	53400	URETHROPLASTY; FIRST STAGE, FOR FISTULA, DIVERTICULUM, OR STRICTURE (EG, JOHANNSEN TYPE)					
532	53405	URETHROPLASTY; SECOND STAGE (FORMATION OF URETHRA), INCLUDING URINARY DIVERSION					
532	53410	URETHROPLASTY, ONE-STAGE RECONSTRUCTION OF MALE ANTERIOR URETHRA					
532	53420	URETHROPLASTY, TWO-STAGE RECONSTRUCTION OR REPAIR OF PROSTATIC OR MEMBRANOUS URETHRA; FIRST STAGE					
532	53425	URETHROPLASTY, TWO-STAGE RECONSTRUCTION OR REPAIR OF PROSTATIC OR MEMBRANOUS URETHRA; SECOND STAGE					
532	53430	URETHROPLASTY, RECONSTRUCTION OF FEMALE URETHRA					
532	53447	REMOVAL, REPAIR, OR REPLACEMENT OF INFLATABLE SPHINCTER INCLUDING PUMP AND/OR RESERVOIR AND/OR CUFF					
532	53449	SURGICAL CORRECTION OF HYDRAULIC ABNORMALITY OF INFLATABLE SPHINCTER DEVICE					
532	53450	URETHROMEATOPLASTY, WITH MUCOSAL ADVANCEMENT					
532	53460	URETHROMEATOPLASTY, WITH PARTIAL EXCISION OF DISTAL URETHRAL SEGMENT (RICHARDSON TYPE PROCEDURE)					
532	53515	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY; PROSTATOMEMBRANOUS					
532	53520	CLOSURE OF URETHROSTOMY OR URETHROCUTANEOUS FISTULA, MALE (SEPARATE PROCEDURE)					
536	Circumcision		T	13.17	\$667.32	\$326.57	\$133.46
536	54150	CIRCUMCISION, USING CLAMP OR OTHER DEVICE; NEWBORN					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
536	54152	CIRCUMCISION, USING CLAMP OR OTHER DEVICE; EXCEPT NEWBORN					
536	54160	CIRCUMCISION, SURGICAL EXCISION OTHER THAN CLAMP, DEVICE OR DORSAL SLIT; NEWBORN					
536	54161	CIRCUMCISION, SURGICAL EXCISION OTHER THAN CLAMP, DEVICE OR DORSAL SLIT; EXCEPT NEWBORN					
537	Penile Procedures		T	28.72	\$1,455.23	\$864.34	\$291.05
537	37790	PENILE VENOUS OCCLUSIVE PROCEDURE					
537	54110	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE);					
537	54111	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE); WITH GRAFT TO 5 CM IN LENGTH					
537	54112	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE); WITH GRAFT GREATER THAN 5 CM IN LENGTH					
537	54120	AMPUTATION OF PENIS; PARTIAL					
537	54205	INJECTION PROCEDURE FOR PEYRONIE DISEASE; WITH SURGICAL EXPOSURE OF PLAQUE					
537	54300	PLASTIC OPERATION OF PENIS FOR STRAIGHTENING OF CHORDEE (EG, HYPOSPADIAS), WITH OR WITHOUT MOBILIZATION OF URETHRA					
537	54304	PLASTIC OPERATION ON PENIS FOR CORRECTION OF CHORDEE OR FOR FIRST STAGE HYPOSPADIAS REPAIR WITH OR WITHOUT TRANSPLANTATION OF PREPUCE AND/OR SKIN FLAPS					
537	54308	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR (INCLUDING URINARY DIVERSION); LESS THAN 3 CM					
537	54312	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR (INCLUDING URINARY DIVERSION); GREATER THAN 3 CM					
537	54316	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR (INCLUDING URINARY DIVERSION) WITH FREE SKIN GRAFT OBTAINED FROM SITE OTHER THAN GENITALIA					
537	54318	URETHROPLASTY FOR THIRD STAGE HYPOSPADIAS REPAIR TO RELEASE PENIS FROM SCROTUM (EG, THIRD STAGE CECIL					
537	54322	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH SIMPLE MEATAL ADVANCEMENT (EG, MAGPI, V-FLAP)					
537	54324	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH URETHROPLASTY BY LOCAL SKIN FLAPS (EG, FLIP-FLAP, PREPUCE FLAP)					
537	54326	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH URETHROPLASTY BY LOCAL SKIN FLAPS AND MOBILIZATION OF URETHRA					
537	54328	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH EXTENSIVE DISSECTION TO CORRECT CHORDEE AND URETHROPLASTY WITH LOCAL SKIN FLAPS, SKIN GRAFT PATCH, AND/OR ISLAND FLAP					
537	54340	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA, STRICTURE, DIVERTICULA); BY CLOSURE, INCISION, OR EXCISION,					
537	54344	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA, STRICTURE, DIVERTICULA); REQUIRING MOBILIZATION OF SKIN FLAPS AND URETHROPLASTY WITH FLAP OR PATCH GRAFT					
537	54348	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA, STRICTURE, DIVERTICULA); REQUIRING EXTENSIVE DISSECTION AND URETHROPLASTY WITH FLAP, PATCH OR TUBED GRAFT (INCLUDES URINARY DIVERSION)					
537	54352	REPAIR OF HYPOSPADIAS CRIPPLE REQUIRING EXTENSIVE DISSECTION AND EXCISION OF PREVIOUSLY CONSTRUCTED STRUCTURES INCLUDING RE-RELEASE OF CHORDEE AND RECONSTRUCTION OF URETHRA AND PENIS BY USE OF LOCAL SKIN AS GRAFTS AND ISLAND FLAPS AND SKIN BROUGHT IN AS F					
537	54360	PLASTIC OPERATION ON PENIS TO CORRECT ANGULATION					
537	54380	PLASTIC OPERATION ON PENIS FOR EPISPADIAS DISTAL TO EXTERNAL SPHINCTER;					
537	54385	PLASTIC OPERATION ON PENIS FOR EPISPADIAS DISTAL TO EXTERNAL SPHINCTER; WITH INCONTINENCE					
537	54402	REMOVAL OR REPLACEMENT OF NON-INFLATABLE (SEMI-RIGID) OR INFLATABLE (SELF-CONTAINED) PENILE PROSTHESIS					
537	54407	REMOVAL, REPAIR, OR REPLACEMENT OF INFLATABLE (MULTI-COMPONENT) PENILE PROSTHESIS, INCLUDING PUMP AND/OR RESERVOIR AND/OR CYLINDERS					
537	54409	SURGICAL CORRECTION OF HYDRAULIC ABNORMALITY OF INFLATABLE (MULTI-COMPONENT) PROSTHESIS INCLUDING PUMP AND/OR RESERVOIR AND/OR CYLINDERS					
537	54420	CORPORA CAVERNOSA-SAPHENOUS VEIN SHUNT (PRIAPISM OPERATION), UNILATERAL OR BILATERAL					
537	54435	CORPORA CAVERNOSA-GLANS PENIS FISTULIZATION (EG, BIOPSY NEEDLE, WINTER PROCEDURE, RONGEUR, OR PUNCH) FOR PRIAPISM					
537	54440	PLASTIC OPERATION OF PENIS FOR INJURY					
538	Insertion of Penile Prosthesis		T	45.59	\$2,310.02	\$1,540.64	\$462.00
538	53440	OPERATION FOR CORRECTION OF MALE URINARY INCONTINENCE, WITH OR WITHOUT INTRODUCTION OF PROSTHESIS					
538	53445	OPERATION FOR CORRECTION OF URINARY INCONTINENCE WITH PLACEMENT OF INFLATABLE URETHRAL OR BLADDER NECK SPHINCTER, INCLUDING PLACEMENT OF PUMP AND/OR RESERVOIR					
538	54400	INSERTION OF PENILE PROSTHESIS; NON-INFLATABLE (SEMI-RIGID)					
538	54401	INSERTION OF PENILE PROSTHESIS; INFLATABLE (SELF-CONTAINED)					
538	54405	INSERTION OF INFLATABLE (MULTI-COMPONENT) PENILE PROSTHESIS, INCLUDING PLACEMENT OF PUMP, CYLINDERS, AND/OR RESERVOIR					
546	Testes/Epididymis Procedures		T	17.14	\$868.47	\$453.81	\$173.69
546	54505	BIOPSY OF TESTIS, INCISIONAL (SEPARATE PROCEDURE)					
546	54510	EXCISION OF LOCAL LESION OF TESTIS					
546	54520	ORCHIECTOMY, SIMPLE (INCLUDING SUBCAPSULAR), WITH OR WITHOUT TESTICULAR PROSTHESIS, SCROTAL OR INGUINAL APPROACH					
546	54530	ORCHIECTOMY, RADICAL, FOR TUMOR; INGUINAL APPROACH					
546	54550	EXPLORATION FOR UNDESCENDED TESTIS (INGUINAL OR SCROTAL AREA)					
546	54600	REDUCTION OF TORSION OF TESTIS, SURGICAL, WITH OR WITHOUT FIXATION OF CONTRALATERAL TESTIS					
546	54620	FIXATION OF CONTRALATERAL TESTIS (SEPARATE PROCEDURE)					
546	54640	ORCHIOPEXY, INGUINAL APPROACH, WITH OR WITHOUT HERNIA REPAIR					
546	54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)					
546	54670	SUTURE OR REPAIR OF TESTICULAR INJURY					
546	54680	TRANSPLANTATION OF TESTIS(ES) TO THIGH (BECAUSE OF SCROTAL DESTRUCTION)					
546	54700	INCISION AND DRAINAGE OF EPIDIDYMI, TESTIS AND/OR SCROTAL SPACE (EG, ABSCESS OR HEMATOMA)					
546	54820	EXPLORATION OF EPIDIDYMI, WITH OR WITHOUT BIOPSY					
546	54830	EXCISION OF LOCAL LESION OF EPIDIDYMI					
546	54840	EXCISION OF SPERMATOCELE, WITH OR WITHOUT EPIDIDYMECTOMY					
546	54860	EPIDIDYMECTOMY; UNILATERAL					
546	54861	EPIDIDYMECTOMY; BILATERAL					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
546	54900	EPIDIDYMOVASOSTOMY, ANASTOMOSIS OF EPIDIDYMIS TO VAS DEFERENS; UNILATERAL					
546	54901	EPIDIDYMOVASOSTOMY, ANASTOMOSIS OF EPIDIDYMIS TO VAS DEFERENS; BILATERAL					
546	55060	REPAIR OF TUNICA VAGINALIS HYDROCELE (BOTTLE TYPE)					
546	55110	SCROTAL EXPLORATION					
546	55120	REMOVAL OF FOREIGN BODY IN SCROTUM					
546	55150	RESECTION OF SCROTUM					
546	55175	SCROTOPLASTY; SIMPLE					
546	55180	SCROTOPLASTY; COMPLICATED					
546	55200	VASOTOMY, CANNULIZATION WITH OR WITHOUT INCISION OF VAS, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)					
546	55250	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING POSTOPERATIVE SEMEN EXAMINATION(S)					
546	55400	VASOVASOSTOMY, VASOVASORRHAPHY					
546	55450	LIGATION (PERCUTANEOUS) OF VAS DEFERENS, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)					
546	55500	EXCISION OF HYDROCELE OF SPERMATIC CORD, UNILATERAL (SEPARATE PROCEDURE)					
546	55520	EXCISION OF LESION OF SPERMATIC CORD (SEPARATE PROCEDURE)					
546	55530	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR VARICOCELE; (SEPARATE PROCEDURE)					
546	55535	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR VARICOCELE; ABDOMINAL APPROACH					
546	55540	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR VARICOCELE; WITH HERNIA REPAIR					
546	55680	EXCISION OF MULLERIAN DUCT CYST					
547	Prostate Biopsy		T	4.39	\$222.44	\$125.2	\$44.49
547	55700	BIOPSY, PROSTATE; NEEDLE OR PUNCH, SINGLE OR MULTIPLE, ANY APPROACH					
547	55705	BIOPSY, PROSTATE; INCISIONAL, ANY APPROACH					
550	Surgical Hysteroscopy		T	16.89	\$855.81	\$447.93	\$171.16
550	56351	HYSTEROSCOPY, SURGICAL; WITH SAMPLING (BIOPSY) OF ENDOMETRIUM AND/OR POLYPECTOMY, WITH OR WITHOUT D & C					
550	56352	HYSTEROSCOPY, SURGICAL; WITH LYSIS OF INTRAUTERINE ADHESIONS (ANY METHOD)					
550	56353	HYSTEROSCOPY, SURGICAL; WITH DIVISION OR RESECTION OF INTRAUTERINE SEPTUM (ANY METHOD)					
550	56354	HYSTEROSCOPY, SURGICAL; WITH REMOVAL OF LEIOMYOMATA					
550	56355	HYSTEROSCOPY, SURGICAL; WITH REMOVAL OF IMPACTED FOREIGN BODY					
550	56356	HYSTEROSCOPY, SURGICAL; WITH ENDOMETRIAL ABLATION (ANY METHOD)					
551	Level I Laparoscopy		T	24.78	\$1,255.59	\$711.67	\$251.12
551	56300	LAPAROSCOPY (PERITONEOSCOPY), DIAGNOSTIC; (SEPARATE PROCEDURE)					
551	56301	LAPAROSCOPY, SURGICAL; WITH FULGURATION OF OVIDUCTS (WITH OR WITHOUT TRANSECTION)					
551	56302	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY DEVICE (EG, BAND, CLIP, OR FALLOPE RING)					
551	56303	LAPAROSCOPY, SURGICAL; WITH FULGURATION OR EXCISION OF LESIONS OF THE OVARY, PELVIC VISCERA, OR PERITONEAL SURFACE BY ANY METHOD					
551	56304	LAPAROSCOPY, SURGICAL; WITH LYSIS OF ADHESIONS (SALPINGOLYSIS, OVARIOLYSIS) (SEPARATE PROCEDURE)					
551	56305	LAPAROSCOPY, SURGICAL; WITH BIOPSY (SINGLE OR MULTIPLE)					
551	56306	LAPAROSCOPY, SURGICAL; WITH ASPIRATION (SINGLE OR MULTIPLE)					
551	56346	LAPAROSCOPY, SURGICAL; GASTROSTOMY, TEMPORARY (TUBE OR RUBBER OR PLASTIC) (SEPARATE PROCEDURE)					
552	Level II Laparoscopy		T	37.71	\$1,910.75	\$1,053.16	\$382.15
552	56307	LAPAROSCOPY, SURGICAL; WITH REMOVAL OF ADNEXAL STRUCTURES (PARTIAL OR TOTAL OOPHORECTOMY AND/OR SALPINGECTOMY)					
552	56309	LAPAROSCOPY, SURGICAL; WITH REMOVAL OF LEIOMYOMATA (SINGLE OR MULTIPLE)					
552	56311	LAPAROSCOPY, SURGICAL; WITH RETROPERITONEAL LYMPH NODE SAMPLING (BIOPSY), SINGLE OR MULTIPLE					
552	56312	LAPAROSCOPY, SURGICAL; WITH BILATERAL TOTAL PELVIC LYMPHADENECTOMY					
552	56313	LAPAROSCOPY, SURGICAL; WITH BILATERAL TOTAL PELVIC LYMPHADENECTOMY AND PERI-AORTIC LYMPH NODE SAMPLING (BIOPSY), SINGLE OR MULTIPLE					
552	56316	LAPAROSCOPY, SURGICAL; REPAIR OF INITIAL INGUINAL HERNIA					
552	56317	LAPAROSCOPY, SURGICAL; REPAIR OF RECURRENT INGUINAL HERNIA					
552	56318	LAPAROSCOPY, SURGICAL; ORCHIECTOMY					
552	56320	LAPAROSCOPY, SURGICAL; WITH LIGATION OF SPERMATIC VEINS FOR VARICOCELE					
552	56343	LAPAROSCOPY, SURGICAL; WITH SALPINGOSTOMY (SALPINGONEOSTOMY)					
552	56344	LAPAROSCOPY, SURGICAL; WITH FIMBRIOPLASTY					
552	56362	LAPAROSCOPY WITH GUIDED TRANSHEPATIC CHOLANGIOGRAPHY; WITHOUT BIOPSY					
552	56363	LAPAROSCOPY WITH GUIDED TRANSHEPATIC CHOLANGIOGRAPHY; WITH BIOPSY					
561	Level I Female Reproductive Procedures		T	1.52	\$77.02	\$24.63	\$15.4
561	56405	INCISION AND DRAINAGE OF VULVA OR PERINEAL ABSCESS					
561	56420	INCISION AND DRAINAGE OF BARTHOLIN'S GLAND ABSCESS					
561	56441	LYSIS OF LABIAL ADHESIONS					
561	57061	DESTRUCTION OF VAGINAL LESION(S); SIMPLE, ANY METHOD					
561	57100	BIOPSY OF VAGINAL MUCOSA; SIMPLE (SEPARATE PROCEDURE)					
561	57150	IRRIGATION OF VAGINA AND/OR APPLICATION OF MEDICAMENT FOR TREATMENT OF BACTERIAL, PARASITIC, OR FUNGOID DISEASE					
561	57160	FITTING AND INSERTION OF PESSARY OR OTHER INTRAVAGINAL SUPPORT DEVICE					
561	57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS					
561	57180	INTRODUCTION OF ANY HEMOSTATIC AGENT OR PACK FOR SPONTANEOUS OR TRAUMATIC NONOBSTETRICAL VAGINAL HEMORRHAGE (SEPARATE PROCEDURE)					
561	57452	COLPOSCOPY (VAGINOSCOPY); (SEPARATE PROCEDURE)					
561	57454	COLPOSCOPY (VAGINOSCOPY); WITH BIOPSY(S) OF THE CERVIX AND/OR ENDOCERVICAL CURETTAGE					
561	57500	BIOPSY, SINGLE OR MULTIPLE, OR LOCAL EXCISION OF LESION, WITH OR WITHOUT FULGURATION (SEPARATE PROCEDURE)					
561	57505	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION AND CURETTAGE)					
561	57510	CAUTERIZATION OF CERVIX; ELECTRO OR THERMAL					
561	57511	CAUTERIZATION OF CERVIX; CRYOCAUTERY, INITIAL OR REPEAT					
561	57513	CAUTERIZATION OF CERVIX; LASER ABLATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
561	57800	DILATION OF CERVICAL CANAL, INSTRUMENTAL (SEPARATE PROCEDURE)					
561	58100	ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT ENDOCERVICAL SAMPLING (BIOPSY), WITHOUT CERVICAL DILATION, ANY METHOD (SEPARATE PROCEDURE)					
561	58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)					
561	59200	INSERTION OF CERVICAL DILATOR (EG, LAMINARIA, PROSTAGLANDIN) (SEPARATE PROCEDURE)					
562	Level II Female Reproductive Procedures		T	12.76	\$646.54	\$330.75	\$129.31
562	56350	HYSTEROSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE)					
562	56399	UNLISTED PROCEDURE, LAPAROSCOPY, HYSTEROSCOPY					
562	56440	MARSUPIALIZATION OF BARTHOLIN'S GLAND CYST					
562	56700	PARTIAL HYMENECTOMY OR REVISION OF HYMENAL RING					
562	56720	HYMENOTOMY, SIMPLE INCISION					
562	56740	EXCISION OF BARTHOLIN'S GLAND OR CYST					
562	56800	PLASTIC REPAIR OF INTROITUS					
562	56810	PERINEOPLASTY, REPAIR OF PERINEUM, NONOBSTETRICAL (SEPARATE PROCEDURE)					
562	57000	COLPOTOMY; WITH EXPLORATION					
562	57010	COLPOTOMY; WITH DRAINAGE OF PELVIC ABSCESS					
562	57020	COLPOCENTESIS (SEPARATE PROCEDURE)					
562	57065	DESTRUCTION OF VAGINAL LESION(S); EXTENSIVE, ANY METHOD					
562	57105	BIOPSY OF VAGINAL MUCOSA; EXTENSIVE, REQUIRING SUTURE (INCLUDING CYSTS)					
562	57130	EXCISION OF VAGINAL SEPTUM					
562	57135	EXCISION OF VAGINAL CYST OR TUMOR					
562	57200	COLPORRHAPHY, SUTURE OF INJURY OF VAGINA (NONOBSTETRICAL)					
562	57210	COLPOPERINEORRHAPHY, SUTURE OF INJURY OF VAGINA AND/OR PERINEUM (NONOBSTETRICAL)					
562	57230	PLASTIC REPAIR OF URETHROCELE					
562	57400	DILATION OF VAGINA UNDER ANESTHESIA					
562	57410	PELVIC EXAMINATION UNDER ANESTHESIA					
562	57415	REMOVAL OF IMPACTED VAGINAL FOREIGN BODY (SEPARATE PROCEDURE) UNDER ANESTHESIA					
562	57460	COLPOSCOPY (VAGINOSCOPY); WITH LOOP ELECTRODE EXCISION PROCEDURE OF THE CERVIX					
562	57700	CERCLAGE OF UTERINE CERVIX, NONOBSTETRICAL					
562	57720	TRACHELORRHAPHY, PLASTIC REPAIR OF UTERINE CERVIX, VAGINAL APPROACH					
562	58345	TRANSCERVICAL INTRODUCTION OF FALLOPIAN TUBE CATHETER FOR DIAGNOSIS AND/OR RE-ESTABLISHING PATENCY (ANY METHOD), WITH OR WITHOUT HYSTEOSALPINGOGRAPHY					
562	58350	CHROMOTUBATION OF OVIDUCT, INCLUDING MATERIALS					
562	58970	FOLLICLE PUNCTURE FOR OOCYTE RETRIEVAL, ANY METHOD					
562	59300	EPISIOTOMY OR VAGINAL REPAIR, BY OTHER THAN ATTENDING PHYSICIAN					
562	59320	CERCLAGE OF CERVIX, DURING PREGNANCY; VAGINAL					
562	59871	REMOVAL OF CERCLAGE SUTURE UNDER ANESTHESIA (OTHER THAN LOCAL)					
563	Level III Female Reproductive Procedures		T	16.90	\$856.31	\$464.88	\$171.26
563	56620	VULVECTOMY SIMPLE; PARTIAL					
563	56625	VULVECTOMY SIMPLE; COMPLETE					
563	57220	PLASTIC OPERATION ON URETHRAL SPHINCTER, VAGINAL APPROACH (EG, KELLY URETHRAL PLICATION)					
563	57240	ANTERIOR COLPORRHAPHY, REPAIR OF CYSTOCELE WITH OR WITHOUT REPAIR OF URETHROCELE					
563	57250	POSTERIOR COLPORRHAPHY, REPAIR OF RECTOCELE WITH OR WITHOUT PERINEORRHAPHY					
563	57260	COMBINED ANTEROPOSTERIOR COLPORRHAPHY;					
563	57265	COMBINED ANTEROPOSTERIOR COLPORRHAPHY; WITH ENTEROCELE REPAIR					
563	57268	REPAIR OF ENTEROCELE, VAGINAL APPROACH (SEPARATE PROCEDURE)					
563	57284	PARAVAGINAL DEFECT REPAIR (INCLUDING REPAIR OF CYSTOCELE, STRESS URINARY INCONTINENCE, AND/OR INCOMPLETE VAGINAL PROLAPSE)					
563	57288	SLING OPERATION FOR STRESS INCONTINENCE (EG, FASCIA OR SYNTHETIC)					
563	57289	PEREYRA PROCEDURE, INCLUDING ANTERIOR COLPORRHAPHY					
563	57291	CONSTRUCTION OF ARTIFICIAL VAGINA; WITHOUT GRAFT					
563	57300	CLOSURE OF RECTOVAGINAL FISTULA; VAGINAL OR TRANSANAL APPROACH					
563	57520	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND CURETTAGE, WITH OR WITHOUT REPAIR; COLD KNIFE OR LASER					
563	57522	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND CURETTAGE, WITH OR WITHOUT REPAIR; LOOP ELECTRODE EXCISION					
563	57530	TRACHELECTOMY (CERVICECTOMY), AMPUTATION OF CERVIX (SEPARATE PROCEDURE)					
563	57550	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH;					
563	57555	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH; WITH ANTERIOR AND/OR POSTERIOR REPAIR					
563	57556	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH; WITH REPAIR OF ENTEROCELE					
563	58145	MYOMECTOMY, EXCISION OF FIBROID TUMOR OF UTERUS, SINGLE OR MULTIPLE (SEPARATE PROCEDURE); VAGINAL APPROACH					
563	58800	DRAINAGE OF OVARIAN CYST(S), UNILATERAL OR BILATERAL, (SEPARATE PROCEDURE); VAGINAL APPROACH					
563	58820	DRAINAGE OF OVARIAN ABSCESS; VAGINAL APPROACH, OPEN					
567	D & C		T	13.61	\$689.61	\$364.09	\$137.92
567	57820	DILATION AND CURETTAGE OF CERVICAL STUMP					
567	58120	DILATION AND CURETTAGE, DIAGNOSTIC AND/OR THERAPEUTIC (NONOBSTETRICAL)					
567	59160	CURRETTAGE, POSTPARTUM					
568	Infertility Procedures		T	2.49	\$126.17	\$49.49	\$25.23
568	55870	ELECTROEJACULATION					
568	58321	ARTIFICIAL INSEMINATION; INTRA-CERVICAL					
568	58322	ARTIFICIAL INSEMINATION; INTRA-UTERINE					
568	58323	SPERM WASHING FOR ARTIFICIAL INSEMINATION					
568	58974	EMBRYO TRANSFER, INTRAUTERINE					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
568	58976	GAMETE, ZYGOTE, OR EMBRYO INTRAFALLOPIAN TRANSFER, ANY METHOD					
578	Pregnancy and Neonatal Care Procedures		T	1.26	\$63.84	\$33.9	\$12.77
578	59000	AMNIOCENTESIS, ANY METHOD					
578	59012	CORDOCENTESIS (INTRAUTERINE), ANY METHOD					
578	59015	CHORIONIC VILLUS SAMPLING, ANY METHOD					
578	59020	FETAL CONTRACTION STRESS TEST					
578	59025	FETAL NON-STRESS TEST					
578	59030	FETAL SCALP BLOOD SAMPLING					
578	59050	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE, NON-ATTENDING PHYSICIAN) WITH WRITTEN REPORT; SUPER-VISION AND INTERPRETATION					
578	59899	UNLISTED PROCEDURE, MATERNITY CARE AND DELIVERY					
580	Vaginal Delivery		T	4.59	\$232.57	\$146.34	\$46.51
580	59409	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS);					
580	59412	EXTERNAL CEPHALIC VERSION, WITH OR WITHOUT TOCOLYSIS (LIST IN ADDITION TO CODE(S) FOR DELIVERY)					
580	59414	DELIVERY OF PLACENTA (SEPARATE PROCEDURE)					
580	59612	VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS);					
586	Therapeutic Abortion		T	12.5	\$633.37	\$431.89	\$126.67
586	59840	INDUCED ABORTION, BY DILATION AND CURETTAGE					
586	59841	INDUCED ABORTION, BY DILATION AND EVACUATION					
587	Spontaneous Abortion		T	13.25	\$671.37	\$347.02	\$134.27
587	59812	TREATMENT OF INCOMPLETE ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY					
587	59820	TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; FIRST TRIMESTER					
587	59821	TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; SECOND TRIMESTER					
587	59870	UTERINE EVACUATION AND CURETTAGE FOR HYDATIDIFORM MOLE					
600	Spinal Tap		T	2.63	\$133.26	\$61.47	\$26.65
600	62270	SPINAL PUNCTURE, LUMBAR, DIAGNOSTIC					
600	62272	SPINAL PUNCTURE, THERAPEUTIC, FOR DRAINAGE OF SPINAL FLUID (BY NEEDLE OR CATHETER)					
601	Level I Nervous System Injections		T	3.11	\$157.58	\$74.13	\$31.52
601	64400	INJECTION, ANESTHETIC AGENT; TRIGEMINAL NERVE, ANY DIVISION OR BRANCH					
601	64402	INJECTION, ANESTHETIC AGENT; FACIAL NERVE					
601	64405	INJECTION, ANESTHETIC AGENT; GREATER OCCIPITAL NERVE					
601	64408	INJECTION, ANESTHETIC AGENT; VAGUS NERVE					
601	64410	INJECTION, ANESTHETIC AGENT; PHRENIC NERVE					
601	64412	INJECTION, ANESTHETIC AGENT; SPINAL ACCESSORY NERVE					
601	64413	INJECTION, ANESTHETIC AGENT; CERVICAL PLEXUS					
601	64415	INJECTION, ANESTHETIC AGENT; BRACHIAL PLEXUS					
601	64417	INJECTION, ANESTHETIC AGENT; AXILLARY NERVE					
601	64418	INJECTION, ANESTHETIC AGENT; SUPRASCAPULAR NERVE					
601	64420	INJECTION, ANESTHETIC AGENT; INTERCOSTAL NERVE, SINGLE					
601	64421	INJECTION, ANESTHETIC AGENT; INTERCOSTAL NERVES, MULTIPLE, REGIONAL BLOCK					
601	64425	INJECTION, ANESTHETIC AGENT; ILIOINGUINAL, ILIOHYPOGASTRIC NERVES					
601	64430	INJECTION, ANESTHETIC AGENT; PUDENDAL NERVE					
601	64435	INJECTION, ANESTHETIC AGENT; PARACERVICAL (UTERINE) NERVE					
601	64440	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL NERVE (THORACIC, LUMBAR, SACRAL, COCCYGEAL), SINGLE VERTEBRAL LEVEL					
601	64441	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL NERVES, MULTIPLE LEVELS (EG, REGIONAL BLOCK)					
601	64442	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, SINGLE LEVEL					
601	64443	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, EACH ADDITIONAL LEVEL					
601	64445	INJECTION, ANESTHETIC AGENT; SCIATIC NERVE					
601	64450	INJECTION, ANESTHETIC AGENT; OTHER PERIPHERAL NERVE OR BRANCH					
601	64505	INJECTION, ANESTHETIC AGENT; SPHENOPALATINE GANGLION					
601	64508	INJECTION, ANESTHETIC AGENT; CAROTID SINUS (SEPARATE PROCEDURE)					
601	64510	INJECTION, ANESTHETIC AGENT; STELLATE GANGLION (CERVICAL SYMPATHETIC)					
601	64520	INJECTION, ANESTHETIC AGENT; LUMBAR OR THORACIC (PARAVERTEBRAL SYMPATHETIC)					
601	64530	INJECTION, ANESTHETIC AGENT; CELIAC PLEXUS, WITH OR WITHOUT RADIOLOGIC MONITORING					
601	64600	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SUPRAORBITAL, INFRAORBITAL, MENTAL, OR INFERIOR ALVEOLAR BRANCH					
601	64605	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE					
601	64610	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE UNDER RADIOLOGIC MONITORING					
601	64612	DESTRUCTION BY NEUROLYTIC AGENT (CHEMODENERVATION OF MUSCLE ENDPLATE); MUSCLES ENERVATED BY FACIAL NERVE (EG, FOR BLEPHAROSPASM, HEMIFACIAL SPASM)					
601	64613	DESTRUCTION BY NEUROLYTIC AGENT (CHEMODENERVATION OF MUSCLE ENDPLATE); CERVICAL SPINAL MUSCLES (EG, FOR SPASMODIC TORTICOLLIS)					
601	64620	DESTRUCTION BY NEUROLYTIC AGENT; INTERCOSTAL NERVE					
601	64622	DESTRUCTION BY NEUROLYTIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, SINGLE LEVEL					
601	64623	DESTRUCTION BY NEUROLYTIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, EACH ADDITIONAL LEVEL					
601	64630	DESTRUCTION BY NEUROLYTIC AGENT; PUDENDAL NERVE					
601	64640	DESTRUCTION BY NEUROLYTIC AGENT; OTHER PERIPHERAL NERVE OR BRANCH					
601	64680	DESTRUCTION BY NEUROLYTIC AGENT, CELIAC PLEXUS, WITH OR WITHOUT RADIOLOGIC MONITORING					
601	64999	UNLISTED PROCEDURE, NERVOUS SYSTEM					
602	Level II Nervous System Injections		T	3.33	\$168.73	\$87.69	\$33.75

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
602	61000	SUBDURAL TAP THROUGH FONTANELLE, OR SUTURE, INFANT, UNILATERAL OR BILATERAL; INITIAL					
602	61001	SUBDURAL TAP THROUGH FONTANELLE, OR SUTURE, INFANT, UNILATERAL OR BILATERAL; SUBSEQUENT TAPS					
602	61020	VENTRICULAR PUNCTURE THROUGH PREVIOUS BURR HOLE, FONTANELLE, SUTURE, OR IMPLANTED VENTRICULAR CATHETER/RESERVOIR; WITHOUT INJECTION					
602	61026	VENTRICULAR PUNCTURE THROUGH PREVIOUS BURR HOLE, FONTANELLE, SUTURE, OR IMPLANTED VENTRICULAR CATHETER/RESERVOIR; WITH INJECTION OF DRUG OR OTHER SUBSTANCE FOR DIAGNOSIS OR TREATMENT					
602	61050	CISTERNAL OR LATERAL CERVICAL (C1-C2) PUNCTURE; WITHOUT INJECTION (SEPARATE PROCEDURE)					
602	61055	CISTERNAL OR LATERAL CERVICAL (C1-C2) PUNCTURE; WITH INJECTION OF DRUG OR OTHER SUBSTANCE FOR DIAGNOSIS OR TREATMENT (EG, C1-C2)					
602	61070	PUNCTURE OF SHUNT TUBING OR RESERVOIR FOR ASPIRATION OR INJECTION PROCEDURE					
602	62194	REPLACEMENT OR IRRIGATION, SUBARACHNOID/SUBDURAL CATHETER					
602	62225	REPLACEMENT OR IRRIGATION, VENTRICULAR CATHETER					
602	62268	PERCUTANEOUS ASPIRATION, SPINAL CORD CYST OR SYRINX					
602	62273	INJECTION, LUMBAR EPIDURAL, OF BLOOD OR CLOT PATCH					
602	62274	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); SUBARACHNOID OR SUBDURAL, SINGLE					
602	62275	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); EPIDURAL, CERVICAL OR THORACIC, SINGLE					
602	62276	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); SUBARACHNOID OR SUBDURAL, DIFFERENTIAL					
602	62277	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); SUBARACHNOID OR SUBDURAL, CONTINUOUS					
602	62278	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); EPIDURAL, LUMBAR OR CAUDAL, SINGLE					
602	62279	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); EPIDURAL, LUMBAR OR CAUDAL, CONTINUOUS					
602	62280	INJECTION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS); SUBARACHNOID					
602	62281	INJECTION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS); EPIDURAL, CERVICAL OR THORACIC					
602	62282	INJECTION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS); EPIDURAL, LUMBAR OR CAUDAL					
602	62288	INJECTION OF SUBSTANCE OTHER THAN ANESTHETIC, ANTISPASMODIC, CONTRAST, OR NEUROLYTIC SOLUTIONS; SUBARACHNOID (SEPARATE PROCEDURE)					
602	62289	INJECTION OF SUBSTANCE OTHER THAN ANESTHETIC, ANTISPASMODIC, CONTRAST, OR NEUROLYTIC SOLUTIONS; LUMBAR OR CAUDAL EPIDURAL (SEPARATE PROCEDURE)					
602	62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, INCLUDING DISKOGRAPHY, INTERVERTEBRAL DISK, SINGLE OR MULTIPLE LEVELS, LUMBAR					
602	62294	INJECTION PROCEDURE, ARTERIAL, FOR OCCLUSION OF ARTERIOVENOUS MALFORMATION, SPINAL					
602	62298	INJECTION OF SUBSTANCE OTHER THAN ANESTHETIC, CONTRAST, OR NEUROLYTIC SOLUTIONS, EPIDURAL, CERVICAL OR THORACIC (SEPARATE PROCEDURE)					
616	Implantation of Neurostimulator Electrodes		T	14.43	\$731.16	\$366.57	\$146.23
616	63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; EPIDURAL					
616	64553	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE					
616	64555	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE					
616	64560	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE					
616	64565	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR					
616	64573	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE					
616	64575	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE					
616	64577	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE					
616	64580	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR					
617	Revision/Removal Neurological Device		T	11.56	\$585.74	\$287.59	\$117.15
617	62230	REPLACEMENT OR REVISION OF CSF SHUNT, OBSTRUCTED VALVE, OR DISTAL CATHETER IN SHUNT SYSTEM					
617	62350	IMPLANTATION, REVISION OR REPOSITIONING OF INTRATHECAL OR EPIDURAL CATHETER, FOR IMPLANTABLE RESERVOIR OR IMPLANTABLE INFUSION PUMP; WITHOUT LAMINECTOMY					
617	62355	REMOVAL OF PREVIOUSLY IMPLANTED INTRATHECAL OR EPIDURAL CATHETER					
617	62365	REMOVAL OF SUBCUTANEOUS RESERVOIR OR PUMP, PREVIOUSLY IMPLANTED FOR INTRATHECAL OR EPIDURAL INFUSION					
617	63660	REVISION OR REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODES					
617	63688	REVISION OR REMOVAL OF IMPLANTED SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER					
617	63744	REPLACEMENT, IRRIGATION OR REVISION OF LUMBOSUBARACHNOID SHUNT					
617	63746	REMOVAL OF ENTIRE LUMBOSUBARACHNOID SHUNT SYSTEM WITHOUT REPLACEMENT					
617	64585	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR ELECTRODES					
617	64595	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER					
618	Implantation of Neurological Device		T	25.56	\$1,295.11	\$780.49	\$259.02
618	61215	INSERTION OF SUBCUTANEOUS RESERVOIR, PUMP OR CONTINUOUS INFUSION SYSTEM FOR CONNECTION TO VENTRICULAR CATHETER					
618	61885	INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING					
618	62360	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; SUBCUTANEOUS RESERVOIR					
618	62361	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; NON-PROGRAMMABLE PUMP					
618	62362	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; PROGRAMMABLE PUMP, INCLUDING PREPARATION OF PUMP, WITH OR WITHOUT PROGRAMMING					
618	63685	INCISION AND SUBCUTANEOUS PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING					
618	64590	INCISION AND SUBCUTANEOUS PLACEMENT OF PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
631	Level I Nerve Procedures		T	12.98	\$657.69	\$333.8	\$131.54
631	27315	NEURECTOMY, HAMSTRING MUSCLE					
631	27320	NEURECTOMY, POPLITEAL (GASTROCNEMIUS)					
631	28030	NEURECTOMY OF INTRINSIC MUSCULATURE OF FOOT					
631	28035	TARSAL TUNNEL RELEASE (POSTERIOR TIBIAL NERVE DECOMPRESSION)					
631	61790	CREATION OF LESION BY STEREOTACTIC METHOD, PERCUTANEOUS, BY NEUROLYTIC AGENT (EG, ALCOHOL, THERMAL, ELECTRIC, RADIOFREQUENCY); GASSERIAN GANGLION					
631	62287	ASPIRATION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISK, ANY METHOD, SINGLE OR MULTIPLE LEVELS, LUMBAR					
631	63600	CREATION OF LESION OF SPINAL CORD BY STEREOTACTIC METHOD, PERCUTANEOUS, ANY MODALITY (INCLUDING STIMULATION AND/OR RECORDING)					
631	63610	STEREOTACTIC STIMULATION OF SPINAL CORD, PERCUTANEOUS, SEPARATE PROCEDURE NOT FOLLOWED BY OTHER SURGERY					
631	63615	STEREOTACTIC BIOPSY, ASPIRATION, OR EXCISION OF LESION, SPINAL CORD					
631	64702	NEUROPLASTY; DIGITAL, ONE OR BOTH, SAME DIGIT					
631	64704	NEUROPLASTY; NERVE OF HAND OR FOOT					
631	64708	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; OTHER THAN SPECIFIED					
631	64712	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; SCIATIC NERVE					
631	64713	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; BRACHIAL PLEXUS					
631	64714	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; LUMBAR PLEXUS					
631	64716	NEUROPLASTY AND/OR TRANSPOSITION; CRANIAL NERVE (SPECIFY)					
631	64718	NEUROPLASTY AND/OR TRANSPOSITION; ULNAR NERVE AT ELBOW					
631	64719	NEUROPLASTY AND/OR TRANSPOSITION; ULNAR NERVE AT WRIST					
631	64721	NEUROPLASTY AND/OR TRANSPOSITION; MEDIAN NERVE AT CARPAL TUNNEL					
631	64722	DECOMPRESSION; UNSPECIFIED NERVE(S) (SPECIFY)					
631	64726	DECOMPRESSION; PLANTAR DIGITAL NERVE					
631	64727	INTERNAL NEUROLYSIS, REQUIRING USE OF OPERATING MICROSCOPE (LIST SEPARATELY IN ADDITION TO CODE FOR NEUROPLASTY) (NEUROPLASTY INCLUDES EXTERNAL NEUROLYSIS)					
631	64732	TRANSECTION OR AVULSION OF; SUPRAORBITAL NERVE					
631	64734	TRANSECTION OR AVULSION OF; INFRAORBITAL NERVE					
631	64736	TRANSECTION OR AVULSION OF; MENTAL NERVE					
631	64738	TRANSECTION OR AVULSION OF; INFERIOR ALVEOLAR NERVE BY OSTEOLOGY					
631	64740	TRANSECTION OR AVULSION OF; LINGUAL NERVE					
631	64742	TRANSECTION OR AVULSION OF; FACIAL NERVE, DIFFERENTIAL OR COMPLETE					
631	64744	TRANSECTION OR AVULSION OF; GREATER OCCIPITAL NERVE					
631	64746	TRANSECTION OR AVULSION OF; PHRENIC NERVE					
631	64761	TRANSECTION OR AVULSION OF; PUDENDAL NERVE					
631	64771	TRANSECTION OR AVULSION OF OTHER CRANIAL NERVE, EXTRADURAL					
631	64772	TRANSECTION OR AVULSION OF OTHER SPINAL NERVE, EXTRADURAL					
631	64774	EXCISION OF NEUROMA; CUTANEOUS NERVE, SURGICALLY IDENTIFIABLE					
631	64776	EXCISION OF NEUROMA; DIGITAL NERVE, ONE OR BOTH, SAME DIGIT					
631	64778	EXCISION OF NEUROMA; DIGITAL NERVE, EACH ADDITIONAL DIGIT (LIST SEPARATELY BY THIS NUMBER)					
631	64782	EXCISION OF NEUROMA; HAND OR FOOT, EXCEPT DIGITAL NERVE					
631	64783	EXCISION OF NEUROMA; HAND OR FOOT, EACH ADDITIONAL NERVE, EXCEPT SAME DIGIT (LIST SEPARATELY BY THIS NUMBER)					
631	64784	EXCISION OF NEUROMA; MAJOR PERIPHERAL NERVE, EXCEPT SCIATIC					
631	64787	IMPLANTATION OF NERVE END INTO BONE OR MUSCLE (LIST SEPARATELY IN ADDITION TO NEUROMA EXCISION)					
631	64788	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; CUTANEOUS NERVE					
631	64790	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; MAJOR PERIPHERAL NERVE					
631	64795	BIOPSY OF NERVE					
631	64830	MICRODISSECTION AND/OR MICROREPAIR OF NERVE (LIST SEPARATELY IN ADDITION TO CODE FOR NERVE REPAIR)					
632	Level II Nerve Procedures		T	18.13	\$918.64	\$461.04	\$183.73
632	64786	EXCISION OF NEUROMA; SCIATIC NERVE					
632	64792	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; EXTENSIVE (INCLUDING MALIGNANT TYPE)					
632	64831	SUTURE OF DIGITAL NERVE, HAND OR FOOT; ONE NERVE					
632	64832	SUTURE OF DIGITAL NERVE, HAND OR FOOT; EACH ADDITIONAL DIGITAL NERVE					
632	64834	SUTURE OF ONE NERVE, HAND OR FOOT; COMMON SENSORY NERVE					
632	64835	SUTURE OF ONE NERVE, HAND OR FOOT; MEDIAN MOTOR THENAR					
632	64836	SUTURE OF ONE NERVE, HAND OR FOOT; ULNAR MOTOR					
632	64837	SUTURE OF EACH ADDITIONAL NERVE, HAND OR FOOT					
632	64840	SUTURE OF POSTERIOR TIBIAL NERVE					
632	64856	SUTURE OF MAJOR PERIPHERAL NERVE, ARM OR LEG, EXCEPT SCIATIC; INCLUDING TRANSPOSITION					
632	64857	SUTURE OF MAJOR PERIPHERAL NERVE, ARM OR LEG, EXCEPT SCIATIC; WITHOUT TRANSPOSITION					
632	64858	SUTURE OF SCIATIC NERVE					
632	64859	SUTURE OF EACH ADDITIONAL MAJOR PERIPHERAL NERVE					
632	64861	SUTURE OF; BRACHIAL PLEXUS					
632	64862	SUTURE OF; LUMBAR PLEXUS					
632	64864	SUTURE OF FACIAL NERVE; EXTRACRANIAL					
632	64865	SUTURE OF FACIAL NERVE; INFRATEMPORAL, WITH OR WITHOUT GRAFTING					
632	64870	ANASTOMOSIS; FACIAL-PHRENIC					
632	64872	SUTURE OF NERVE; REQUIRING SECONDARY OR DELAYED SUTURE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY NEUORRHAPHY)					
632	64874	SUTURE OF NERVE; REQUIRING EXTENSIVE MOBILIZATION, OR TRANSPOSITION OF NERVE (LIST SEPARATELY IN ADDITION TO CODE FOR NERVE SUTURE)					
632	64876	SUTURE OF NERVE; REQUIRING SHORTENING OF BONE OF EXTREMITY (LIST SEPARATELY IN ADDITION TO CODE FOR NERVE SUTURE)					
632	64885	NERVE GRAFT (INCLUDES OBTAINING GRAFT), HEAD OR NECK; UP TO 4 CM IN LENGTH					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
632	64886	NERVE GRAFT (INCLUDES OBTAINING GRAFT), HEAD OR NECK; MORE THAN 4 CM LENGTH					
632	64890	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, HAND OR FOOT; UP TO 4 CM LENGTH					
632	64891	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, HAND OR FOOT; MORE THAN 4 CM LENGTH					
632	64892	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, ARM OR LEG; UP TO 4 CM LENGTH					
632	64893	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, ARM OR LEG; MORE THAN 4 CM LENGTH					
632	64895	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), HAND OR FOOT; UP TO 4 CM LENGTH					
632	64896	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), HAND OR FOOT; MORE THAN 4 CM LENGTH					
632	64897	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), ARM OR LEG; UP TO 4 CM LENGTH					
632	64898	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), ARM OR LEG; MORE THAN 4 CM LENGTH					
632	64901	NERVE GRAFT, EACH ADDITIONAL NERVE; SINGLE STRAND					
632	64902	NERVE GRAFT, EACH ADDITIONAL NERVE; MULTIPLE STRANDS (CABLE)					
632	64905	NERVE PEDICLE TRANSFER; FIRST STAGE					
632	64907	NERVE PEDICLE TRANSFER; SECOND STAGE					
648	Laser Retinal Procedures		T	3.94	\$199.64	\$95.15	\$39.93
648	67105	REPAIR OF RETINAL DETACHMENT, ONE OR MORE SESSIONS; PHOTOCOAGULATION, WITH OR WITHOUT DRAINAGE OF SUBRETINAL FLUID					
648	67145	PROPHYLAXIS OF RETINAL DETACHMENT (EG, RETINAL BREAK, LATTICE DEGENERATION) WITHOUT DRAINAGE, ONE OR MORE SESSIONS; PHOTOCOAGULATION (LASER OR XENON ARC)					
648	67210	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULOPATHY, CHOROIDOPATHY, SMALL TUMORS), ONE OR MORE SESSIONS; PHOTOCOAGULATION (LASER OR XENON ARC)					
648	67228	DESTRUCTION OF EXTENSIVE OR PROGRESSIVE RETINOPATHY (EG, DIABETIC RETINOPATHY), ONE OR MORE SESSIONS; PHOTOCOAGULATION (LASER OR XENON ARC)					
649	Laser Eye Procedures except Retinal		T	4.44	\$224.97	\$111.64	\$44.99
649	65855	TRABECULOPLASTY BY LASER SURGERY, ONE OR MORE SESSIONS (DEFINED TREATMENT SERIES)					
649	65860	SEVERING ADHESIONS OF ANTERIOR SEGMENT, LASER TECHNIQUE (SEPARATE PROCEDURE)					
649	66761	IRIDOTOMY/IRIDECTOMY BY LASER SURGERY (EG, FOR GLAUCOMA) (ONE OR MORE SESSIONS)					
649	66762	IRIDOPLASTY BY PHOTOCOAGULATION (ONE OR MORE SESSIONS) (EG, FOR IMPROVEMENT OF VISION, FOR WIDENING OF ANTERIOR CHAMBER ANGLE)					
649	66770	DESTRUCTION OF CYST OR LESION IRIS OR CILIARY BODY (NONEXCISIONAL PROCEDURE)					
649	66821	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); LASER SURGERY (EG, YAG LASER) (ONE OR MORE STAGES)					
649	66999	UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE					
649	67031	SEVERING OF VITREOUS STRANDS, VITREOUS FACE ADHESIONS, SHEETS, MEMBRANES OR OPACITIES, LASER SURGERY (ONE OR MORE STAGES)					
649	67299	UNLISTED PROCEDURE, POSTERIOR SEGMENT					
651	Level I Anterior Segment Eye Procedures		T	7.24	\$366.85	\$174.7	\$73.37
651	65272	REPAIR OF LACERATION; CONJUNCTIVA, BY MOBILIZATION AND REARRANGEMENT, WITHOUT HOSPITALIZATION					
651	65275	REPAIR OF LACERATION; CORNEA, NONPERFORATING, WITH OR WITHOUT REMOVAL FOREIGN BODY					
651	65286	REPAIR OF LACERATION; APPLICATION OF TISSUE GLUE, WOUNDS OF CORNEA AND/OR SCLERA					
651	65420	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITHOUT GRAFT					
651	65436	REMOVAL OF CORNEAL EPITHELIUM; WITH APPLICATION OF CHELATING AGENT (EG, EDTA)					
651	65450	DESTRUCTION OF LESION OF CORNEA BY CRYOTHERAPY, PHOTOCOAGULATION OR THERMOCAUTERIZATION					
651	65772	CORNEAL RELAXING INCISION FOR CORRECTION OF SURGICALLY INDUCED ASTIGMATISM					
651	65810	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH REMOVAL OF VITREOUS AND/OR DISCISSION OF ANTERIOR HYALOID MEMBRANE, WITH OR WITHOUT AIR INJECTION					
651	65815	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH REMOVAL OF BLOOD, WITH OR WITHOUT IRRIGATION AND/OR AIR INJECTION					
651	65820	GONIOTOMY					
651	66130	EXCISION OF LESION, SCLERA					
651	66500	IRIDOTOMY BY STAB INCISION (SEPARATE PROCEDURE); EXCEPT TRANSFIXION					
651	66505	IRIDOTOMY BY STAB INCISION (SEPARATE PROCEDURE); WITH TRANSFIXION AS FOR IRIS BOMBE					
651	66600	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; FOR REMOVAL OF LESION					
651	66625	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; PERIPHERAL FOR GLAUCOMA (SEPARATE PROCEDURE)					
651	66630	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; SECTOR FOR GLAUCOMA (SEPARATE PROCEDURE)					
651	66700	CILIARY BODY DESTRUCTION; DIATHERMY					
651	66710	CILIARY BODY DESTRUCTION; CYCLOPHOTOCOAGULATION					
651	66720	CILIARY BODY DESTRUCTION; CRYOTHERAPY					
651	66820	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); STAB INCISION TECHNIQUE (ZIEGLER OR WHEELER KNIFE)					
651	66825	REPOSITIONING OF INTRAOCULAR LENS PROSTHESIS, REQUIRING AN INCISION (SEPARATE PROCEDURE)					
652	Level II Anterior Segment Eye Procedures		T	16.48	\$835.03	\$433.69	\$167.01
652	65235	REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM ANTERIOR CHAMBER OR LENS					
652	65280	REPAIR OF LACERATION; CORNEA AND/OR SCLERA, PERFORATING, NOT INVOLVING UVEAL TISSUE					
652	65285	REPAIR OF LACERATION; CORNEA AND/OR SCLERA, PERFORATING, WITH REPOSITION OR RESECTION OF UVEAL TISSUE					
652	65400	EXCISION OF LESION, CORNEA (KERATECTOMY, LAMELLAR, PARTIAL), EXCEPT PTERYGIUM					
652	65426	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITH GRAFT					
652	65770	KERATOPROSTHESIS					
652	65775	CORNEAL WEDGE RESECTION FOR CORRECTION OF SURGICALLY INDUCED ASTIGMATISM					
652	65850	TRABECULOTOMY AB EXTERNO					
652	65865	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); GONIOSYNECHIAE					
652	65870	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); ANTERIOR SYNECHIAE, EXCEPT GONIOSYNECHIAE					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
652	65875	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); POSTERIOR SYNECHIAE					
652	65880	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); CORNEOVITREAL ADHESIONS					
652	65900	REMOVAL OF EPITHELIAL DOWNGROWTH, ANTERIOR CHAMBER EYE					
652	65920	REMOVAL OF IMPLANTED MATERIAL, ANTERIOR SEGMENT EYE					
652	65930	REMOVAL OF BLOOD CLOT, ANTERIOR SEGMENT EYE					
652	66150	FISTULIZATION OF SCLERA FOR GLAUCOMA; TREPHINATION WITH IRIDECTOMY					
652	66155	FISTULIZATION OF SCLERA FOR GLAUCOMA; THERMOCAUTERIZATION WITH IRIDECTOMY					
652	66160	FISTULIZATION OF SCLERA FOR GLAUCOMA; SCLERECTOMY WITH PUNCH OR SCISSORS, WITH IRIDECTOMY					
652	66165	FISTULIZATION OF SCLERA FOR GLAUCOMA; IRIDENCLEISIS OR IRIDOTASIS					
652	66170	FISTULIZATION OF SCLERA FOR GLAUCOMA; TRABECULECTOMY AB EXTERNO IN ABSENCE OF PREVIOUS SURGERY					
652	66172	FISTULIZATION OF SCLERA FOR GLAUCOMA; TRABECULECTOMY AB EXTERNO WITH SCARRING FROM PREVIOUS OCULAR SURGERY OR TRAUMA (INCLUDES INJECTION OF ANTIFIBROTIC AGENTS)					
652	66180	AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR (EG, MOLTEÑO, SCHOCKET, DENVER-KRUPIN)					
652	66185	REVISION OF AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR					
652	66225	REPAIR OF SCLERAL STAPHYLOMA; WITH GRAFT					
652	66250	REVISION OR REPAIR OF OPERATIVE WOUND OF ANTERIOR SEGMENT, ANY TYPE, EARLY OR LATE, MAJOR OR MINOR PROCEDURE					
652	66605	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; WITH CYCLECTOMY					
652	66635	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; OPTICAL (SEPARATE PROCEDURE)					
652	66680	REPAIR OF IRIS, CILIARY BODY (AS FOR IRIDODIALYSIS)					
652	66682	SUTURE OF IRIS, CILIARY BODY (SEPARATE PROCEDURE) WITH RETRIEVAL OF SUTURE THROUGH SMALL INCISION (EG, MCCANNEL SUTURE)					
652	66740	CILIARY BODY DESTRUCTION; CYCLODIALYSIS					
652	66830	REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID) WITH CORNEO-SCLERAL SECTION, WITH OR WITHOUT IRIDECTOMY (IRIDOCAPSULOTOMY, IRIDOCAPSULECTOMY)					
652	68130	EXCISION OF LESION, CONJUNCTIVA; WITH ADJACENT SCLERA					
652	68330	REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT GRAFT					
652	68360	CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE)					
652	68362	CONJUNCTIVAL FLAP; TOTAL (SUCH AS GUNDERSON THIN FLAP OR PURSE STRING FLAP)					
667	Cataract Procedures		T	15.33	\$776.40	\$521.72	\$155.28
667	66840	REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, ONE OR MORE STAGES					
667	66850	REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRASONIC) (EG, PHACOEMULSIFICATION), WITH ASPIRATION					
667	66852	REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY					
667	66920	REMOVAL OF LENS MATERIAL; INTRACAPSULAR					
667	66930	REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED LENS					
667	66940	REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)					
668	Cataract Procedures with IOL Insert		T	19.28	\$976.91	\$530.87	\$195.38
668	66983	INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE STAGE PROCEDURE)					
668	66984	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION)					
668	66985	INSERTION OF INTRAOCULAR LENS PROSTHESIS (SECONDARY IMPLANT), NOT ASSOCIATED WITH CONCURRENT CATARACT REMOVAL					
668	66986	EXCHANGE OF INTRAOCULAR LENS					
670	Corneal Transplant		T	29.23	\$1,481.07	\$847.5	\$296.21
670	65710	KERATOPLASTY (CORNEAL TRANSPLANT); LAMELLAR					
670	65730	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (EXCEPT IN APHAKIA)					
670	65750	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN APHAKIA)					
670	65755	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN PSEUDOPHAKIA)					
676	Posterior Segment Eye Procedures		T	6.3	\$319.22	\$140.35	\$63.84
676	65260	REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM POSTERIOR SEGMENT, MAGNETIC EXTRACTION, ANTERIOR OR POSTERIOR ROUTE					
676	65265	REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM POSTERIOR SEGMENT, NONMAGNETIC EXTRACTION					
676	66220	REPAIR OF SCLERAL STAPHYLOMA; WITHOUT GRAFT					
676	67005	REMOVAL OF VITREOUS, ANTERIOR APPROACH (OPEN SKY TECHNIQUE OR LIMBAL INCISION); PARTIAL REMOVAL					
676	67010	REMOVAL OF VITREOUS, ANTERIOR APPROACH (OPEN SKY TECHNIQUE OR LIMBAL INCISION); SUBTOTAL REMOVAL WITH MECHANICAL VITRECTOMY					
676	67015	ASPIRATION OR RELEASE OF VITREOUS, SUBRETINAL OR CHOROIDAL FLUID, PARS PLANA APPROACH (POSTERIOR SCLEROTOMY)					
676	67030	DISSECTION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS PLANA APPROACH					
676	67101	REPAIR OF RETINAL DETACHMENT, ONE OR MORE SESSIONS; CRYOTHERAPY OR DIATHERMY, WITH OR WITHOUT DRAINAGE OF SUBRETINAL FLUID					
676	67110	REPAIR OF RETINAL DETACHMENT; BY INJECTION OF AIR OR OTHER GAS (EG, PNEUMATIC RETINOPEXY)					
676	67115	RELEASE OF ENCIRCLING MATERIAL (POSTERIOR SEGMENT)					
676	67120	REMOVAL OF IMPLANTED MATERIAL, POSTERIOR SEGMENT; EXTRAOCULAR					
676	67121	REMOVAL OF IMPLANTED MATERIAL, POSTERIOR SEGMENT; INTRAOCULAR					
676	67141	PROPHYLAXIS OF RETINAL DETACHMENT (EG, RETINAL BREAK, LATTICE DEGENERATION) WITHOUT DRAINAGE, ONE OR MORE SESSIONS; CRYOTHERAPY, DIATHERMY					
676	67208	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULOPATHY, CHOROIDOPATHY, SMALL TUMORS), ONE OR MORE SESSIONS; CRYOTHERAPY, DIATHERMY					
676	67218	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULOPATHY, CHOROIDOPATHY, SMALL TUMORS), ONE OR MORE SESSIONS; RADIATION BY IMPLANTATION OF SOURCE (INCLUDES REMOVAL OF SOURCE)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT 1/ HCPCS 2	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
676	67227	DESTRUCTION OF EXTENSIVE OR PROGRESSIVE RETINOPATHY (EG, DIABETIC RETINOPATHY), ONE OR MORE SESSIONS; CRYOTHERAPY, DIATHERMY					
676	92018	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER GENERAL ANESTHESIA, WITH OR WITHOUT MANIPULATION OF GLOBE FOR PASSIVE RANGE OF MOTION OR OTHER MANIPULATION TO FACILITATE DIAGNOSTIC EXAMINATION; COMPLETE					
676	92019	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER GENERAL ANESTHESIA, WITH OR WITHOUT MANIPULATION OF GLOBE FOR PASSIVE RANGE OF MOTION OR OTHER MANIPULATION TO FACILITATE DIAGNOSTIC EXAMINATION; LIMITED					
677	Strabismus/Muscle Procedures		T	16.26	\$823.89	\$436.63	\$164.78
677	65290	REPAIR OF WOUND, EXTRAOCULAR MUSCLE, TENDON AND/OR TENON'S CAPSULE					
677	67311	STRABISMUS SURGERY, RECESSIO OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); ONE HORIZONTAL MUSCLE					
677	67312	STRABISMUS SURGERY, RECESSIO OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); TWO HORIZONTAL MUSCLES					
677	67314	STRABISMUS SURGERY, RECESSIO OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); ONE VERTICAL MUSCLE (EXCLUDING SUPERIOR OBLIQUE)					
677	67316	STRABISMUS SURGERY, RECESSIO OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); TWO OR MORE VERTICAL MUSCLES (EXCLUDING SUPERIOR OBLIQUE)					
677	67318	STRABISMUS SURGERY, ANY PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON), SUPERIOR OBLIQUE MUSCLE					
677	67320	TRANSPOSITION PROCEDURE (EG, FOR PARETIC EXTRAOCULAR MUSCLE), ANY EXTRAOCULAR MUSCLE (SPECIFY)					
677	67331	STRABISMUS SURGERY ON PATIENT WITH PREVIOUS EYE SURGERY OR INJURY THAT DID NOT INVOLVE THE EXTRAOCULAR MUSCLES					
677	67332	STRABISMUS SURGERY ON PATIENT WITH SCARRING OF EXTRAOCULAR MUSCLES (EG, PRIOR OCULAR INJURY, STRABISMUS OR RETINAL DETACHMENT SURGERY) OR RESTRICTIVE MYOPATHY (EG, DYSTHYROID OPHTHALMOPATHY)					
677	67334	STRABISMUS SURGERY BY POSTERIOR FIXATION SUTURE TECHNIQUE, WITH OR WITHOUT MUSCLE RECESSIO					
677	67335	PLACEMENT OF ADJUSTABLE SUTURE(S) DURING STRABISMUS SURGERY, INCLUDING POSTOPERATIVE ADJUSTMENT(S) OF SUTURE(S) (REPORT IN ADDITION TO CODE FOR SPECIFIC STRABISMUS SURGERY)					
677	67340	STRABISMUS SURGERY INVOLVING EXPLORATION AND/OR REPAIR OF DETACHED EXTRAOCULAR MUSCLE(S)					
677	67343	RELEASE OF EXTENSIVE SCAR TISSUE WITHOUT DETACHING EXTRAOCULAR MUSCLE (SEPARATE PROCEDURE)					
681	Level I Eye Procedures		T	1.67	\$84.62	\$30.51	\$16.92
681	65125	MODIFICATION OF OCULAR IMPLANT WITH PLACEMENT OR REPLACEMENT OF PEGS (EG, DRILLING RECEPTACLE FOR PROSTHESIS APPENDAGE) (SEPARATE PROCEDURE)					
681	65205	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL SUPERFICIAL					
681	65210	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL EMBEDDED (INCLUDES CONCRETIONS), SUBCONJUNCTIVAL, OR SCLERAL NONPERFORATING					
681	65220	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CORNEAL, WITHOUT SLIT LAMP					
681	65222	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CORNEAL, WITH SLIT LAMP					
681	65430	SCRAPING OF CORNEA, DIAGNOSTIC, FOR SMEAR AND/OR CULTURE					
681	65435	REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT CHEMOCAUTERIZATION (ABRASION, CURETTAGE)					
681	65600	MULTIPLE PUNCTURES OF ANTERIOR CORNEA (EG, FOR CORNEAL EROSION, TATTOO)					
681	67345	CHEMODENERVATION OF EXTRAOCULAR MUSCLE					
681	67500	RETROBULBAR INJECTION; MEDICATION (SEPARATE PROCEDURE, DOES NOT INCLUDE SUPPLY OF MEDICATION)					
681	67505	RETROBULBAR INJECTION; ALCOHOL					
681	67515	INJECTION OF THERAPEUTIC AGENT INTO TENON'S CAPSULE					
681	67599	UNLISTED PROCEDURE, ORBIT					
681	68200	SUBCONJUNCTIVAL INJECTION					
681	68761	CLOSURE OF THE LACRIMAL PUNCTUM; BY PLUG, EACH					
681	68899	UNLISTED PROCEDURE, LACRIMAL SYSTEM					
682	Level II Eye Procedures		T	3.54	\$179.37	\$81.36	\$35.87
682	67028	INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT (SEPARATE PROCEDURE)					
682	67700	BLEPHAROTOMY, DRAINAGE OF ABSCESS, EYELID					
682	67710	SEVERING OF TARSORRHAPHY					
682	67800	EXCISION OF CHALAZION; SINGLE					
682	67801	EXCISION OF CHALAZION; MULTIPLE, SAME LID					
682	67805	EXCISION OF CHALAZION; MULTIPLE, DIFFERENT LIDS					
682	67810	BIOPSY OF EYELID					
682	67820	CORRECTION OF TRICHIASIS; EPILATION, BY FORCEPS ONLY					
682	67825	CORRECTION OF TRICHIASIS; EPILATION BY OTHER THAN FORCEPS (EG, BY ELECTROSURGERY, CRYOTHERAPY, LASER SURGERY)					
682	67840	EXCISION OF LESION OF EYELID (EXCEPT CHALAZION) WITHOUT CLOSURE OR WITH SIMPLE DIRECT CLOSURE					
682	67850	DESTRUCTION OF LESION OF LID MARGIN (UP TO 1 CM)					
682	67875	TEMPORARY CLOSURE OF EYELIDS BY SUTURE (EG, FROST SUTURE)					
682	67915	REPAIR OF ECTROPION; THERMOCAUTERIZATION					
682	67922	REPAIR OF ENTROPION; THERMOCAUTERIZATION					
682	67930	SUTURE OF RECENT WOUND, EYELID, INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA DIRECT CLOSURE; PARTIAL THICKNESS					
682	67938	REMOVAL OF EMBEDDED FOREIGN BODY, EYELID					
682	67999	UNLISTED PROCEDURE, EYELIDS					
682	68020	INCISION OF CONJUNCTIVA, DRAINAGE OF CYST					
682	68040	EXPRESSION OF CONJUNCTIVAL FOLLICLES (EG, FOR TRACHOMA)					
682	68400	INCISION, DRAINAGE OF LACRIMAL GLAND					
682	68420	INCISION, DRAINAGE OF LACRIMAL SAC (DACRYOCYSTOTOMY OR DACRYOCYSTOSTOMY)					
682	68440	SNIP INCISION OF LACRIMAL PUNCTUM					
682	68530	REMOVAL OF FOREIGN BODY OR DACRYOLITH, LACRIMAL PASSAGES					
682	68705	CORRECTION OF EVERTED PUNCTUM, CAUTERY					
682	68760	CLOSURE OF THE LACRIMAL PUNCTUM; BY THERMOCAUTERIZATION, LIGATION, OR LASER SURGERY					
682	68801	DILATION OF LACRIMAL PUNCTUM, WITH OR WITHOUT IRRIGATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
682	68840	PROBING OF LACRIMAL CANALICULI, WITH OR WITHOUT IRRIGATION					
683	Level III Eye Procedures		T	10.19	\$516.32	\$257.87	\$103.26
683	65175	REMOVAL OF OCULAR IMPLANT					
683	65410	BIOPSY OF CORNEA					
683	65800	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH DIAGNOSTIC ASPIRATION OF AQUEOUS					
683	65805	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH THERAPEUTIC RELEASE OF AQUEOUS					
683	66020	INJECTION, ANTERIOR CHAMBER (SEPARATE PROCEDURE); AIR OR LIQUID					
683	66030	INJECTION, ANTERIOR CHAMBER (SEPARATE PROCEDURE); MEDICATION					
683	67025	INJECTION OF VITREOUS SUBSTITUTE, PARS PLANA OR LIMBAL APPROACH, (FLUID-GAS EXCHANGE), WITH OR WITHOUT ASPIRATION (SEPARATE PROCEDURE)					
683	67715	CANTHOTOMY (SEPARATE PROCEDURE)					
683	67830	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN					
683	67880	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN TARSORRHAPHY, OR CANTHORRHAPHY					
683	67935	SUTURE OF RECENT WOUND, EYELID, INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA DIRECT CLOSURE; FULL THICKNESS					
683	68510	BIOPSY OF LACRIMAL GLAND					
683	68525	BIOPSY OF LACRIMAL SAC					
683	68810	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION;					
684	Level IV Eye Procedures		T	13.48	\$683.02	\$348.94	\$136.6
684	65091	EVISCERATION OF OCULAR CONTENTS; WITHOUT IMPLANT					
684	65093	EVISCERATION OF OCULAR CONTENTS; WITH IMPLANT					
684	65101	ENUCLEATION OF EYE; WITHOUT IMPLANT					
684	65103	ENUCLEATION OF EYE; WITH IMPLANT, MUSCLES NOT ATTACHED TO IMPLANT					
684	65105	ENUCLEATION OF EYE; WITH IMPLANT, MUSCLES ATTACHED TO IMPLANT					
684	65130	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER EVISCERATION, IN SCLERAL SHELL					
684	65135	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER ENUCLEATION, MUSCLES NOT ATTACHED TO IMPLANT					
684	65140	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER ENUCLEATION, MUSCLES ATTACHED TO IMPLANT					
684	65150	REINSERTION OF OCULAR IMPLANT; WITH OR WITHOUT CONJUNCTIVAL GRAFT					
684	65155	REINSERTION OF OCULAR IMPLANT; WITH USE OF FOREIGN MATERIAL FOR REINFORCEMENT AND/OR ATTACHMENT OF MUSCLES TO IMPLANT					
684	67250	SCLERAL REINFORCEMENT (SEPARATE PROCEDURE); WITHOUT GRAFT					
684	67255	SCLERAL REINFORCEMENT (SEPARATE PROCEDURE); WITH GRAFT					
684	67400	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); FOR EXPLORATION, WITH OR WITHOUT BIOPSY					
684	67405	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); WITH DRAINAGE ONLY					
684	67412	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); WITH REMOVAL OF LESION					
684	67413	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); WITH REMOVAL OF FOREIGN BODY					
684	67550	ORBITAL IMPLANT (IMPLANT OUTSIDE MUSCLE CONE); INSERTION					
684	67560	ORBITAL IMPLANT (IMPLANT OUTSIDE MUSCLE CONE); REMOVAL OR REVISION					
684	67808	EXCISION OF CHALAZION; UNDER GENERAL ANESTHESIA AND/OR REQUIRING HOSPITALIZATION, SINGLE OR MULTIPLE					
684	67835	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN, WITH FREE MUCOUS MEMBRANE GRAFT					
684	67882	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN TARSORRHAPHY, OR CANTHORRHAPHY; WITH TRANSPOSITION OF TARSAL PLATE					
684	67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)					
684	67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL					
684	67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)					
684	67903	REPAIR OF BLEPHAROPTOSIS; (TARSO)LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH					
684	67904	REPAIR OF BLEPHAROPTOSIS; (TARSO)LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH					
684	67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)					
684	67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RESECTION (EG, FASANELLA-SERVAT TYPE)					
684	67909	REDUCTION OF OVERCORRECTION OF PTOSIS					
684	67911	CORRECTION OF LID RETRACTION					
684	67914	REPAIR OF ECTROPION; SUTURE					
684	67916	REPAIR OF ECTROPION; BLEPHAROPLASTY, EXCISION TARSAL WEDGE					
684	67917	REPAIR OF ECTROPION; BLEPHAROPLASTY, EXTENSIVE (EG, KUHN-TSZYMANOWSKI OR TARSAL STRIP OPERATIONS)					
684	67921	REPAIR OF ENTROPION; SUTURE					
684	67923	REPAIR OF ENTROPION; BLEPHAROPLASTY, EXCISION TARSAL WEDGE					
684	67924	REPAIR OF ENTROPION; BLEPHAROPLASTY, EXTENSIVE (EG, WHEELER OPERATION)					
684	67950	CANTHOPLASTY (RECONSTRUCTION OF CANTHUS)					
684	67961	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT; UP TO ONE-FOURTH OF LID MARGIN					
684	67966	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT; OVER ONE-FOURTH OF LID MARGIN					
684	67971	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; UP TO TWO-THIRDS OF EYELID, ONE STAGE OR FIRST STAGE					
684	67973	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, LOWER, ONE STAGE OR FIRST STAGE					
684	67974	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, UPPER, ONE STAGE OR FIRST STAGE					
684	67975	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; SECOND STAGE					
684	68320	CONJUNCTIVOPLASTY; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE REARRANGEMENT					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
684	68325	CONJUNCTIVOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT (INCLUDES OBTAINING GRAFT)					
684	68326	CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE REARRANGEMENT					
684	68328	CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH BUCCAL MUCOUS MEMBRANE GRAFT (INCLUDES OBTAINING GRAFT)					
684	68335	REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR BUCCAL MUCOUS MEMBRANE (INCLUDES OBTAINING GRAFT)					
684	68340	REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR WITHOUT INSERTION OF CONFORMER OR CONTACT LENS					
684	68500	EXCISION OF LACRIMAL GLAND (DACRYOADENECTOMY), EXCEPT FOR TUMOR; TOTAL					
684	68505	EXCISION OF LACRIMAL GLAND (DACRYOADENECTOMY), EXCEPT FOR TUMOR; PARTIAL					
684	68520	EXCISION OF LACRIMAL SAC (DACRYOCYSTECTOMY)					
684	68540	EXCISION OF LACRIMAL GLAND TUMOR; FRONTAL APPROACH					
684	68550	EXCISION OF LACRIMAL GLAND TUMOR; INVOLVING OSTEOTOMY					
684	68700	PLASTIC REPAIR OF CANALICULI					
684	68720	DACRYOCYSTORRHINOSTOMY (FISTULIZATION OF LACRIMAL SAC TO NASAL CAVITY)					
684	68745	CONJUNCTIVORHINOSTOMY (FISTULIZATION OF CONJUNCTIVA TO NASAL CAVITY); WITHOUT TUBE					
684	68750	CONJUNCTIVORHINOSTOMY (FISTULIZATION OF CONJUNCTIVA TO NASAL CAVITY); WITH INSERTION OF TUBE OR STENT					
684	68770	CLOSURE OF LACRIMAL FISTULA (SEPARATE PROCEDURE)					
684	68811	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; REQUIRING GENERAL ANESTHESIA					
684	68815	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; WITH INSERTION OF TUBE OR STENT					
690	Vitrectomy		T	30.54	\$1,547.45	\$852.02	\$309.49
690	67027	IMPLANTATION OR REPLACEMENT OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, GANCICLOVIR IMPLANT), INCLUDES CONCOMITANT REMOVAL OF VITREOUS					
690	67036	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH;					
690	67038	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH EPIRETINAL MEMBRANE STRIPPING					
690	67039	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH FOCAL ENDOLASER PHOTOCOAGULATION					
690	67040	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH ENDOLASER PANRETINAL PHOTOCOAGULATION					
690	67107	REPAIR OF RETINAL DETACHMENT; SCLERAL BUCKLING (SUCH AS LAMELLAR SCLERAL DISSECTION, IMBRICATION OR ENCIRCLING PROCEDURE), WITH OR WITHOUT IMPLANT, WITH OR WITHOUT CRYOTHERAPY, PHOTOCOAGULATION, AND DRAINAGE OF SUBRETINAL FLUID					
690	67108	REPAIR OF RETINAL DETACHMENT; WITH VITRECTOMY, ANY METHOD, WITH OR WITHOUT AIR OR GAS TAMPONADE, FOCAL ENDOLASER PHOTOCOAGULATION, CRYOTHERAPY, DRAINAGE OF SUBRETINAL FLUID, SCLERAL BUCKLING, AND/OR REMOVAL OF LENS BY SAME TECHNIQUE					
690	67112	REPAIR OF RETINAL DETACHMENT; BY SCLERAL BUCKLING OR VITRECTOMY, ON PATIENT HAVING PREVIOUS IPSILATERAL RETINAL DETACHMENT REPAIR(S) USING SCLERAL BUCKLING OR VITRECTOMY TECHNIQUES					
700	Plain Film		X	0.78	\$39.52	\$22.37	\$7.90
700	70030	RADIOLOGIC EXAMINATION, EYE, FOR DETECTION OF FOREIGN BODY					
700	70100	RADIOLOGIC EXAMINATION, MANDIBLE; PARTIAL, LESS THAN FOUR VIEWS					
700	70110	RADIOLOGIC EXAMINATION, MANDIBLE; COMPLETE, MINIMUM OF FOUR VIEWS					
700	70120	RADIOLOGIC EXAMINATION, MASTOIDS; LESS THAN THREE VIEWS PER SIDE					
700	70130	RADIOLOGIC EXAMINATION, MASTOIDS; COMPLETE, MINIMUM OF THREE VIEWS PER SIDE					
700	70134	RADIOLOGIC EXAMINATION, INTERNAL AUDITORY MEAT, COMPLETE					
700	70140	RADIOLOGIC EXAMINATION, FACIAL BONES; LESS THAN THREE VIEWS					
700	70150	RADIOLOGIC EXAMINATION, FACIAL BONES; COMPLETE, MINIMUM OF THREE VIEWS					
700	70160	RADIOLOGIC EXAMINATION, NASAL BONES, COMPLETE, MINIMUM OF THREE VIEWS					
700	70190	RADIOLOGIC EXAMINATION; OPTIC FORAMINA					
700	70200	RADIOLOGIC EXAMINATION; ORBITS, COMPLETE, MINIMUM OF FOUR VIEWS					
700	70210	RADIOLOGIC EXAMINATION, SINUSES, PARANASAL, LESS THAN THREE VIEWS					
700	70220	RADIOLOGIC EXAMINATION, SINUSES, PARANASAL, COMPLETE, MINIMUM OF THREE VIEWS					
700	70240	RADIOLOGIC EXAMINATION, SELLA TURCICA					
700	70250	RADIOLOGIC EXAMINATION, SKULL; LESS THAN FOUR VIEWS, WITH OR WITHOUT STEREO					
700	70260	RADIOLOGIC EXAMINATION, SKULL; COMPLETE, MINIMUM OF FOUR VIEWS, WITH OR WITHOUT STEREO					
700	70300	RADIOLOGIC EXAMINATION, TEETH; SINGLE VIEW					
700	70310	RADIOLOGIC EXAMINATION, TEETH; PARTIAL EXAMINATION, LESS THAN FULL MOUTH					
700	70320	RADIOLOGIC EXAMINATION, TEETH; COMPLETE, FULL MOUTH					
700	70328	RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN AND CLOSED MOUTH; UNILATERAL					
700	70330	RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN AND CLOSED MOUTH; BILATERAL					
700	70350	CEPHALOGRAM, ORTHODONTIC					
700	70355	ORTHOPANTOGRAM					
700	70360	RADIOLOGIC EXAMINATION; NECK, SOFT TISSUE					
700	70380	RADIOLOGIC EXAMINATION, SALIVARY GLAND FOR CALCULUS					
700	71010	RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL					
700	71015	RADIOLOGIC EXAMINATION, CHEST; STEREO, FRONTAL					
700	71020	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL;					
700	71021	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL; WITH APICAL LORDOTIC PROCEDURE					
700	71022	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL; WITH OBLIQUE PROJECTIONS					
700	71030	RADIOLOGIC EXAMINATION, CHEST, COMPLETE, MINIMUM OF FOUR VIEWS;					
700	71035	RADIOLOGIC EXAMINATION, CHEST, SPECIAL VIEWS (EG, LATERAL DECUBITUS, BUCKY STUDIES)					
700	71100	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; TWO VIEWS					
700	71101	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; INCLUDING POSTEROANTERIOR CHEST, MINIMUM OF THREE VIEWS					
700	71110	RADIOLOGIC EXAMINATION, RIBS, BILATERAL; THREE VIEWS					
700	71111	RADIOLOGIC EXAMINATION, RIBS, BILATERAL; INCLUDING POSTEROANTERIOR CHEST, MINIMUM OF FOUR VIEWS					
700	71120	RADIOLOGIC EXAMINATION; STERNUM, MINIMUM OF TWO VIEWS					
700	71130	RADIOLOGIC EXAMINATION; STERNOCLAVICULAR JOINT OR JOINTS, MINIMUM OF THREE VIEWS					
700	72010	RADIOLOGIC EXAMINATION, SPINE, ENTIRE, SURVEY STUDY, ANTEROPOSTERIOR AND LATERAL					
700	72020	RADIOLOGIC EXAMINATION, SPINE, SINGLE VIEW, SPECIFY LEVEL					
700	72040	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; ANTEROPOSTERIOR AND LATERAL					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
700	72050	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; MINIMUM OF FOUR VIEWS					
700	72052	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; COMPLETE, INCLUDING OBLIQUE AND FLEXION AND/OR EXTENSION STUDIES					
700	72069	RADIOLOGIC EXAMINATION, SPINE, THORACOLUMBAR, STANDING (SCOLIOSIS)					
700	72070	RADIOLOGIC EXAMINATION, SPINE; THORACIC, ANTEROPOSTERIOR AND LATERAL					
700	72072	RADIOLOGIC EXAMINATION, SPINE; THORACIC, ANTEROPOSTERIOR AND LATERAL, INCLUDING SWIMMER'S VIEW OF THE CERVICOTHORACIC JUNCTION					
700	72074	RADIOLOGIC EXAMINATION, SPINE; THORACIC, COMPLETE, INCLUDING OBLIQUES, MINIMUM OF FOUR VIEWS					
700	72080	RADIOLOGIC EXAMINATION, SPINE; THORACOLUMBAR, ANTEROPOSTERIOR AND LATERAL					
700	72090	RADIOLOGIC EXAMINATION, SPINE; SCOLIOSIS STUDY, INCLUDING SUPINE AND ERECT STUDIES					
700	72100	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; ANTEROPOSTERIOR AND LATERAL					
700	72110	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; COMPLETE, WITH OBLIQUE VIEWS					
700	72114	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; COMPLETE, INCLUDING BENDING VIEWS					
700	72120	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL, BENDING VIEWS ONLY, MINIMUM OF FOUR VIEWS					
700	72170	RADIOLOGIC EXAMINATION, PELVIS; ANTEROPOSTERIOR ONLY					
700	72190	RADIOLOGIC EXAMINATION, PELVIS; COMPLETE, MINIMUM OF THREE VIEWS					
700	72200	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; LESS THAN THREE VIEWS					
700	72202	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; THREE OR MORE VIEWS					
700	72220	RADIOLOGIC EXAMINATION, SACRUM AND COCCYX, MINIMUM OF TWO VIEWS					
700	73000	RADIOLOGIC EXAMINATION; CLAVICLE, COMPLETE					
700	73010	RADIOLOGIC EXAMINATION; SCAPULA, COMPLETE					
700	73020	RADIOLOGIC EXAMINATION, SHOULDER; ONE VIEW					
700	73030	RADIOLOGIC EXAMINATION, SHOULDER; COMPLETE, MINIMUM OF TWO VIEWS					
700	73050	RADIOLOGIC EXAMINATION; ACROMIOCLAVICULAR JOINTS, BILATERAL, WITH OR WITHOUT WEIGHTED DISTRACTION					
700	73060	RADIOLOGIC EXAMINATION; HUMERUS, MINIMUM OF TWO VIEWS					
700	73070	RADIOLOGIC EXAMINATION, ELBOW; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73080	RADIOLOGIC EXAMINATION, ELBOW; COMPLETE, MINIMUM OF THREE VIEWS					
700	73090	RADIOLOGIC EXAMINATION; FOREARM, ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73092	RADIOLOGIC EXAMINATION; UPPER EXTREMITY, INFANT, MINIMUM OF TWO VIEWS					
700	73100	RADIOLOGIC EXAMINATION, WRIST; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73110	RADIOLOGIC EXAMINATION, WRIST; COMPLETE, MINIMUM OF THREE VIEWS					
700	73120	RADIOLOGIC EXAMINATION, HAND; TWO VIEWS					
700	73130	RADIOLOGIC EXAMINATION, HAND; MINIMUM OF THREE VIEWS					
700	73140	RADIOLOGIC EXAMINATION, FINGER(S), MINIMUM OF TWO VIEWS					
700	73500	RADIOLOGIC EXAMINATION, HIP, UNILATERAL; ONE VIEW					
700	73510	RADIOLOGIC EXAMINATION, HIP, UNILATERAL; COMPLETE, MINIMUM OF TWO VIEWS					
700	73520	RADIOLOGIC EXAMINATION, HIPS, BILATERAL, MINIMUM OF TWO VIEWS OF EACH HIP, INCLUDING ANTEROPOSTERIOR VIEW OF PELVIS					
700	73530	RADIOLOGIC EXAMINATION, HIP, DURING OPERATIVE PROCEDURE					
700	73540	RADIOLOGIC EXAMINATION, PELVIS AND HIPS, INFANT OR CHILD, MINIMUM OF TWO VIEWS					
700	73550	RADIOLOGIC EXAMINATION, FEMUR, ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73560	RADIOLOGIC EXAMINATION, KNEE; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73562	RADIOLOGIC EXAMINATION, KNEE; ANTEROPOSTERIOR AND LATERAL, WITH OBLIQUE(S), MINIMUM OF THREE VIEWS					
700	73564	RADIOLOGIC EXAMINATION, KNEE; COMPLETE, INCLUDING OBLIQUE(S), AND TUNNEL, AND/OR PATELLAR AND/OR STANDING VIEWS					
700	73565	RADIOLOGIC EXAMINATION, KNEE; BOTH KNEES, STANDING, ANTEROPOSTERIOR					
700	73590	RADIOLOGIC EXAMINATION; TIBIA AND FIBULA, ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73592	RADIOLOGIC EXAMINATION; LOWER EXTREMITY, INFANT, MINIMUM OF TWO VIEWS					
700	73600	RADIOLOGIC EXAMINATION, ANKLE; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73610	RADIOLOGIC EXAMINATION, ANKLE; COMPLETE, MINIMUM OF THREE VIEWS					
700	73620	RADIOLOGIC EXAMINATION, FOOT; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73630	RADIOLOGIC EXAMINATION, FOOT; COMPLETE, MINIMUM OF THREE VIEWS					
700	73650	RADIOLOGIC EXAMINATION; CALCANEUS, MINIMUM OF TWO VIEWS					
700	73660	RADIOLOGIC EXAMINATION; TOE(S), MINIMUM OF TWO VIEWS					
700	74000	RADIOLOGIC EXAMINATION, ABDOMEN; SINGLE ANTEROPOSTERIOR VIEW					
700	74010	RADIOLOGIC EXAMINATION, ABDOMEN; ANTEROPOSTERIOR AND ADDITIONAL OBLIQUE AND CONE VIEWS					
700	74020	RADIOLOGIC EXAMINATION, ABDOMEN; COMPLETE, INCLUDING DECUBITUS AND/OR ERECT VIEWS					
700	74022	RADIOLOGIC EXAMINATION, ABDOMEN; COMPLETE ACUTE ABDOMEN SERIES, INCLUDING SUPINE, ERECT, AND/OR DECUBITUS VIEWS, UPRIGHT PA CHEST					
700	74710	PELVIMETRY, WITH OR WITHOUT PLACENTAL LOCALIZATION					
700	76010	RADIOLOGIC EXAMINATION FROM NOSE TO RECTUM FOR FOREIGN BODY, SINGLE FILM, CHILD					
700	76020	BONE AGE STUDIES					
700	76040	BONE LENGTH STUDIES (ORTHOROENTGENOGRAM, SCANOGRAM)					
700	76061	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; LIMITED (EG, FOR METASTASES)					
700	76062	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; COMPLETE (AXIAL AND APPENDICULAR SKELETON)					
700	76065	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY, INFANT					
700	76066	JOINT SURVEY, SINGLE VIEW, ONE OR MORE JOINTS (SPECIFY)					
700	76076	DUAL ENERGY X-RAY ABSORPTIOMETRY (DEXA), BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)					
700	76078	RADIOGRAPHIC ABSORPTIOMETRY (PHOTODENSITOMETRY), ONE OR MORE SITES					
700	76098	RADIOLOGICAL EXAMINATION, SURGICAL SPECIMEN					
700	76100	RADIOLOGIC EXAMINATION, SINGLE PLANE BODY SECTION (EG, TOMOGRAPHY), OTHER THAN WITH UROGRAPHY					
700	76120	CINERADIOGRAPHY, EXCEPT WHERE SPECIFICALLY INCLUDED					
700	76125	CINERADIOGRAPHY TO COMPLEMENT ROUTINE EXAMINATION					
700	76150	XERORADIOGRAPHY					
700	76499	UNLISTED DIAGNOSTIC RADIOLOGIC PROCEDURE					
700	77417	THERAPEUTIC RADIOLOGY PORT FILM(S)					
700	78350	BONE DENSITY (BONE MINERAL CONTENT) STUDY, ONE OR MORE SITES; SINGLE PHOTON ABSORPTIOMETRY					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
706		Miscellaneous Radiological Procedures	X	1.96	\$99.31	\$57.63	\$19.86
706	70170	DACRYOCYSTOGRAPHY, NASOLACRIMAL DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	70373	LARYNGOGRAPHY, CONTRAST, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	70390	SIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	71040	BRONCHOGRAPHY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	71060	BRONCHOGRAPHY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74190	PERITONEOGRAM (EG, AFTER INJECTION OF AIR OR CONTRAST), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74305	CHOLANGIOGRAPHY AND/OR PANCREATOGRAPHY; POSTOPERATIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74320	CHOLANGIOGRAPHY, PERCUTANEOUS, TRANSHEPATIC, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74328	ENDOSCOPIC CATHETERIZATION OF THE BILIARY DUCTAL SYSTEM, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74329	ENDOSCOPIC CATHETERIZATION OF THE PANCREATIC DUCTAL SYSTEM, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74330	COMBINED ENDOSCOPIC CATHETERIZATION OF THE BILIARY AND PANCREATIC DUCTAL SYSTEMS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74350	PERCUTANEOUS PLACEMENT OF GASTROSTOMY TUBE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74355	PERCUTANEOUS PLACEMENT OF ENTEROCLYSIS TUBE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74470	RADIOLOGIC EXAMINATION, RENAL CYST STUDY, TRANSUMBILIC, CONTRAST VISUALIZATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74740	HYSTEOSALPINGOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74742	TRANSERCERVICAL CATHETERIZATION OF FALLOPIAN TUBE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75801	LYMPHANGIOGRAPHY, EXTREMITY ONLY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75803	LYMPHANGIOGRAPHY, EXTREMITY ONLY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75805	LYMPHANGIOGRAPHY, PELVIC/ABDOMINAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75807	LYMPHANGIOGRAPHY, PELVIC/ABDOMINAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75809	SHUNTOGRAM FOR INVESTIGATION OF PREVIOUSLY PLACED INDWELLING NONVASCULAR SHUNT (EG, LEVEEN SHUNT, VENTRICULOPERITONEAL SHUNT), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75898	ANGIOGRAM THROUGH EXISTING CATHETER FOR FOLLOW-UP STUDY FOR TRANSCATHETER THERAPY, EMBOLIZATION OR INFUSION					
706	76075	DUAL ENERGY X-RAY ABSORPTIOMETRY (DEXA), BONE DENSITY STUDY, ONE OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)					
706	76080	RADIOLOGIC EXAMINATION, ABSCESS, FISTULA OR SINUS TRACT STUDY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76086	MAMMARY DUCTOGRAM OR GALACTOGRAM, SINGLE DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76088	MAMMARY DUCTOGRAM OR GALACTOGRAM, MULTIPLE DUCTS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76095	STEREOTACTIC LOCALIZATION FOR BREAST BIOPSY, EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76096	PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76101	RADIOLOGIC EXAMINATION, COMPLEX MOTION (IE, HYPERCYCLOIDAL) BODY SECTION (EG, MASTOID POLYTOMOGRAPHY), OTHER THAN WITH UROGRAPHY; UNILATERAL					
706	76102	RADIOLOGIC EXAMINATION, COMPLEX MOTION (IE, HYPERCYCLOIDAL) BODY SECTION (EG, MASTOID POLYTOMOGRAPHY), OTHER THAN WITH UROGRAPHY; BILATERAL					
710		Computerized Axial Tomography	S	5.06	\$256.39	\$176.28	\$51.28
710	70450	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL					
710	70460	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD OR BRAIN; WITH CONTRAST MATERIAL(S)					
710	70470	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	70480	COMPUTERIZED AXIAL TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL					
710	70481	COMPUTERIZED AXIAL TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITH CONTRAST MATERIAL(S)					
710	70482	COMPUTERIZED AXIAL TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	70486	COMPUTERIZED AXIAL TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL					
710	70487	COMPUTERIZED AXIAL TOMOGRAPHY, MAXILLOFACIAL AREA; WITH CONTRAST MATERIAL(S)					
710	70488	COMPUTERIZED AXIAL TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	70490	COMPUTERIZED AXIAL TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL					
710	70491	COMPUTERIZED AXIAL TOMOGRAPHY, SOFT TISSUE NECK; WITH CONTRAST MATERIAL(S)					
710	70492	COMPUTERIZED AXIAL TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	71250	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL					
710	71260	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX; WITH CONTRAST MATERIAL(S)					
710	71270	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72125	COMPUTERIZED AXIAL TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL					
710	72126	COMPUTERIZED AXIAL TOMOGRAPHY, CERVICAL SPINE; WITH CONTRAST MATERIAL					
710	72127	COMPUTERIZED AXIAL TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72128	COMPUTERIZED AXIAL TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL					
710	72129	COMPUTERIZED AXIAL TOMOGRAPHY, THORACIC SPINE; WITH CONTRAST MATERIAL					
710	72130	COMPUTERIZED AXIAL TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72131	COMPUTERIZED AXIAL TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL					
710	72132	COMPUTERIZED AXIAL TOMOGRAPHY, LUMBAR SPINE; WITH CONTRAST MATERIAL					
710	72133	COMPUTERIZED AXIAL TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72192	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL					
710	72193	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT-1/ HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
710	72194	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	73200	COMPUTERIZED AXIAL TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL					
710	73201	COMPUTERIZED AXIAL TOMOGRAPHY, UPPER EXTREMITY; WITH CONTRAST MATERIAL(S)					
710	73202	COMPUTERIZED AXIAL TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	73700	COMPUTERIZED AXIAL TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL					
710	73701	COMPUTERIZED AXIAL TOMOGRAPHY, LOWER EXTREMITY; WITH CONTRAST MATERIAL(S)					
710	73702	COMPUTERIZED AXIAL TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	74150	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL					
710	74160	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN; WITH CONTRAST MATERIAL(S)					
710	74170	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	76355	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION					
710	76360	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR NEEDLE BIOPSY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
710	76365	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR CYST ASPIRATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
710	76370	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS					
710	76375	CORONAL, SAGITTAL, MULTIPLANAR, OBLIQUE, 3-DIMENSIONAL AND/OR HOLOGRAPHIC RECONSTRUCTION OF COMPUTERIZED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, OR OTHER TOMOGRAPHIC MODALITY					
710	76380	COMPUTERIZED TOMOGRAPHY, LIMITED OR LOCALIZED FOLLOW-UP STUDY					
716	Fluoroscopy		X	1.59	\$80.56	\$47.91	\$16.11
716	70370	RADIOLOGIC EXAMINATION; PHARYNX OR LARYNX, INCLUDING FLUOROSCOPY AND/OR MAGNIFICATION TECHNIQUE					
716	70371	COMPLEX DYNAMIC PHARYNGEAL AND SPEECH EVALUATION BY CINE OR VIDEO RECORDING					
716	71023	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL; WITH FLUOROSCOPY					
716	71034	RADIOLOGIC EXAMINATION, CHEST, COMPLETE, MINIMUM OF FOUR VIEWS; WITH FLUOROSCOPY					
716	71036	NEEDLE BIOPSY OF INTRATHORACIC LESION, INCLUDING FOLLOW-UP FILMS, FLUOROSCOPIC LOCALIZATION ONLY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	71038	FLUOROSCOPIC LOCALIZATION FOR TRANSBRONCHIAL BIOPSY OR BRUSHING					
716	71090	INSERTION PACEMAKER, FLUOROSCOPY AND RADIOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	74340	INTRODUCTION OF LONG GASTROINTESTINAL TUBE (EG, MILLER-ABBOTT), INCLUDING MULTIPLE FLUOROSCOPIES AND FILMS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	75989	RADIOLOGICAL GUIDANCE FOR PERCUTANEOUS DRAINAGE OF ABSCESS, OR SPECIMEN COLLECTION (IE, FLUOROSCOPY, ULTRASOUND, OR COMPUTED TOMOGRAPHY), WITH PLACEMENT OF INDWELLING CATHETER, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	76000	FLUOROSCOPY (SEPARATE PROCEDURE), UP TO ONE HOUR PHYSICIAN TIME, OTHER THAN 71023 OR 71034 (EG, CARDIAC FLUOROSCOPY)					
716	76001	FLUOROSCOPY, PHYSICIAN TIME MORE THAN ONE HOUR, ASSISTING A NON-RADIOLOGIC PHYSICIAN (EG, NEPHROSTOLITHOTOMY, ERCP, BRONCHOSCOPY, TRANSBRONCHIAL BIOPSY)					
716	76003	FLUOROSCOPIC LOCALIZATION FOR NEEDLE BIOPSY OR FINE NEEDLE ASPIRATION					
720	Magnetic Resonance Angiography		S	6.34	\$321.24	206.11	\$64.25
720	70541	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD AND/OR NECK, WITH OR WITHOUT CONTRAST MATERIAL(S)					
726	Magnetic Resonance Imaging		S	7.96	\$403.33	\$258.09	\$80.67
726	70336	MAGNETIC RESONANCE (EG, PROTON) IMAGING, TEMPOROMANDIBULAR JOINT					
726	70540	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND NECK					
726	70551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL					
726	70552	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITH CONTRAST MATERIAL(S)					
726	70553	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES					
726	71550	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY)					
726	72141	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITHOUT CONTRAST MATERIAL					
726	72142	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITH CONTRAST MATERIAL(S)					
726	72146	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITHOUT CONTRAST MATERIAL					
726	72147	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITH CONTRAST MATERIAL(S)					
726	72148	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITHOUT CONTRAST MATERIAL					
726	72149	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITH CONTRAST MATERIAL(S)					
726	72156	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; CERVICAL					
726	72157	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; THORACIC					
726	72158	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; LUMBAR					
726	72196	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS					
726	73220	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT					
726	73221	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY					
726	73720	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY, OTHER THAN JOINT					
726	73721	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY					
726	74181	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN					
726	75552	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY; WITHOUT CONTRAST MATERIAL					
726	75553	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY; WITH CONTRAST MATERIAL					
726	75554	CARDIAC MAGNETIC RESONANCE IMAGING FOR FUNCTION, WITH OR WITHOUT MORPHOLOGY; COMPLETE STUDY					
726	75555	CARDIAC MAGNETIC RESONANCE IMAGING FOR FUNCTION, WITH OR WITHOUT MORPHOLOGY; LIMITED STUDY					
726	76093	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); UNILATERAL					
726	76094	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); BILATERAL					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT 1/ HCPCS 2	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
726	76390	MAGNETIC RESONANCE SPECTROSCOPY					
726	76400	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BONE MARROW BLOOD SUPPLY					
728	Myelography		S	4.07	\$206.22	\$113.23	\$41.24
728	70010	MYELOGRAPHY, POSTERIOR FOSSA, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	70015	CISTERNOGRAPHY, POSITIVE CONTRAST, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72240	MYELOGRAPHY, CERVICAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72255	MYELOGRAPHY, THORACIC, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72265	MYELOGRAPHY, LUMBOSACRAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72270	MYELOGRAPHY, ENTIRE SPINAL CANAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72285	DISKOGRAPHY, CERVICAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72295	DISKOGRAPHY, LUMBAR, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	Arthrography		S	2.48	\$125.66	\$72.09	\$25.13
730	70332	TEMPOROMANDIBULAR JOINT ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73040	RADIOLOGIC EXAMINATION, SHOULDER, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73085	RADIOLOGIC EXAMINATION, ELBOW, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73115	RADIOLOGIC EXAMINATION, WRIST, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73525	RADIOLOGIC EXAMINATION, HIP, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73580	RADIOLOGIC EXAMINATION, KNEE, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73615	RADIOLOGIC EXAMINATION, ANKLE, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
736	Digestive Radiology		S	1.85	\$93.74	\$54.24	\$18.75
736	74210	RADIOLOGIC EXAMINATION; PHARYNX AND/OR CERVICAL ESOPHAGUS					
736	74220	RADIOLOGIC EXAMINATION; ESOPHAGUS					
736	74230	SWALLOWING FUNCTION, PHARYNX AND/OR ESOPHAGUS, WITH CINERADIOGRAPHY AND/OR VIDEO					
736	74240	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER; WITH OR WITHOUT DELAYED FILMS, WITHOUT KUB					
736	74241	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER; WITH OR WITHOUT DELAYED FILMS, WITH KUB					
736	74245	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER; WITH SMALL BOWEL, INCLUDES MULTIPLE SERIAL FILMS					
736	74246	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER, AIR CONTRAST, WITH SPECIFIC HIGH DENSITY BARIUM, EFFERVESCENT AGENT, WITH OR WITHOUT GLUCAGON; WITH OR WITHOUT DELAYED FILMS, WITHOUT KUB					
736	74247	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER, AIR CONTRAST, WITH SPECIFIC HIGH DENSITY BARIUM, EFFERVESCENT AGENT, WITH OR WITHOUT GLUCAGON; WITH OR WITHOUT DELAYED FILMS, WITH KUB					
736	74249	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER, AIR CONTRAST, WITH SPECIFIC HIGH DENSITY BARIUM, EFFERVESCENT AGENT, WITH OR WITHOUT GLUCAGON; WITH SMALL BOWEL FOLLOW-THROUGH					
736	74250	RADIOLOGIC EXAMINATION, SMALL BOWEL, INCLUDES MULTIPLE SERIAL FILMS;					
736	74251	RADIOLOGIC EXAMINATION, SMALL BOWEL, INCLUDES MULTIPLE SERIAL FILMS; VIA ENTEROCLYSIS TUBE					
736	74260	DUODENOGRAPHY, HYPOTONIC					
736	74270	RADIOLOGIC EXAMINATION, COLON; BARIUM ENEMA, WITH OR WITHOUT KUB					
736	74280	RADIOLOGIC EXAMINATION, COLON; AIR CONTRAST WITH SPECIFIC HIGH DENSITY BARIUM, WITH OR WITHOUT GLUCAGON					
736	74283	THERAPEUTIC ENEMA, CONTRAST OR AIR, FOR REDUCTION OF INTUSSUSCEPTION OR OTHER INTRALUMINAL OBSTRUCTION (EG, MECONIUM ILEUS)					
736	74290	CHOLECYSTOGRAPHY, ORAL CONTRAST;					
736	74291	CHOLECYSTOGRAPHY, ORAL CONTRAST; ADDITIONAL OR REPEAT EXAMINATION OR MULTIPLE DAY EXAMINATION					
736	G0106	Colorectal Ca screening					
736	G0120	Colorectal Ca screening					
737	Diagnostic Urography		S	2.81	\$142.38	\$86.56	\$28.48
737	74400	UROGRAPHY (PYELOGRAPHY), INTRAVENOUS, WITH OR WITHOUT KUB, WITH OR WITHOUT TOMOGRAPHY;					
737	74405	UROGRAPHY (PYELOGRAPHY), INTRAVENOUS, WITH OR WITHOUT KUB, WITH OR WITHOUT TOMOGRAPHY; WITH SPECIAL HYPER-TENSIVE CONTRAST CONCENTRATION AND/OR CLEARANCE STUDIES					
737	74410	UROGRAPHY, INFUSION, DRIP TECHNIQUE AND/OR BOLUS TECHNIQUE;					
737	74415	UROGRAPHY, INFUSION, DRIP TECHNIQUE AND/OR BOLUS TECHNIQUE; WITH NEPHROTOMOGRAPHY					
737	74420	UROGRAPHY, RETROGRADE, WITH OR WITHOUT KUB					
737	74425	UROGRAPHY, ANTEGRADE, (PYELOSTOGRAM, NEPHROSTOGRAM, LOOPOGRAM), RADIOLOGICAL SUPERVISION AND					
737	74430	CYSTOGRAPHY, MINIMUM OF THREE VIEWS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74440	VASOGRAPHY, VESICULOGRAPHY, OR EPIDIDYMOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74445	CORPORA CAVERNOSOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74450	URETHROCYSTOGRAPHY, RETROGRADE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74455	URETHROCYSTOGRAPHY, VOIDING, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74775	PERINEOGRAM (EG, VAGINOGRAM, FOR SEX DETERMINATION OR EXTENT OF ANOMALIES)					
738	Therapeutic Radiologic Procedures		S	4.48	\$227.00	\$133.23	\$45.4
738	74235	REMOVAL OF FOREIGN BODY(S), ESOPHAGEAL, WITH USE OF BALLOON CATHETER, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74327	POSTOPERATIVE BILIARY DUCT STONE REMOVAL, PERCUTANEOUS VIA T-TUBE TRACT, BASKET, OR SNARE (EG, BURHENNE TECHNIQUE), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74360	INTRALUMINAL DILATION OF STRICTURES AND/OR OBSTRUCTIONS (EG, ESOPHAGUS), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74363	PERCUTANEOUS TRANSHEPATIC DILATATION OF BILIARY DUCT STRICTURE WITH OR WITHOUT PLACEMENT OF STENT, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74475	INTRODUCTION OF INTRACATHETER OR CATHETER INTO RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74480	INTRODUCTION OF URETERAL CATHETER OR STENT INTO URETER THROUGH RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74485	DILATION OF NEPHROSTOMY, URETERS, OR URETHRA, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	75980	PERCUTANEOUS TRANSHEPATIC BILIARY DRAINAGE WITH CONTRAST MONITORING, RADIOLOGICAL SUPERVISION AND INTERPRETATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
738	75982	PERCUTANEOUS PLACEMENT OF DRAINAGE CATHETER FOR COMBINED INTERNAL AND EXTERNAL BILIARY DRAINAGE OR OF A DRAINAGE STENT FOR INTERNAL BILIARY DRAINAGE IN PATIENTS WITH AN INOPERABLE MECHANICAL BILIARY OBSTRUCTION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	75984	CHANGE OF PERCUTANEOUS TUBE OR DRAINAGE CATHETER WITH CONTRAST MONITORING (EG, GASTROINTESTINAL SYSTEM, GENITOURINARY SYSTEM, ABSCESS), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	Diagnostic	Angiography and Venography	S	5.83	\$295.40	\$168.71	\$59.08
739	75600	AORTOGRAPHY, THORACIC, WITHOUT SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75605	AORTOGRAPHY, THORACIC, BY SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75625	AORTOGRAPHY, ABDOMINAL, BY SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75630	AORTOGRAPHY, ABDOMINAL PLUS BILATERAL ILIOFEMORAL LOWER EXTREMITY, CATHETER, BY SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75650	ANGIOGRAPHY, CERVICOCEREBRAL, CATHETER, INCLUDING VESSEL ORIGIN, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75658	ANGIOGRAPHY, BRACHIAL, RETROGRADE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75660	ANGIOGRAPHY, EXTERNAL CAROTID, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75662	ANGIOGRAPHY, EXTERNAL CAROTID, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75665	ANGIOGRAPHY, CAROTID, CEREBRAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75671	ANGIOGRAPHY, CAROTID, CEREBRAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75676	ANGIOGRAPHY, CAROTID, CERVICAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75680	ANGIOGRAPHY, CAROTID, CERVICAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75685	ANGIOGRAPHY, VERTEBRAL, CERVICAL, AND/OR INTRACRANIAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75705	ANGIOGRAPHY, SPINAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75710	ANGIOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75716	ANGIOGRAPHY, EXTREMITY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75722	ANGIOGRAPHY, RENAL, UNILATERAL, SELECTIVE (INCLUDING FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75724	ANGIOGRAPHY, RENAL, BILATERAL, SELECTIVE (INCLUDING FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75726	ANGIOGRAPHY, VISCERAL, SELECTIVE OR SUPRASELECTIVE, (WITH OR WITHOUT FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75731	ANGIOGRAPHY, ADRENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75733	ANGIOGRAPHY, ADRENAL, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75736	ANGIOGRAPHY, PELVIC, SELECTIVE OR SUPRASELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75741	ANGIOGRAPHY, PULMONARY, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75743	ANGIOGRAPHY, PULMONARY, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75746	ANGIOGRAPHY, PULMONARY, BY NONSELECTIVE CATHETER OR VENOUS INJECTION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75756	ANGIOGRAPHY, INTERNAL MAMMARY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75774	ANGIOGRAPHY, SELECTIVE, EACH ADDITIONAL VESSEL STUDIED AFTER BASIC EXAMINATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75790	ANGIOGRAPHY, ARTERIOVENOUS SHUNT (EG, DIALYSIS PATIENT), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75810	SPLENOPTOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75820	VENOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75822	VENOGRAPHY, EXTREMITY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75825	VENOGRAPHY, CAVAL, INFERIOR, WITH SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75827	VENOGRAPHY, CAVAL, SUPERIOR, WITH SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75831	VENOGRAPHY, RENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75833	VENOGRAPHY, RENAL, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75840	VENOGRAPHY, ADRENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75842	VENOGRAPHY, ADRENAL, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75860	VENOGRAPHY, SINUS OR JUGULAR, CATHETER, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75870	VENOGRAPHY, SUPERIOR SAGITTAL SINUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75872	VENOGRAPHY, EPIDURAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75880	VENOGRAPHY, ORBITAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75885	PERCUTANEOUS TRANSHEPATIC PORTOGRAPHY WITH HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75887	PERCUTANEOUS TRANSHEPATIC PORTOGRAPHY WITHOUT HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75889	HEPATIC VENOGRAPHY, WEDGED OR FREE, WITH HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75891	HEPATIC VENOGRAPHY, WEDGED OR FREE, WITHOUT HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
746	Mammography		S	0.69	\$34.96	\$19.44	\$6.99
746	76090	MAMMOGRAPHY; UNILATERAL					
746	76091	MAMMOGRAPHY; BILATERAL					
747	Diagnostic	Ultrasound Except Vascular	S	1.65	\$83.60	\$54.69	\$16.72
747	76506	ECHOENCEPHALOGRAPHY, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION (GRAY SCALE) (FOR DETERMINATION OF VENTRICULAR SIZE, DELINEATION OF CEREBRAL CONTENTS AND DETECTION OF FLUID MASSES OR OTHER INTRACRANIAL ABNORMALITIES), INCLUDING A-MODE ENCEPHALOGRAPH					
747	76511	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; A-SCAN ONLY, WITH AMPLITUDE QUANTIFICATION					
747	76512	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; CONTACT B-SCAN (WITH OR WITHOUT SIMULTANEOUS A-SCAN)					
747	76513	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; IMMERSION (WATER BATH) B-SCAN					
747	76516	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN;					
747	76519	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN; WITH INTRAOCULAR LENS POWER CALCULATION					
747	76529	OPHTHALMIC ULTRASONIC FOREIGN BODY LOCALIZATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
747	76536	ECHOGRAPHY, SOFT TISSUES OF HEAD AND NECK (EG, THYROID, PARATHYROID, PAROTID), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76604	ECHOGRAPHY, CHEST, B-SCAN (INCLUDES MEDIASTINUM) AND/OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76645	ECHOGRAPHY, BREAST(S) (UNILATERAL OR BILATERAL), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76700	ECHOGRAPHY, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE					
747	76705	ECHOGRAPHY, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED (EG, SINGLE ORGAN, QUADRANT, FOLLOW-UP)					
747	76770	ECHOGRAPHY, RETROPERITONEAL (EG, RENAL, AORTA, NODES), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE					
747	76775	ECHOGRAPHY, RETROPERITONEAL (EG, RENAL, AORTA, NODES), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED					
747	76778	ECHOGRAPHY OF TRANSPLANTED KIDNEY, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION, WITH OR WITHOUT DUPLEX DOPPLER STUDIES					
747	76800	ECHOGRAPHY, SPINAL CANAL AND CONTENTS					
747	76805	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE (COMPLETE FETAL AND MATERNAL EVALUATION)					
747	76810	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE (COMPLETE FETAL AND MATERNAL EVALUATION), MULTIPLE GESTATION, AFTER THE FIRST TRIMESTER					
747	76815	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED (FETAL SIZE, HEART BEAT, PLACENTAL LOCATION, FETAL POSITION, OR EMERGENCY IN THE DELIVERY ROOM)					
747	76816	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; FOLLOW-UP OR REPEAT					
747	76818	FETAL BIOPHYSICAL PROFILE					
747	76830	ECHOGRAPHY, TRANSVAGINAL					
747	76831	HYSTEROSONOGRAPHY, WITH OR WITHOUT COLOR FLOW DOPPLER					
747	76856	ECHOGRAPHY, PELVIC (NONOBSTETRIC), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE					
747	76857	ECHOGRAPHY, PELVIC (NONOBSTETRIC), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED OR FOLLOW-UP (EG, FOR FOLLICLES)					
747	76870	ECHOGRAPHY, SCROTUM AND CONTENTS					
747	76872	ECHOGRAPHY, TRANSRECTAL					
747	76880	ECHOGRAPHY, EXTREMITY, NON-VASCULAR, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76885	ECHOGRAPHY OF INFANT HIPS, REAL TIME WITH IMAGING DOCUMENTATION; DYNAMIC (EG, REQUIRING MANIPULATION)					
747	76886	ECHOGRAPHY OF INFANT HIPS, REAL TIME WITH IMAGING DOCUMENTATION; LIMITED, STATIC (EG, NOT REQUIRING MANIPULATION)					
747	76970	ULTRASOUND STUDY FOLLOW-UP (SPECIFY)					
747	76975	GASTROINTESTINAL ENDOSCOPIC ULTRASOUND, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
747	76986	ECHOGRAPHY, INTRAOPERATIVE					
747	76999	UNLISTED ULTRASOUND PROCEDURE					
747	G0050	POST-VOIDAL RESIDUAL URINE/BLADDER CAPACITY					
749	Guidance under Ultrasound		X	2.44	\$123.63	\$76.16	\$24.73
749	76930	ULTRASONIC GUIDANCE FOR PERICARDIOCENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76932	ULTRASONIC GUIDANCE FOR ENDOMYOCARDIAL BIOPSY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76934	ULTRASONIC GUIDANCE FOR THORACENTESIS OR ABDOMINAL PARACENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76936	ULTRASOUND GUIDED COMPRESSION REPAIR OF ARTERIAL PSEUDO-ANEURYSM OR ARTERIOVENOUS FISTULAE (INCLUDES DIAGNOSTIC ULTRASOUND EVALUATION, COMPRESSION OF LESION AND IMAGING)					
749	76938	ULTRASONIC GUIDANCE FOR CYST (ANY LOCATION) OR RENAL PELVIS ASPIRATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76941	ULTRASONIC GUIDANCE FOR INTRAUTERINE FETAL TRANSFUSION OR CORDOCENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76942	ULTRASONIC GUIDANCE FOR NEEDLE BIOPSY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76945	ULTRASONIC GUIDANCE FOR CHORIONIC VILLUS SAMPLING, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76946	ULTRASONIC GUIDANCE FOR AMNIOCENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76948	ULTRASONIC GUIDANCE FOR ASPIRATION OF OVA, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76950	ECHOGRAPHY FOR PLACEMENT OF RADIATION THERAPY FIELDS, B-SCAN					
749	76960	ULTRASONIC GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS, EXCEPT FOR B-SCAN ECHOGRAPHY					
749	76965	ULTRASONIC GUIDANCE FOR INTERSTITIAL RADIOELEMENT APPLICATION					
750	Therapeutic Radiation Treatment Planning		X	0.91	\$46.11	\$25.54	\$9.22
750	77261	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; SIMPLE					
750	77262	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; INTERMEDIATE					
750	77263	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; COMPLEX					
750	77336	CONTINUING MEDICAL RADIATION PHYSICS CONSULTATION IN SUPPORT OF THERAPEUTIC RADIOLOGIST INCLUDING CONTINUING QUALITY ASSURANCE REPORTED PER WEEK OF THERAPY					
750	77370	SPECIAL MEDICAL RADIATION PHYSICS CONSULTATION					
750	77399	UNLISTED PROCEDURE, MEDICAL RADIATION PHYSICS, DOSIMETRY AND TREATMENT DEVICES					
750	77431	RADIATION THERAPY MANAGEMENT WITH COMPLETE COURSE OF THERAPY CONSISTING OF ONE OR TWO FRACTIONS ONLY					
750	77432	STEREOTACTIC RADIATION TREATMENT MANAGEMENT OF CEREBRAL LESION(S) (COMPLETE COURSE OF TREATMENT CONSISTING OF ONE SESSION)					
751	Level I Therapeutic Radiation Treatment Preparation		X	1.15	\$58.27	\$33.22	\$11.65
751	77299	UNLISTED PROCEDURE, THERAPEUTIC RADIOLOGY CLINICAL TREATMENT PLANNING					
751	77300	BASIC RADIATION DOSIMETRY CALCULATION, CENTRAL AXIS DEPTH DOSE, TDF, NSD, GAP CALCULATION, OFF AXIS FACTOR, TISSUE INHOMOGENEITY FACTORS, AS REQUIRED DURING COURSE OF TREATMENT, ONLY WHEN PRESCRIBED BY THE TREATING PHYSICIAN					
751	77305	TELETHERAPY, ISODOSE PLAN (WHETHER HAND OR COMPUTER CALCULATED); SIMPLE (ONE OR TWO PARALLEL OPPOSED UNMODIFIED PORTS DIRECTED TO A SINGLE AREA OF INTEREST)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
751	77310	TELETHERAPY, ISODOSE PLAN (WHETHER HAND OR COMPUTER CALCULATED); INTERMEDIATE (THREE OR MORE TREATMENT PORTS DIRECTED TO A SINGLE AREA OF INTEREST)					
751	77315	TELETHERAPY, ISODOSE PLAN (WHETHER HAND OR COMPUTER CALCULATED); COMPLEX (MANTLE OR INVERTED Y, TANGENTIAL PORTS, THE USE OF WEDGES, COMPENSATORS, COMPLEX BLOCKING, ROTATIONAL BEAM, OR SPECIAL BEAM CONSIDERATIONS)					
751	77321	SPECIAL TELETHERAPY PORT PLAN, PARTICLES, HEMIBODY, TOTAL BODY					
751	77326	BRACHYTHERAPY ISODOSE CALCULATION; SIMPLE (CALCULATION MADE FROM SINGLE PLANE, ONE TO FOUR SOURCES/ RIBBON APPLICATION, REMOTE AFTERLOADING BRACHYTHERAPY, 1 TO 8 SOURCES)					
751	77327	BRACHYTHERAPY ISODOSE CALCULATION; INTERMEDIATE (MULTIPLANE DOSAGE CALCULATIONS, APPLICATION INVOLVING 5 TO 10 SOURCES/RIBBONS, REMOTE AFTERLOADING BRACHYTHERAPY, 9 TO 12 SOURCES)					
751	77328	BRACHYTHERAPY ISODOSE CALCULATION; COMPLEX (MULTIPLANE ISODOSE PLAN, VOLUME IMPLANT CALCULATIONS, OVER 10 SOURCES/RIBBONS USED, SPECIAL SPATIAL RECONSTRUCTION, REMOTE AFTERLOADING BRACHYTHERAPY, OVER 12 SOURCES)					
751	77331	SPECIAL DOSIMETRY (EG, TLD, MICRODOSIMETRY) (SPECIFY), ONLY WHEN PRESCRIBED BY THE TREATING PHYSICIAN					
751	77332	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; SIMPLE (SIMPLE BLOCK, SIMPLE BOLUS)					
751	77333	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; INTERMEDIATE (MULTIPLE BLOCKS, STENTS, BITE BLOCKS, SPECIAL BOLUS)					
751	77334	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; COMPLEX (IRREGULAR BLOCKS, SPECIAL SHIELDS, COMPENSATORS, WEDGES, MOLDS OR CASTS)					
752	Level II Therapeutic Radiation Treatment		X	3.54	\$179.37	\$88.82	\$35.87
752	77280	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; SIMPLE					
752	77285	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; INTERMEDIATE					
752	77290	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; COMPLEX					
752	77295	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; THREE-DIMENSIONAL					
757	Radiation Therapy		S	2.30	\$116.54	\$52.43	\$23.31
757	61793	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY OR LINEAR ACCELERATOR), ONE OR MORE SESSIONS					
757	77401	RADIATION TREATMENT DELIVERY, SUPERFICIAL AND/OR ORTHO VOLTAGE					
757	77402	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; UP TO 5 MEV					
757	77403	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 6-10 MEV					
757	77404	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 11-19 MEV					
757	77406	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 20 MEV OR GREATER					
757	77407	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; UP TO 5 MEV					
757	77408	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; 6-10 MEV					
757	77409	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; 11-19 MEV					
757	77411	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; 20 MEV OR GREATER					
757	77412	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); UP TO 5 MEV					
757	77413	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); 6-10 MEV					
757	77414	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); 11-19 MEV					
757	77416	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); 20 MEV OR GREATER					
757	77470	SPECIAL TREATMENT PROCEDURE (EG, TOTAL BODY IRRADIATION, HEMIBODY IRRADIATION, PER ORAL, VAGINAL CONE IRRADIATION)					
758	Hyperthermic Therapies		S	3.41	\$172.78	\$76.84	\$34.56
758	77600	HYPERTHERMIA, EXTERNALLY GENERATED; SUPERFICIAL (IE, HEATING TO A DEPTH OF 4 CM OR LESS)					
758	77605	HYPERTHERMIA, EXTERNALLY GENERATED; DEEP (IE, HEATING TO DEPTHS GREATER THAN 4 CM)					
758	77610	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); 5 OR FEWER INTERSTITIAL APPLICATORS					
758	77615	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); MORE THAN 5 INTERSTITIAL APPLICATORS					
758	77620	HYPERTHERMIA GENERATED BY INTRACAVITARY PROBE(S)					
759	Brachytherapy and Complex Radioelement Applications		S	7.98	\$404.34	\$160.01	\$80.87
759	77750	INFUSION OR INSTALLATION OF RADIOELEMENT SOLUTION					
759	77761	INTRACAVITARY RADIOELEMENT APPLICATION; SIMPLE					
759	77762	INTRACAVITARY RADIOELEMENT APPLICATION; INTERMEDIATE					
759	77763	INTRACAVITARY RADIOELEMENT APPLICATION; COMPLEX					
759	77776	INTERSTITIAL RADIOELEMENT APPLICATION; SIMPLE					
759	77777	INTERSTITIAL RADIOELEMENT APPLICATION; INTERMEDIATE					
759	77778	INTERSTITIAL RADIOELEMENT APPLICATION; COMPLEX					
759	77781	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; 1-4 SOURCE POSITIONS OR CATHETERS					
759	77782	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; 5-8 SOURCE POSITIONS OR CATHETERS					
759	77783	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; 9-12 SOURCE POSITIONS OR CATHETERS					
759	77784	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; OVER 12 SOURCE POSITIONS OR CATHETERS					
759	77789	SURFACE APPLICATION OF RADIOELEMENT					
759	77799	UNLISTED PROCEDURE, CLINICAL BRACHYTHERAPY					
760	PET Scans		S	17.26	\$874.55	\$419.46	\$174.91
760	78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
760	78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); METABOLIC EVALUATION					
760	78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); PERFUSION EVALUATION					
760	78810	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION					
760	G0030	PET imaging prev PET single					
760	G0031	PET imaging prev PET multiple					
760	G0032	PET follow SPECT 78464 single					
760	G0033	PET follow SPECT 78464 multiple					
760	G0034	PET follow SPECT 78865 single					
760	G0035	PET follow SPECT 78465 multiple					
760	G0036	PET follow coronary angiography single					
760	G0037	PET follow coronary angiography multiple					
760	G0038	PET follow myocardial perfusion single					
760	G0039	PET follow myocardial perfusion multiple					
760	G0040	PET follow stress echocardiography single					
760	G0041	PET follow stress echocardiography multiple					
760	G0042	PET follow ventriculography single					
760	G0043	PET follow ventriculography multiple					
760	G0044	PET following rest ECG single					
760	G0045	PET following rest ECG multiple					
760	G0046	PET follow stress ECG single					
760	G0047	PET follow stress ECG multiple					
761	Standard	Non-Imaging Nuclear Medicine	S	2.04	\$103.37	\$61.47	\$20.67
761	78000	THYROID UPTAKE; SINGLE DETERMINATION					
761	78099	UNLISTED ENDOCRINE PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
761	78110	PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION TECHNIQUE (SEPARATE PROCEDURE); SINGLE SAMPLING					
761	78111	PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION TECHNIQUE (SEPARATE PROCEDURE); MULTIPLE SAMPLINGS					
761	78120	RED CELL VOLUME DETERMINATION (SEPARATE PROCEDURE); SINGLE SAMPLING					
761	78199	UNLISTED HEMATOPOIETIC, RETICULOENDOTHELIAL AND LYMPHATIC PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
761	78270	VITAMIN B-12 ABSORPTION STUDY (EG, SCHILLING TEST); WITHOUT INTRINSIC FACTOR					
761	78271	VITAMIN B-12 ABSORPTION STUDY (EG, SCHILLING TEST); WITH INTRINSIC FACTOR					
761	78272	VITAMIN B-12 ABSORPTION STUDIES COMBINED, WITH AND WITHOUT INTRINSIC FACTOR					
761	78282	GASTROINTESTINAL PROTEIN LOSS					
761	78299	UNLISTED GASTROINTESTINAL PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
761	78725	KIDNEY FUNCTION STUDY WITHOUT PHARMACOLOGIC INTERVENTION					
761	78999	UNLISTED MISCELLANEOUS PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
762	Complex	Non-Imaging Nuclear Medicine	S	1.78	\$90.19	\$51.53	\$18.04
762	78001	THYROID UPTAKE; MULTIPLE DETERMINATIONS					
762	78003	THYROID UPTAKE; STIMULATION, SUPPRESSION OR DISCHARGE (NOT INCLUDING INITIAL UPTAKE STUDIES)					
762	78121	RED CELL VOLUME DETERMINATION (SEPARATE PROCEDURE); MULTIPLE SAMPLINGS					
762	78122	WHOLE BLOOD VOLUME DETERMINATION, INCLUDING SEPARATE MEASUREMENT OF PLASMA VOLUME AND RED CELL VOLUME (RADIOPHARMACEUTICAL VOLUME-DILUTION TECHNIQUE)					
762	78130	RED CELL SURVIVAL STUDY;					
762	78135	RED CELL SURVIVAL STUDY; DIFFERENTIAL ORGAN/TISSUE KINETICS, (EG, SPLENIC AND/OR HEPATIC SEQUESTRATION)					
762	78140	LABELED RED CELL SEQUESTRATION, DIFFERENTIAL ORGAN/TISSUE, (EG, SPLENIC AND/OR HEPATIC)					
762	78160	PLASMA RADIOIRON DISAPPEARANCE (TURNOVER) RATE					
762	78162	RADIOIRON ORAL ABSORPTION					
762	78170	RADIOIRON RED CELL UTILIZATION					
762	78172	CHELATABLE IRON FOR ESTIMATION OF TOTAL BODY IRON					
762	78190	KINETICS, STUDY OF PLATELET SURVIVAL, WITH OR WITHOUT DIFFERENTIAL ORGAN/TISSUE LOCALIZATION					
762	78191	PLATELET SURVIVAL STUDY					
762	78414	DETERMINATION OF CENTRAL C-V HEMODYNAMICS (NON-IMAGING) (EG, EJECTION FRACTION WITH PROBE TECHNIQUE) WITH OR WITHOUT PHARMACOLOGIC INTERVENTION OR EXERCISE, SINGLE OR MULTIPLE DETERMINATIONS					
762	78455	VENOUS THROMBOSIS STUDY (EG, RADIOACTIVE FIBRINOGEN)					
762	78499	UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	Standard	Planar Nuclear Medicine	S	3.78	\$191.53	\$116.84	\$38.31
771	78006	THYROID IMAGING, WITH UPTAKE; SINGLE DETERMINATION					
771	78010	THYROID IMAGING; ONLY					
771	78011	THYROID IMAGING; WITH VASCULAR FLOW					
771	78015	THYROID CARCINOMA METASTASES IMAGING; LIMITED AREA (EG, NECK AND CHEST ONLY)					
771	78102	BONE MARROW IMAGING; LIMITED AREA					
771	78103	BONE MARROW IMAGING; MULTIPLE AREAS					
771	78104	BONE MARROW IMAGING; WHOLE BODY					
771	78185	SPLEEN IMAGING ONLY, WITH OR WITHOUT VASCULAR FLOW					
771	78201	LIVER IMAGING; STATIC ONLY					
771	78202	LIVER IMAGING; WITH VASCULAR FLOW					
771	78215	LIVER AND SPLEEN IMAGING; STATIC ONLY					
771	78216	LIVER AND SPLEEN IMAGING; WITH VASCULAR FLOW					
771	78230	SALIVARY GLAND IMAGING;					
771	78231	SALIVARY GLAND IMAGING; WITH SERIAL IMAGES					
771	78261	GASTRIC MUCOSA IMAGING					
771	78290	BOWEL IMAGING (EG, ECTOPIC GASTRIC MUCOSA, MECKEL'S LOCALIZATION, VOLVULUS)					
771	78300	BONE AND/OR JOINT IMAGING; LIMITED AREA					
771	78305	BONE AND/OR JOINT IMAGING; MULTIPLE AREAS					
771	78306	BONE AND/OR JOINT IMAGING; WHOLE BODY					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
771	78399	UNLISTED MUSCULOSKELETAL PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	78428	CARDIAC SHUNT DETECTION					
771	78445	NON-CARDIAC VASCULAR FLOW IMAGING (IE, ANGIOGRAPHY, VENOGRAPHY)					
771	78457	VENOUS THROMBOSIS IMAGING (EG, VENOGRAM); UNILATERAL					
771	78458	VENOUS THROMBOSIS IMAGING (EG, VENOGRAM); BILATERAL					
771	78460	MYOCARDIAL PERFUSION IMAGING; (PLANAR) SINGLE STUDY, AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT QUANTIFICATION					
771	78466	MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; QUALITATIVE OR QUANTITATIVE					
771	78478	MYOCARDIAL PERFUSION STUDY WITH WALL MOTION, QUALITATIVE OR QUANTITATIVE STUDY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (USE ONLY FOR CODES 78460, 78461, 78464, 78465)					
771	78480	MYOCARDIAL PERFUSION STUDY WITH EJECTION FRACTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (USE ONLY FOR CODES 78460, 78461, 78464, 78465)					
771	78481	CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; SINGLE STUDY, AT REST OR WITH STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT QUANTIFICATION					
771	78580	PULMONARY PERFUSION IMAGING, PARTICULATE					
771	78586	PULMONARY VENTILATION IMAGING, AEROSOL; SINGLE PROJECTION					
771	78587	PULMONARY VENTILATION IMAGING, AEROSOL; MULTIPLE PROJECTIONS (EG, ANTERIOR, POSTERIOR, LATERAL VIEWS)					
771	78591	PULMONARY VENTILATION IMAGING, GASEOUS, SINGLE BREATH, SINGLE PROJECTION					
771	78593	PULMONARY VENTILATION IMAGING, GASEOUS, WITH REBREATHING AND WASHOUT WITH OR WITHOUT SINGLE BREATH; SINGLE PROJECTION					
771	78599	UNLISTED RESPIRATORY PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	78600	BRAIN IMAGING, LIMITED PROCEDURE; STATIC					
771	78601	BRAIN IMAGING, LIMITED PROCEDURE; WITH VASCULAR FLOW					
771	78605	BRAIN IMAGING, COMPLETE STUDY; STATIC					
771	78610	BRAIN IMAGING, VASCULAR FLOW ONLY					
771	78660	RADIOPHARMACEUTICAL DACRYOCYSTOGRAPHY					
771	78699	UNLISTED NERVOUS SYSTEM PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	78700	KIDNEY IMAGING; STATIC ONLY					
771	78701	KIDNEY IMAGING; WITH VASCULAR FLOW					
771	78704	KIDNEY IMAGING; WITH FUNCTION STUDY (IE, IMAGING RENOGRAM)					
771	78707	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; SINGLE STUDY WITHOUT PHARMACOLOGICAL INTERVENTION					
771	78715	KIDNEY VASCULAR FLOW ONLY					
771	78730	URINARY BLADDER RESIDUAL STUDY					
771	78760	TESTICULAR IMAGING;					
771	78761	TESTICULAR IMAGING; WITH VASCULAR FLOW					
771	78799	UNLISTED GENITOURINARY PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
772	Complex Planar Nuclear Medicine		S	4.22	\$213.83	\$127.92	\$42.77
772	78007	THYROID IMAGING, WITH UPTAKE; MULTIPLE DETERMINATIONS					
772	78016	THYROID CARCINOMA METASTASES IMAGING; WITH ADDITIONAL STUDIES (EG, URINARY RECOVERY)					
772	78017	THYROID CARCINOMA METASTASES IMAGING; MULTIPLE AREAS					
772	78018	THYROID CARCINOMA METASTASES IMAGING; WHOLE BODY					
772	78070	PARATHYROID IMAGING					
772	78075	ADRENAL IMAGING, CORTEX AND/OR MEDULLA					
772	78195	LYMPHATICS AND LYMPH GLANDS IMAGING					
772	78220	LIVER FUNCTION STUDY WITH HEPATOBILIARY AGENTS, WITH SERIAL IMAGES					
772	78223	HEPATOBILIARY DUCTAL SYSTEM IMAGING, INCLUDING GALLBLADDER, WITH OR WITHOUT PHARMACOLOGIC INTERVENTION, WITH OR WITHOUT QUANTITATIVE MEASUREMENT OF GALLBLADDER FUNCTION					
772	78232	SALIVARY GLAND FUNCTION STUDY					
772	78258	ESOPHAGEAL MOTILITY					
772	78262	GASTROESOPHAGEAL REFLUX STUDY					
772	78264	GASTRIC EMPTYING STUDY					
772	78278	ACUTE GASTROINTESTINAL BLOOD LOSS IMAGING					
772	78291	PERITONEAL-VEIN SHUNT PATENCY TEST (EG, FOR LEVEEN, DENVER SHUNT)					
772	78315	BONE AND/OR JOINT IMAGING; THREE PHASE STUDY					
772	78461	MYOCARDIAL PERFUSION IMAGING; MULTIPLE STUDIES, (PLANAR) AT REST AND/OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), AND REDISTRIBUTION AND/OR REST INJECTION, WITH OR WITHOUT QUANTIFICATION					
772	78468	MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; WITH EJECTION FRACTION BY FIRST PASS TECHNIQUE					
772	78472	CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; SINGLE STUDY AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT ADDITIONAL QUANTITATIVE PROCESSING					
772	78473	MULTIPLE STUDIES, WALL MOTION STUDY PLUS EJECTION FRACTION, AT REST AND STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT ADDITIONAL QUANTIFICATION					
772	78483	CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; MULTIPLE STUDIES, AT REST AND WITH STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT QUANTIFICATION					
772	78584	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION; SINGLE BREATH					
772	78585	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION; REBREATHING AND WASHOUT, WITH OR WITHOUT SINGLE BREATH					
772	78594	PULMONARY VENTILATION IMAGING, GASEOUS, WITH REBREATHING AND WASHOUT WITH OR WITHOUT SINGLE BREATH; MULTIPLE PROJECTIONS (EG, ANTERIOR, POSTERIOR, LATERAL VIEWS)					
772	78596	PULMONARY QUANTITATIVE DIFFERENTIAL FUNCTION (VENTILATION/PERFUSION) STUDY					
772	78606	BRAIN IMAGING, COMPLETE STUDY; WITH VASCULAR FLOW					
772	78615	CEREBRAL BLOOD FLOW					
772	78630	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); CISTERNOGRAPHY					
772	78635	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); VENTRICULOGRAPHY					
772	78645	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); SHUNT EVALUATION					
772	78650	CSF LEAKAGE DETECTION AND LOCALIZATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
772	78708	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; SINGLE STUDY, WITH PHARMACOLOGICAL INTERVENTION (EG, ANGIOTENSIN CONVERTING ENZYME INHIBITOR AND/OR DIURETIC)					
772	78709	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; MULTIPLE STUDIES, WITH AND WITHOUT PHARMACOLOGICAL INTERVENTION (EG, ANGIOTENSIN CONVERTING ENZYME INHIBITOR AND/OR DIURETIC)					
772	78740	URETERAL REFLUX STUDY (RADIOPHARMACEUTICAL VOIDING CYSTOGRAM)					
772	78800	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; LIMITED AREA					
772	78801	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; MULTIPLE AREAS					
772	78802	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; WHOLE BODY					
772	78805	RADIOPHARMACEUTICAL LOCALIZATION OF ABSCESS; LIMITED AREA					
772	78806	RADIOPHARMACEUTICAL LOCALIZATION OF ABSCESS; WHOLE BODY					
781	Standard	SPECT Nuclear Medicine	S	5.26	\$266.52	\$145.77	\$53.30
781	78205	LIVER IMAGING (SPECT)					
781	78320	BONE AND/OR JOINT IMAGING; TOMOGRAPHIC (SPECT)					
781	78464	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), SINGLE STUDY AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT QUANTIFICATION					
781	78469	MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; TOMOGRAPHIC SPECT WITH OR WITHOUT QUANTIFICATION					
781	78607	BRAIN IMAGING, COMPLETE STUDY; TOMOGRAPHIC (SPECT)					
781	78647	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); TOMOGRAPHIC (SPECT)					
781	78710	KIDNEY IMAGING, TOMOGRAPHIC (SPECT)					
782	Complex	SPECT Nuclear Medicine	S	9.28	\$470.21	\$275.04	\$94.04
782	78465	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE AND/OR PHARMACOLOGIC) AND REDISTRIBUTION AND/OR REST INJECTION, WITH OR WITHOUT QUANTIFICATION					
782	78803	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; TOMOGRAPHIC (SPECT)					
782	78807	RADIOPHARMACEUTICAL LOCALIZATION OF ABSCESS; TOMOGRAPHIC (SPECT)					
791	Standard	Therapeutic Nuclear Medicine	S	15.83	\$802.10	\$562.06	\$160.42
791	79001	RADIOPHARMACEUTICAL THERAPY, HYPERTHYROIDISM; SUBSEQUENT, EACH THERAPY					
791	79100	RADIOPHARMACEUTICAL THERAPY, POLYCYTHEMIA VERA, CHRONIC LEUKEMIA, EACH TREATMENT					
791	79300	INTERSTITIAL RADIOACTIVE COLLOID THERAPY					
791	79400	RADIOPHARMACEUTICAL THERAPY, NONTHYROID, NONHEMATOLOGIC					
791	79420	INTRAVASCULAR RADIOPHARMACEUTICAL THERAPY, PARTICULATE					
791	79440	INTRA-ARTICULAR RADIOPHARMACEUTICAL THERAPY					
791	79999	UNLISTED RADIOPHARMACEUTICAL THERAPEUTIC PROCEDURE					
792	Complex	Therapeutic Nuclear Medicine	S	4.80	\$243.21	\$144.19	\$48.64
792	79000	RADIOPHARMACEUTICAL THERAPY, HYPERTHYROIDISM; INITIAL, INCLUDING EVALUATION OF PATIENT					
792	79020	RADIOPHARMACEUTICAL THERAPY, THYROID SUPPRESSION (EUTHYROID CARDIAC DISEASE), INCLUDING EVALUATION OF PATIENT					
792	79030	RADIOPHARMACEUTICAL ABLATION OF GLAND FOR THYROID CARCINOMA					
792	79035	RADIOPHARMACEUTICAL THERAPY FOR METASTASES OF THYROID CARCINOMA					
792	79200	INTRACAVITARY RADIOACTIVE COLLOID THERAPY					
861	Immunology Tests		X	0.13	\$6.59	\$3.62	\$1.32
861	86485	SKIN TEST; CANDIDA					
861	86490	SKIN TEST; COCCIDIOIDOMYCOSIS					
861	86510	SKIN TEST; HISTOPLASMOSIS					
861	86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL					
861	86585	SKIN TEST; TUBERCULOSIS, TINE TEST					
861	86586	SKIN TEST; UNLISTED ANTIGEN, EACH					
881	Level I Pathology		X	0.20	\$10.13	\$6.78	\$2.03
881	88125	CYTOPATHOLOGY, FORENSIC (EG, SPERM)					
881	88199	UNLISTED CYTOPATHOLOGY PROCEDURE					
881	88300	LEVEL I - SURGICAL PATHOLOGY, GROSS EXAMINATION ONLY					
881	88311	DECALCIFICATION PROCEDURE (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION)					
881	88313	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION); GROUP II, ALL OTHER, (EG, IRON, TRICHROME), EXCEPT IMMUNOCYTOCHEMISTRY AND IMMUNOPEROXIDASE STAINS, EACH					
881	88399	UNLISTED SURGICAL PATHOLOGY PROCEDURE					
881	89350	SPUTUM, OBTAINING SPECIMEN, AEROSOL INDUCED TECHNIQUE (SEPARATE PROCEDURE)					
881	89360	SWEAT COLLECTION BY IONTOPHORESIS					
881	89399	UNLISTED MISCELLANEOUS PATHOLOGY TEST					
881	G0025	Collagen skin test kit					
882	Level II Pathology		X	0.39	\$19.76	\$11.75	\$3.95
882	80500	CLINICAL PATHOLOGY CONSULTATION; LIMITED, WITHOUT REVIEW OF PATIENT'S HISTORY AND MEDICAL RECORDS					
882	80502	CLINICAL PATHOLOGY CONSULTATION; COMPREHENSIVE, FOR A COMPLEX DIAGNOSTIC PROBLEM, WITH REVIEW OF PATIENT'S HISTORY AND MEDICAL RECORDS					
882	85060	BLOOD SMEAR, PERIPHERAL, INTERPRETATION BY PHYSICIAN WITH WRITTEN REPORT					
882	85097	BONE MARROW; SMEAR INTERPRETATION ONLY, WITH OR WITHOUT DIFFERENTIAL CELL COUNT					
882	86077	BLOOD BANK PHYSICIAN SERVICES; DIFFICULT CROSS MATCH AND/OR EVALUATION OF IRREGULAR ANTIBODY(S), INTERPRETATION AND WRITTEN REPORT					
882	86078	BLOOD BANK PHYSICIAN SERVICES; INVESTIGATION OF TRANSFUSION REACTION INCLUDING SUSPICION OF TRANSMISSIBLE DISEASE, INTERPRETATION AND WRITTEN REPORT					
882	86079	BLOOD BANK PHYSICIAN SERVICES; AUTHORIZATION FOR DEVIATION FROM STANDARD BLOOD BANKING PROCEDURES (EG, USE OF OUTDATED BLOOD, TRANSFUSION OF RH INCOMPATIBLE UNITS), WITH WRITTEN REPORT					
882	88104	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT CERVICAL OR VAGINAL; SMEARS WITH INTERPRETATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
882	88106	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT CERVICAL OR VAGINAL; FILTER METHOD ONLY WITH INTERPRETATION					
882	88107	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT CERVICAL OR VAGINAL; SMEARS AND FILTER PREPARATION WITH INTERPRETATION					
882	88108	CYTOPATHOLOGY, CONCENTRATION TECHNIQUE, SMEARS AND INTERPRETATION (EG, SACCOMANNO TECHNIQUE)					
882	88160	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; SCREENING AND INTERPRETATION					
882	88161	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; PREPARATION, SCREENING AND INTERPRETATION					
882	88162	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; EXTENDED STUDY INVOLVING OVER 5 SLIDES AND/OR MULTIPLE STAINS					
882	88172	EVALUATION OF FINE NEEDLE ASPIRATE WITH OR WITHOUT PREPARATION OF SMEARS; IMMEDIATE CYTOHISTOLOGIC STUDY TO DETERMINE ADEQUACY OF SPECIMEN(S)					
882	88173	EVALUATION OF FINE NEEDLE ASPIRATE WITH OR WITHOUT PREPARATION OF SMEARS; INTERPRETATION AND REPORT					
882	88180	FLOW CYTOMETRY; EACH CELL SURFACE MARKER					
882	88182	FLOW CYTOMETRY; CELL CYCLE OR DNA ANALYSIS					
882	88302	LEVEL II - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
882	88304	LEVEL III - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
882	88305	LEVEL IV - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
882	88312	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION); GROUP I FOR MICROORGANISMS (EG, GRIDLEY, ACID FAST, METHENAMINE SILVER), EACH					
882	88314	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION); HISTOCHEMICAL STAINING WITH FROZEN SECTION(S)					
882	88318	DETERMINATIVE HISTOCHEMISTRY TO IDENTIFY CHEMICAL COMPONENTS (EG, COPPER, ZINC)					
882	88319	DETERMINATIVE HISTOCHEMISTRY OR CYTOCHEMISTRY TO IDENTIFY ENZYME CONSTITUENTS, EACH					
882	88321	CONSULTATION AND REPORT ON REFERRED SLIDES PREPARED ELSEWHERE					
882	88323	CONSULTATION AND REPORT ON REFERRED MATERIAL REQUIRING PREPARATION OF SLIDES					
882	88325	CONSULTATION, COMPREHENSIVE, WITH REVIEW OF RECORDS AND SPECIMENS, WITH REPORT ON REFERRED MATERIAL					
882	88329	PATHOLOGY CONSULTATION DURING SURGERY;					
882	88331	PATHOLOGY CONSULTATION DURING SURGERY; WITH FROZEN SECTION(S), SINGLE SPECIMEN					
882	88332	PATHOLOGY CONSULTATION DURING SURGERY; EACH ADDITIONAL TISSUE BLOCK WITH FROZEN SECTION(S)					
882	88342	IMMUNOCYTOCHEMISTRY (INCLUDING TISSUE IMMUNOPEROXIDASE), EACH ANTIBODY					
882	88346	IMMUNOFLUORESCENT STUDY, EACH ANTIBODY; DIRECT METHOD					
882	88347	IMMUNOFLUORESCENT STUDY, EACH ANTIBODY; INDIRECT METHOD					
883	Level III Pathology		X	0.65	\$32.94	\$20.34	\$6.59
883	88307	LEVEL V - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
883	88309	LEVEL VI - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
883	88348	ELECTRON MICROSCOPY; DIAGNOSTIC					
883	88349	ELECTRON MICROSCOPY; SCANNING					
883	88355	MORPHOMETRIC ANALYSIS; SKELETAL MUSCLE					
883	88356	MORPHOMETRIC ANALYSIS; NERVE					
883	88358	MORPHOMETRIC ANALYSIS; TUMOR					
883	88362	NERVE TEASING PREPARATIONS					
883	88365	TISSUE IN SITU HYBRIDIZATION, INTERPRETATION AND REPORT					
900	Critical Care		V	7.44	\$376.98	\$144.87	\$75.40
900	99291	CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE UNSTABLE CRITICALLY ILL OR UNSTABLE CRITICALLY INJURED PATIENT, REQUIRING THE CONSTANT ATTENDANCE OF THE PHYSICIAN; FIRST HOUR					
901	Level I Immunization		X	0.07	\$3.55	\$2.49	\$0.71
901	90700	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP)					
901	90701	IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE (DTP)					
901	90702	IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS (DT)					
901	90703	IMMUNIZATION, ACTIVE; TETANUS TOXOID					
901	90704	IMMUNIZATION, ACTIVE; MUMPS VIRUS VACCINE, LIVE					
901	90705	IMMUNIZATION, ACTIVE; MEASLES VIRUS VACCINE, LIVE, ATTENUATED					
901	90706	IMMUNIZATION, ACTIVE; RUBELLA VIRUS VACCINE, LIVE					
901	90708	IMMUNIZATION, ACTIVE; MEASLES AND RUBELLA VIRUS VACCINE, LIVE					
901	90709	IMMUNIZATION, ACTIVE; RUBELLA AND MUMPS VIRUS VACCINE, LIVE					
901	90710	IMMUNIZATION, ACTIVE; MEASLES, MUMPS, RUBELLA, AND VARICELLA VACCINE					
901	90711	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS (DTP) AND INJECTABLE POLIOMYELITIS VACCINE					
901	90714	IMMUNIZATION, ACTIVE; TYPHOID VACCINE					
901	90718	IMMUNIZATION, ACTIVE; TETANUS AND DIPHTHERIA TOXOIDS ABSORBED, FOR ADULT USE (TD)					
901	90719	IMMUNIZATION, ACTIVE; DIPHTHERIA TOXOID					
901	90724	IMMUNIZATION, ACTIVE; INFLUENZA VIRUS VACCINE					
901	90725	IMMUNIZATION, ACTIVE; CHOLERA VACCINE					
901	90730	IMMUNIZATION, ACTIVE; HEPATITIS A VACCINE					
901	90732	IMMUNIZATION, ACTIVE; PNEUMOCOCCAL VACCINE, POLYVALENT					
901	90748	IMMUNIZATION, ACTIVE; HEPATITIS B AND HEMOPHILUS INFLUENZA B (HIB) VACCINE					
901	90749	UNLISTED IMMUNIZATION PROCEDURE					
901	95149	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); FIVE SINGLE STINGING INSECT VENOMS					
901	95170	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY; WHOLE BODY EXTRACT OF BITING INSECT OR OTHER ARTHROPOD (SPECIFY NUMBER OF DOSES)					
901	G0008	INFLUENZA VACCINE					
901	G0009	PNEUMOCOCCAL VACCINE					
901	Q0034	INFLUENZA VACCINE					
902	Level II Immunization		X	1.78	\$90.19	\$41.47	\$18.04

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
902	90707	IMMUNIZATION, ACTIVE; MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE					
902	90712	IMMUNIZATION, ACTIVE; POLIOVIRUS VACCINE, LIVE, ORAL (ANY TYPE(S))					
902	90713	IMMUNIZATION, ACTIVE; POLIOMYELITIS VACCINE					
902	90716	IMMUNIZATION, ACTIVE; VARICELLA (CHICKEN POX) VACCINE					
902	90717	IMMUNIZATION, ACTIVE; YELLOW FEVER VACCINE					
902	90720	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS (DTP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE					
902	90733	IMMUNIZATION, ACTIVE; MENINGOCOCCAL POLYSACCHARIDE VACCINE (ANY GROUP(S))					
902	90737	IMMUNIZATION, ACTIVE; HEMOPHILUS INFLUENZA B					
902	90741	IMMUNIZATION, PASSIVE; IMMUNE SERUM GLOBULIN, HUMAN (ISG)					
902	90744	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; NEWBORN TO 11 YEARS					
902	90745	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; 11–19 YEARS					
902	90746	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; 20 YEARS AND ABOVE					
902	90747	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; DIALYSIS OR IMMUNOSUPPRESSED PATIENT, ANY AGE					
902	G0010	HEPATITIS B VACCINE					
903	Level III Immunization		X	1.16	\$58.78	\$25.65	\$11.76
903	90721	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE					
903	90726	IMMUNIZATION, ACTIVE; RABIES VACCINE					
903	90727	IMMUNIZATION, ACTIVE; PLAGUE VACCINE					
903	90728	IMMUNIZATION, ACTIVE; BCG VACCINE					
903	90735	IMMUNIZATION, ACTIVE; ENCEPHALITIS VIRUS VACCINE					
903	90742	IMMUNIZATION, PASSIVE; SPECIFIC HYPERIMMUNE SERUM GLOBULIN (EG, HEPATITIS B, MEASLES, PERTUSSIS, RABIES, RHO(D), TETANUS, VACCINIA, VARICELLA-ZOSTER)					
906	Infusion Therapy except Chemotherapy		X	1.46	\$73.98	\$42.49	\$14.80
906	36680	PLACEMENT OF NEEDLE FOR INTRAOSSEOUS INFUSION					
906	90780	IV INFUSION FOR THERAPY/DIAGNOSIS, ADMINISTERED BY PHYSICIAN OR UNDER DIRECT SUPERVISION OF PHYSICIAN; UP TO ONE HOUR					
906	90781	IV INFUSION FOR THERAPY/DIAGNOSIS, ADMINISTERED BY PHYSICIAN OR UNDER DIRECT SUPERVISION OF PHYSICIAN; EACH ADDITIONAL HOUR, UP TO EIGHT (8) HOURS					
906	Q0081	INFUSION THERAPY					
907	Intramuscular Injections		X	0.85	\$43.07	\$11.98	\$8.61
907	90782	THERAPEUTIC OR DIAGNOSTIC INJECTION (SPECIFY MATERIAL INJECTED); SUBCUTANEOUS OR INTRAMUSCULAR					
907	90783	THERAPEUTIC OR DIAGNOSTIC INJECTION (SPECIFY MATERIAL INJECTED); INTRA-ARTERIAL					
907	90784	THERAPEUTIC OR DIAGNOSTIC INJECTION (SPECIFY MATERIAL INJECTED); INTRAVENOUS					
907	90788	INTRAMUSCULAR INJECTION OF ANTIBIOTIC (SPECIFY)					
907	90799	UNLISTED THERAPEUTIC OR DIAGNOSTIC INJECTION					
919	Electroconvulsive Therapy		S	3.17	\$160.62	\$80.00	\$32.12
919	90870	ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY MONITORING); SINGLE SEIZURE					
919	90871	ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY MONITORING); MULTIPLE SEIZURES, PER DAY					
920	Biofeedback and other Training		S	1.17	\$59.28	\$29.61	\$11.86
920	90901	BIOFEEDBACK TRAINING BY ANY MODALITY					
920	90911	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR URETHRAL SPHINCTER, INCLUDING EMG AND/OR MANOMETRY					
921	Diabetes Education		S				
921	99078	PHYSICIAN EDUCATIONAL SERVICES RENDERED TO PATIENTS IN A GROUP SETTING (EG, PRENATAL, OBESITY, OR DIABETIC INSTRUCTIONS)					
926	Dialysis for other than ESRD patients		S	4.28	\$216.87	\$69.83	\$43.37
926	90935	HEMODIALYSIS PROCEDURE WITH SINGLE PHYSICIAN EVALUATION					
926	90937	HEMODIALYSIS PROCEDURE REQUIRING REPEATED EVALUATION(S) WITH OR WITHOUT SUBSTANTIAL REVISION OF DIALYSIS PRESCRIPTION					
926	90945	DIALYSIS PROCEDURE OTHER THAN HEMODIALYSIS (EG, PERITONEAL, HEMOFILTRATION), WITH SINGLE PHYSICIAN EVALUATION					
926	90947	DIALYSIS PROCEDURE OTHER THAN HEMODIALYSIS (EG, PERITONEAL, HEMOFILTRATION) REQUIRING REPEATED EVALUATIONS, WITH OR WITHOUT SUBSTANTIAL REVISION OF DIALYSIS PRESCRIPTION					
926	90997	HEMOPERFUSION (EG, WITH ACTIVATED CHARCOAL OR RESIN)					
926	90999	UNLISTED DIALYSIS PROCEDURE, INPATIENT OR OUTPATIENT					
928	Alimentary Tests		X	3.11	\$157.58	\$83.85	\$31.52
928	89100	DUODENAL INTUBATION AND ASPIRATION; SINGLE SPECIMEN (EG, SIMPLE BILE STUDY OR AFFERENT LOOP CULTURE) PLUS APPROPRIATE TEST PROCEDURE					
928	89105	DUODENAL INTUBATION AND ASPIRATION; COLLECTION OF MULTIPLE FRACTIONAL SPECIMENS WITH PANCREATIC OR GALLBLADDER STIMULATION, SINGLE OR DOUBLE LUMEN TUBE					
928	89130	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC, EACH SPECIMEN, FOR CHEMICAL ANALYSES OR CYTOPATHOLOGY;					
928	89132	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC, EACH SPECIMEN, AFTER STIMULATION					
928	89135	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); ONE HOUR					
928	89136	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); TWO HOURS					
928	89140	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); TWO HOURS INCLUDING GASTRIC STIMULATION (EG, HISTALOG, PENTAGASTRIN)					
928	89141	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); THREE HOURS, INCLUDING GASTRIC STIMULATION					
928	91000	ESOPHAGEAL INTUBATION AND COLLECTION OF WASHINGS FOR CYTOLOGY, INCLUDING PREPARATION OF SPECIMENS (SEPARATE PROCEDURE)					
928	91010	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY;					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT-1/ HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
928	91011	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY; WITH MECHOLYL OR SIMILAR STIMULANT					
928	91012	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY; WITH ACID PERFUSION STUDIES					
928	91020	GASTRIC MOTILITY (MANOMETRIC) STUDIES					
928	91030	ESOPHAGUS, ACID PERFUSION (BERNSTEIN) TEST FOR ESOPHAGITIS					
928	91032	ESOPHAGUS, ACID REFLUX TEST, WITH INTRALUMINAL PH ELECTRODE FOR DETECTION OF GASTROESOPHAGEAL REFLUX;					
928	91033	ESOPHAGUS, ACID REFLUX TEST, WITH INTRALUMINAL PH ELECTRODE FOR DETECTION OF GASTROESOPHAGEAL REFLUX; PRO- LONGED RECORDING					
928	91052	GASTRIC ANALYSIS TEST WITH INJECTION OF STIMULANT OF GASTRIC SECRETION (EG, HISTAMINE, INSULIN, PENTAGASTRIN, CAL- CIUM AND SECRETIN)					
928	91055	GASTRIC INTUBATION, WASHINGS, AND PREPARING SLIDES FOR CYTOLOGY (SEPARATE PROCEDURE)					
928	91060	GASTRIC SALINE LOAD TEST					
928	91065	BREATH HYDROGEN TEST (EG, FOR DETECTION OF LACTASE DEFICIENCY)					
928	91100	INTESTINAL BLEEDING TUBE, PASSAGE, POSITIONING AND MONITORING					
928	91105	GASTRIC INTUBATION, AND ASPIRATION OR LAVAGE FOR TREATMENT (EG, FOR INGESTED POISONS)					
928	91299	UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE					
928	95075	INGESTION CHALLENGE TEST (SEQUENTIAL AND INCREMENTAL INGESTION OF TEST ITEMS, EG, FOOD, DRUG OR OTHER SUB- STANCE SUCH AS METABISULFITE)					
930	Minor Eye Examinations		X	1.02	\$51.68	\$22.83	\$10.34
930	92060	SENSORIMOTOR EXAMINATION WITH MULTIPLE MEASUREMENTS OF OCULAR DEVIATION (EG, RESTRICTIVE OR PARETIC MUSCLE WITH DIPLOPIA) WITH INTERPRETATION AND REPORT (SEPARATE PROCEDURE)					
930	92065	ORTHOPTIC AND/OR PLEOPTIC TRAINING, WITH CONTINUING MEDICAL DIRECTION AND EVALUATION					
930	92081	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT; LIMITED EXAMINATION (EG, TAN- GENT SCREEN, AUTOPLAT, ARC PERIMETER, OR SINGLE STIMULUS LEVEL AUTOMATED TEST, SUCH AS OCTOPUS 3 OR 7 EQUIVA- LENT)					
930	92082	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT; INTERMEDIATE EXAMINATION (EG, AT LEAST 2 ISOPTERS ON GOLDMANN PERIMETER, OR SEMIQUANTITATIVE, AUTOMATED SUPRATHRESHOLD SCREENING PRO- GRAM, HUMPHREY SUPRATHRESHOLD AUTOMATIC					
930	92083	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT; EXTENDED EXAMINATION (EG, GOLDMANN VISUAL FIELDS WITH AT LEAST 3 ISOPTERS PLOTTED AND STATIC DETERMINATION WITHIN THE CENTRAL 30°, OR QUANTITATIVE, AUTOMATED THRESHOLD PERI					
930	92140	PROVOCATIVE TESTS FOR GLAUCOMA, WITH INTERPRETATION AND REPORT, WITHOUT TONOGRAPHY					
930	92283	COLOR VISION EXAMINATION, EXTENDED, EG, ANOMALOSCOPE OR EQUIVALENT					
930	92284	DARK ADAPTATION EXAMINATION WITH INTERPRETATION AND REPORT					
930	92285	EXTERNAL OCULAR PHOTOGRAPHY WITH INTERPRETATION AND REPORT FOR DOCUMENTATION OF MEDICAL PROGRESS (EG, CLOSE-UP PHOTOGRAPHY, SLIT LAMP PHOTOGRAPHY, GONIOPHOTOGRAPHY, STEREO-PHOTOGRAPHY)					
931	Level I Eye Tests		X	0.74	\$37.5	\$21.47	\$7.50
931	92120	TONOGRAPHY WITH INTERPRETATION AND REPORT, RECORDING INDENTATION TONOMETER METHOD OR PERILIMBAL SUCTION METHOD					
931	92130	TONOGRAPHY WITH WATER PROVOCATION					
931	92230	FLUORESCEIN ANGIOSCOPY WITH INTERPRETATION AND REPORT					
931	92240	INDOCYANINE-GREEN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT					
931	92250	FUNDUS PHOTOGRAPHY WITH INTERPRETATION AND REPORT					
931	92499	UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE					
932	Level II Eye Tests		X	2.52	\$127.69	\$65.09	\$25.54
932	92235	FLUORESCEIN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT					
932	92265	NEEDLE OCULOELECTROMYOGRAPHY, ONE OR MORE EXTRAOCULAR MUSCLES, ONE OR BOTH EYES, WITH INTERPRETATION AND REPORT					
932	92270	ELECTRO-OCULOGRAPHY WITH INTERPRETATION AND REPORT					
932	92286	SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY WITH INTERPRETATION AND REPORT; WITH SPECULAR ENDOTHELIAL MICROSCOPY AND CELL COUNT					
932	92287	SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY WITH INTERPRETATION AND REPORT; WITH FLUORESCEIN ANGIOGRAPHY					
936	Fitting of Vision Aids		X	0.52	\$26.35	\$9.49	\$5.27
936	92311	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS FOR APHAKIA, ONE EYE					
936	92312	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS FOR APHAKIA, BOTH EYES					
936	92313	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEOSCLERAL LENS					
936	92315	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION AND DIRECTION OF FITTING BY INDEPENDENT TECHNICIAN; CORNEAL LENS FOR APHAKIA, ONE EYE					
936	92316	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION AND DIRECTION OF FITTING BY INDEPENDENT TECHNICIAN; CORNEAL LENS FOR APHAKIA, BOTH EYES					
936	92317	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION AND DIRECTION OF FITTING BY INDEPENDENT TECHNICIAN; CORNEOSCLERAL LENS					
936	92325	MODIFICATION OF CONTACT LENS (SEPARATE PROCEDURE), WITH MEDICAL SUPERVISION OF ADAPTATION					
936	92326	REPLACEMENT OF CONTACT LENS					
936	92330	PRESCRIPTION, FITTING, AND SUPPLY OF OCULAR PROSTHESIS (ARTIFICIAL EYE), WITH MEDICAL SUPERVISION OF ADAPTATION					
936	92352	FITTING OF SPECTACLE PROSTHESIS FOR APHAKIA; MONOFOCAL					
936	92353	FITTING OF SPECTACLE PROSTHESIS FOR APHAKIA; MULTIFOCAL					
936	92354	FITTING OF SPECTACLE MOUNTED LOW VISION AID; SINGLE ELEMENT SYSTEM					
936	92355	FITTING OF SPECTACLE MOUNTED LOW VISION AID; TELESCOPIC OR OTHER COMPOUND LENS SYSTEM					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
936	92358	PROSTHESIS SERVICE FOR APHAKIA, TEMPORARY (DISPOSABLE OR LOAN, INCLUDING MATERIALS)					
936	92371	REPAIR AND REFITTING SPECTACLES; SPECTACLE PROSTHESIS FOR APHAKIA					
940	Otorhinolaryngologic Function Tests		X	3.04	\$154.04	\$51.98	\$30.81
940	92512	NASAL FUNCTION STUDIES (EG, RHINOMANOMETRY)					
940	92516	FACIAL NERVE FUNCTION STUDIES (EG, ELECTRONEURONOGRAPHY)					
940	92520	LARYNGEAL FUNCTION STUDIES					
940	92541	SPONTANEOUS NYSTAGMUS TEST, INCLUDING GAZE AND FIXATION NYSTAGMUS, WITH RECORDING					
940	92542	POSITIONAL NYSTAGMUS TEST, MINIMUM OF 4 POSITIONS, WITH RECORDING					
940	92543	CALORIC VESTIBULAR TEST, EACH IRRIGATION (BINAURAL, BITHERMAL STIMULATION CONSTITUTES FOUR TESTS), WITH					
940	92544	OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL, FOVEAL OR PERIPHERAL STIMULATION, WITH RECORDING					
940	92545	OSCILLATING TRACKING TEST, WITH RECORDING					
940	92546	SINUSOIDAL VERTICAL AXIS ROTATIONAL TESTING					
940	92547	USE OF VERTICAL ELECTRODES IN ANY OR ALL OF ABOVE TESTS COUNTS AS ONE ADDITIONAL TEST					
940	92548	COMPUTERIZED DYNAMIC POSTUROGRAPHY					
940	92584	ELECTROCOCHLEOGRAPHY					
940	92587	EVOLED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCTS)					
940	92588	EVOLED OTOACOUSTIC EMISSIONS; COMPREHENSIVE OR DIAGNOSTIC EVALUATION (COMPARISON OF TRANSIENT AND/OR DISTOR- TION PRODUCT OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND FREQUENCIES)					
941	Level I Audiometry		X	0.74	\$37.50	\$13.56	\$7.50
941	92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY					
941	92553	PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE					
941	92555	SPEECH AUDIOMETRY THRESHOLD;					
941	92556	SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION					
941	92567	TYMPANOMETRY (IMPEDANCE TESTING)					
941	92599	UNLISTED OTORHINOLARYNGOLOGICAL SERVICE OR PROCEDURE					
942	Level II Audiometry		X	1.48	\$74.99	\$22.15	\$15.00
942	92557	COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (92553 AND 92556 COMBINED)					
942	92561	BEKESY AUDIOMETRY; DIAGNOSTIC					
942	92562	LOUDNESS BALANCE TEST, ALTERNATE BINAURAL OR MONAURAL					
942	92563	TONE DECAY TEST					
942	92564	SHORT INCREMENT SENSITIVITY INDEX (SISI)					
942	92565	STENGER TEST, PURE TONE					
942	92568	ACOUSTIC REFLEX TESTING					
942	92569	ACOUSTIC REFLEX DECAY TEST					
942	92571	FILTERED SPEECH TEST					
942	92572	STAGGERED SPONDAIC WORD TEST					
942	92573	LOMBARD TEST					
942	92575	SENSORINEURAL ACUITY LEVEL TEST					
942	92576	SYNTHETIC SENTENCE IDENTIFICATION TEST					
942	92577	STENGER TEST, SPEECH					
942	92579	VISUAL REINFORCEMENT AUDIOMETRY (VRA)					
942	92582	CONDITIONING PLAY AUDIOMETRY					
942	92583	SELECT PICTURE AUDIOMETRY					
942	92589	CENTRAL AUDITORY FUNCTION TEST(S) (SPECIFY)					
942	92596	EAR PROTECTOR ATTENUATION MEASUREMENTS					
947	Resuscitation and Cardioversion		S	4.07	\$206.22	\$109.61	\$41.24
947	31500	INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE					
947	92950	CARDIOPULMONARY RESUSCITATION (EG, IN CARDIAC ARREST)					
947	92953	TEMPORARY TRANSCUTANEOUS PACING					
947	92960	CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL					
947	99440	NEWBORN RESUSCITATION: PROVISION OF POSITIVE PRESSURE VENTILATION AND/OR CHEST COMPRESSIONS IN THE PRESENCE OF ACUTE INADEQUATE VENTILATION AND/OR CARDIAC OUTPUT					
948	Cardiac Rehabilitation		X	0.81	\$41.04	\$16.95	\$8.21
948	93797	PHYSICIAN SERVICES FOR OUTPATIENT CARDIAC REHABILITATION; WITHOUT CONTINUOUS ECG MONITORING (PER SESSION)					
948	93798	PHYSICIAN SERVICES FOR OUTPATIENT CARDIAC REHABILITATION; WITH CONTINUOUS ECG MONITORING (PER SESSION)					
949	Cardiovascular Stress Test		X	1.46	\$73.98	\$62.83	\$14.80
949	93017	CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL TREADMILL OR BICYCLE EXERCISE, CONTINUOUS ELECTRO- CARDIOGRAPHIC MONITORING, AND/OR PHARMACOLOGICAL STRESS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT					
949	93024	ERGONOVINE PROVOCATION TEST					
950	Electrocardiogram (ECG)		X	0.35	\$17.73	\$15.82	\$3.55
950	93005	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT					
950	93041	RHYTHM ECG, ONE TO THREE LEADS; TRACING ONLY WITHOUT INTERPRETATION AND REPORT					
950	Q0035	CARDIOKYMNOGRAPHY					
956	Continuous ECG and Blood Pressure Monitoring		X	1.11	\$56.24	\$55.82	\$11.25
956	93012	TELEPHONIC TRANSMISSION OF POST-SYMPTOM ELECTROCARDIOGRAM RHYTHM STRIP(S), PER 30 DAY PERIOD OF TIME; TRACING ONLY					
956	93224	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE, WITH VISUAL SUPERIMPOSITION SCANNING; INCLUDES RECORDING, SCANNING ANALYSIS WITH REPORT, PHYSICIAN REVIEW AND INTERPRETATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
956	93225	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE, WITH VISUAL SUPERIMPOSITION SCANNING; RECORDING (INCLUDES HOOK-UP, RECORDING, AND DISCONNECTION)					
956	93226	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE, WITH VISUAL SUPERIMPOSITION SCANNING; SCANNING ANALYSIS WITH REPORT					
956	93230	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; INCLUDES RECORDING, MICROPROCESSOR-BASED ANALYSIS					
956	93231	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; RECORDING (INCLUDES HOOK-UP, RECORDING, AND DISCO					
956	93232	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; MICROPROCESSOR-BASED ANALYSIS WITH REPORT					
956	93235	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS COMPUTERIZED MONITORING AND NON-CONTINUOUS RECORDING, AND REAL-TIME DATA ANALYSIS UTILIZING A DEVICE CAPABLE OF PRODUCING INTERMITTENT FULL-SIZED WAVEFORM TRACINGS, POSSIBLY PATIENT ACTIVATED; INC					
956	93236	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS COMPUTERIZED MONITORING AND NON-CONTINUOUS RECORDING, AND REAL-TIME DATA ANALYSIS UTILIZING A DEVICE CAPABLE OF PRODUCING INTERMITTENT FULL-SIZED WAVEFORM TRACINGS, POSSIBLY PATIENT ACTIVATED; MON					
956	93268	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH PRESYMPTOM MEMORY LOOP, PER 30 DAY PERIOD OF TIME; INCLUDES TRANSMISSION, PHYSICIAN REVIEW AND INTERPRETATION					
956	93270	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH PRESYMPTOM MEMORY LOOP, PER 30 DAY PERIOD OF TIME; RECORDING (INCLUDES HOOK-UP, RECORDING, AND DISCONNECTION)					
956	93271	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH PRESYMPTOM MEMORY LOOP, PER 30 DAY PERIOD OF TIME; MONITORING, RECEIPT OF TRANSMISSIONS, AND ANALYSIS					
956	93278	SIGNAL-AVERAGED ELECTROCARDIOGRAPHY (SAECG), WITH OR WITHOUT ECG					
956	G0004	ECG TRANSM PHYS REVIEW & INT					
956	G0005	ECG 24 HOUR RECORDING					
956	G0006	ECG TRANSMISSION & ANALYSIS					
956	G0015	POST SYMPTOM ECG TRACING					
957	Echocardiography		S	2.83	\$143.39	\$117.07	\$28.68
957	76825	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME WITH IMAGE DOCUMENTATION (2D), WITH OR WITHOUT M-MODE RECORDING;					
957	76826	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME WITH IMAGE DOCUMENTATION (2D), WITH OR WITHOUT M-MODE RECORDING; FOLLOW-UP OR REPEAT STUDY					
957	76827	DOPPLER ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY; COMPLETE					
957	76828	DOPPLER ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY; FOLLOW-UP OR REPEAT STUDY					
957	93303	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; COMPLETE					
957	93304	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; FOLLOW-UP OR LIMITED STUDY					
957	93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; COMPLETE					
957	93308	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; FOLLOW-UP OR LIMITED STUDY					
957	93312	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT					
957	93313	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY					
957	93315	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT					
957	93316	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY					
957	93320	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY (LIST SEPARATELY IN ADDITION TO CODES FOR ECHOCARDIOGRAPHIC IMAGING 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350); COMPLETE					
957	93321	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY (LIST SEPARATELY IN ADDITION TO CODES FOR ECHOCARDIOGRAPHIC IMAGING 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350); FOLLOW-UP OR LIMITED STUDY					
957	93325	DOPPLER COLOR FLOW VELOCITY MAPPING (LIST SEPARATELY IN ADDITION TO CODE FOR ECHOCARDIOGRAPHY 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350)					
957	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					
958	Diagnostic	Cardiac Catheterization	T	26.11	\$1,322.98	\$659.47	\$264.60
958	93501	RIGHT HEART CATHETERIZATION					
958	93503	INSERTION AND PLACEMENT OF FLOW DIRECTED CATHETER (EG, SWAN-GANZ) FOR MONITORING PURPOSES					
958	93505	ENDOMYOCARDIAL BIOPSY					
958	93510	LEFT HEART CATHETERIZATION, RETROGRADE, FROM THE BRACHIAL ARTERY, AXILLARY ARTERY OR FEMORAL ARTERY; PERCUTANEOUS					
958	93511	LEFT HEART CATHETERIZATION, RETROGRADE, FROM THE BRACHIAL ARTERY, AXILLARY ARTERY OR FEMORAL ARTERY; BY CUTDOWN					
958	93514	LEFT HEART CATHETERIZATION BY LEFT VENTRICULAR PUNCTURE					
958	93524	COMBINED TRANSSEPTAL AND RETROGRADE LEFT HEART CATHETERIZATION					
958	93526	COMBINED RIGHT HEART CATHETERIZATION AND RETROGRADE LEFT HEART CATHETERIZATION					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
958	93527	COMBINED RIGHT HEART CATHETERIZATION AND TRANSEPTAL LEFT HEART CATHETERIZATION THROUGH INTACT SEPTUM (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)					
958	93528	COMBINED RIGHT HEART CATHETERIZATION WITH LEFT VENTRICULAR PUNCTURE (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)					
958	93529	COMBINED RIGHT HEART CATHETERIZATION AND LEFT HEART CATHETERIZATION THROUGH EXISTING SEPTAL OPENING (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)					
958	93530	RIGHT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93531	COMBINED RIGHT HEART CATHETERIZATION AND RETROGRADE LEFT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93532	COMBINED RIGHT HEART CATHETERIZATION AND TRANSEPTAL LEFT HEART CATHETERIZATION THROUGH INTACT SEPTUM WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93533	COMBINED RIGHT HEART CATHETERIZATION AND TRANSEPTAL LEFT HEART CATHETERIZATION THROUGH EXISTING SEPTAL OPENING, WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93536	PERCUTANEOUS INSERTION OF INTRA-AORTIC BALLOON CATHETER					
960	Cardiac Electrophysiologic Tests/Procedures		S	4.24	\$214.84	\$144.41	\$42.97
960	93600	BUNDLE OF HIS RECORDING					
960	93602	INTRA-ATRIAL RECORDING					
960	93603	RIGHT VENTRICULAR RECORDING					
960	93607	LEFT VENTRICULAR RECORDING					
960	93609	INTRAVENTRICULAR AND/OR INTRA-ATRIAL MAPPING OF TACHYCARDIA SITE(S) WITH CATHETER MANIPULATION TO RECORD FROM MULTIPLE SITES TO IDENTIFY ORIGIN OF TACHYCARDIA					
960	93610	INTRA-ATRIAL PACING					
960	93612	INTRAVENTRICULAR PACING					
960	93615	ESOPHAGEAL RECORDING OF ATRIAL ELECTROGRAM WITH OR WITHOUT VENTRICULAR ELECTROGRAM(S);					
960	93616	ESOPHAGEAL RECORDING OF ATRIAL ELECTROGRAM WITH OR WITHOUT VENTRICULAR ELECTROGRAM(S); WITH PACING					
960	93618	INDUCTION OF ARRHYTHMIA BY ELECTRICAL PACING					
960	93619	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITHOUT INDUCTION OR ATTEMPTED INDUCTION					
960	93620	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITH INDUCTION OR ATTEMPTED INDUCTION					
960	93621	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITH LEFT ATRIAL RECORDINGS FROM CORON					
960	93622	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITH LEFT VENTRICULAR RECORDINGS, WITH					
960	93623	PROGRAMMED STIMULATION AND PACING AFTER INTRAVENOUS DRUG INFUSION (USE THIS CODE WITH 93620, 93621, 93622)					
960	93624	ELECTROPHYSIOLOGIC FOLLOW-UP STUDY WITH PACING AND RECORDING TO TEST EFFECTIVENESS OF THERAPY, INCLUDING INDUCTION OR ATTEMPTED INDUCTION OF ARRHYTHMIA					
960	93631	INTRA-OPERATIVE EPICARDIAL AND ENDOCARDIAL PACING AND MAPPING TO LOCALIZE THE SITE OF TACHYCARDIA OR ZONE OF SLOW CONDUCTION FOR SURGICAL CORRECTION					
960	93640	ELECTROPHYSIOLOGIC EVALUATION OF CARDIOVERTER-DEFIBRILLATOR LEADS (INCLUDES DEFIBRILLATION THRESHOLD TESTING AND SENSING FUNCTION) AT TIME OF INITIAL IMPLANTATION OR REPLACEMENT;					
960	93641	ELECTROPHYSIOLOGIC EVALUATION OF CARDIOVERTER-DEFIBRILLATOR LEADS (INCLUDES DEFIBRILLATION THRESHOLD TESTING AND SENSING FUNCTION) AT TIME OF INITIAL IMPLANTATION OR REPLACEMENT; WITH TESTING OF CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR					
960	93642	ELECTROPHYSIOLOGIC EVALUATION OF CARDIOVERTER-DEFIBRILLATOR (INCLUDES DEFIBRILLATION THRESHOLD EVALUATION, INDUCTION OF ARRHYTHMIA, EVALUATION OF SENSING AND PACING FOR ARRHYTHMIA TERMINATION, AND PROGRAMMING OR REPROGRAMMING OF SENSING OR THERAPEUTIC PAR					
960	93650	INTRACARDIAC CATHETER ABLATION OF ATRIOVENTRICULAR NODE FUNCTION, ATRIOVENTRICULAR CONDUCTION FOR CREATION OF COMPLETE HEART BLOCK, WITH OR WITHOUT TEMPORARY PACEMAKER PLACEMENT					
960	93651	INTRACARDIAC CATHETER ABLATION OF ARRHYTHMOGENIC FOCUS; FOR TREATMENT OF SUPRAVENTRICULAR TACHYCARDIA BY ABLATION OF FAST OR SLOW ATRIOVENTRICULAR PATHWAYS, ACCESSORY ATRIOVENTRICULAR CONNECTIONS OR OTHER ATRIAL FOCI, SINGLY OR IN COMBINATION					
960	93652	INTRACARDIAC CATHETER ABLATION OF ARRHYTHMOGENIC FOCUS; FOR TREATMENT OF VENTRICULAR TACHYCARDIA					
960	93660	EVALUATION OF CARDIOVASCULAR FUNCTION WITH TILT TABLE EVALUATION, WITH CONTINUOUS ECG MONITORING AND INTERMITTENT BLOOD PRESSURE MONITORING, WITH OR WITHOUT PHARMACOLOGICAL INTERVENTION					
960	93724	ELECTRONIC ANALYSIS OF ANTITACHYCARDIA PACEMAKER SYSTEM (INCLUDES ELECTROCARDIOGRAPHIC RECORDING, PROGRAMMING OF DEVICE, INDUCTION AND TERMINATION OF TACHYCARDIA VIA IMPLANTED PACEMAKER, AND INTERPRETATION OF RECORDINGS)					
966	Electronic Analysis of Pacemakers/other devices		X	0.39	\$19.76	\$12.43	\$3.95
966	62367	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL DRUG INFUSION (INCLUDES EVALUATION OF RESERVOIR STATUS, ALARM STATUS, DRUG PRESCRIPTION STATUS); WITHOUT REPROGRAMMING					
966	62368	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL DRUG INFUSION (INCLUDES EVALUATION OF RESERVOIR STATUS, ALARM STATUS, DRUG PRESCRIPTION STATUS); WITH REPROGRAMMING					
966	63690	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, BATTERY STATUS, ELECTRODE SELECTABILITY, OUTPUT MODULATION, CYCLING, IMPEDANCE AND PATIENT COMPLIANCE MEAS					
966	63691	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, BATTERY STATUS, ELECTRODE SELECTABILITY, OUTPUT MODULATION, CYCLING, IMPEDANCE AND PATIENT COMPLIANCE MEAS					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
966	93731	ELECTRONIC ANALYSIS OF DUAL-CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSIS					
966	93732	ELECTRONIC ANALYSIS OF DUAL-CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSIS					
966	93733	ELECTRONIC ANALYSIS OF DUAL CHAMBER INTERNAL PACEMAKER SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, AND/OR TESTING OF SENSORY FUNCTION OF PACEMAKER), TELEPHONIC ANALYSIS					
966	93734	ELECTRONIC ANALYSIS OF SINGLE CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSIS					
966	93735	ELECTRONIC ANALYSIS OF SINGLE CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSIS					
966	93736	ELECTRONIC ANALYSIS OF SINGLE CHAMBER INTERNAL PACEMAKER SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, AND/OR TESTING OF SENSORY FUNCTION OF PACEMAKER), TELEPHONIC ANALYSIS					
966	93737	ELECTRONIC ANALYSIS OF CARDIOVERTER/DEFIBRILLATOR ONLY (INTERROGATION, EVALUATION OF PULSE GENERATOR STATUS); WITHOUT REPROGRAMMING					
966	93738	ELECTRONIC ANALYSIS OF CARDIOVERTER/DEFIBRILLATOR ONLY (INTERROGATION, EVALUATION OF PULSE GENERATOR STATUS); WITH REPROGRAMMING					
967	Non-Invasive Vascular Studies		X	1.70	\$86.14	\$57.40	\$17.23
967	93720	PLETHYSMOGRAPHY, TOTAL BODY; WITH INTERPRETATION AND REPORT					
967	93721	PLETHYSMOGRAPHY, TOTAL BODY; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT					
967	93740	TEMPERATURE GRADIENT STUDIES					
967	93799	UNLISTED CARDIOVASCULAR SERVICE OR PROCEDURE					
967	93922	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, SINGLE LEVEL, BILATERAL (EG, ANKLE/BRACHIAL INDICES, DOPPLER WAVEFORM ANALYSIS, VOLUME PLETHYSMOGRAPHY, TRANSCUTANEOUS OXYGEN TENSION MEASUREMENT)					
967	93923	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, MULTIPLE LEVELS OR WITH PROVOCATIVE FUNCTIONAL MANEUVERS, COMPLETE BILATERAL STUDY (EG, SEGMENTAL BLOOD PRESSURE MEASUREMENTS, SEGMENTAL DOPPLER WAVEFORM ANALYSIS, SEGMENTAL VOLUME PLE					
967	93924	NON-INVASIVE PHYSIOLOGIC STUDIES OF LOWER EXTREMITY ARTERIES, AT REST AND FOLLOWING TREADMILL STRESS TESTING, COMPLETE BILATERAL STUDY					
967	93965	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTREMITY VEINS, COMPLETE BILATERAL STUDY (EG, DOPPLER WAVEFORM ANALYSIS WITH RESPONSES TO COMPRESSION AND OTHER MANEUVERS, PHLEBORHEOGRAPHY, IMPEDANCE PLETHYSMOGRAPHY)					
968	Vascular Ultrasound		X	2.37	\$120.09	\$79.55	\$24.02
968	93875	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTRACRANIAL ARTERIES, COMPLETE BILATERAL STUDY (EG, PERIORBITAL FLOW DIRECTION WITH ARTERIAL COMPRESSION, OCULAR PNEUMOPLETHYSMOGRAPHY, DOPPLER ULTRASOUND SPECTRAL ANALYSIS)					
968	93880	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL STUDY					
968	93882	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; UNILATERAL OR LIMITED STUDY					
968	93886	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES; COMPLETE STUDY					
968	93888	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES; LIMITED STUDY					
968	93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY					
968	93926	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY					
968	93930	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY					
968	93931	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY					
968	93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY					
968	93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; UNILATERAL OR LIMITED STUDY					
968	93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; COMPLETE STUDY					
968	93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; LIMITED STUDY					
968	93978	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR BYPASS GRAFTS; COMPLETE STUDY					
968	93979	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY					
968	93980	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF PENILE VESSELS; COMPLETE STUDY					
968	93981	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF PENILE VESSELS; FOLLOW-UP OR LIMITED STUDY					
968	93990	DUPLEX SCAN OF HEMODIALYSIS ACCESS (INCLUDING ARTERIAL INFLOW, BODY OF ACCESS AND VENOUS OUTFLOW)					
969	Hyperbaric Oxygen		S	2.65	\$134.27	\$141.70	\$26.85
969	99183	PHYSICIAN ATTENDANCE AND SUPERVISION OF HYPERBARIC OXYGEN THERAPY, PER SESSION					
971	Level I Pulmonary Tests		X	0.78	\$39.52	\$21.47	\$7.90
971	94010	SPIROMETRY, INCLUDING GRAPHIC RECORD, TOTAL AND TIMED VITAL CAPACITY, EXPIRATORY FLOW RATE MEASUREMENT(S), WITH OR WITHOUT MAXIMAL VOLUNTARY VENTILATION					
971	94060	BRONCHOSPASM EVALUATION: SPIROMETRY AS IN 94010, BEFORE AND AFTER BRONCHODILATOR (AEROSOL OR PARENTERAL) OR EXERCISE					
971	94200	MAXIMUM BREATHING CAPACITY, MAXIMAL VOLUNTARY VENTILATION					
971	94250	EXPIRED GAS COLLECTION, QUANTITATIVE, SINGLE PROCEDURE (SEPARATE PROCEDURE)					
971	94260	THORACIC GAS VOLUME					
971	94360	DETERMINATION OF RESISTANCE TO AIRFLOW, OSCILLATORY OR PLETHYSMOGRAPHIC METHODS					
971	94375	RESPIRATORY FLOW VOLUME LOOP					
971	94400	BREATHING RESPONSE TO CO ₂ (CO ₂ RESPONSE CURVE)					
971	94450	BREATHING RESPONSE TO HYPOXIA (HYPOXIA RESPONSE CURVE)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
971	94762	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; BY CONTINUOUS OVERNIGHT MONITORING (SEPARATE PROCEDURE)					
971	94770	CARBON DIOXIDE, EXPIRED GAS DETERMINATION BY INFRARED ANALYZER					
971	94799	UNLISTED PULMONARY SERVICE OR PROCEDURE					
972	Level II Pulmonary Tests		X	1.02	\$51.68	\$29.38	\$10.34
972	94240	FUNCTIONAL RESIDUAL CAPACITY OR RESIDUAL VOLUME: HELIUM METHOD, NITROGEN OPEN CIRCUIT METHOD, OR OTHER METHOD					
972	94350	DETERMINATION OF MALDISTRIBUTION OF INSPIRED GAS: MULTIPLE BREATH NITROGEN WASHOUT CURVE INCLUDING ALVEOLAR NITROGEN OR HELIUM EQUILIBRATION TIME					
972	94370	DETERMINATION OF AIRWAY CLOSING VOLUME, SINGLE BREATH TESTS					
972	94680	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST AND EXERCISE, DIRECT, SIMPLE					
972	94681	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; INCLUDING CO ₂ OUTPUT, PERCENTAGE OXYGEN EXTRACTED					
972	94690	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST, INDIRECT (SEPARATE PROCEDURE)					
972	94720	CARBON MONOXIDE DIFFUSING CAPACITY, ANY METHOD					
972	94725	MEMBRANE DIFFUSION CAPACITY					
973	Level III Pulmonary Tests		S	1.89	\$95.77	\$55.82	\$19.15
973	94070	PROLONGED POSTEXPOSURE EVALUATION OF BRONCHOSPASM WITH MULTIPLE SPIROMETRIC DETERMINATIONS AFTER ANTIGEN, COLD AIR, METHACHOLINE OR OTHER CHEMICAL AGENT, WITH SPIROMETRY AS IN 94010					
973	94620	PULMONARY STRESS TESTING, SIMPLE OR COMPLEX					
973	94750	PULMONARY COMPLIANCE STUDY, ANY METHOD					
973	94772	CIRCADIAN RESPIRATORY PATTERN RECORDING (PEDIATRIC PNEUMOGRAM), 12 TO 24 HOUR CONTINUOUS RECORDING, INFANT					
973	95070	INHALATION BRONCHIAL CHALLENGE TESTING (NOT INCLUDING NECESSARY PULMONARY FUNCTION TESTS); WITH HISTAMINE, METHACHOLINE, OR SIMILAR COMPOUNDS					
973	95071	INHALATION BRONCHIAL CHALLENGE TESTING (NOT INCLUDING NECESSARY PULMONARY FUNCTION TESTS); WITH ANTIGENS OR GASES, SPECIFY					
976	Pulmonary Therapy		S	0.44	\$22.29	\$14.92	\$4.46
976	94640	NONPRESSURIZED INHALATION TREATMENT FOR ACUTE AIRWAY OBSTRUCTION					
976	94642	AEROSOL INHALATION OF PENTAMIDINE FOR PNEUMOCYSTIS CARINII PNEUMONIA TREATMENT OR PROPHYLAXIS					
976	94650	INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) TREATMENT, AIR OR OXYGEN, WITH OR WITHOUT NEBULIZED MEDICATION; INITIAL DEMONSTRATION AND/OR EVALUATION					
976	94651	INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) TREATMENT, AIR OR OXYGEN, WITH OR WITHOUT NEBULIZED MEDICATION; SUBSEQUENT					
976	94657	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; SUBSEQUENT DAYS					
976	94660	CONTINUOUS POSITIVE AIRWAY PRESSURE VENTILATION (CPAP), INITIATION AND MANAGEMENT					
976	94662	CONTINUOUS NEGATIVE PRESSURE VENTILATION (CNP), INITIATION AND MANAGEMENT					
976	94664	AEROSOL OR VAPOR INHALATIONS FOR SPUTUM MOBILIZATION, BRONCHODILATION, OR SPUTUM INDUCTION FOR DIAGNOSTIC PURPOSES; INITIAL DEMONSTRATION AND/OR EVALUATION					
976	94665	AEROSOL OR VAPOR INHALATIONS FOR SPUTUM MOBILIZATION, BRONCHODILATION, OR SPUTUM INDUCTION FOR DIAGNOSTIC PURPOSES; SUBSEQUENT					
977	Allergy Tests		X	0.63	\$31.92	\$12.66	\$6.38
977	95004	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK) WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95010	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK) SEQUENTIAL AND INCREMENTAL, WITH DRUGS, BIOLOGICALS OR VENOMS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95015	INTRACUTANEOUS (INTRADERMAL) TESTS, SEQUENTIAL AND INCREMENTAL, WITH DRUGS, BIOLOGICALS, OR VENOMS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95024	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95027	SKIN END POINT TITRATION					
977	95028	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, DELAYED TYPE REACTION, INCLUDING READING, SPECIFY NUMBER OF TESTS					
977	95044	PATCH OR APPLICATION TEST(S) (SPECIFY NUMBER OF TESTS)					
977	95052	PHOTO PATCH TEST(S) (SPECIFY NUMBER OF TESTS)					
977	95056	PHOTO TESTS					
977	95060	OPHTHALMIC MUCOUS MEMBRANE TESTS					
977	95065	DIRECT NASAL MUCOUS MEMBRANE TEST					
977	95078	PROVOCATIVE TESTING (EG, RINKEL TEST)					
977	95180	RAPID DESENSITIZATION PROCEDURE, EACH HOUR (EG, INSULIN, PENICILLIN, HORSE SERUM)					
977	95199	UNLISTED ALLERGY/CLINICAL IMMUNOLOGIC SERVICE OR PROCEDURE					
978	Allergy Injections		X	0.31	\$15.71	\$3.39	\$3.14
978	95115	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT INCLUDING PROVISION OF ALLERGENIC EXTRACTS; SINGLE INJECTION					
978	95117	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT INCLUDING PROVISION OF ALLERGENIC EXTRACTS; TWO OR MORE INJECTIONS					
978	95144	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY, SINGLE OR MULTIPLE ANTIGENS, SINGLE DOSE VIALS (SPECIFY NUMBER OF VIALS)					
978	95145	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); SINGLE STINGING INSECT VENOM					
978	95146	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); TWO SINGLE STINGING INSECT VENOMS					
978	95147	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); THREE SINGLE STINGING INSECT VENOMS					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ¹ / HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
978	95148	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); FOUR SINGLE STINGING INSECT VENOMS					
978	95165	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY; SINGLE OR MULTIPLE ANTIGENS (SPECIFY NUMBER OF DOSES)					
979	Extended	EEG Studies and Sleep Studies	S	10.17	\$515.31	\$288.83	\$103.06
979	95805	MULTIPLE SLEEP LATENCY OR MAINTENANCE OF WAKEFULNESS TESTING, RECORDING, ANALYSIS AND INTERPRETATION OF PHYSIOLOGICAL MEASUREMENTS OF SLEEP DURING MULTIPLE TRIALS TO ASSESS SLEEPINESS					
979	95806	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, UNATTENDED BY A TECHNOLOGIST					
979	95807	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, ATTENDED BY A TECHNOLOGIST					
979	95808	POLYSOMNOGRAPHY; SLEEP STAGING WITH 1-3 ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST					
979	95810	POLYSOMNOGRAPHY; OF SLEEP, ATTENDED BY A TECHNOLOGIST SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST					
979	95811	POLYSOMNOGRAPHY; OF SLEEP, ATTENDED BY A TECHNOLOGIST SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, WITH INITIATION OF CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY OR BILEVEL VENTILATION, ATTENDED BY A TECHNOLOGIST					
979	95812	ELECTROENCEPHALOGRAM (EEG) EXTENDED MONITORING; UP TO ONE HOUR					
979	95813	ELECTROENCEPHALOGRAM (EEG) EXTENDED MONITORING; GREATER THAN ONE HOUR					
979	95827	ELECTROENCEPHALOGRAM (EEG); ALL NIGHT SLEEP ONLY					
979	95951	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY CABLE OR RADIO, 16 OR MORE CHANNEL TELEMETRY, COMBINED ELECTROENCEPHALOGRAPHIC (EEG) AND VIDEO RECORDING AND INTERPRETATION (EG, FOR PRESURGICAL LOCALIZATION), EACH 24 HOURS					
979	95953	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY COMPUTERIZED PORTABLE 16 OR MORE CHANNEL EEG, ELECTROENCEPHALOGRAPHIC (EEG) RECORDING AND INTERPRETATION, EACH 24 HOURS					
979	95954	PHARMACOLOGICAL OR PHYSICAL ACTIVATION REQUIRING PHYSICIAN ATTENDANCE DURING EEG RECORDING OF ACTIVATION PHASE (EG, THIOPENTAL ACTIVATION TEST)					
979	95956	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY CABLE OR RADIO, 16 OR MORE CHANNEL TELEMETRY, ELECTROENCEPHALOGRAPHIC (EEG) RECORDING AND INTERPRETATION, EACH 24 HOURS					
979	95958	WADA ACTIVATION TEST FOR HEMISPHERIC FUNCTION, INCLUDING ELECTROENCEPHALOGRAPHIC (EEG) MONITORING					
980	Electroencephalogram		S	2.15	\$108.94	\$57.86	\$21.79
980	92275	ELECTRORETINOGRAPHY WITH INTERPRETATION AND REPORT					
980	95857	TENSILON TEST FOR MYASTHENIA GRAVIS;					
980	95867	NEEDLE ELECTROMYOGRAPHY, CRANIAL NERVE SUPPLIED MUSCLES, UNILATERAL					
980	95869	NEEDLE ELECTROMYOGRAPHY; THORACIC PARASPINAL MUSCLES					
980	95870	NEEDLE ELECTROMYOGRAPHY; OTHER THAN PARASPINAL (EG, ABDOMEN, THORAX)					
980	95900	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE, ANY/ALL SITE(S) ALONG THE NERVE; MOTOR, WITHOUT F-WAVE STUDY					
980	95921	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; CARDIOVAGAL INNERVATION (PARASYMPATHETIC FUNCTION), INCLUDING TWO OR MORE OF THE FOLLOWING: HEART RATE RESPONSE TO DEEP BREATHING WITH RECORDED R-R INTERVAL, VALSALVA RATIO, AND 30:15 RATIO					
980	95922	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; VASOMOTOR ADRENERGIC INNERVATION (SYMPATHETIC ADRENERGIC FUNCTION), INCLUDING BEAT-TO-BEAT BLOOD PRESSURE AND R-R INTERVAL CHANGES DURING VALSALVA MANEUVER AND AT LEAST FIVE MINUTES OF PASSIVE TILT					
980	95923	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; SUDOMOTOR, INCLUDING ONE OR MORE OF THE FOLLOWING: QUANTITATIVE SUDOMOTOR AXON REFLEX TEST (QSART), SILASTIC SWEAT IMPRINT, THERMOREGULATORY SWEAT TEST, AND CHANGES IN SYMPATHETIC SKIN POTENTIAL					
980	95926	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL PERIPHERAL NERVES OR SKIN SITES, RECORDING FROM THE CENTRAL NERVOUS SYSTEM; IN LOWER LIMBS					
980	95927	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL PERIPHERAL NERVES OR SKIN SITES, RECORDING FROM THE CENTRAL NERVOUS SYSTEM; IN THE TRUNK OR HEAD					
980	95930	VISUAL EVOKED POTENTIAL (VEP) TESTING CENTRAL NERVOUS SYSTEM, CHECKERBOARD OR FLASH					
980	95933	ORBICULARIS OCULI (BLINK) REFLEX, BY ELECTRODIAGNOSTIC TESTING					
980	95934	H-REFLEX, AMPLITUDE AND LATENCY STUDY; RECORD GASTROCNEMIUS/SOLEUS MUSCLE					
980	95936	H-REFLEX, AMPLITUDE AND LATENCY STUDY; RECORD MUSCLE OTHER THAN GASTROCNEMIUS/SOLEUS MUSCLE					
980	95937	NEUROMUSCULAR JUNCTION TESTING (REPETITIVE STIMULATION, PAIRED STIMULI), EACH NERVE, ANY ONE METHOD					
980	95950	MONITORING FOR IDENTIFICATION AND LATERALIZATION OF CEREBRAL SEIZURE FOCUS, ELECTROENCEPHALOGRAPHIC (EG, 8 CHANNEL EEG) RECORDING AND INTERPRETATION, EACH 24 HOURS					
981	Level I Nerve and Muscle Tests		X	1.46	\$73.98	\$41.81	\$14.80
981	92585	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS SYSTEM					
981	95858	TENSILON TEST FOR MYASTHENIA GRAVIS; WITH ELECTROMYOGRAPHIC RECORDING					
981	95860	NEEDLE ELECTROMYOGRAPHY, ONE EXTREMITY WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95861	NEEDLE ELECTROMYOGRAPHY, TWO EXTREMITIES WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95863	NEEDLE ELECTROMYOGRAPHY, THREE EXTREMITIES WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95864	NEEDLE ELECTROMYOGRAPHY, FOUR EXTREMITIES WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95868	NEEDLE ELECTROMYOGRAPHY, CRANIAL NERVE SUPPLIED MUSCLES, BILATERAL					
981	95872	NEEDLE ELECTROMYOGRAPHY USING SINGLE FIBER ELECTRODE, WITH QUANTITATIVE MEASUREMENT OF JITTER, BLOCKING AND/OR FIBER DENSITY, ANY/ALL SITES OF EACH MUSCLE STUDIED					
981	95875	ISCHEMIC LIMB EXERCISE WITH NEEDLE ELECTROMYOGRAPHY, WITH LACTIC ACID DETERMINATION					
981	95903	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE, ANY/ALL SITE(S) ALONG THE NERVE; MOTOR, WITH F-WAVE STUDY					
981	95904	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE, ANY/ALL SITE(S) ALONG THE NERVE; SENSORY					
981	95920	INTRAOPERATIVE NEUROPHYSIOLOGY TESTING, PER HOUR					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT ^{1/} HCPCS ²	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
981	95925	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL PERIPHERAL NERVES OR SKIN SITES, RECORDING FROM THE CENTRAL NERVOUS SYSTEM; IN UPPER LIMBS					
982	Level II Nerve and Muscle Tests		X	1.39	\$70.43	\$38.87	\$14.09
982	92585	Auditory evoked potential					
982	95858	Tensilon test & myogram					
982	95860	Muscle test, one limb					
982	95861	Muscle test, two limbs					
982	95863	Muscle test, 3 limbs					
982	95864	Muscle test, 4 limbs					
982	95868	Muscle test, head or neck					
982	95872	Muscle test, one fiber					
982	95875	Limb exercise test					
982	95925	Somatosensory testing					
987	Subcutaneous or Intramuscular Chemotherapy		S	.65	\$32.94	\$13.33	\$6.59
987	96400	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR, WITH OR WITHOUT LOCAL ANESTHESIA					
987	96405	CHEMOTHERAPY ADMINISTRATION, INTRALESIONAL; UP TO AND INCLUDING 7 LESIONS					
987	96406	CHEMOTHERAPY ADMINISTRATION, INTRALESIONAL; MORE THAN 7 LESIONS					
987	96549	UNLISTED CHEMOTHERAPY PROCEDURE					
987	Q0083	Chemo other than infusion					
988	Chemotherapy except by Extended Infusion		S	4.15	\$210.28	\$97.52	\$42.06
988	96408	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; PUSH TECHNIQUE					
988	96410	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, UP TO ONE HOUR					
988	96412	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, ONE TO 8 HOURS, EACH ADDITIONAL HOUR					
988	96420	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH TECHNIQUE					
988	96422	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, UP TO ONE HOUR					
988	96423	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, ONE TO 8 HOURS, EACH ADDITIONAL HOUR					
989	Chemotherapy by Extended Infusion		S	1.72	\$87.15	\$40.68	\$17.43
989	96414	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, INITIATION OF PROLONGED INFUSION (MORE THAN 8 HOURS), REQUIRING THE USE OF A PORTABLE OR IMPLANTABLE PUMP					
989	96425	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, INITIATION OF PROLONGED INFUSION (MORE THAN 8 HOURS), REQUIRING THE USE OF A PORTABLE OR IMPLANTABLE PUMP					
989	96440	CHEMOTHERAPY ADMINISTRATION INTO PLEURAL CAVITY, REQUIRING AND INCLUDING THORACENTESIS					
989	96445	CHEMOTHERAPY ADMINISTRATION INTO PERITONEAL CAVITY, REQUIRING AND INCLUDING PERITONEOCENTESIS					
989	96450	CHEMOTHERAPY ADMINISTRATION, INTO CNS (EG, INTRATHECAL), REQUIRING AND INCLUDING LUMBAR PUNCTURE					
989	96542	CHEMOTHERAPY INJECTION, SUBARACHNOID OR INTRAVENTRICULAR VIA SUBCUTANEOUS RESERVOIR, SINGLE OR MULTIPLE AGENTS					
989	Q0084	Chemo, infusion only					
989	Q0085	Chemo, infusion and other technique					
990	Photochemotherapy		S	.43	\$21.79	\$8.14	\$4.36
990	96900	ACTINOTHERAPY (ULTRAVIOLET LIGHT)					
990	96910	PHOTOCHEMOTHERAPY; TAR AND ULTRAVIOLET B (GOECKERMAN TREATMENT) OR PETROLATUM AND ULTRAVIOLET B					
990	96912	PHOTOCHEMOTHERAPY; PSORALENS AND ULTRAVIOLET A (PUVA)					
990	96913	PHOTOCHEMOTHERAPY (GOECKERMAN AND/OR PUVA) FOR SEVERE PHOTORESPONSIVE DERMATOSES REQUIRING AT LEAST FOUR TO EIGHT HOURS OF CARE UNDER DIRECT SUPERVISION OF THE PHYSICIAN (INCLUDES APPLICATION OF MEDICATION AND DRESSINGS)					
990	96999	UNLISTED SPECIAL DERMATOLOGICAL SERVICE OR PROCEDURE					
997	Manipulation Therapy		S	.69	\$34.96	\$7.23	\$6.99
997	97250	MYOFASCIAL RELEASE/SOFT TISSUE MOBILIZATION, ONE OR MORE REGIONS					
997	97260	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; ONE AREA					
997	97261	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; EACH ADDITIONAL AREA					
997	98925	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); ONE TO TWO BODY REGIONS INVOLVED					
997	98926	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); THREE TO FOUR BODY REGIONS INVOLVED					
997	98927	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); FIVE TO SIX BODY REGIONS INVOLVED					
997	98928	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); SEVEN TO EIGHT BODY REGIONS INVOLVED					
997	98929	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); NINE TO TEN BODY REGIONS INVOLVED					
997	98940	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS					
997	98941	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, THREE TO FOUR REGIONS					
997	98942	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, FIVE REGIONS					
999	Therapeutic Phlebotomy		X	.43	\$21.79	\$10.85	\$4.36
999	99195	PHLEBOTOMY, THERAPEUTIC (SEPARATE PROCEDURE)					

ADDENDUM D.—SUMMARY OF MEDICAL APCs

APC	CPT ¹ HCPCS ²	Description
911 Low Level Clinic Visits	99201 99202 99211 99212 99241 99242 99271 99272 G0101	Office/outpatient visit, new Office/outpatient visit, new Office/outpatient visit, est Office/outpatient visit, est Office consultation Office consultation Confirmatory consultation Confirmatory consultation Cancer Screening Exam, Women
913 Mid Level Clinic Visits	92002 92012 99203 99213 99243 99273	Eye exam, new patient Eye exam established pt Office/outpatient visit, new Office/outpatient visit, est Office consultation Confirmatory consultation
915 High Level Clinic Visits	92004 92014 92506 99204 99205 99214 99215 99244 99245 99274 99275	Eye exam, new patient Eye exam & treatment Speech & hearing evaluation Office/outpatient visit, new Office/outpatient visit, new Office/outpatient visit, est Office/outpatient visit, est Office consultation Office consultation Confirmatory consultation Confirmatory consultation
951 Low Level Emergency Visits	99281 99282	Emergency dept visit Emergency dept visit
953 Mid Level Emergency Visits	99283	Emergency dept visit
955 High Level Emergency Visits	99284 99285	Emergency dept visit Emergency dept visit

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Note: Medical visit APCs are created by combining level of visit from Addendum D with reason for visit from Addendum E. Thus a midlevel clinic visit (99203) for an eye disorder groups to APC 91368.

ADDENDUM E.—MAJOR DIAGNOSTIC CATEGORIES (MDCs)

MDC	Description
11	Well care and administrative
18	Skin and breast diseases
24	Musculoskeletal diseases
31	Ear, nose, mouth and throat diseases
33	Respiratory system diseases
36	Cardiovascular system diseases
41	Digestive system diseases
53	Kidney, urinary tract and male genital diseases
56	Female genital system diseases
57	Pregnancy and Neonatal Care
63	Nervous System Diseases
68	Eye Diseases
72	Trauma and poisoning
78	Major signs, symptoms and findings
82	Endocrine, nutritional and metabolic diseases
86	Immunologic and hematologic diseases
88	Malignancy
91	Psychiatric Disorders
97	Infectious disease
99	Unknown cause of mortality

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS

ICD-9	ICD-9 Description	MDC
0010	CHOLERA D/T VIB CHOLERA E	41
0011	CHOLERA D/T VIB EL TOR	41
0019	CHOLERA NOS	41

*ICD-9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
0020	TYPHOID FEVER	97
0021	PARATYPHOID FEVER A	97
0022	PARATYPHOID FEVER B	97
0023	PARATYPHOID FEVER C	97
0029	PARATYPHOID FEVER NOS	97
0030	SALMONELLA ENTERITIS	41
0031	SALMONELLA SEPTICEMIA	97
00320	LOCAL SALMONELLA INF NOS	97
00321	SALMONELLA MENINGITIS	97
00322	SALMONELLA PNEUMONIA	33
00323	SALMONELLA ARTHRITIS	24
00324	SALMONELLA OSTEOMYELITIS	24
00329	LOCAL SALMONELLA INF NEC	97
0038	SALMONELLA INFECTION NEC	97
0039	SALMONELLA INFECTION NOS	97
0040	SHIGELLA DYSENTERIAE	41
0041	SHIGELLA FLEXNERI	41
0042	SHIGELLA BOYDII	41
0043	SHIGELLA SONNEI	41
0048	SHIGELLA INFECTION NEC	41
0049	SHIGELLOSIS NOS	41
0050	STAPH FOOD POISONING	41
0051	BOTULISM	97
0052	FOOD POIS D/T C. PERFRIN	41
0053	FOOD POIS: CLOSTRID NEC	41
0054	FOOD POIS: V. PARAHAE	41
00581	FOOD POISN D/T V. VULNIF	41
00589	BACT FOOD POISONING NEC	41
0059	FOOD POISONING NOS	41
0060	AC AMEBIASIS W/O ABSCESS	41
0061	CHR AMEBIASIS W/O ABSCESS	41
0062	AMEBIC NONDYSENT COLITIS	41
0063	AMEBIC LIVER ABSCESS	41
0064	AMEBIC LUNG ABSCESS	33
0065	AMEBIC BRAIN ABSCESS	97
0066	AMEBIC SKIN ULCERATION	18
0068	AMEBIC INFECTION NEC	97
0069	AMEBIASIS NOS	97
0070	BALANTIDIASIS	41
0071	GIARDIASIS	41
0072	COCCIDIOSIS	41
0073	INTEST TRICHOMONIASIS	41
0078	PROTOZOAL INTEST DIS NEC	41
0079	PROTOZOAL INTEST DIS NOS	41
00800	INTEST INFEC E COLI NOS	41
00801	INT INF E COLI ENTRPATH	41
00802	INT INF E COLI ENTRTOXGN	41
00803	INT INF E COLI ENTRNVSV	41
00804	INT INF E COLI ENTRHMRG	41
00809	INT INF E COLI SPCF NEC	41
0081	ARIZONA ENTERITIS	41
0082	AEROBACTER ENTERITIS	41
0083	PROTEUS ENTERITIS	41
00841	STAPHYLOCOCC ENTERITIS	41
00842	PSEUDOMONAS ENTERITIS	41
00843	INT INFEC CAMPYLOBACTER	41
00844	INT INF YRSNIA ENTRCLTCA	41
00845	INT INF CLSTRDIUM DFCILE	41
00846	INTES INFEC OTH ANEROBES	41
00847	INT INF OTH GRM NEG BCTR	41
00849	BACTERIAL ENTERITIS NEC	41
0085	BACTERIAL ENTERITIS NOS	41
00861	INTES INFEC ROTAVIRUS	41
00862	INTES INFEC ADENOVIRUS	41
00863	INT INF NORWALK VIRUS	41
00864	INT INF OTH SML RND VRUS	41
00865	INTES INFEC CALCIVIRUS	41
00866	INTES INFEC ASTROVIRUS	41
00867	INT INF ENTEROVIRUS NEC	41
00869	OTHER VIRAL INTES INFEC	41
0088	VIRAL ENTERITIS NOS	41
0090	INFECTIOUS ENTERITIS NOS	41
0091	ENTERITIS OF INFECT ORIG	41
0092	INFECTIOUS DIARRHEA NOS	41
0093	DIARRHEA OF INFECT ORIG	41
01000	PRIM TB COMPLEX-UNSPEC	33

*ICD-9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01001	PRIM TB COMPLEX-NO EXAM	33
01002	PRIM TB COMPLEX-EXM UNKN	33
01003	PRIM TB COMPLEX-MICRO DX	33
01004	PRIM TB COMPLEX-CULT DX	33
01005	PRIM TB COMPLEX-HISTO DX	33
01006	PRIM TB COMPLEX-OTH TEST	33
01010	PRIM TB PLEURISY-UNSPEC	33
01011	PRIM TB PLEURISY-NO EXAM	33
01012	PRIM TB PLEUR-EXAM UNKN	33
01013	PRIM TB PLEURIS-MICRO DX	33
01014	PRIM TB PLEURISY-CULT DX	33
01015	PRIM TB PLEURIS-HISTO DX	33
01016	PRIM TB PLEURIS-OTH TEST	33
01080	PRIM PROG TB NEC-UNSPEC	33
01081	PRIM PROG TB NEC-NO EXAM	33
01082	PRIM PR TB NEC-EXAM UNKN	33
01083	PRIM PRG TB NEC-MICRO DX	33
01084	PRIM PROG TB NEC-CULT DX	33
01085	PRIM PRG TB NEC-HISTO DX	33
01086	PRIM PRG TB NEC-OTH TEST	33
01090	PRIMARY TB NOS-UNSPEC	33
01091	PRIMARY TB NOS-NO EXAM	33
01092	PRIMARY TB NOS-EXAM UNKN	33
01093	PRIMARY TB NOS-MICRO DX	33
01094	PRIMARY TB NOS-CULT DX	33
01095	PRIMARY TB NOS-HISTO DX	33
01096	PRIMARY TB NOS-OTH TEST	33
01100	TB LUNG INFILTR-UNSPEC	33
01101	TB LUNG INFILTR-NO EXAM	33
01102	TB LUNG INFILTR-EXM UNKN	33
01103	TB LUNG INFILTR-MICRO DX	33
01104	TB LUNG INFILTR-CULT DX	33
01105	TB LUNG INFILTR-HISTO DX	33
01106	TB LUNG INFILTR-OTH TEST	33
01110	TB LUNG NODULAR-UNSPEC	33
01111	TB LUNG NODULAR-NO EXAM	33
01112	TB LUNG NODUL-EXAM UNKN	33
01113	TB LUNG NODULAR-MICRO DX	33
01114	TB LUNG NODULAR-CULT DX	33
01115	TB LUNG NODULAR-HISTO DX	33
01116	TB LUNG NODULAR-OTH TEST	33
01120	TB LUNG W CAVITY-UNSPEC	33
01121	TB LUNG W CAVITY-NO EXAM	33
01122	TB LUNG CAVITY-EXAM UNKN	33
01123	TB LUNG W CAVIT-MICRO DX	33
01124	TB LUNG W CAVITY-CULT DX	33
01125	TB LUNG W CAVIT-HISTO DX	33
01126	TB LUNG W CAVIT-OTH TEST	33
01130	TB OF BRONCHUS-UNSPEC	33
01131	TB OF BRONCHUS-NO EXAM	33
01132	TB OF BRONCHUS-EXAM UNKN	33
01133	TB OF BRONCHUS-MICRO DX	33
01134	TB OF BRONCHUS-CULT DX	33
01135	TB OF BRONCHUS-HISTO DX	33
01136	TB OF BRONCHUS-OTH TEST	33
01140	TB LUNG FIBROSIS-UNSPEC	33
01141	TB LUNG FIBROSIS-NO EXAM	33
01142	TB LUNG FIBROS-EXAM UNKN	33
01143	TB LUNG FIBROS-MICRO DX	33
01144	TB LUNG FIBROSIS-CULT DX	33
01145	TB LUNG FIBROS-HISTO DX	33
01146	TB LUNG FIBROS-OTH TEST	33
01150	TB BRONCHIECTASIS-UNSPEC	33
01151	TB BRONCHIECT-NO EXAM	33
01152	TB BRONCHIECT-EXAM UNKN	33
01153	TB BRONCHIECT-MICRO DX	33
01154	TB BRONCHIECT-CULT DX	33
01155	TB BRONCHIECT-HISTO DX	33
01156	TB BRONCHIECT-OTH TEST	33
01160	TB PNEUMONIA-UNSPEC	33
01161	TB PNEUMONIA-NO EXAM	33
01162	TB PNEUMONIA-EXAM UNKN	33
01163	TB PNEUMONIA-MICRO DX	33
01164	TB PNEUMONIA-CULT DX	33
01165	TB PNEUMONIA-HISTO DX	33
01166	TB PNEUMONIA-OTH TEST	33

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
01170	TB PNEUMOTHORAX-UNSPEC	33
01171	TB PNEUMOTHORAX-NO EXAM	33
01172	TB PNEUMOTHORAX-EXAM UNKN	33
01173	TB PNEUMOTHORAX-MICRO DX	33
01174	TB PNEUMOTHORAX-CULT DX	33
01175	TB PNEUMOTHORAX-HISTO DX	33
01176	TB PNEUMOTHORAX-OTH TEST	33
01180	PULMONARY TB NEC-UNSPEC	33
01181	PULMONARY TB NEC-NO EXAM	33
01182	PULMON TB NEC-EXAM UNKN	33
01183	PULMON TB NEC-MICRO DX	33
01184	PULMON TB NEC-CULT DX	33
01185	PULMON TB NEC-HISTO DX	33
01186	PULMON TB NEC-OTH TEST	33
01190	PULMONARY TB NOS-UNSPEC	33
01191	PULMONARY TB NOS-NO EXAM	33
01192	PULMON TB NOS-EXAM UNKN	33
01193	PULMON TB NOS-MICRO DX	33
01194	PULMON TB NOS-CULT DX	33
01195	PULMON TB NOS-HISTO DX	33
01196	PULMON TB NOS-OTH TEST	33
01200	TB PLEURISY-UNSPEC	33
01201	TB PLEURISY-NO EXAM	33
01202	TB PLEURISY-EXAM UNKN	33
01203	TB PLEURISY-MICRO DX	33
01204	TB PLEURISY-CULT DX	33
01205	TB PLEURISY-HISTOLOG DX	33
01206	TB PLEURISY-OTH TEST	33
01210	TB THORACIC NODES-UNSPEC	33
01211	TB THORAX NODE-NO EXAM	33
01212	TB THORAX NODE-EXAM UNKN	33
01213	TB THORAX NODE-MICRO DX	33
01214	TB THORAX NODE-CULT DX	33
01215	TB THORAX NODE-HISTO DX	33
01216	TB THORAX NODE-OTH TEST	33
01220	ISOL TRACHEAL TB-UNSPEC	31
01221	ISOL TRACHEAL TB-NO EXAM	31
01222	ISOL TRACH TB-EXAM UNKN	31
01223	ISOLAT TRACH TB-MICRO DX	31
01224	ISOL TRACHEAL TB-CULT DX	31
01225	ISOLAT TRACH TB-HISTO DX	31
01226	ISOLAT TRACH TB-OTH TEST	31
01230	TB LARYNGITIS-UNSPEC	31
01231	TB LARYNGITIS-NO EXAM	31
01232	TB LARYNGITIS-EXAM UNKN	31
01233	TB LARYNGITIS-MICRO DX	31
01234	TB LARYNGITIS-CULT DX	31
01235	TB LARYNGITIS-HISTO DX	31
01236	TB LARYNGITIS-OTH TEST	31
01280	RESP TB NEC-UNSPEC	33
01281	RESP TB NEC-NO EXAM	33
01282	RESP TB NEC-EXAM UNKN	33
01283	RESP TB NEC-MICRO DX	33
01284	RESP TB NEC-CULT DX	33
01285	RESP TB NEC-HISTO DX	33
01286	RESP TB NEC-OTH TEST	33
01300	TB MENINGITIS-UNSPEC	63
01301	TB MENINGITIS-NO EXAM	63
01302	TB MENINGITIS-EXAM UNKN	63
01303	TB MENINGITIS-MICRO DX	63
01304	TB MENINGITIS-CULT DX	63
01305	TB MENINGITIS-HISTO DX	63
01306	TB MENINGITIS-OTH TEST	63
01310	TUBRCLMA MENINGES-UNSPEC	63
01311	TUBRCLMA MENING-NO EXAM	63
01312	TUBRCLMA MENING-EXAM UNKN	63
01313	TUBRCLMA MENING-MICRO DX	63
01314	TUBRCLMA MENING-CULT DX	63
01315	TUBRCLMA MENING-HISTO DX	63
01316	TUBRCLMA MENING-OTH TEST	63
01320	TUBERCULOMA BRAIN-UNSPEC	63
01321	TUBRCLOMA BRAIN-NO EXAM	63
01322	TUBRCLMA BRAIN-EXAM UNKN	63
01323	TUBRCLOMA BRAIN-MICRO DX	63
01324	TUBRCLOMA BRAIN-CULT DX	63
01325	TUBRCLOMA BRAIN-HISTO DX	63

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01326	TUBRCLOMA BRAIN-OTH TEST	63
01330	TB BRAIN ABSCESS-UNSPEC	63
01331	TB BRAIN ABSCESS-NO EXAM	63
01332	TB BRAIN ABSC-EXAM UNKN	63
01333	TB BRAIN ABSC-MICRO DX	63
01334	TB BRAIN ABSCESS-CULT DX	63
01335	TB BRAIN ABSC-HISTO DX	63
01336	TB BRAIN ABSC-OTH TEST	63
01340	TUBRCLMA SP CORD-UNSPEC	63
01341	TUBRCLMA SP CORD-NO EXAM	63
01342	TUBRCLMA SP CD-EXAM UNKN	63
01343	TUBRCLMA SP CRD-MICRO DX	63
01344	TUBRCLMA SP CORD-CULT DX	63
01345	TUBRCLMA SP CRD-HISTO DX	63
01346	TUBRCLMA SP CRD-OTH TEST	63
01350	TB SP CRD ABSCESS-UNSPEC	63
01351	TB SP CRD ABSC-NO EXAM	63
01352	TB SP CRD ABSC-EXAM UNKN	63
01353	TB SP CRD ABSC-MICRO DX	63
01354	TB SP CRD ABSC-CULT DX	63
01355	TB SP CRD ABSC-HISTO DX	63
01356	TB SP CRD ABSC-OTH TEST	63
01360	TB ENCEPHALITIS-UNSPEC	63
01361	TB ENCEPHALITIS-NO EXAM	63
01362	TB ENCEPHALIT-EXAM UNKN	63
01363	TB ENCEPHALITIS-MICRO DX	63
01364	TB ENCEPHALITIS-CULT DX	63
01365	TB ENCEPHALITIS-HISTO DX	63
01366	TB ENCEPHALITIS-OTH TEST	63
01380	CNS TB NEC-UNSPEC	63
01381	CNS TB NEC-NO EXAM	63
01382	CNS TB NEC-EXAM UNKN	63
01383	CNS TB NEC-MICRO DX	63
01384	CNS TB NEC-CULT DX	63
01385	CNS TB NEC-HISTO DX	63
01386	CNS TB NEC-OTH TEST	63
01390	CNS TB NOS-UNSPEC	63
01391	CNS TB NOS-NO EXAM	63
01392	CNS TB NOS-EXAM UNKN	63
01393	CNS TB NOS-MICRO DX	63
01394	CNS TB NOS-CULT DX	63
01395	CNS TB NOS-HISTO DX	63
01396	CNS TB NOS-OTH TEST	63
01400	TB PERITONITIS-UNSPEC	41
01401	TB PERITONITIS-NO EXAM	41
01402	TB PERITONITIS-EXAM UNKN	41
01403	TB PERITONITIS-MICRO DX	41
01404	TB PERITONITIS-CULT DX	41
01405	TB PERITONITIS-HISTO DX	41
01406	TB PERITONITIS-OTH TEST	41
01480	INTESTINAL TB NEC-UNSPEC	41
01481	INTESTIN TB NEC-NO EXAM	41
01482	INTEST TB NEC-EXAM UNKN	41
01483	INTESTIN TB NEC-MICRO DX	41
01484	INTESTIN TB NEC-CULT DX	41
01485	INTESTIN TB NEC-HISTO DX	41
01486	INTESTIN TB NEC-OTH TEST	41
01500	TB OF VERTEBRA-UNSPEC	24
01501	TB OF VERTEBRA-NO EXAM	24
01502	TB OF VERTEBRA-EXAM UNKN	24
01503	TB OF VERTEBRA-MICRO DX	24
01504	TB OF VERTEBRA-CULT DX	24
01505	TB OF VERTEBRA-HISTO DX	24
01506	TB OF VERTEBRA-OTH TEST	24
01510	TB OF HIP-UNSPEC	24
01511	TB OF HIP-NO EXAM	24
01512	TB OF HIP-EXAM UNKN	24
01513	TB OF HIP-MICRO DX	24
01514	TB OF HIP-CULT DX	24
01515	TB OF HIP-HISTO DX	24
01516	TB OF HIP-OTH TEST	24
01520	TB OF KNEE-UNSPEC	24
01521	TB OF KNEE-NO EXAM	24
01522	TB OF KNEE-EXAM UNKN	24
01523	TB OF KNEE-MICRO DX	24
01524	TB OF KNEE-CULT DX	24

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
01525	TB OF KNEE-HISTO DX	24
01526	TB OF KNEE-OTH TEST	24
01550	TB OF LIMB BONES-UNSPEC	24
01551	TB LIMB BONES-NO EXAM	24
01552	TB LIMB BONES-EXAM UNKN	24
01553	TB LIMB BONES-MICRO DX	24
01554	TB LIMB BONES-CULT DX	24
01555	TB LIMB BONES-HISTO DX	24
01556	TB LIMB BONES-OTH TEST	24
01560	TB OF MASTOID-UNSPEC	31
01561	TB OF MASTOID-NO EXAM	31
01562	TB OF MASTOID-EXAM UNKN	31
01563	TB OF MASTOID-MICRO DX	31
01564	TB OF MASTOID-CULT DX	31
01565	TB OF MASTOID-HISTO DX	31
01566	TB OF MASTOID-OTH TEST	31
01570	TB OF BONE NEC-UNSPEC	24
01571	TB OF BONE NEC-NO EXAM	24
01572	TB OF BONE NEC-EXAM UNKN	24
01573	TB OF BONE NEC-MICRO DX	24
01574	TB OF BONE NEC-CULT DX	24
01575	TB OF BONE NEC-HISTO DX	24
01576	TB OF BONE NEC-OTH TEST	24
01580	TB OF JOINT NEC-UNSPEC	24
01581	TB OF JOINT NEC-NO EXAM	24
01582	TB JOINT NEC-EXAM UNKN	24
01583	TB OF JOINT NEC-MICRO DX	24
01584	TB OF JOINT NEC-CULT DX	24
01585	TB OF JOINT NEC-HISTO DX	24
01586	TB OF JOINT NEC-OTH TEST	24
01590	TB BONE/JOINT NOS-UNSPEC	24
01591	TB BONE/JT NOS-NO EXAM	24
01592	TB BONE/JT NOS-EXAM UNKN	24
01593	TB BONE/JT NOS-MICRO DX	24
01594	TB BONE/JT NOS-CULT DX	24
01595	TB BONE/JT NOS-HISTO DX	24
01596	TB BONE/JT NOS-OTH TEST	24
01600	TB OF KIDNEY-UNSPEC	53
01601	TB OF KIDNEY-NO EXAM	53
01602	TB OF KIDNEY-EXAM UNKN	53
01603	TB OF KIDNEY-MICRO DX	53
01604	TB OF KIDNEY-CULT DX	53
01605	TB OF KIDNEY-HISTO DX	53
01606	TB OF KIDNEY-OTH TEST	53
01610	TB OF BLADDER-UNSPEC	53
01611	TB OF BLADDER-NO EXAM	53
01612	TB OF BLADDER-EXAM UNKN	53
01613	TB OF BLADDER-MICRO DX	53
01614	TB OF BLADDER-CULT DX	53
01615	TB OF BLADDER-HISTO DX	53
01616	TB OF BLADDER-OTH TEST	53
01620	TB OF URETER-UNSPEC	53
01621	TB OF URETER-NO EXAM	53
01622	TB OF URETER-EXAM UNKN	53
01623	TB OF URETER-MICRO DX	53
01624	TB OF URETER-CULT DX	53
01625	TB OF URETER-HISTO DX	53
01626	TB OF URETER-OTH TEST	53
01630	TB URINARY NEC-UNSPEC	53
01631	TB URINARY NEC-NO EXAM	53
01632	TB URINARY NEC-EXAM UNKN	53
01633	TB URINARY NEC-MICRO DX	53
01634	TB URINARY NEC-CULT DX	53
01635	TB URINARY NEC-HISTO DX	53
01636	TB URINARY NEC-OTH TEST	53
01640	TB EPIDIDYMIS-UNSPEC	53
01641	TB EPIDIDYMIS-NO EXAM	53
01642	TB EPIDIDYMIS-EXAM UNKN	53
01643	TB EPIDIDYMIS-MICRO DX	53
01644	TB EPIDIDYMIS-CULT DX	53
01645	TB EPIDIDYMIS-HISTO DX	53
01646	TB EPIDIDYMIS-OTH TEST	53
01650	TB MALE GENIT NEC-UNSPEC	53
01651	TB MALE GEN NEC-NO EXAM	53
01652	TB MALE GEN NEC-EX UNKN	53
01653	TB MALE GEN NEC-MICRO DX	53

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
01654	TB MALE GEN NEC-CULT DX	53
01655	TB MALE GEN NEC-HISTO DX	53
01656	TB MALE GEN NEC-OTH TEST	53
01660	TB OVARY & TUBE-UNSPEC	56
01661	TB OVARY & TUBE-NO EXAM	56
01662	TB OVARY/TUBE-EXAM UNKN	56
01663	TB OVARY & TUBE-MICRO DX	56
01664	TB OVARY & TUBE-CULT DX	56
01665	TB OVARY & TUBE-HISTO DX	56
01666	TB OVARY & TUBE-OTH TEST	56
01670	TB FEMALE GEN NEC-UNSPEC	56
01671	TB FEM GEN NEC-NO EXAM	56
01672	TB FEM GEN NEC-EXAM UNKN	56
01673	TB FEM GEN NEC-MICRO DX	56
01674	TB FEM GEN NEC-CULT DX	56
01675	TB FEM GEN NEC-HISTO DX	56
01676	TB FEM GEN NEC-OTH TEST	56
01690	GU TB NOS-UNSPEC	53
01691	GU TB NOS-NO EXAM	53
01692	GU TB NOS-EXAM UNKN	53
01693	GU TB NOS-MICRO DX	53
01694	GU TB NOS-CULT DX	53
01695	GU TB NOS-HISTO DX	53
01696	GU TB NOS-OTH TEST	53
01700	TB SKIN/SUBCUTAN-UNSPEC	18
01701	TB SKIN/SUBCUT-NO EXAM	18
01702	TB SKIN/SUBCUT-EXAM UNKN	18
01703	TB SKIN/SUBCUT-MICRO DX	18
01704	TB SKIN/SUBCUT-CULT DX	18
01705	TB SKIN/SUBCUT-HISTO DX	18
01706	TB SKIN/SUBCUT-OTH TEST	18
01710	ERYTHEMA NODOS TB-UNSPEC	18
01711	ERYTHEM NODOS TB-NO EXAM	18
01712	ERYTHEM NOD TB-EXAM UNKN	18
01713	ERYTHEM NOD TB-MICRO DX	18
01714	ERYTHEM NODOS TB-CULT DX	18
01715	ERYTHEM NOD TB-HISTO DX	18
01716	ERYTHEM NOD TB-OTH TEST	18
01720	TB PERIPH LYMPH-UNSPEC	86
01721	TB PERIPH LYMPH-NO EXAM	86
01722	TB PERIPH LYMPH-EXAM UNK	86
01723	TB PERIPH LYMPH-MICRO DX	86
01724	TB PERIPH LYMPH-CULT DX	86
01725	TB PERIPH LYMPH-HISTO DX	86
01726	TB PERIPH LYMPH-OTH TEST	86
01730	TB OF EYE-UNSPEC	68
01731	TB OF EYE-NO EXAM	68
01732	TB OF EYE-EXAM UNKN	68
01733	TB OF EYE-MICRO DX	68
01734	TB OF EYE-CULT DX	68
01735	TB OF EYE-HISTO DX	68
01736	TB OF EYE-OTH TEST	68
01740	TB OF EAR-UNSPEC	31
01741	TB OF EAR-NO EXAM	31
01742	TB OF EAR-EXAM UNKN	31
01743	TB OF EAR-MICRO DX	31
01744	TB OF EAR-CULT DX	31
01745	TB OF EAR-HISTO DX	31
01746	TB OF EAR-OTH TEST	31
01750	TB OF THYROID-UNSPEC	82
01751	TB OF THYROID-NO EXAM	82
01752	TB OF THYROID-EXAM UNKN	82
01753	TB OF THYROID-MICRO DX	82
01754	TB OF THYROID-CULT DX	82
01755	TB OF THYROID-HISTO DX	82
01756	TB OF THYROID-OTH TEST	82
01760	TB OF ADRENAL-UNSPEC	82
01761	TB OF ADRENAL-NO EXAM	82
01762	TB OF ADRENAL-EXAM UNKN	82
01763	TB OF ADRENAL-MICRO DX	82
01764	TB OF ADRENAL-CULT DX	82
01765	TB OF ADRENAL-HISTO DX	82
01766	TB OF ADRENAL-OTH TEST	82
01770	TB OF SPLEEN-UNSPEC	86
01771	TB OF SPLEEN-NO EXAM	86
01772	TB OF SPLEEN-EXAM UNKN	86

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
01773	TB OF SPLEEN-MICRO DX	86
01774	TB OF SPLEEN-CULT DX	86
01775	TB OF SPLEEN-HISTO DX	86
01776	TB OF SPLEEN-OTH TEST	86
01780	TB ESOPHAGUS-UNSPEC	41
01781	TB ESOPHAGUS-NO EXAM	41
01782	TB ESOPHAGUS-EXAM UNKN	41
01783	TB ESOPHAGUS-MICRO DX	41
01784	TB ESOPHAGUS-CULT DX	41
01785	TB ESOPHAGUS-HISTO DX	41
01786	TB ESOPHAGUS-OTH TEST	41
01790	TB OF ORGAN NEC-UNSPEC	97
01791	TB OF ORGAN NEC-NO EXAM	97
01792	TB ORGAN NEC-EXAM UNKN	97
01793	TB OF ORGAN NEC-MICRO DX	97
01794	TB OF ORGAN NEC-CULT DX	97
01795	TB OF ORGAN NEC-HISTO DX	97
01796	TB OF ORGAN NEC-OTH TEST	97
01800	ACUTE MILIARY TB-UNSPEC	97
01801	ACUTE MILIARY TB-NO EXAM	97
01802	AC MILIARY TB-EXAM UNKN	97
01803	AC MILIARY TB-MICRO DX	97
01804	ACUTE MILIARY TB-CULT DX	97
01805	AC MILIARY TB-HISTO DX	97
01806	AC MILIARY TB-OTH TEST	97
01880	MILIARY TB NEC-UNSPEC	97
01881	MILIARY TB NEC-NO EXAM	97
01882	MILIARY TB NEC-EXAM UNKN	97
01883	MILIARY TB NEC-MICRO DX	97
01884	MILIARY TB NEC-CULT DX	97
01885	MILIARY TB NEC-HISTO DX	97
01886	MILIARY TB NEC-OTH TEST	97
01890	MILIARY TB NOS-UNSPEC	97
01891	MILIARY TB NOS-NO EXAM	97
01892	MILIARY TB NOS-EXAM UNKN	97
01893	MILIARY TB NOS-MICRO DX	97
01894	MILIARY TB NOS-CULT DX	97
01895	MILIARY TB NOS-HISTO DX	97
01896	MILIARY TB NOS-OTH TEST	97
0200	BUBONIC PLAGUE	97
0201	CELLULOCUTANEOUS PLAGUE	97
0202	SEPTICEMIC PLAGUE	97
0203	PRIMARY PNEUMONIC PLAGUE	33
0204	SECONDARY PNEUMON PLAGUE	33
0205	PNEUMONIC PLAGUE NOS	33
0208	OTHER TYPES OF PLAGUE	97
0209	PLAGUE NOS	97
0210	ULCEROGLANDUL TULAREMIA	97
0211	ENTERIC TULAREMIA	41
0212	PULMONARY TULAREMIA	33
0213	OCULOGLANDULAR TULAREMIA	97
0218	TULAREMIA NEC	97
0219	TULAREMIA NOS	97
0220	CUTANEOUS ANTHRAX	18
0221	PULMONARY ANTHRAX	33
0222	GASTROINTESTINAL ANTHRAX	41
0223	ANTHRAX SEPTICEMIA	97
0228	OTHER ANTHRAX MANIFEST	97
0229	ANTHRAX NOS	97
0230	BRUCELLA MELITENSIS	97
0231	BRUCELLA ABORTUS	97
0232	BRUCELLA SUIS	97
0233	BRUCELLA CANIS	97
0238	BRUCELLOSIS NEC	97
0239	BRUCELLOSIS NOS	97
024	GLANDERS	97
025	MELIOIDOSIS	97
0260	SPIRILLARY FEVER	97
0261	STREPTOBACILLARY FEVER	97
0269	RAT-BITE FEVER NOS	97
0270	LISTERIOSIS	97
0271	ERYSIPELOTHRIX INFECTION	97
0272	PASTEURRELLOSIS	97
0278	ZOONOTIC BACT DIS NEC	97
0279	ZOONOTIC BACT DIS NOS	97
0300	LEPROMATOUS LEPROSY	97

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
0301	TUBERCULOID LEPROSY	97
0302	INDETERMINATE LEPROSY	97
0303	BORDERLINE LEPROSY	97
0308	LEPROSY NEC	97
0309	LEPROSY NOS	97
0310	PULMONARY MYCOBACTERIA	33
0311	CUTANEOUS MYCOBACTERIA	18
0318	MYCOBACTERIAL DIS NEC	97
0319	MYCOBACTERIAL DIS NOS	97
0320	FAUCIAL DIPHTHERIA	31
0321	NASOPHARYNX DIPHTHERIA	31
0322	ANT NASAL DIPHTHERIA	31
0323	LARYNGEAL DIPHTHERIA	31
03281	CONJUNCTIVAL DIPHTHERIA	68
03282	DIPHTHERITIC MYOCARDITIS	36
03283	DIPHTHERITIC PERITONITIS	41
03284	DIPHTHERITIC CYSTITIS	53
03285	CUTANEOUS DIPHTHERIA	18
03289	DIPHTHERIA NEC	97
0329	DIPHTHERIA NOS	97
0330	BORDETELLA PERTUSSIS	33
0331	BORDETELLA PARAPERTUSSIS	33
0338	WHOOPING COUGH NEC	33
0339	WHOOPING COUGH NOS	33
0340	STREP SORE THROAT	31
0341	SCARLET FEVER	97
035	ERYSIPELAS	18
0360	MENINGOCOCCAL MENINGITIS	63
0361	MENINGOCOCC ENCEPHALITIS	63
0362	MENINGOCOCC EMIA	97
0363	MENINGOCOCC ADRENAL SYND	97
03640	MENINGOCOCC CARDITIS NOS	36
03641	MENINGOCOCC PERICARDITIS	36
03642	MENINGOCOCC ENDOCARDITIS	36
03643	MENINGOCOCC MYOCARDITIS	36
03681	MENINGOCOCC OPTIC NEURIT	68
03682	MENINGOCOCC ARTHROPATHY	24
03689	MENINGOCOCCAL INFECT NEC	97
0369	MENINGOCOCCAL INFECT NOS	97
037	TETANUS	97
0380	STREPTOCOCCAL SEPTICEMIA	97
0382	PNEUMOCOCCAL SEPTICEMIA	97
0383	ANAEROBIC SEPTICEMIA	97
03840	GRAM-NEG SEPTICEMIA NOS	97
03841	H. INFLUENAE SEPTICEMIA	97
03842	E COLI SEPTICEMIA	97
03843	PSEUDOMONAS SEPTICEMIA	97
03844	SERRATIA SEPTICEMIA	97
03849	GRAM-NEG SEPTICEMIA NEC	97
0388	SEPTICEMIA NEC	97
0389	SEPTICEMIA NOS	97
0390	CUTANEOUS ACTINOMYCOSIS	18
0391	PULMONARY ACTINOMYCOSIS	33
0392	ABDOMINAL ACTINOMYCOSIS	41
0393	CERVICOFAC ACTINOMYCOSIS	18
0394	MADURA FOOT	18
0398	ACTINOMYCOSIS NEC	97
0399	ACTINOMYCOSIS NOS	97
0400	GAS GANGRENE	97
0401	RHINOSCLEROMA	97
0402	WHIPPLE'S DISEASE	41
0403	NECROBACILLOSIS	97
04081	TROPICAL PYOMYOSITIS	24
04089	BACTERIAL DISEASES NEC	97
04100	STREPTOCOCCUS UNSPECF	97
04101	STREPTOCOCCUS GROUP A	97
04102	STREPTOCOCCUS GROUP B	97
04103	STREPTOCOCCUS GROUP C	97
04104	STREPTOCOCCUS GROUP D	97
04105	STREPTOCOCCUS GROUP G	97
04109	OTHER STREPTOCOCCUS	97
04110	STAPHYLOCOCCUS UNSPECIFIED	97
04111	STAPHYLOCOCCUS AUREUS	97
04119	OTHER STAPHYLOCOCCUS	97
0412	PNEUMOCOCCUS INFECT NOS	97
0413	KLEBSIELLA INFECT NOS	97

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
0414	E. COLI INFECT NOS	97
0415	H. INFLUENZAE INFECT NOS	97
0416	PROTEUS INFECTION NOS	97
0417	PSEUDOMONAS INFECT NOS	97
04181	MYCOPLASMA	97
04182	BACILLUS FRAGILIS	97
04183	CLOSTRIDIUM PERFRINGENS	97
04184	OTHER ANAEROBES	97
04185	OTH GRAM NEGATV BACTERIA	97
04186	HELICOBACTER PYLORI	41
04189	OTH SPECF BACTERIA	97
0419	BACTERIAL INFECTION NOS	97
042	HUMAN IMMUNO VIRUS DIS	86
04500	AC BULBAR POLIO-TYPE NOS	63
04501	AC BULBAR POLIO-TYPE 1	63
04502	AC BULBAR POLIO-TYPE 2	63
04503	AC BULBAR POLIO-TYPE 3	63
04510	PARAL POLIO NEC-TYPE NOS	63
04511	PARAL POLIO NEC-TYPE 1	63
04512	PARAL POLIO NEC-TYPE 2	63
04513	PARAL POLIO NEC-TYPE 3	63
04520	NONPARALYT POLIO-TYPE NOS	63
04521	NONPARALYT POLIO-TYPE 1	63
04522	NONPARALYT POLIO-TYPE 2	63
04523	NONPARALYT POLIO-TYPE 3	63
04590	AC POLIO NOS-TYPE NOS	63
04591	AC POLIO NOS-TYPE 1	63
04592	AC POLIO NOS-TYPE 2	63
04593	AC POLIO NOS-TYPE 3	63
0460	KURU	63
0461	JAKOB-CREUTZFELDT DIS	63
0462	SUBAC SCLEROS PANENCEPH	63
0463	PROG MULTIFOC LEUKOENCEPH	63
0468	CNS SLOW VIRUS INFEC NEC	63
0469	CNS SLOW VIRUS INFEC NOS	63
0470	COXSACKIE VIRUS MENING	63
0471	ECHO VIRUS MENINGITIS	63
0478	VIRAL MENINGITIS NEC	63
0479	VIRAL MENINGITIS NOS	63
048	OTH ENTEROVIRAL CNS DIS	97
0490	LYMPHOCYTIC CHORIOMENING	63
0491	ADENOVIRAL MENINGITIS	63
0498	VIRAL ENCEPHALITIS NEC	63
0499	VIRAL ENCEPHALITIS NOS	63
0500	VARIOLA MAJOR	97
0501	ALASTRIM	97
0502	MODIFIED SMALLPOX	97
0509	SMALLPOX NOS	97
0510	COWPOX	97
0511	PSEUDOCOWPOX	18
0512	CONTAGIOUS PUSTULAR DERM	18
0519	PARAVACCINIA NOS	97
0520	POSTVARICELLA ENCEPHALIT	63
0521	VARICELLA PNEUMONITIS	33
0527	VARICELLA COMPLICAT NEC	97
0528	VARICELLA COMPLICAT NOS	97
0529	VARICELLA UNCOMPLICATED	97
0530	HERPES ZOSTER MENINGITIS	63
05310	H ZOSTER NERV SYST NOS	63
05311	GENICULATE HERPES ZOSTER	63
05312	POSTHERPES TRIGEM NEURAL	63
05313	POSTHERPES POLYNEUROPATH	63
05319	H ZOSTER NERV SYST NEC	63
05320	HERPES ZOSTER OF EYELID	68
05321	H ZOSTER KERATOCONJUNCT	68
05322	H ZOSTER IRIDOCYCLITIS	68
05329	HERPES ZOSTER OF EYE NEC	68
05371	H ZOSTER OTITIS EXTERNA	31
05379	H ZOSTER COMPLICATED NEC	97
0538	H ZOSTER COMPLICATED NOS	97
0539	HERPES ZOSTER NOS	18
0540	ECZEMA HERPETICUM	18
05410	GENITAL HERPES NOS	97
05411	HERPETIC VULVOVAGINITIS	97
05412	HERPETIC ULCER OF VULVA	97
05413	HERPETIC INFECT OF PENIS	97

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
05419	GENITAL HERPES NEC	97
0542	HERPETIC GINGIVOSTOMAT	31
0543	HERPETIC ENCEPHALITIS	63
05440	HERPES SIMPLEX EYE NOS	68
05441	HERPES SIMPLEX OF EYELID	68
05442	DENDRITIC KERATITIS	68
05443	H SIMPLEX KERATITIS	68
05444	H SIMPLEX IRIDOCYCLITIS	68
05449	HERPES SIMPLEX EYE NEC	68
0545	HERPETIC SEPTICEMIA	97
0546	HERPETIC WHITLOW	18
05471	VISCERAL HERPES SIMPLEX	41
05472	H SIMPLEX MENINGITIS	63
05473	H SIMPLEX OTITIS EXTERNA	31
05479	H SIMPLEX COMPLICAT NEC	97
0548	H SIMPLEX COMPLICAT NOS	97
0549	HERPES SIMPLEX NOS	18
0550	POSTMEASLES ENCEPHALITIS	63
0551	POSTMEASLES PNEUMONIA	33
0552	POSTMEASLES OTITIS MEDIA	31
05571	MEASLES KERATITIS	68
05579	MEASLES COMPLICATION NEC	97
0558	MEASLES COMPLICATION NOS	97
0559	MEASLES UNCOMPLICATED	97
05600	RUBELLA NERVE COMPL NOS	63
05601	RUBELLA ENCEPHALITIS	63
05609	RUBELLA NERVE COMPL NEC	63
05671	ARTHRITIS DUE TO RUBELLA	24
05679	RUBELLA COMPLICATION NEC	97
0568	RUBELLA COMPLICATION NOS	97
0569	RUBELLA UNCOMPLICATED	97
0570	ERYTHEMA INFECTIOSUM	97
0578	VIRAL EXANTHEMATA NEC	97
0579	VIRAL EXANTHEMATA NOS	97
0600	SYLVATIC YELLOW FEVER	97
0601	URBAN YELLOW FEVER	97
0609	YELLOW FEVER NOS	97
061	DENGUE	97
0620	JAPANESE ENCEPHALITIS	63
0621	WEST EQUINE ENCEPHALITIS	63
0622	EAST EQUINE ENCEPHALITIS	63
0623	ST LOUIS ENCEPHALITIS	63
0624	AUSTRALIAN ENCEPHALITIS	63
0625	CALIFORNIA ENCEPHALITIS	97
0628	MOSQUIT-BORNE ENCEPH NEC	97
0629	MOSQUIT-BORNE ENCEPH NOS	97
0630	RUSSIA SPR-SUMMER ENCEPH	97
0631	LOUPING ILL	97
0632	CENT EUROPE ENCEPHALITIS	63
0638	TICK-BORNE ENCEPH NEC	97
0639	TICK-BORNE ENCEPH NOS	97
064	VIR ENCEPH ARTHROPOD NEC	63
0650	CRIMEAN HEMORRHAGIC FEV	97
0651	OMSK HEMORRHAGIC FEVER	97
0652	KYASANUR FOREST DISEASE	97
0653	TICK-BORNE HEM FEVER NEC	97
0654	MOSQUITO-BORNE HEM FEVER	97
0658	ARTHROPOD HEM FEVER NEC	97
0659	ARTHROPOD HEM FEVER NOS	97
0660	PHLEBOTOMUS FEVER	97
0661	TICK-BORNE FEVER	97
0662	VENEZUELAN EQUINE FEVER	63
0663	MOSQUITO-BORNE FEVER NEC	97
0668	ARTHROPOD VIRUS NEC	97
0669	ARTHROPOD VIRUS NOS	97
0700	HEPATITIS A WITH COMA	78
0701	HEPATITIS A W/O COMA	41
07020	HPT B ACTE COMA WO DLTA	78
07021	HPT B ACTE COMA W DLTA	78
07022	HPT B CHRN COMA WO DLTA	78
07023	HPT B CHRN COMA W DLTA	78
07030	HPT B ACTE WO CM WO DLTA	41
07031	HPT B ACTE WO CM W DLTA	41
07032	HPT B CHRN WO CM WO DLTA	41
07033	HPT B CHRN WO CM W DLTA	41
07041	HPT C ACUTE W HEPAT COMA	78

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
07042	HPT DLT WO B W HPT COMA	78
07043	HPT E W HEPAT COMA	78
07044	CHRNA HPT C W HEPAT COMA	78
07049	OTH VRL HEPAT W HPT COMA	78
07051	HPT C ACUTE WO HPAT COMA	41
07052	HPT DLT WO B WO HPT COMA	41
07053	HPT E WO HEPAT COMA	41
07054	CHRNA HPT C WO HPAT COMA	41
07059	OTH VRL HPAT WO HPT COMA	41
0706	VIRAL HEPAT NOS W COMA	78
0709	VIRAL HEPAT NOS W/O COMA	41
071	RABIES	63
0720	MUMPS ORCHITIS	53
0721	MUMPS MENINGITIS	63
0722	MUMPS ENCEPHALITIS	63
0723	MUMPS PANCREATITIS	41
07271	MUMPS HEPATITIS	41
07272	MUMPS POLYNEUROPATHY	63
07279	MUMPS COMPLICATION NEC	97
0728	MUMPS COMPLICATION NOS	97
0729	MUMPS UNCOMPLICATED	97
0730	ORNITHOSIS PNEUMONIA	33
0737	ORNITHOSIS COMPLICAT NEC	97
0738	ORNITHOSIS COMPLICAT NOS	97
0739	ORNITHOSIS NOS	97
0740	HERPANGINA	31
0741	EPIDEMIC PLEURODYNIA	33
07420	COXSACKIE CARDITIS NOS	36
07421	COXSACKIE PERICARDITIS	36
07422	COXSACKIE ENDOCARDITIS	36
07423	COXSACKIE MYOCARDITIS	36
0743	HAND, FOOT & MOUTH DIS	97
0748	COXSACKIE VIRUS NEC	97
075	INFECTIOUS MONONUCLEOSIS	97
0760	TRACHOMA, INITIAL STAGE	68
0761	TRACHOMA, ACTIVE STAGE	68
0769	TRACHOMA NOS	68
0770	INCLUSION CONJUNCTIVITIS	68
0771	EPIDEM KERATOCONJUNCTIV	68
0772	PHARYNGOCONJUNCT FEVER	68
0773	ADENOVIRAL CONJUNCT NEC	68
0774	EPIDEM HEM CONJUNCTIVIT	68
0778	VIRAL CONJUNCTIVITIS NEC	68
07798	UNSP DS CONJUC CHLAMYDIA	97
07799	UNSP DS CONJUC VIRUSES	97
0780	MOLLUSCUM CONTAGIOSUM	18
07810	VIRAL WARTS NOS	97
07811	CONDYLOMA ACUMINATUM	97
07819	OTH SPECIFD VIRAL WARTS	97
0782	SWEATING FEVER	97
0783	CAT-SCRATCH DISEASE	97
0784	FOOT & MOUTH DISEASE	97
0785	CYTOMEGALOVIRAL DISEASE	97
0786	HEM NEPHROSONEPHRITIS	53
0787	ARENAVIRAL HEM FEVER	97
07881	EPIDEMIC VERTIGO	31
07882	EPIDEMIC VOMITING SYND	41
07888	OTH SPEC DIS CHLAMYDIAE	97
07889	OTH SPEC DIS VIRUSES	97
0790	ADENOVIRUS INFECT NOS	97
0791	ECHO VIRUS INFECT NOS	97
0792	COXSACKIE VIRUS INF NOS	97
0793	RHINOVIRUS INFECT NOS	97
0794	HUMAN PAPILLOMA VIRUS	97
07950	RETROVIRUS, UNSPECIFIED	86
07951	HTLV-1 INFECTION OTH DIS	86
07952	HTLV-II INFECTN OTH DIS	86
07953	HIV-2 INFECTION OTH DIS	86
07959	OTH SPECIFED RETROVIRUS	86
07981	HANTAVIRUS INFECTION	97
07988	OTH SPCF CHLAMYDIAL INFC	97
07989	OTH SPECF VIRAL INFECTN	97
07998	CHLAMYDIAL INFECTION NOS	97
07999	VIRAL INFECTION NOS	97
080	LOUSE-BORNE TYPHUS	97
0810	MURINE TYPHUS	97

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
0811	BRILL'S DISEASE	97
0812	SCRUB TYPHUS	97
0819	TYPHUS NOS	97
0820	SPOTTED FEVERS	97
0821	BOUTONNEUSE FEVER	97
0822	NORTH ASIAN TICK FEVER	97
0823	QUEENSLAND TICK TYPHUS	97
0828	TICK-BORNE RICKETTS NEC	97
0829	TICK-BORNE RICKETTS NOS	97
0830	Q FEVER	97
0831	TRENCH FEVER	97
0832	RICKETTSIALPOX	97
0838	RICKETTSIOSSES NEC	97
0839	RICKETTSIOSIS NOS	97
0840	FALCIPARUM MALARIA	97
0841	VIVAX MALARIA	97
0842	QUARTAN MALARIA	97
0843	OVALE MALARIA	97
0844	MALARIA NEC	97
0845	MIXED MALARIA	97
0846	MALARIA NOS	97
0847	INDUCED MALARIA	97
0848	BLACKWATER FEVER	97
0849	MALARIA COMPLICATED NEC	97
0850	VISCERAL LEISHMANIASIS	97
0851	CUTAN LEISHMANIAS URBAN	18
0852	CUTAN LEISHMANIAS ASIAN	18
0853	CUTAN LEISHMANIAS ETHIOP	18
0854	CUTAN LEISHMANIAS AMER	18
0855	MUCOCUTAN LEISHMANIASIS	18
0859	LEISHMANIASIS NOS	97
0860	CHAGAS DISEASE OF HEART	36
0861	CHAGAS DIS OF OTH ORGAN	97
0862	CHAGAS DISEASE NOS	97
0863	GAMBIAN TRYPANOSOMIASIS	97
0864	RHODESIAN TRYPANOSOMIAS	97
0865	AFRICAN TRYPANOSOMA NOS	97
0869	TRYPANOSOMIASIS NOS	97
0870	LOUSE-BORNE RELAPS FEVER	97
0871	TICK-BORNE RELAPS FEVER	97
0879	RELAPSING FEVER NOS	97
0880	BARTONELLOSIS	97
08881	LYME DISEASE	97
08882	BABESIOSIS	97
08889	OTH ARTHROPOD-BORNE DIS	97
0889	ARTHROPOD-BORNE DIS NOS	97
0900	EARLY CONG SYPH SYMPTOM	97
0901	EARLY CONGEN SYPH LATENT	97
0902	EARLY CONGEN SYPH NOS	97
0903	SYPHILITIC KERATITIS	68
09040	JUVENILE NEUROSYPH NOS	63
09041	CONGEN SYPH ENCEPHALITIS	63
09042	CONGEN SYPH MENINGITIS	63
09049	JUVENILE NEUROSYPH NEC	63
0905	LATE CONGEN SYPH SYMPTOM	97
0906	LATE CONGEN SYPH LATENT	97
0907	LATE CONGEN SYPH NOS	97
0909	CONGENITAL SYPHILIS NOS	97
0910	PRIMARY GENITAL SYPHILIS	97
0911	PRIMARY ANAL SYPHILIS	41
0912	PRIMARY SYPHILIS NEC	97
0913	SECONDARY SYPH SKIN	18
0914	SYPHILITIC ADENOPATHY	97
09150	SYPHILITIC UVEITIS NOS	68
09151	SYPHILIT CHORIORETINITIS	68
09152	SYPHILITIC IRIDOCYCLITIS	68
09161	SYPHILITIC PERIOSTITIS	24
09162	SYPHILITIC HEPATITIS	41
09169	SECOND SYPH VISCERA NEC	41
0917	SECOND SYPHILIS RELAPSE	97
09181	ACUTE SYPHIL MENINGITIS	63
09182	SYPHILITIC ALOPECIA	18
09189	SECONDARY SYPHILIS NEC	97
0919	SECONDARY SYPHILIS NOS	97
0920	EARLY SYPH LATENT RELAPS	97
0929	EARLY SYPHIL LATENT NOS	97

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
0930	AORTIC ANEURYSM, SYPHIL	36
0931	SYPHILITIC AORTITIS	36
09320	SYPHIL ENDOCARDITIS NOS	36
09321	SYPHILITIC MITRAL VALVE	36
09322	SYPHILITIC AORTIC VALVE	36
09323	SYPHIL TRICUSPID VALVE	36
09324	SYPHIL PULMONARY VALVE	36
09381	SYPHILITIC PERICARDITIS	36
09382	SYPHILITIC MYOCARDITIS	36
09389	CARDIOVASCULAR SYPH NEC	36
0939	CARDIOVASCULAR SYPH NOS	36
0940	TABES DORSALIS	63
0941	GENERAL PARESIS	63
0942	SYPHILITIC MENINGITIS	63
0943	ASYMPTOMAT NEUROSYPHILIS	63
09481	SYPHILITIC ENCEPHALITIS	63
09482	SYPHILITIC PARKINSONISM	63
09483	SYPH DISSEM RETINITIS	68
09484	SYPHILITIC OPTIC ATROPHY	68
09485	SYPH RETROBULB NEURITIS	63
09486	SYPHIL ACOUSTIC NEURITIS	31
09487	SYPH RUPT CEREB ANEURYSM	63
09489	NEUROSYPHILIS NEC	63
0949	NEUROSYPHILIS NOS	63
0950	SYPHILITIC EPISCLERITIS	68
0951	SYPHILIS OF LUNG	33
0952	SYPHILITIC PERITONITIS	41
0953	SYPHILIS OF LIVER	41
0954	SYPHILIS OF KIDNEY	53
0955	SYPHILIS OF BONE	24
0956	SYPHILIS OF MUSCLE	24
0957	SYPHILIS OF TENDON/BURSA	24
0958	LATE SYMPT SYPHILIS NEC	97
0959	LATE SYMPT SYPHILIS NOS	97
096	LATE SYPHILIS LATENT	97
0970	LATE SYPHILIS NOS	97
0971	LATENT SYPHILIS NOS	97
0979	SYPHILIS NOS	97
0980	ACUTE GC INFECT LOWER GU	97
09810	GC (ACUTE) UPPER GU NOS	97
09811	GC CYSTITIS (ACUTE)	53
09812	GC PROSTATITIS (ACUTE)	53
09813	GC ORCHITIS (ACUTE)	97
09814	GC SEM VESICULIT (ACUTE)	97
09815	GC CERVICITIS (ACUTE)	97
09816	GC ENDOMETRITIS (ACUTE)	97
09817	ACUTE GC SALPINGITIS	97
09819	GC (ACUTE) UPPER GU NEC	97
0982	CHR GC INFECT LOWER GU	97
09830	CHR GC UPPER GU NOS	53
09831	GC CYSTITIS, CHRONIC	53
09832	GC PROSTATITIS, CHRONIC	53
09833	GC ORCHITIS, CHRONIC	97
09834	GC SEM VESICULITIS, CHR	97
09835	GC CERVICITIS, CHRONIC	97
09836	GC ENDOMETRITIS, CHRONIC	97
09837	GC SALPINGITIS (CHRONIC)	97
09839	CHR GC UPPER GU NEC	97
09840	GONOCOCCAL CONJUNCTIVIT	68
09841	GONOCOCCAL IRIDOCYCLITIS	68
09842	GONOCOCCAL ENDOPHTHALMIA	68
09843	GONOCOCCAL KERATITIS	68
09849	GONOCOCCAL EYE NEC	68
09850	GONOCOCCAL ARTHRITIS	24
09851	GONOCOCCAL SYNOVITIS	24
09852	GONOCOCCAL BURSITIS	24
09853	GONOCOCCAL SPONDYLITIS	24
09859	GC INFECT JOINT NEC	24
0986	GONOCOCCAL INFEC PHARYNX	31
0987	GC INFECT ANUS & RECTUM	97
09881	GONOCOCCAL KERATOSIS	68
09882	GONOCOCCAL MENINGITIS	63
09883	GONOCOCCAL PERICARDITIS	36
09884	GONOCOCCAL ENDOCARDITIS	36
09885	GONOCOCCAL HEART DIS NEC	36
09886	GONOCOCCAL PERITONITIS	41

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
09889	GONOCOCCAL INF SITE NEC	97
0990	CHANCROID	97
0991	LYMPHOGRANULOMA VENEREUM	97
0992	GRANULOMA INGUINALE	97
0993	REITER'S DISEASE	24
09940	UNSPCF NONGNCCCL URETHRITS	97
09941	CHLMYD TRACHOMATIS URETH	97
09949	NONGC URTH OTH SPF ORGSM	97
09950	OTH VD CHLM TRCH UNSP ST	97
09951	OTH VD CHLM TRCH PHARYNX	97
09952	OTH VD CHLM TRCH ANS RCT	97
09953	OTH VD CHLM TRCH LOWR GU	97
09954	OTH VD CHLM TRCH OTH GU	97
09955	OT VD CHLM TRCH UNSPF GU	97
09956	OT VD CHLM TRCH PRONEUM	97
09959	OTH VD CHLM TRCH SPCF ST	97
0998	VENEREAL DISEASE NEC	97
0999	VENEREAL DISEASE NOS	97
1000	LEPTOSPIROS ICTEROHEM	97
10081	LEPTOSPIRAL MENINGITIS	63
10089	LEPTOSPIRAL INFECT NEC	63
1009	LEPTOSPIROSIS NOS	97
101	VINCENT'S ANGINA	31
1020	INITIAL LESIONS YAWS	18
1021	MULTIPLE PAPILLOMATA	18
1022	EARLY SKIN YAWS NEC	18
1023	HYPERKERATOSIS OF YAWS	18
1024	GUMMATA AND ULCERS, YAWS	18
1025	GANGOSA	31
1026	YAWS OF BONE & JOINT	24
1027	YAWS MANIFESTATIONS NEC	97
1028	LATENT YAWS	97
1029	YAWS NOS	97
1030	PINTA PRIMARY LESIONS	18
1031	PINTA INTERMED LESIONS	18
1032	PINTA LATE LESIONS	97
1033	PINTA MIXED LESIONS	18
1039	PINTA NOS	97
1040	NONVENEREAL ENDEMIC SYPH	97
1048	SPIROCHETAL INFECT NEC	97
1049	SPIROCHETAL INFECT NOS	97
1100	DERMATOPHYT SCALP/BEARD	18
1101	DERMATOPHYTOSIS OF NAIL	18
1102	DERMATOPHYTOSIS OF HAND	18
1103	DERMATOPHYTOSIS OF GROIN	18
1104	DERMATOPHYTOSIS OF FOOT	18
1105	DERMATOPHYTOSIS OF BODY	18
1106	DEEP DERMATOPHYTOSIS	18
1108	DERMATOPHYTOSIS SITE NEC	18
1109	DERMATOPHYTOSIS SITE NOS	18
1110	PITYRIASIS VERSICOLOR	18
1111	TINEA NIGRA	18
1112	TINEA BLANCA	18
1113	BLACK PIEDRA	18
1118	DERMATOMYCOSIS NEC	18
1119	DERMATOMYCOSIS NOS	18
1120	THRUSH	31
1121	CANDIDAL VULVOVAGINITIS	97
1122	CANDIDIAS UROGENITAL NEC	97
1123	CUTANEOUS CANDIDIASIS	18
1124	CANDIDIASIS OF LUNG	33
1125	DISSEMINATED CANDIDIASIS	97
11281	CANDIDAL ENDOCARDITIS	36
11282	CANDIDAL OTITIS EXTERNA	31
11283	CANDIDAL MENINGITIS	63
11284	CANDIDAL ESOPHAGITIS	97
11285	CANDIDAL ENTERITIS	97
11289	CANDIDIASIS SITE NEC	97
1129	CANDIDIASIS SITE NOS	18
1140	PRIMARY COCCIDIOIDOMYCOSIS	33
1141	PRIM CUTAN COCCIDIOID	18
1142	COCCIDIOIDAL MENINGITIS	63
1143	PROGRESS COCCIDIOID NEC	97
1144	CH PL COCCIDIOIDOMYCOSIS	97
1145	PL COCCIDIOIDOMYCOSIS NOS	97
1149	COCCIDIOIDOMYCOSIS NOS	97

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
11500	HISTOPLASMA CAPSULAT NOS	97
11501	HISTOPLASM CAPSUL MENING	63
11502	HISTOPLASM CAPSUL RETINA	68
11503	HISTOPLASM CAPS PERICARD	36
11504	HISTOPLASM CAPS ENDOCARD	36
11505	HISTOPLASM CAPS PNEUMON	33
11509	HISTOPLASMA CAPSULAT NEC	97
11510	HISTOPLASMA DUBOISII NOS	97
11511	HISTOPLASM DUBOIS MENING	63
11512	HISTOPLASM DUBOIS RETINA	68
11513	HISTOPLASM DUB PERICARD	36
11514	HISTOPLASM DUB ENDOCARD	36
11515	HISTOPLASM DUB PNEUMONIA	33
11519	HISTOPLASMA DUBOISII NEC	97
11590	HISTOPLASMOSIS NOS	97
11591	HISTOPLASMOSIS MENINGIT	63
11592	HISTOPLASMOSIS RETINITIS	68
11593	HISTOPLASMOSIS PERICARD	36
11594	HISTOPLASMOSIS ENDOCARD	36
11595	HISTOPLASMOSIS PNEUMONIA	33
11599	HISTOPLASMOSIS NEC	97
1160	BLASTOMYCOSIS	97
1161	PARACOCCIDIOIDOMYCOSIS	97
1162	LOBOMYCOSIS	97
1170	RHINOSPORIDIOSIS	97
1171	SPOROTRICHOSIS	97
1172	CHROMOBLASTOMYCOSIS	97
1173	ASPERGILLOSIS	97
1174	MYCOTIC MYCETOMAS	97
1175	CRYPTOCOCCOSIS	97
1176	ALLESCHERIOSIS	97
1177	ZYGOMYCOSIS	97
1178	DEMATIACIOUS FUNGI INF	97
1179	MYCOSES NEC & NOS	18
118	OPPORTUNISTIC MYCOSES	97
1200	SCHISTOSOMA HAEMATOBIIUM	53
1201	SCHISTOSOMA MANSONI	41
1202	SCHISTOSOMA JAPONICUM	97
1203	CUTANEOUS SCHISTOSOMA	18
1208	SCHISTOSOMIASIS NEC	97
1209	SCHISTOSOMIASIS NOS	97
1210	OPISTHORCHIASIS	41
1211	CLONORCHIASIS	41
1212	PARAGONIMIASIS	33
1213	FASCIOLIASIS	41
1214	FASCIOLOPSIASIS	41
1215	METAGONIMIASIS	97
1216	HETEROPHYIASIS	97
1218	TREMATODE INFECTION NEC	97
1219	TREMATODE INFECTION NOS	97
1220	ECHINOCOCC GRANUL LIVER	41
1221	ECHINOCOCC GRANUL LUNG	33
1222	ECHINOCOCC GRAN THYROID	82
1223	ECHINOCOCC GRANUL NEC	97
1224	ECHINOCOCC GRANUL NOS	97
1225	ECHINOCOC MULTILOC LIVER	41
1226	ECHINOCOCC MULTILOC NEC	97
1227	ECHINOCOCC MULTILOC NOS	97
1228	ECHINOCOCCOSIS NOS LIVER	41
1229	ECHINOCOCCOSIS NEC/NOS	97
1230	TAENIA SOLIUM INTESTINE	41
1231	CYSTICERCOSIS	41
1232	TAENIA SAGINATA INFECT	41
1233	TAENIASIS NOS	41
1234	DIPHYLLOBOTHRIAS INTEST	41
1235	SPARGANOSIS	41
1236	HYMENOLEPIASIS	41
1238	CESTODE INFECTION NEC	41
1239	CESTODE INFECTION NOS	41
124	TRICHINOSIS	97
1250	BANCROFTIAN FILARIASIS	97
1251	MALAYAN FILARIASIS	97
1252	LOIASIS	97
1253	ONCHOCERCIASIS	97
1254	DIPETALONEMIASIS	97
1255	MANSONELLA OZZARDI INFEC	97

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
1256	FILARIASIS NEC	97
1257	DRACONTIASIS	97
1259	FILARIASIS NOS	97
1260	ANCYLOSTOMA DUODENALE	41
1261	NECATOR AMERICANUS	41
1262	ANCYLOSTOMA BRAZILIENSE	41
1263	ANCYLOSTOMA CEYLANICUM	41
1268	ANCYLOSTOMA NEC	41
1269	ANCYLOSTOMIASIS NOS	41
1270	ASCARIASIS	41
1271	ANISAKIASIS	41
1272	STRONGYLOIDIASIS	41
1273	TRICHURIASIS	41
1274	ENTEROBIASIS	41
1275	CAPILLARIASIS	41
1276	TRICHOSTRONGYLIASIS	41
1277	INTEST HELMINTHIASIS NEC	41
1278	MIXED INTESTINE HELMINTH	97
1279	INTEST HELMINTHIASIS NOS	41
1280	TOXOCARIASIS	97
1281	GNATHOSTOMIASIS	97
1288	HELMINTHIASIS NEC	97
1289	HELMINTHIASIS NOS	97
129	INTESTIN PARASITISM NOS	41
1300	TOXOPLASM MENINGOENCEPH	63
1301	TOXOPLASM CONJUNCTIVITIS	68
1302	TOXOPLASM CHORIORETINIT	68
1303	TOXOPLASMA MYOCARDITIS	36
1304	TOXOPLASMA PNEUMONITIS	33
1305	TOXOPLASMA HEPATITIS	41
1307	TOXOPLASMOSIS SITE NEC	97
1308	MULTISYSTEM TOXOPLASMOS	97
1309	TOXOPLASMOSIS NOS	97
13100	UROGENITAL TRICHOMON NOS	97
13101	TRICHOMONAL VAGINITIS	97
13102	TRICHOMONAL URETHRITIS	97
13103	TRICHOMONAL PROSTATITIS	97
13109	UROGENITAL TRICHOMON NEC	97
1318	TRICHOMONIASIS NEC	97
1319	TRICHOMONIASIS NOS	97
1320	PEDICULUS CAPITIS	18
1321	PEDICULUS CORPORIS	18
1322	PHTHIRUS PUBIS	18
1323	MIXED PEDICUL & PHTHIRUS	18
1329	PEDICULOSIS NOS	18
1330	SCABIES	18
1338	ACARIASIS NEC	18
1339	ACARIASIS NOS	18
1340	MYIASIS	18
1341	ARTHROPOD INFEST NEC	18
1342	HIRUDINIASIS	18
1348	INFESTATION NEC	18
1349	INFESTATION NOS	18
135	SARCOIDOSIS	33
1360	AINHUM	97
1361	BEHCET'S SYNDROME	24
1362	FREE-LIVING AMEBA INFECT	97
1363	PNEUMOCYSTOSIS	33
1364	PSOROSPERMIASIS	97
1365	SARCOSPORIDIOSIS	97
1368	INFECT/PARASITE DIS NEC	97
1369	INFECT/PARASITE DIS NOS	97
1370	LATE EFFECT TB, RESP/NOS	33
1371	LATE EFFECT CNS TB	63
1372	LATE EFFECT GU TB	53
1373	LATE EFF BONE & JOINT TB	24
1374	LATE EFFECT TB NEC	97
138	LATE EFFECT ACUTE POLIO	63
1390	LATE EFF VIRAL ENCEPHAL	63
1391	LATE EFFECT OF TRACHOMA	68
1398	LATE EFF INFECT DIS NEC	97
1400	MAL NEO UPPER VERMILION	88
1401	MAL NEO LOWER VERMILION	88
1403	MAL NEO UPPER LIP, INNER	88
1404	MAL NEO LOWER LIP, INNER	88
1405	MAL NEO LIP, INNER NOS	88

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
1406	MAL NEO LIP, COMMISSURE	88
1408	MAL NEO LIP NEC	88
1409	MAL NEO LIP/VERMIL NOS	88
1410	MAL NEO TONGUE BASE	88
1411	MAL NEO DORSAL TONGUE	88
1412	MAL NEO TIP/LAT TONGUE	88
1413	MAL NEO VENTRAL TONGUE	88
1414	MAL NEO ANT 2/3 TONGUE	88
1415	MAL NEO TONGUE JUNCTION	88
1416	MAL NEO LINGUAL TONSIL	88
1418	MALIG NEO TONGUE NEC	88
1419	MALIG NEO TONGUE NOS	88
1420	MALIG NEO PAROTID	88
1421	MALIG NEO SUBMANDIBULAR	88
1422	MALIG NEO SUBLINGUAL	88
1428	MAL NEO MAJ SALIVARY NEC	88
1429	MAL NEO SALIVARY NOS	88
1430	MALIG NEO UPPER GUM	88
1431	MALIG NEO LOWER GUM	88
1438	MALIG NEO GUM NEC	88
1439	MALIG NEO GUM NOS	88
1440	MAL NEO ANT FLOOR MOUTH	88
1441	MAL NEO LAT FLOOR MOUTH	88
1448	MAL NEO MOUTH FLOOR NEC	88
1449	MAL NEO MOUTH FLOOR NOS	88
1450	MAL NEO CHEEK MUCOSA	88
1451	MAL NEO MOUTH VESTIBULE	88
1452	MALIG NEO HARD PALATE	88
1453	MALIG NEO SOFT PALATE	88
1454	MALIGNANT NEOPLASM UVULA	88
1455	MALIGNANT NEO PALATE NOS	88
1456	MALIG NEO RETROMOLAR	88
1458	MALIG NEOPLASM MOUTH NEC	88
1459	MALIG NEOPLASM MOUTH NOS	88
1460	MALIGNANT NEOPL TONSIL	88
1461	MAL NEO TONSILLAR FOSSA	88
1462	MAL NEO TONSIL PILLARS	88
1463	MALIGN NEOPL VALLECULA	88
1464	MAL NEO ANT EPIGLOTTIS	88
1465	MAL NEO EPIGLOTTIS JUNCT	88
1466	MAL NEO LAT OROPHARYNX	88
1467	MAL NEO POST OROPHARYNX	88
1468	MAL NEO OROPHARYNX NEC	88
1469	MALIG NEO OROPHARYNX NOS	88
1470	MAL NEO SUPER NASOPHARYNX	88
1471	MAL NEO POST NASOPHARYNX	88
1472	MAL NEO LAT NASOPHARYNX	88
1473	MAL NEO ANT NASOPHARYNX	88
1478	MAL NEO NASOPHARYNX NEC	88
1479	MAL NEO NASOPHARYNX NOS	88
1480	MAL NEO POSTCRICOID	88
1481	MAL NEO PYRIFORM SINUS	88
1482	MAL NEO ARYEPIGLOTT FOLD	88
1483	MAL NEO POST HYPOPHARYNX	88
1488	MAL NEO HYPOPHARYNX NEC	88
1489	MAL NEO HYPOPHARYNX NOS	88
1490	MAL NEO PHARYNX NOS	88
1491	MAL NEO WALDEYER'S RING	88
1498	MAL NEO ORAL/PHARYNX NEC	88
1499	MAL NEO OROPHRYN ILL-DEF	88
1500	MAL NEO CERVICAL ESOPHAG	88
1501	MAL NEO THORACIC ESOPHAG	88
1502	MAL NEO ABDOMIN ESOPHAG	88
1503	MAL NEO UPPER 3RD ESOPH	88
1504	MAL NEO MIDDLE 3RD ESOPH	88
1505	MAL NEO LOWER 3RD ESOPH	88
1508	MAL NEO ESOPHAGUS NEC	88
1509	MAL NEO ESOPHAGUS NOS	88
1510	MAL NEO STOMACH CARDIA	88
1511	MALIGNANT NEO PYLORUS	88
1512	MAL NEO PYLORIC ANTRUM	88
1513	MAL NEO STOMACH FUNDUS	88
1514	MAL NEO STOMACH BODY	88
1515	MAL NEO STOM LESSER CURV	88
1516	MAL NEO STOM GREAT CURV	88
1518	MALIG NEOPL STOMACH NEC	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
1519	MALIG NEOPL STOMACH NOS	88
1520	MALIGNANT NEOPL DUODENUM	88
1521	MALIGNANT NEOPL JEJUNUM	88
1522	MALIGNANT NEOPLASM ILEUM	88
1523	MAL NEO MECKEL'S DIVERT	88
1528	MAL NEO SMALL BOWEL NEC	88
1529	MAL NEO SMALL BOWEL NOS	88
1530	MAL NEO HEPATIC FLEXURE	88
1531	MAL NEO TRANSVERSE COLON	88
1532	MAL NEO DESCEND COLON	88
1533	MAL NEO SIGMOID COLON	88
1534	MALIGNANT NEOPLASM CECUM	88
1535	MALIGNANT NEO APPENDIX	88
1536	MALIG NEO ASCEND COLON	88
1537	MAL NEO SPLENIC FLEXURE	88
1538	MALIGNANT NEO COLON NEC	88
1539	MALIGNANT NEO COLON NOS	88
1540	MAL NEO RECTOSIGMOID JCT	88
1541	MALIGNANT NEOPL RECTUM	88
1542	MALIG NEOPL ANAL CANAL	88
1543	MALIGNANT NEO ANUS NOS	88
1548	MAL NEO RECTUM/ANUS NEC	88
1550	MAL NEO LIVER, PRIMARY	88
1551	MAL NEO INTRAHEPAT DUCTS	88
1552	MALIGNANT NEO LIVER NOS	88
1560	MALIG NEO GALLBLADDER	88
1561	MAL NEO EXTRAHEPAT DUCTS	88
1562	MAL NEO AMPULLA OF VATER	88
1568	MALIG NEO BILIARY NEC	88
1569	MALIG NEO BILIARY NOS	88
1570	MAL NEO PANCREAS HEAD	88
1571	MAL NEO PANCREAS BODY	88
1572	MAL NEO PANCREAS TAIL	88
1573	MAL NEO PANCREATIC DUCT	88
1574	MAL NEO ISLET LANGERHANS	88
1578	MALIG NEO PANCREAS NEC	88
1579	MALIG NEO PANCREAS NOS	88
1580	MAL NEO RETROPERITONEUM	88
1588	MAL NEO PERITONEUM NEC	88
1589	MAL NEO PERITONEUM NOS	88
1590	MALIG NEO INTESTINE NOS	88
1591	MALIGNANT NEO SPLEEN NEC	88
1598	MAL NEO GI/INTRA-ABD NEC	88
1599	MAL NEO GI TRACT ILL-DEF	88
1600	MAL NEO NASAL CAVITIES	88
1601	MALIG NEO MIDDLE EAR	88
1602	MAL NEO MAXILLARY SINUS	88
1603	MAL NEO ETHMOIDAL SINUS	88
1604	MALIG NEO FRONTAL SINUS	88
1605	MAL NEO SPHENOID SINUS	88
1608	MAL NEO ACCESS SINUS NEC	88
1609	MAL NEO ACCESS SINUS NOS	88
1610	MALIGNANT NEO GLOTTIS	88
1611	MALIG NEO SUPRAGLOTTIS	88
1612	MALIG NEO SUBGLOTTIS	88
1613	MAL NEO CARTILAGE LARYNX	88
1618	MALIGNANT NEO LARYNX NEC	88
1619	MALIGNANT NEO LARYNX NOS	88
1620	MALIGNANT NEO TRACHEA	88
1622	MALIG NEO MAIN BRONCHUS	88
1623	MAL NEO UPPER LOBE LUNG	88
1624	MAL NEO MIDDLE LOBE LUNG	88
1625	MAL NEO LOWER LOBE LUNG	88
1628	MAL NEO BRONCH/LUNG NEC	88
1629	MAL NEO BRONCH/LUNG NOS	88
1630	MAL NEO PARIETAL PLEURA	88
1631	MAL NEO VISCERAL PLEURA	88
1638	MALIG NEOPL PLEURA NEC	88
1639	MALIG NEOPL PLEURA NOS	88
1640	MALIGNANT NEOPL THYMUS	88
1641	MALIGNANT NEOPL HEART	88
1642	MAL NEO ANT MEDIASTINUM	88
1643	MAL NEO POST MEDIASTINUM	88
1648	MAL NEO MEDIASTINUM NEC	88
1649	MAL NEO MEDIASTINUM NOS	88
1650	MAL NEO UPPER RESP NOS	88

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
1658	MAL NEO THORAX/RESP NEC	88
1659	MAL NEO RESP SYSTEM NOS	88
1700	MAL NEO SKULL/FACE BONE	88
1701	MALIGNANT NEO MANDIBLE	88
1702	MALIG NEO VERTEBRAE	88
1703	MAL NEO RIBS/STERN/CLAV	88
1704	MAL NEO LONG BONES ARM	88
1705	MAL NEO BONES WRIST/HAND	88
1706	MAL NEO PELVIC GIRDLE	88
1707	MAL NEO LONG BONES LEG	88
1708	MAL NEO BONES ANKLE/FOOT	88
1709	MALIG NEOPL BONE NOS	88
1710	MAL NEO SOFT TISSUE HEAD	88
1712	MAL NEO SOFT TISSUE ARM	88
1713	MAL NEO SOFT TISSUE LEG	88
1714	MAL NEO SOFT TIS THORAX	88
1715	MAL NEO SOFT TIS ABDOMEN	88
1716	MAL NEO SOFT TIS PELVIS	88
1717	MAL NEOPL TRUNK NOS	88
1718	MAL NEO SOFT TISSUE NEC	88
1719	MAL NEO SOFT TISSUE NOS	88
1720	MALIG MELANOMA LIP	88
1721	MALIG MELANOMA EYELID	88
1722	MALIG MELANOMA EAR	88
1723	MAL MELANOM FACE NEC/NOS	88
1724	MAL MELANOMA SCALP/NECK	88
1725	MALIG MELANOMA TRUNK	88
1726	MALIG MELANOMA ARM	88
1727	MALIG MELANOMA LEG	88
1728	MALIG MELANOMA SKIN NEC	88
1729	MALIG MELANOMA SKIN NOS	88
1730	MALIG NEO SKIN LIP	88
1731	MALIG NEO SKIN EYELID	88
1732	MALIG NEO SKIN EAR	88
1733	MAL NEO SKIN FACE NEC	88
1734	MAL NEO SCALP/SKIN NECK	88
1735	MALIG NEO SKIN TRUNK	88
1736	MALIG NEO SKIN ARM	88
1737	MALIG NEO SKIN LEG	88
1738	MALIG NEO SKIN NEC	88
1739	MALIG NEO SKIN NOS	88
1740	MALIG NEO NIPPLE	88
1741	MAL NEO BREAST-CENTRAL	88
1742	MAL NEO BREAST UP-INNER	88
1743	MAL NEO BREAST LOW-INNER	88
1744	MAL NEO BREAST UP-OUTER	88
1745	MAL NEO BREAST LOW-OUTER	88
1746	MAL NEO BREAST-AXILLARY	88
1748	MALIGN NEOPL BREAST NEC	88
1749	MALIGN NEOPL BREAST NOS	88
1750	MAL NEO MALE NIPPLE	88
1759	MAL NEO MALE BREAST NEC	88
1760	SKIN - KAPOSI'S SARCOMA	86
1761	SFT TISSUE - KPSI'S SRCMA	86
1762	PALATE - KPSI'S SARCOMA	86
1763	GI SITES - KPSI'S SRCOMA	86
1764	LUNG - KAPOSI'S SARCOMA	86
1765	LYM NDS - KPSI'S SARCOMA	86
1768	SPF STS - KPSI'S SARCOMA	86
1769	KAPOSI'S SARCOMA NOS	86
179	MALIG NEOPL UTERUS NOS	88
1800	MALIG NEO ENDOCERVIX	88
1801	MALIG NEO EXOCERVIX	88
1808	MALIG NEO CERVIX NEC	88
1809	MAL NEO CERVIX UTERI NOS	88
181	MALIGNANT NEOPL PLACENTA	88
1820	MALIG NEO CORPUS UTERI	88
1821	MAL NEO UTERINE ISTHMUS	88
1828	MAL NEO BODY UTERUS NEC	88
1830	MALIGN NEOPL OVARY	88
1832	MAL NEO FALLOPIAN TUBE	88
1833	MAL NEO BROAD LIGAMENT	88
1834	MALIG NEO PARAMETRIUM	88
1835	MAL NEO ROUND LIGAMENT	88
1838	MAL NEO ADNEXA NEC	88
1839	MAL NEO ADNEXA NOS	88

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
1840	MALIGN NEOPL VAGINA	88
1841	MAL NEO LABIA MAJORA	88
1842	MAL NEO LABIA MINORA	88
1843	MALIGN NEOPL CLITORIS	88
1844	MALIGN NEOPL VULVA NOS	88
1848	MAL NEO FEMALE GENIT NEC	88
1849	MAL NEO FEMALE GENIT NOS	88
185	MALIGN NEOPL PROSTATE	88
1860	MAL NEO UNDESCEND TESTIS	88
1869	MALIG NEO TESTIS NEC	88
1871	MALIGN NEOPL PREPUCE	88
1872	MALIG NEO GLANS PENIS	88
1873	MALIG NEO PENIS BODY	88
1874	MALIG NEO PENIS NOS	88
1875	MALIG NEO EPIDIDYMIS	88
1876	MAL NEO SPERMATIC CORD	88
1877	MALIGN NEOPL SCROTUM	88
1878	MAL NEO MALE GENITAL NEC	88
1879	MAL NEO MALE GENITAL NOS	88
1880	MAL NEO BLADDER-TRIGONE	88
1881	MAL NEO BLADDER-DOME	88
1882	MAL NEO BLADDER-LATERAL	88
1883	MAL NEO BLADDER-ANTERIOR	88
1884	MAL NEO BLADDER-POST	88
1885	MAL NEO BLADDER NECK	88
1886	MAL NEO URETERIC ORIFICE	88
1887	MALIG NEO URACHUS	88
1888	MALIG NEO BLADDER NEC	88
1889	MALIG NEO BLADDER NOS	88
1890	MALIG NEOPL KIDNEY	88
1891	MALIG NEO RENAL PELVIS	88
1892	MALIGN NEOPL URETER	88
1893	MALIGN NEOPL URETHRA	88
1894	MAL NEO PARAURETHRAL	88
1898	MAL NEO URINARY NEC	88
1899	MAL NEO URINARY NOS	88
1900	MALIGN NEOPL EYEBALL	88
1901	MALIGN NEOPL ORBIT	88
1902	MAL NEO LACRIMAL GLAND	88
1903	MAL NEO CONJUNCTIVA	88
1904	MALIGN NEOPL CORNEA	88
1905	MALIGN NEOPL RETINA	88
1906	MALIGN NEOPL CHOROID	88
1907	MAL NEO LACRIMAL DUCT	88
1908	MALIGN NEOPL EYE NEC	88
1909	MALIGN NEOPL EYE NOS	88
1910	MALIGN NEOPL CEREBRUM	88
1911	MALIG NEO FRONTAL LOBE	88
1912	MAL NEO TEMPORAL LOBE	88
1913	MAL NEO PARIETAL LOBE	88
1914	MAL NEO OCCIPITAL LOBE	88
1915	MAL NEO CEREB VENTRICLE	88
1916	MAL NEO CEREBELLUM NOS	88
1917	MAL NEO BRAIN STEM	88
1918	MALIG NEO BRAIN NEC	88
1919	MALIG NEO BRAIN NOS	88
1920	MAL NEO CRANIAL NERVES	88
1921	MAL NEO CEREBRAL MENING	88
1922	MAL NEO SPINAL CORD	88
1923	MAL NEO SPINAL MENINGES	88
1928	MAL NEO NERVOUS SYST NEC	88
1929	MAL NEO NERVOUS SYST NOS	88
193	MALIGN NEOPL THYROID	88
1940	MALIGN NEOPL ADRENAL	88
1941	MALIG NEO PARATHYROID	88
1943	MALIG NEO PITUITARY	88
1944	MALIGN NEO PINEAL GLAND	88
1945	MAL NEO CAROTID BODY	88
1946	MAL NEO PARAGANGLIA NEC	88
1948	MAL NEO ENDOCRINE NEC	88
1949	MAL NEO ENDOCRINE NOS	88
1950	MAL NEO HEAD/FACE/NECK	88
1951	MALIGN NEOPL THORAX	88
1952	MALIG NEO ABDOMEN	88
1953	MALIGN NEOPL PELVIS	88
1954	MALIGN NEOPL ARM	88

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
1955	MALIGN NEOPL LEG	88
1958	MALIG NEO SITE NEC	88
1960	MAL NEO LYMPH-HEAD/NECK	88
1961	MAL NEO LYMPH-INTRATHOR	88
1962	MAL NEO LYMPH INTRA-ABD	88
1963	MAL NEO LYMPH-AXILLA/ARM	88
1965	MAL NEO LYMPH-INGUIN/LEG	88
1966	MAL NEO LYMPH-INTRAPELV	88
1968	MAL NEO LYMPH NODE-MULT	88
1969	MAL NEO LYMPH NODE NOS	88
1970	SECONDARY MALIG NEO LUNG	88
1971	SEC MAL NEO MEDIASTINUM	88
1972	SECOND MALIG NEO PLEURA	88
1973	SEC MALIG NEO RESP NEC	88
1974	SEC MALIG NEO SM BOWEL	88
1975	SEC MALIG NEO LG BOWEL	88
1976	SEC MAL NEO PERITONEUM	88
1977	SECOND MALIG NEO LIVER	88
1978	SEC MAL NEO GI NEC	88
1980	SECOND MALIG NEO KIDNEY	88
1981	SEC MALIG NEO URIN NEC	88
1982	SECONDARY MALIG NEO SKIN	88
1983	SEC MAL NEO BRAIN/SPINE	88
1984	SEC MALIG NEO NERVE NEC	88
1985	SECONDARY MALIG NEO BONE	88
1986	SECOND MALIG NEO OVARY	88
1987	SECOND MALIG NEO ADRENAL	88
19881	SECOND MALIG NEO BREAST	88
19882	SECOND MALIG NEO GENITAL	88
19889	SECONDARY MALIG NEO NEC	88
1990	MALIG NEO DISSEMINATED	88
1991	MALIGNANT NEOPLASM NOS	88
20000	RETCLSRC UNSP XTRNDL ORG	88
20001	RETICULOSARCOMA HEAD	88
20002	RETICULOSARCOMA THORAX	88
20003	RETICULOSARCOMA ABDOM	88
20004	RETICULOSARCOMA AXILLA	88
20005	RETICULOSARCOMA INGUIN	88
20006	RETICULOSARCOMA PELVIC	88
20007	RETICULOSARCOMA SPLEEN	88
20008	RETICULOSARCOMA MULT	88
20010	LYMPHSRC UNSP XTRNDL ORG	88
20011	LYMPHOSARCOMA HEAD	88
20012	LYMPHOSARCOMA THORAX	88
20013	LYMPHOSARCOMA ABDOM	88
20014	LYMPHOSARCOMA AXILLA	88
20015	LYMPHOSARCOMA INGUIN	88
20016	LYMPHOSARCOMA PELVIC	88
20017	LYMPHOSARCOMA SPLEEN	88
20018	LYMPHOSARCOMA MULT	88
20020	BRKT TMR UNSP XTRNDL ORG	88
20021	BURKITT'S TUMOR HEAD	88
20022	BURKITT'S TUMOR THORAX	88
20023	BURKITT'S TUMOR ABDOM	88
20024	BURKITT'S TUMOR AXILLA	88
20025	BURKITT'S TUMOR INGUIN	88
20026	BURKITT'S TUMOR PELVIC	88
20027	BURKITT'S TUMOR SPLEEN	88
20028	BURKITT'S TUMOR MULT	88
20080	OTH VARN UNSP XTRNDL ORG	88
20081	MIXED LYMPHOSARC HEAD	88
20082	MIXED LYMPHOSARC THORAX	88
20083	MIXED LYMPHOSARC ABDOM	88
20084	MIXED LYMPHOSARC AXILLA	88
20085	MIXED LYMPHOSARC INGUIN	88
20086	MIXED LYMPHOSARC PELVIC	88
20087	MIXED LYMPHOSARC SPLEEN	88
20088	MIXED LYMPHOSARC MULT	88
20100	HGK PRG UNSP XTRNDL ORG	88
20101	HODGKINS PARAGRAN HEAD	88
20102	HODGKINS PARAGRAN THORAX	88
20103	HODGKINS PARAGRAN ABDOM	88
20104	HODGKINS PARAGRAN AXILLA	88
20105	HODGKINS PARAGRAN INGUIN	88
20106	HODGKINS PARAGRAN PELVIC	88
20107	HODGKINS PARAGRAN SPLEEN	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
20108	HODGKINS PARAGRAN MULT	88
20110	HDGK GRN UNSP XTRNDL ORG	88
20111	HODGKINS GRANULOM HEAD	88
20112	HODGKINS GRANULOM THORAX	88
20113	HODGKINS GRANULOM ABDOM	88
20114	HODGKINS GRANULOM AXILLA	88
20115	HODGKINS GRANULOM INGUIN	88
20116	HODGKINS GRANULOM PELVIC	88
20117	HODGKINS GRANULOM SPLEEN	88
20118	HODGKINS GRANULOM MULT	88
20120	HDGK SRC UNSP XTRNDL ORG	88
20121	HODGKINS SARCOMA HEAD	88
20122	HODGKINS SARCOMA THORAX	88
20123	HODGKINS SARCOMA ABDOM	88
20124	HODGKINS SARCOMA AXILLA	88
20125	HODGKINS SARCOMA INGUIN	88
20126	HODGKINS SARCOMA PELVIC	88
20127	HODGKINS SARCOMA SPLEEN	88
20128	HODGKINS SARCOMA MULT	88
20140	LYM-HST UNSP XTRNDL ORGN	88
20141	HODG LYMPH-HISTIO HEAD	88
20142	HODG LYMPH-HISTIO THORAX	88
20143	HODG LYMPH-HISTIO ABDOM	88
20144	HODG LYMPH-HISTIO AXILLA	88
20145	HODG LYMPH-HISTIO INGUIN	88
20146	HODG LYMPH-HISTIO PELVIC	88
20147	HODG LYMPH-HISTIO SPLEEN	88
20148	HODG LYMPH-HISTIO MULT	88
20150	NDR SCLR UNSP XTRNDL ORG	88
20151	HODG NODUL SCLERO HEAD	88
20152	HODG NODUL SCLERO THORAX	88
20153	HODG NODUL SCLERO ABDOM	88
20154	HODG NODUL SCLERO AXILLA	88
20155	HODG NODUL SCLERO INGUIN	88
20156	HODG NODUL SCLERO PELVIC	88
20157	HODG NODUL SCLERO SPLEEN	88
20158	HODG NODUL SCLERO MULT	88
20160	MXD CELR UNSP XTRNDL ORG	88
20161	HODGKINS MIX CELL HEAD	88
20162	HODGKINS MIX CELL THORAX	88
20163	HODGKINS MIX CELL ABDOM	88
20164	HODGKINS MIX CELL AXILLA	88
20165	HODGKINS MIX CELL INGUIN	88
20166	HODGKINS MIX CELL PELVIC	88
20167	HODGKINS MIX CELL SPLEEN	88
20168	HODGKINS MIX CELL MULT	88
20170	LYM DPLT UNSP XTRNDL ORG	88
20171	HODG LYMPH DEPLET HEAD	88
20172	HODG LYMPH DEPLET THORAX	88
20173	HODG LYMPH DEPLET ABDOM	88
20174	HODG LYMPH DEPLET AXILLA	88
20175	HODG LYMPH DEPLET INGUIN	88
20176	HODG LYMPH DEPLET PELVIC	88
20177	HODG LYMPH DEPLET SPLEEN	88
20178	HODG LYMPH DEPLET MULT	88
20190	HDGK DIS UNSP XTRNDL ORG	88
20191	HODGKINS DIS NOS HEAD	88
20192	HODGKINS DIS NOS THORAX	88
20193	HODGKINS DIS NOS ABDOM	88
20194	HODGKINS DIS NOS AXILLA	88
20195	HODGKINS DIS NOS INGUIN	88
20196	HODGKINS DIS NOS PELVIC	88
20197	HODGKINS DIS NOS SPLEEN	88
20198	HODGKINS DIS NOS MULT	88
20200	NDLR LYM UNSP XTRNDL ORG	88
20201	NODULAR LYMPHOMA HEAD	88
20202	NODULAR LYMPHOMA THORAX	88
20203	NODULAR LYMPHOMA ABDOM	88
20204	NODULAR LYMPHOMA AXILLA	88
20205	NODULAR LYMPHOMA INGUIN	88
20206	NODULAR LYMPHOMA PELVIC	88
20207	NODULAR LYMPHOMA SPLEEN	88
20208	NODULAR LYMPHOMA MULT	88
20210	MYCS FNG UNSP XTRNDL ORG	88
20211	MYCOSIS FUNGOIDES HEAD	88
20212	MYCOSIS FUNGOIDES THORAX	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
20213	MYCOSIS FUNGOIDES ABDOM	88
20214	MYCOSIS FUNGOIDES AXILLA	88
20215	MYCOSIS FUNGOIDES INGUIN	88
20216	MYCOSIS FUNGOIDES PELVIC	88
20217	MYCOSIS FUNGOIDES SPLEEN	88
20218	MYCOSIS FUNGOIDES MULT	88
20220	SZRY DIS UNSP XTRNDL ORG	88
20221	SEZARY'S DISEASE HEAD	88
20222	SEZARY'S DISEASE THORAX	88
20223	SEZARY'S DISEASE ABDOM	88
20224	SEZARY'S DISEASE AXILLA	88
20225	SEZARY'S DISEASE INGUIN	88
20226	SEZARY'S DISEASE PELVIC	88
20227	SEZARY'S DISEASE SPLEEN	88
20228	SEZARY'S DISEASE MULT	88
20230	MLG HIST UNSP XTRNDL ORG	88
20231	MAL HISTIOCYTOSIS HEAD	88
20232	MAL HISTIOCYTOSIS THORAX	88
20233	MAL HISTIOCYTOSIS ABDOM	88
20234	MAL HISTIOCYTOSIS AXILLA	88
20235	MAL HISTIOCYTOSIS INGUIN	88
20236	MAL HISTIOCYTOSIS PELVIC	88
20237	MAL HISTIOCYTOSIS SPLEEN	88
20238	MAL HISTIOCYTOSIS MULT	88
20240	LK RTCTL UNSP XTRNDL ORG	88
20241	HAIRY-CELL LEUKEM HEAD	88
20242	HAIRY-CELL LEUKEM THORAX	88
20243	HAIRY-CELL LEUKEM ABDOM	88
20244	HAIRY-CELL LEUKEM AXILLA	88
20245	HAIRY-CELL LEUKEM INGUIN	88
20246	HAIRY-CELL LEUKEM PELVIC	88
20247	HAIRY-CELL LEUKEM SPLEEN	88
20248	HAIRY-CELL LEUKEM MULT	88
20250	LTR-SIWE UNSP XTRNDL ORG	88
20251	LETTERER-SIWE DIS HEAD	88
20252	LETTERER-SIWE DIS THORAX	88
20253	LETTERER-SIWE DIS ABDOM	88
20254	LETTERER-SIWE DIS AXILLA	88
20255	LETTERER-SIWE DIS INGUIN	88
20256	LETTERER-SIWE DIS PELVIC	88
20257	LETTERER-SIWE DIS SPLEEN	88
20258	LETTERER-SIWE DIS MULT	88
20260	MLG MAST UNSP XTRNDL ORG	88
20261	MAL MASTOCYTOSIS HEAD	88
20262	MAL MASTOCYTOSIS THORAX	88
20263	MAL MASTOCYTOSIS ABDOM	88
20264	MAL MASTOCYTOSIS AXILLA	88
20265	MAL MASTOCYTOSIS INGUIN	88
20266	MAL MASTOCYTOSIS PELVIC	88
20267	MAL MASTOCYTOSIS SPLEEN	88
20268	MAL MASTOCYTOSIS MULT	88
20280	OTH LYMP UNSP XTRNDL ORG	88
20281	LYMPHOMAS NEC HEAD	88
20282	LYMPHOMAS NEC THORAX	88
20283	LYMPHOMAS NEC ABDOM	88
20284	LYMPHOMAS NEC AXILLA	88
20285	LYMPHOMAS NEC INGUIN	88
20286	LYMPHOMAS NEC PELVIC	88
20287	LYMPHOMAS NEC SPLEEN	88
20288	LYMPHOMAS NEC MULT	88
20290	UNSP LYM UNSP XTRNDL ORG	88
20291	LYMPHOID MAL NEC HEAD	88
20292	LYMPHOID MAL NEC THORAX	88
20293	LYMPHOID MAL NEC ABDOM	88
20294	LYMPHOID MAL NEC AXILLA	88
20295	LYMPHOID MAL NEC INGUIN	88
20296	LYMPHOID MAL NEC PELVIC	88
20297	LYMPHOID MAL NEC SPLEEN	88
20298	LYMPHOID MAL NEC MULT	88
20300	MULT MYELM W/O REMISSION	88
20301	MULT MYELM W REMISSION	88
20310	PLSM CELL LEUK W/O RMSN	88
20311	PLSM CELL LEUK W RMSN	88
20380	OTH IMNPRFL NPL W/O RMSN	88
20381	OTH IMNPRFL NPL W RMSN	88
20400	ACT LYM LEUK W/O RMSN	88

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
20401	ACT LYM LEUK W RMSION	88
20410	CHR LYM LEUK W/O RMSION	88
20411	CHR LYM LEUK W RMSION	88
20420	SBAC LYM LEUK W/O RMSION	88
20421	SBAC LYM LEUK W RMSION	88
20480	OTH LYM LEUK W/O RMSION	88
20481	OTH LYM LEUK W RMSION	88
20490	UNS LYM LEUK W/O RMSION	88
20491	UNS LYM LEUK W RMSION	88
20500	ACT MYL LEUK W/O RMSION	88
20501	ACT MYL LEUK W RMSION	88
20510	CHR MYL LEUK W/O RMSION	88
20511	CHR MYL LEUK W RMSION	88
20520	SBAC MYL LEUK W/O RMSION	88
20521	SBAC MYL LEUK W RMSION	88
20530	MYL SRCOMA W/O RMSION	88
20531	MYL SRCOMA W RMSION	88
20580	OTH MYL LEUK W/O RMSION	88
20581	OTH MYL LEUK W RMSION	88
20590	UNS MYL LEUK W/O RMSION	88
20591	UNS MYL LEUK W RMSION	88
20600	ACT MONO LEUK W/O RMSION	88
20601	ACT MONO LEUK W RMSION	88
20610	CHR MONO LEUK W/O RMSION	88
20611	CHR MONO LEUK W RMSION	88
20620	SBAC MONO LEUK W/O RMSION	88
20621	SBAC MONO LEUK W RMSION	88
20680	OTH MONO LEUK W/O RMSION	88
20681	OTH MONO LEUK W RMSION	88
20690	UNS MONO LEUK W/O RMSION	88
20691	UNS MONO LEUK W RMSION	88
20700	ACT ERTH/ERYLK W/O RMSION	88
20701	ACT ERTH/ERYLK W RMSION	88
2071	CHRONIC ERYTHREMIA*	88
20710	CHR ERYTHRM W/O REMISION	88
20711	CHR ERYTHRM W REMISION	88
2072	MEGAKARYOCYTIC LEUKEMIA*	88
20720	MGKRYCYT LEUK W/O RMSION	88
20721	MGKRYCYT LEUK W RMSION	88
2078	SPECIFIED LEUKEMIA NEC*	88
20780	OTH SPF LEUK W/O REMISION	88
20781	OTH SPF LEUK W REMISION	88
2080	ACT LEUK UNS CL W/O RMSN*	88
20800	ACT LEUK UNS CL W/O RMSN	88
20801	ACT LEUK UNS CL W RMSION	88
2081	CHRONIC LEUKEMIA NOS*	88
20810	CHR LEUK UNS CL W/O RMSN	88
20811	CHR LEUK UNS CL W RMSION	88
2082	SUBACUTE LEUKEMIA NOS*	88
20820	SBAC LEUK UNS CL W/O RMS	88
20821	SBAC LEUK UNS CL W RMSION	88
2088	LEUKEMIA-UNSPEC CELL NEC*	88
20880	OTH LEUK UNS CL W/O RMSN	88
20881	OTH LEUK UNS CL W RMSION	88
2089	LEUKEMIA-UNSPEC CELL NOS*	88
20890	LEUKEMIA NOS W/O REMISION	88
20891	LEUKEMIA NOS W REMISION	88
2100	BENIGN NEOPLASM LIP	31
2101	BENIGN NEOPLASM TONGUE	31
2102	BEN NEO MAJOR SALIVARY	31
2103	BENIGN NEO MOUTH FLOOR	31
2104	BENIGN NEO MOUTH NEC/NOS	31
2105	BENIGN NEOPLASM TONSIL	31
2106	BENIGN NEO OROPHARYN NEC	31
2107	BENIGN NEO NASOPHARYNX	31
2108	BENIGN NEO HYPOPHARYNX	31
2109	BENIGN NEO PHARYNX NOS	31
2110	BENIGN NEO ESOPHAGUS	41
2111	BENIGN NEOPLASM STOMACH	41
2112	BENIGN NEOPLASM SM BOWEL	41
2113	BENIGN NEOPLASM LG BOWEL	41
2114	BENIGN NEOPL RECTUM/ANUS	41
2115	BEN NEO LIVER/BILE DUCTS	41
2116	BENIGN NEOPLASM PANCREAS	41
2117	BEN NEO ISLETS LANGERHAN	82
2118	BEN NEO PERITONEUM	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2119	BEN NEO GI TRACT NEC/NOS	41
2120	BEN NEO NASAL CAV/SINUS	31
2121	BENIGN NEO LARYNX	31
2122	BENIGN NEO TRACHEA	33
2123	BENIGN NEO BRONCHUS/LUNG	33
2124	BENIGN NEOPLASM PLEURA	33
2125	BENIGN NEO MEDIASTINUM	33
2126	BENIGN NEOPLASM THYMUS	86
2127	BENIGN NEOPLASM HEART	36
2128	BENIGN NEO RESP SYS NEC	33
2129	BENIGN NEO RESP SYS NOS	33
2130	BEN NEO SKULL/FACE BONE	24
2131	BEN NEO LOWER JAW BONE	31
2132	BENIGN NEO VERTEBRAE	24
2133	BEN NEO RIBS/STERN/CLAV	33
2134	BEN NEO LONG BONES ARM	24
2135	BEN NEO BONES WRIST/HAND	24
2136	BENIGN NEO PELVIC GIRDLE	24
2137	BEN NEO LONG BONES LEG	24
2138	BEN NEO BONES ANKLE/FOOT	24
2139	BENIGN NEO BONE NOS	24
2140	LIPOMA SKIN FACE	18
2141	LIPOMA SKIN NEC	18
2142	LIPOMA INTRATHORACIC	33
2143	LIPOMA INTRA-ABDOMINAL	41
2144	LIPOMA SPERMATIC CORD	53
2148	LIPOMA NEC	18
2149	LIPOMA NOS	18
2150	BEN NEO SOFT TISSUE HEAD	18
2152	BEN NEO SOFT TISSUE ARM	18
2153	BEN NEO SOFT TISSUE LEG	18
2154	BEN NEO SOFT TIS THORAX	18
2155	BEN NEO SOFT TIS ABDOMEN	18
2156	BEN NEO SOFT TIS PELVIS	18
2157	BENIGN NEO TRUNK NOS	18
2158	BEN NEO SOFT TISSUE NEC	18
2159	BEN NEO SOFT TISSUE NOS	18
2160	BENIGN NEO SKIN LIP	18
2161	BENIGN NEO SKIN EYELID	68
2162	BENIGN NEO SKIN EAR	18
2163	BENIGN NEO SKIN FACE NEC	18
2164	BEN NEO SCALP/SKIN NECK	18
2165	BENIGN NEO SKIN TRUNK	18
2166	BENIGN NEO SKIN ARM	18
2167	BENIGN NEO SKIN LEG	18
2168	BENIGN NEOPLASM SKIN NEC	18
2169	BENIGN NEOPLASM SKIN NOS	18
217	BENIGN NEOPLASM BREAST	18
2180	SUBMUCOUS LEIOMYOMA	56
2181	INTRAMURAL LEIOMYOMA	56
2182	SUBSEROUS LEIOMYOMA	56
2189	UTERINE LEIOMYOMA NOS	56
2190	BENIGN NEO CERVIX UTERI	56
2191	BENIGN NEO CORPUS UTERI	56
2198	BENIGN NEO UTERUS NEC	56
2199	BENIGN NEO UTERUS NOS	56
220	BENIGN NEOPLASM OVARY	56
2210	BEN NEO FALLOPIAN TUBE	56
2211	BENIGN NEOPLASM VAGINA	56
2212	BENIGN NEOPLASM VULVA	56
2218	BEN NEO FEM GENITAL NEC	56
2219	BEN NEO FEM GENITAL NOS	56
2220	BENIGN NEOPLASM TESTIS	53
2221	BENIGN NEOPLASM PENIS	53
2222	BENIGN NEOPLASM PROSTATE	53
2223	BENIGN NEO EPIDIDYMIS	53
2224	BENIGN NEOPLASM SCROTUM	53
2228	BEN NEO MALE GENITAL NEC	53
2229	BEN NEO MALE GENITAL NOS	53
2230	BENIGN NEOPLASM KIDNEY	53
2231	BENIGN NEO RENAL PELVIS	53
2232	BENIGN NEOPLASM URETER	53
2233	BENIGN NEOPLASM BLADDER	53
22381	BENIGN NEOPLASM URETHRA	53
22389	BENIGN NEO URINARY NEC	53
2239	BENIGN NEO URINARY NOS	53

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2240	BENIGN NEOPLASM EYEBALL	68
2241	BENIGN NEOPLASM ORBIT	68
2242	BEN NEO LACRIMAL GLAND	68
2243	BENIGN NEO CONJUNCTIVA	68
2244	BENIGN NEOPLASM CORNEA	68
2245	BENIGN NEOPLASM RETINA	68
2246	BENIGN NEOPLASM CHOROID	68
2247	BEN NEO LACRIMAL DUCT	68
2248	BENIGN NEOPLASM EYE NEC	68
2249	BENIGN NEOPLASM EYE NOS	68
2250	BENIGN NEOPLASM BRAIN	63
2251	BENIGN NEO CRANIAL NERVE	63
2252	BEN NEO CEREBR MENINGES	63
2253	BENIGN NEO SPINAL CORD	63
2254	BEN NEO SPINAL MENINGES	63
2258	BENIGN NEO NERV SYS NEC	63
2259	BENIGN NEO NERV SYS NOS	63
226	BENIGN NEOPLASM THYROID	82
2270	BENIGN NEOPLASM ADRENAL	82
2271	BENIGN NEO PARATHYROID	82
2273	BENIGN NEO PITUITARY	82
2274	BEN NEOPL PINEAL GLAND	63
2275	BENIGN NEO CAROTID BODY	63
2276	BEN NEO PARAGANGLIA NEC	63
2278	BENIGN NEO ENDOCRINE NEC	82
2279	BENIGN NEO ENDOCRINE NOS	82
22800	HEMANGIOMA NOS	36
22801	HEMANGIOMA SKIN	18
22802	HEMANGIOMA INTRACRANIAL	63
22803	HEMANGIOMA RETINA	68
22804	HEMANGIOMA INTRA-ABDOM	41
22809	HEMANGIOMA NEC	36
2281	LYMPHANGIOMA, ANY SITE	86
2290	BENIGN NEO LYMPH NODES	86
2298	BENIGN NEOPLASM NEC	18
2299	BENIGN NEOPLASM NOS	18
2300	CA IN SITU ORAL CAV/PHAR	88
2301	CA IN SITU ESOPHAGUS	88
2302	CA IN SITU STOMACH	88
2303	CA IN SITU COLON	88
2304	CA IN SITU RECTUM	88
2305	CA IN SITU ANAL CANAL	88
2306	CA IN SITU ANUS NOS	88
2307	CA IN SITU BOWEL NEC/NOS	88
2308	CA IN SITU LIVER/BILIARY	88
2309	CA IN SITU GI NEC/NOS	88
2310	CA IN SITU LARYNX	88
2311	CA IN SITU TRACHEA	88
2312	CA IN SITU BRONCHUS/LUNG	88
2318	CA IN SITU RESP SYS NEC	88
2319	CA IN SITU RESP SYS NOS	88
2320	CA IN SITU SKIN LIP	88
2321	CA IN SITU EYELID	88
2322	CA IN SITU SKIN EAR	88
2323	CA IN SITU SKIN FACE NEC	88
2324	CA IN SITU SCALP	88
2325	CA IN SITU SKIN TRUNK	88
2326	CA IN SITU SKIN ARM	88
2327	CA IN SITU SKIN LEG	88
2328	CA IN SITU SKIN NEC	88
2329	CA IN SITU SKIN NOS	88
2330	CA IN SITU BREAST	88
2331	CA IN SITU CERVIX UTERI	88
2332	CA IN SITU UTERUS NEC	88
2333	CA IN SITU FEM GEN NEC	88
2334	CA IN SITU PROSTATE	88
2335	CA IN SITU PENIS	88
2336	CA IN SITU MALE GEN NEC	88
2337	CA IN SITU BLADDER	88
2339	CA IN SITU URINARY NEC	88
2340	CA IN SITU EYE	88
2348	CA IN SITU NEC	88
2349	CA IN SITU NOS	88
2350	UNC BEHAV NEO SALIVARY	88
2351	UNC BEHAV NEO ORAL/PHAR	88
2352	UNC BEHAV NEO INTESTINE	88

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
2353	UNC BEHAV NEO LIVER	88
2354	UNC BEHAV NEO PERITONEUM	88
2355	UNC BEHAV NEO GI NEC	88
2356	UNC BEHAV NEO LARYNX	88
2357	UNC BEHAV NEO LUNG	88
2358	UNC BEHAV NEO PLEURA	88
2359	UNC BEHAV NEO RESP NEC	88
2360	UNCERT BEHAV NEO UTERUS	88
2361	UNC BEHAV NEO PLACENTA	88
2362	UNC BEHAV NEO OVARY	88
2363	UNC BEHAV NEO FEMALE NEC	88
2364	UNC BEHAV NEO TESTIS	88
2365	UNC BEHAV NEO PROSTATE	88
2366	UNC BEHAV NEO MALE NEC	88
2367	UNC BEHAV NEO BLADDER	88
23690	UNC BEHAV NEO URINAR NOS	88
23691	UNC BEHAV NEO KIDNEY	88
23699	UNC BEHAV NEO URINAR NEC	88
2370	UNC BEHAV NEO PITUITARY	88
2371	UNC BEHAV NEO PINEAL	88
2372	UNC BEHAV NEO ADRENAL	88
2373	UNC BEHAV NEO PARAGANG	88
2374	UNCER NEO ENDOCRINE NEC	88
2375	UNC BEH NEO BRAIN/SPINAL	88
2376	UNC BEHAV NEO MENINGES	88
2377	NEUROFIBROMATOSIS*	88
23770	NEUROFIBROMATOSIS NOS	63
23771	NEUROFIBROMATOSIS TYPE I	63
23772	NEUROFIBROMATOSIS TYP II	63
2379	UNC BEH NEO NERV SYS NEC	88
2380	UNC BEHAV NEO BONE	88
2381	UNC BEHAV NEO SOFT TISSU	88
2382	UNC BEHAV NEO SKIN	88
2383	UNC BEHAV NEO BREAST	88
2384	POLYCYTHEMIA VERA	88
2385	MASTOCYTOMA NOS	88
2386	PLASMACYTOMA NOS	88
2387	LYMPHOPROLIFERAT DIS NOS	88
2388	UNCERT BEHAVIOR NEO NEC	88
2389	UNCERT BEHAVIOR NEO NOS	88
2390	DIGESTIVE NEOPLASM NOS	88
2391	RESPIRATORY NEOPLASM NOS	88
2392	BONE/SKIN NEOPLASM NOS	88
2393	BREAST NEOPLASM NOS	88
2394	BLADDER NEOPLASM NOS	88
2395	OTHER GU NEOPLASM NOS	88
2396	BRAIN NEOPLASM NOS	88
2397	ENDOCRINE/NERV NEO NOS	88
2398	NEOPLASM NOS, SITE NEC	88
2399	NEOPLASM NOS	88
2400	SIMPLE GOITER	82
2409	GOITER NOS	82
2410	NONTOX UNINODULAR GOITER	82
2411	NONTOX MULTINODUL GOITER	82
2419	NONTOX NODUL GOITER NOS	82
24200	TOX DIF GOITER NO CRISIS	82
24201	TOX DIF GOITER W CRISIS	78
24210	TOX UNINOD GOIT NO CRIS	82
24211	TOX UNINOD GOIT W CRISIS	78
24220	TOX MULTNOD GOIT NO CRIS	82
24221	TOX MULTNOD GOIT W CRIS	78
24230	TOX NOD GOITER NO CRISIS	82
24231	TOX NOD GOITER W CRISIS	78
24240	THYROTOX-ECT NOD NO CRIS	82
24241	THYROTOX-ECT NOD W CRIS	78
24280	THYRTOX ORIG NEC NO CRIS	82
24281	THYROTOX ORIG NEC W CRIS	78
24290	THYROTOX NOS NO CRISIS	82
24291	THYROTOX NOS W CRISIS	78
243	CONGENITAL HYPOTHYROIDISM	82
2440	POSTSURGICAL HYPOTHYROID	82
2441	POSTABLAT HYPOTHYR NEC	82
2442	IODINE HYPOTHYROIDISM	82
2443	IATROGEN HYPOTHYROID NEC	82
2448	ACQUIRED HYPOTHYROID NEC	82
2449	HYPOTHYROIDISM NOS	82

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2450	ACUTE THYROIDITIS	82
2451	SUBACUTE THYROIDITIS	82
2452	CHR LYMPHOCYT THYROIDIT	82
2453	CHR FIBROUS THYROIDITIS	82
2454	IATROGENIC THYROIDITIS	82
2458	CHR THYROIDITIS NEC/NOS	82
2459	THYROIDITIS NOS	82
2460	DIS THYROCALCITON SECRET	82
2461	DYSHORMONOGENIC GOITER	82
2462	CYST OF THYROID	82
2463	HEMORR/INFARC THYROID	82
2468	DISORDERS OF THYROID NEC	82
2469	DISORDER OF THYROID NOS	82
25000	DMII WO CMP NT ST UNCINTR	82
25001	DMI WO CMP NT ST UNCINTRL	82
25002	DMII WO CMP UNCINTRLD	82
25003	DMI WO CMP UNCINTRLD	82
25010	DMII KETO NT ST UNCINTRLD	78
25011	DMI KETO NT ST UNCINTRLD	78
25012	DMII KETOACD UNCONTROLD	78
25013	DMI KETOACD UNCONTROLD	78
25020	DMII HPRSM NT ST UNCINTRL	78
25021	DMI HPRSM NT ST UNCINTRLD	78
25022	DMII HPROSMLR UNCONTROLD	78
25023	DMI HPROSMLR UNCONTROLD	78
25030	DMII O CM NT ST UNCINTRLD	78
25031	DMI O CM NT ST UNCINTRLD	78
25032	DMII OTH COMA UNCONTROLD	78
25033	DMI OTH COMA UNCONTROLD	78
25040	DMII RENL NT ST UNCINTRLD	53
25041	DMI RENL NT ST UNCINTRLD	53
25042	DMII RENAL UNCINTRLD	82
25043	DMI RENAL UNCINTRLD	82
25050	DMII OPTH NT ST UNCINTRL	68
25051	DMI OPTH NT ST UNCINTRLD	68
25052	DMII OPTH UNCINTRLD	82
25053	DMI OPTH UNCINTRLD	82
25060	DMII NEURO NT ST UNCINTRL	63
25061	DMI NEURO NT ST UNCINTRLD	63
25062	DMII NEURO UNCINTRLD	82
25063	DMI NEURO UNCINTRLD	82
25070	DMII CIRC NT ST UNCINTRLD	82
25071	DMI CIRC NT ST UNCINTRLD	82
25072	DMII CIRC UNCINTRLD	82
25073	DMI CIRC UNCINTRLD	82
25080	DMII OTH NT ST UNCINTRLD	82
25081	DMI OTH NT ST UNCINTRLD	82
25082	DMII OTH UNCINTRLD	82
25083	DMI OTH UNCINTRLD	82
25090	DMII UNSPF NT ST UNCINTRL	82
25091	DMI UNSPF NT ST UNCINTRLD	82
25092	DMII UNSPF UNCINTRLD	82
25093	DMI UNSPF UNCINTRLD	82
2510	HYPOGLYCEMIC COMA	78
2511	OTH SPCF HYPOGLYCEMIA	82
2512	HYPOGLYCEMIA NOS	82
2513	POSTSURG HYPOINSULINEMIA	82
2514	ABN SECRETION GLUCAGON	82
2515	ABNORM SECRETION GASTRIN	41
2518	PANCREATIC DISORDER NEC	82
2519	PANCREATIC DISORDER NOS	82
2520	HYPERPARATHYROIDISM	82
2521	HYPOPARATHYROIDISM	82
2528	PARATHYROID DISORDER NEC	82
2529	PARATHYROID DISORDER NOS	82
2530	ACROMEGALY AND GIGANTISM	82
2531	ANT PITUIT HYPERFUNC NEC	82
2532	PANHYPOPITUITARISM	82
2533	PITUITARY DWARFISM	82
2534	ANTER PITUITARY DIS NEC	82
2535	DIABETES INSIPIDUS	82
2536	NEUROHYPOPHYSIS DIS NEC	82
2537	IATROGENIC PITUITARY DIS	82
2538	PITUITARY DISORDER NEC	82
2539	PITUITARY DISORDER NOS	82
2540	PERSIST HYPERPLAS THYMUS	86

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
2541	ABSCCESS OF THYMUS	86
2548	DISEASES OF THYMUS NEC	86
2549	DISEASE OF THYMUS NOS	86
2550	CUSHING'S SYNDROME	82
2551	HYPERALDOSTERONISM	82
2552	ADRENOGENITAL DISORDERS	82
2553	CORTICOADREN OVERACT NEC	82
2554	CORTICOADRENAL INSUFFIC	82
2555	ADRENAL HYPOFUNCTION NEC	82
2556	MEDULLOADRENAL HYPERFUNC	82
2558	ADRENAL DISORDER NEC	82
2559	ADRENAL DISORDER NOS	82
2560	HYPERESTROGENISM	56
2561	OVARIAN HYPERFUNC NEC	56
2562	POSTABLATIV OVARIAN FAIL	56
2563	OVARIAN FAILURE NEC	56
2564	POLYCYSTIC OVARIES	56
2568	OVARIAN DYSFUNCTION NEC	56
2569	OVARIAN DYSFUNCTION NOS	56
2570	TESTICULAR HYPERFUNCTION	82
2571	POSTABLAT TESTIC HYPOFUN	82
2572	TESTICULAR HYPOFUNC NEC	82
2578	TESTICULAR DYSFUNCT NEC	82
2579	TESTICULAR DYSFUNCT NOS	82
2580	WERMER'S SYNDROME	82
2581	COMB ENDOCR DYSFUNCT NEC	82
2588	POLYGLANDUL DYSFUNC NEC	82
2589	POLYGLANDUL DYSFUNC NOS	82
2590	DELAY SEXUAL DEVELOP NEC	82
2591	SEXUAL PRECOCITY NEC	82
2592	CARCINOID SYNDROME	82
2593	ECTOPIC HORMONE SECR NEC	82
2594	DWARFISM NEC	82
2598	ENDOCRINE DISORDERS NEC	82
2599	ENDOCRINE DISORDER NOS	82
260	KWASHIORKOR	82
261	NUTRITIONAL MARASMUS	82
262	OTH SEVERE MALNUTRITION	82
2630	MALNUTRITION MOD DEGREE	82
2631	MALNUTRITION MILD DEGREE	82
2632	ARREST DEVEL D/T MALNUTR	82
2638	PROTEIN-CAL MALNUTR NEC	82
2639	PROTEIN-CAL MALNUTR NOS	82
2640	VIT A CONJUNCTIV XEROSIS	68
2641	VIT A BITOT'S SPOT	68
2642	VIT A CORNEAL XEROSIS	68
2643	VIT A CORNEA ULCER/XEROS	68
2644	VIT A KERATOMALACIA	68
2645	VIT A NIGHT BLINDNESS	68
2646	VIT A DEF W CORNEAL SCAR	68
2647	VIT A OCULAR DEFIC NEC	68
2648	VITAMIN A DEFICIENCY NEC	82
2649	VITAMIN A DEFICIENCY NOS	82
2650	BERIBERI	82
2651	THIAMINE DEFIC NEC/NOS	82
2652	PELLAGRA	82
2660	ARIBOFLAVINOSIS	82
2661	VITAMIN B6 DEFICIENCY	82
2662	B-COMPLEX DEFIC NEC	82
2669	VITAMIN B DEFICIENCY NOS	82
267	ASCORBIC ACID DEFICIENCY	82
2680	RICKETS, ACTIVE	24
2681	RICKETS, LATE EFFECT	24
2682	OSTEOMALACIA NOS	24
2689	VITAMIN D DEFICIENCY NOS	82
2690	DEFICIENCY OF VITAMIN K	82
2691	VITAMIN DEFICIENCY NEC	82
2692	VITAMIN DEFICIENCY NOS	82
2693	MINERAL DEFICIENCY NEC	82
2698	NUTRITION DEFICIENCY NEC	82
2699	NUTRITION DEFICIENCY NOS	82
2700	AMINO-ACID TRANSPORT DIS	82
2701	PHENYLKETONURIA-PKU	82
2702	AROM AMIN-ACID METAB NEC	82
2703	BRAN-CHAIN AMIN-ACID DIS	82
2704	SULPH AMINO-ACID MET DIS	82

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2705	DIS HISTIDINE METABOLISM	82
2706	DIS UREA CYCLE METABOL	82
2707	STRAIG AMIN-ACID MET NEC	82
2708	DIS AMINO-ACID METAB NEC	82
2709	DIS AMINO-ACID METAB NOS	82
2710	GLYCOGENOSIS	82
2711	GALACTOSEMIA	82
2712	HERED FRUCTOSE INTOLERAN	41
2713	DISACCHARIDASE DEF/MALAB	41
2714	RENAL GLYCOSURIA	82
2718	DIS CARBOHYDR METAB NEC	82
2719	DIS CARBOHYDR METAB NOS	82
2720	PURE HYPERCHOLESTEROLEM	82
2721	PURE HYPERGLYCERIDEMIA	82
2722	MIXED HYPERLIPIDEMIA	82
2723	HYPERCHYLOMICRONEMIA	82
2724	HYPERLIPIDEMIA NEC/NOS	82
2725	LIPOPROTEIN DEFICIENCIES	82
2726	LIPODYSTROPHY	82
2727	LIPIDOSES	82
2728	LIPOID METABOL DIS NEC	82
2729	LIPOID METABOL DIS NOS	82
2730	POLYCLON HYPERGAMMAGLOBU	86
2731	MONOCLON PARAPROTEINEMIA	86
2732	PARAPROTEINEMIA NEC	88
2733	MACROGLOBULINEMIA	88
2738	DIS PLAS PROTEIN MET NEC	88
2739	DIS PLAS PROTEIN MET NOS	88
2740	GOUTY ARTHROPATHY	24
27410	GOUTY NEPHROPATHY NOS	53
27411	URIC ACID NEPHROLITHIAS	53
27419	GOUTY NEPHROPATHY NEC	53
27481	GOUTY TOPHI OF EAR	24
27482	GOUTY TOPHI SITE NEC	24
27489	GOUT W MANIFESTATION NEC	24
2749	GOUT NOS	24
2750	DIS IRON METABOLISM	82
2751	DIS COPPER METABOLISM	82
2752	DIS MAGNESIUM METABOLISM	82
2753	DIS PHOSPHORUS METABOL	82
2754	DIS CALCIUM METABOLISM*	82
2758	DIS MINERAL METABOL NEC	82
2759	DIS MINERAL METABOL NOS	82
2760	HYPEROSMOLALITY	82
2761	HYPOSMOLALITY	82
2762	ACIDOSIS	82
2763	ALKALOSIS	82
2764	MIXED ACID-BASE BAL DIS	82
2765	HYPOVOLEMIA	82
2766	FLUID OVERLOAD	82
2767	HYPERPOTASSEMIA	82
2768	HYPOPOTASSEMIA	82
2769	ELECTROLYT/FLUID DIS NEC	82
27700	CYSTIC FIBROS W/O ILEUS	82
27701	CYSTIC FIBROSIS W ILEUS	57
2771	DIS PORPHYRIN METABOLISM	82
2772	PURINE/PYRIMID DIS NEC	82
2773	AMYLOIDOSIS	86
2774	DIS BILIRUBIN EXCRETION	41
2775	MUCOPOLYSACCHARIDOSIS	82
2776	DEFIC CIRCUL ENZYME NEC	82
2778	METABOLISM DISORDER NEC	82
2779	METABOLISM DISORDER NOS	82
2780	OBESITY*	82
27800	OBESITY NOS	82
27801	MORBID OBESITY	82
2781	LOCALIZED ADIPOSITY	82
2782	HYPERVITAMINOSIS A	82
2783	HYPERCAROTINEMIA	82
2784	HYPERVITAMINOSIS D	82
2788	OTHER HYPERALIMENTATION	82
27900	HYPOGAMMAGLOBULINEM NOS	86
27901	SELECTIVE IGA IMMUNODEF	86
27902	SELECTIVE IGM IMMUNODEF	86
27903	SELECTIVE IG DEFIC NEC	86
27904	CONG HYPOGAMMAGLOBULINEM	86

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
27905	IMMUNODEFIC W HYPER-IGM	86
27906	COMMON VARIABL IMMUNODEF	86
27909	HUMORAL IMMUNITY DEF NEC	86
27910	IMMUNDEF T-CELL DEF NOS	86
27911	DIGEORGE'S SYNDROME	86
27912	WISKOTT-ALDRICH SYNDROME	86
27913	NEZELOF'S SYNDROME	86
27919	DEFIC CELL IMMUNITY NOS	86
2792	COMBINED IMMUNITY DEFIC	86
2793	IMMUNITY DEFICIENCY NOS	86
2794	AUTOIMMUNE DISEASE NEC	24
2798	IMMUNE MECHANISM DIS NEC	86
2799	IMMUNE MECHANISM DIS NOS	86
2800	CHR BLOOD LOSS ANEMIA	86
2801	IRON DEF ANEMIA DIETARY	86
2808	IRON DEFIC ANEMIA NEC	86
2809	IRON DEFIC ANEMIA NOS	86
2810	PERNICIOUS ANEMIA	86
2811	B12 DEFIC ANEMIA NEC	86
2812	FOLATE-DEFICIENCY ANEMIA	86
2813	MEGALOBLASTIC ANEMIA NEC	86
2814	PROTEIN DEFIC ANEMIA	86
2818	NUTRITIONAL ANEMIA NEC	86
2819	DEFICIENCY ANEMIA NOS	86
2820	HEREDITARY SPHEROCYTOSIS	86
2821	HEREDIT ELLIPTOCYTOSIS	86
2822	GLUTATHIONE DIS ANEMIA	86
2823	ENZYME DEFIC ANEMIA NEC	86
2824	THALASSEMIAS	86
2825	SICKLE-CELL TRAIT	86
28260	SICKLE-CELL ANEMIA NOS	86
28261	HB-S DISEASE W/O CRISIS	86
28262	HB-S DISEASE WITH CRISIS	86
28263	SICKLE-CELL/HB-C DISEASE	86
28269	SICKLE-CELL ANEMIA NEC	86
2827	HEMOGLOBINOPATHIES NEC	86
2828	HERED HEMOLYTIC ANEM NEC	86
2829	HERED HEMOLYTIC ANEM NOS	86
2830	AUTOIMMUN HEMOLYTIC ANEM	86
2831	NONAUTOIMMU HEMOLYT ANEM*	86
28310	NONAUTO HEM ANEMIA NOS	86
28311	HEMOLYTIC UREMIC SYND	86
28319	OTH NONAUTO HEM ANEMIA	86
2832	HEMOLYTIC HEMOGLOBINURIA	86
2839	ACQ HEMOLYTIC ANEMIA NOS	86
2840	CONGEN APLASTIC ANEMIA	86
2848	APLASTIC ANEMIAS NEC	86
2849	APLASTIC ANEMIA NOS	86
2850	SIDEROBLASTIC ANEMIA	86
2851	AC POSTHEMORRHAG ANEMIA	86
2858	ANEMIA NEC	86
2859	ANEMIA NOS	86
2860	CONG FACTOR VIII DIORD	86
2861	CONG FACTOR IX DISORDER	86
2862	CONG FACTOR XI DISORDER	86
2863	CONG DEF CLOT FACTOR NEC	86
2864	VON WILLEBRAND'S DISEASE	86
2865	CIRCULATING ANTICOAG DIS	86
2866	DEFIBRATION SYNDROME	86
2867	ACQ COAGUL FACTOR DEFIC	86
2869	COAGULAT DEFECT NEC/NOS	86
2870	ALLERGIC PURPURA	86
2871	THROMBOCYTOPATHY	86
2872	PURPURA NOS	86
2873	PRIMARY THROMBOCYTOPENIA	86
2874	SECOND THROMBOCYTOPENIA	86
2875	THROMBOCYTOPENIA NOS	86
2878	HEMORRHAGIC COND NEC	86
2879	HEMORRHAGIC COND NOS	86
2880	AGRANULOCYTOSIS	86
2881	FUNCTION DIS NEUTROPHILS	86
2882	GENETIC ANOMALY LEUKOCYT	86
2883	EOSINOPHILIA	86
2888	WBC DISEASE NEC	86
2889	WBC DISEASE NOS	86
2890	SECONDARY POLYCYTHEMIA	86

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2891	CHRONIC LYMPHADENITIS	86
2892	MESENTERIC LYMPHADENITIS	41
2893	LYMPHADENITIS NOS	86
2894	HYPERSPLENISM	86
28950	SPLEEN DISEASE NOS	86
28951	CHR CONGEST SPLENOMEGALY	86
28959	SPLEEN DISEASE NEC	86
2896	FAMILIAL POLYCYTHEMIA	86
2897	METHEMOGLOBINEMIA	86
2898	BLOOD DISEASES NEC	86
2899	BLOOD DISEASE NOS	86
*2900	SENILE DEMENTIA UNCOMP .....	.....
29010	PRESENILE DEMENTIA	91
29011	PRESENILE DELIRIUM	91
29012	PRESENILE DELUSION	91
29013	PRESENILE DEPRESSION	91
29020	SENILE DELUSION	91
29021	SENILE DEPRESSIVE	91
2903	SENILE DELIRIUM	91
29040	ARTERIOSCLER DEMENT NOS	91
29041	ARTERIOSCLER DELIRIUM	91
29042	ARTERIOSCLER DELUSION	91
29043	ARTERIOSCLER DEPRESSIVE	91
2908	SENILE PSYCHOSIS NEC	91
2909	SENILE PSYCHOT COND NOS	91
2910	DELIRIUM TREMENS	91
2911	ALCOHOL AMNESTIC SYND	91
2912	ALCOHOLIC DEMENTIA NEC	91
2913	ALCOHOL HALLUCINOSIS	91
2914	PATHOLOGIC ALCOHOL INTOX	91
2915	ALCOHOLIC JEALOUSY	91
2918	ALCOHOLIC PSYCHOSIS NEC*	91
2919	ALCOHOLIC PSYCHOSIS NOS	91
2920	DRUG WITHDRAWAL SYNDROME	91
29211	DRUG PARANOID STATE	91
29212	DRUG HALLUCINOSIS	91
2922	PATHOLOGIC DRUG INTOX	91
29281	DRUG-INDUCED DELIRIUM	91
29282	DRUG-INDUCED DEMENTIA	91
29283	DRUG AMNESTIC SYNDROME	91
29284	DRUG DEPRESSIVE SYNDROME	91
29289	DRUG MENTAL DISORDER NEC	91
2929	DRUG MENTAL DISORDER NOS	91
2930	ACUTE DELIRIUM	91
2931	SUBACUTE DELIRIUM	91
29381	ORGANIC DELUSIONAL SYND	91
29382	ORGANIC HALLUCINOSIS SYN	91
29383	ORGANIC AFFECTIVE SYND	91
29389	TRANSIENT ORG MENTAL NEC	91
2939	TRANSIENT ORG MENTAL NOS	91
2940	AMNESTIC SYNDROME	91
2941	DEMENTIA IN OTH DISEASES	91
2948	ORGANIC BRAIN SYND NEC	91
2949	ORGANIC BRAIN SYND NOS	91
29500	SIMPL SCHIZOPHREN-UNSPEC	91
29501	SIMPL SCHIZOPHREN-SUBCHR	91
29502	SIMPLE SCHIZOPHREN-CHR	91
29503	SIMP SCHIZ-SUBCHR/EXACER	91
29504	SIMPL SCHIZO-CHR/EXACERB	91
29505	SIMPL SCHIZOPHREN-REMISS	91
29510	HEBEPHRENIA-UNSPEC	91
29511	HEBEPHRENIA-SUBCHRONIC	91
29512	HEBEPHRENIA-CHRONIC	91
29513	HEBEPHREN-SUBCHR/EXACERB	91
29514	HEBEPHRENIA-CHR/EXACERB	91
29515	HEBEPHRENIA-REMISSION	91
29520	CATATONIA-UNSPEC	91
29521	CATATONIA-SUBCHRONIC	91
29522	CATATONIA-CHRONIC	91
29523	CATATONIA-SUBCHR/EXACERB	91
29524	CATATONIA-CHR/EXACERB	91
29525	CATATONIA-REMISSION	91
29530	PARANOID SCHIZO-UNSPEC	91
29531	PARANOID SCHIZO-SUBCHR	91
29532	PARANOID SCHIZO-CHRONIC	91
29533	PARAN SCHIZO-SUBCHR/EXAC	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
29534	PARAN SCHIZO-CHR/EXACERB	91
29535	PARANOID SCHIZO-REMISS	91
29540	AC SCHIZOPHRENIA-UNSPEC	91
29541	AC SCHIZOPHRENIA-SUBCHR	91
29542	AC SCHIZOPHRENIA-CHR	91
29543	AC SCHIZO-SUBCHR/EXACERB	91
29544	AC SCHIZOPHR-CHR/EXACERB	91
29545	AC SCHIZOPHRENIA-REMISS	91
29550	LATENT SCHIZOPHREN-UNSP	91
29551	LAT SCHIZOPHREN-SUBCHR	91
29552	LATENT SCHIZOPHREN-CHR	91
29553	LAT SCHIZO-SUBCHR/EXACER	91
29554	LATENT SCHIZO-CHR/EXACER	91
29555	LAT SCHIZOPHREN-REMISS	91
29560	RESID SCHIZOPHREN-UNSP	91
29561	RESID SCHIZOPHREN-SUBCHR	91
29562	RESIDUAL SCHIZOPHREN-CHR	91
29563	RESID SCHIZO-SUBCHR/EXAC	91
29564	RESID SCHIZO-CHR/EXACERB	91
29565	RESID SCHIZOPHREN-REMISS	91
29570	SCHIZOAFFECTIVE-UNSPEC	91
29571	SCHIZOAFFECTIVE-SUBCHR	91
29572	SCHIZOAFFECTIVE-CHRONIC	91
29573	SCHIZOAFF-SUBCHR/EXACER	91
29574	SCHIZOAFFECT-CHR/EXACER	91
29575	SCHIZOAFFECTIVE-REMISS	91
29580	SCHIZOPHRENIA NEC-UNSPEC	91
29581	SCHIZOPHRENIA NEC-SUBCHR	91
29582	SCHIZOPHRENIA NEC-CHR	91
29583	SCHIZO NEC-SUBCHR/EXACER	91
29584	SCHIZO NEC-CHR/EXACERB	91
29585	SCHIZOPHRENIA NEC-REMISS	91
29590	SCHIZOPHRENIA NOS-UNSPEC	91
29591	SCHIZOPHRENIA NOS-SUBCHR	91
29592	SCHIZOPHRENIA NOS-CHR	91
29593	SCHIZO NOS-SUBCHR/EXACER	91
29594	SCHIZO NOS-CHR/EXACERB	91
29595	SCHIZOPHRENIA NOS-REMISS	91
29600	MANIC DISORDER-UNSPEC	91
29601	MANIC DISORDER-MILD	91
29602	MANIC DISORDER-MOD	91
29603	MANIC DISORDER-SEVERE	91
29604	MANIC DIS-SEVERE W PSYCH	91
29605	MANIC DIS-PARTIAL REMISS	91
29606	MANIC DIS-FULL REMISSION	91
29610	RECUR MANIC DIS-UNSPEC	91
29611	RECUR MANIC DIS-MILD	91
29612	RECUR MANIC DIS-MOD	91
29613	RECUR MANIC DIS-SEVERE	91
29614	RECUR MANIC-SEV W PSYCHO	91
29615	RECUR MANIC-PART REMISS	91
29616	RECUR MANIC-FULL REMISS	91
29620	DEPRESS PSYCHOSIS-UNSPEC	91
29621	DEPRESS PSYCHOSIS-MILD	91
29622	DEPRESSIVE PSYCHOSIS-MOD	91
29623	DEPRESS PSYCHOSIS-SEVERE	91
29624	DEPR PSYCHOS-SEV W PSYCH	91
29625	DEPR PSYCHOS-PART REMISS	91
29626	DEPR PSYCHOS-FULL REMISS	91
29630	RECURR DEPR PSYCHOS-UNSP	91
29631	RECURR DEPR PSYCHOS-MILD	91
29632	RECURR DEPR PSYCHOS-MOD	91
29633	RECUR DEPR PSYCH-SEVERE	91
29634	REC DEPR PSYCH-PSYCHOTIC	91
29635	RECUR DEPR PSYC-PART REM	91
29636	RECUR DEPR PSYC-FULL REM	91
29640	BIPOL AFF, MANIC-UNSPEC	91
29641	BIPOLAR AFF, MANIC-MILD	91
29642	BIPOLAR AFFEC, MANIC-MOD	91
29643	BIPOL AFF, MANIC-SEVERE	91
29644	BIPOL MANIC-SEV W PSYCH	91
29645	BIPOL AFF MANIC-PART REM	91
29646	BIPOL AFF MANIC-FULL REM	91
29650	BIPOLAR AFF, DEPR-UNSPEC	91
29651	BIPOLAR AFFEC, DEPR-MILD	91
29652	BIPOLAR AFFEC, DEPR-MOD	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
29653	BIPOL AFF, DEPR-SEVERE	91
29654	BIPOL DEPR-SEV W PSYCH	91
29655	BIPOL AFF DEPR-PART REM	91
29656	BIPOL AFF DEPR-FULL REM	91
29660	BIPOL AFF, MIXED-UNSPEC	91
29661	BIPOLAR AFF, MIXED-MILD	91
29662	BIPOLAR AFFEC, MIXED-MOD	91
29663	BIPOL AFF, MIXED-SEVERE	91
29664	BIPOL MIXED-SEV W PSYCH	91
29665	BIPOL AFF, MIX-PART REM	91
29666	BIPOL AFF, MIX-FULL REM	91
2967	BIPOLAR AFFECTIVE NOS	91
29680	MANIC-DEPRESSIVE NOS	91
29681	ATYPICAL MANIC DISORDER	91
29682	ATYPICAL DEPRESSIVE DIS	91
29689	MANIC-DEPRESSIVE NEC	91
29690	AFFECTIVE PSYCHOSIS NOS	91
29699	AFFECTIVE PSYCHOSIS NEC	91
2970	PARANOID STATE, SIMPLE	91
2971	PARANOIA	91
2972	PARAPHRENIA	91
2973	SHARED PARANOID DISORDER	91
2978	PARANOID STATES NEC	91
2979	PARANOID STATE NOS	91
2980	REACT DEPRESS PSYCHOSIS	91
2981	EXCITATIV TYPE PSYCHOSIS	91
2982	REACTIVE CONFUSION	91
2983	ACUTE PARANOID REACTION	91
2984	PSYCHOGEN PARANOID PSYCH	91
2988	REACT PSYCHOSIS NEC/NOS	91
2989	PSYCHOSIS NOS	91
29900	INFANTILE AUTISM-ACTIVE	91
29901	INFANTILE AUTISM-RESID	91
29910	DISINTEGR PSYCH-ACTIVE	91
29911	DISINTEGR PSYCH-RESIDUAL	91
29980	CHILD PSYCHOS NEC-ACTIVE	91
29981	CHILD PSYCHOS NEC-RESID	91
29990	CHILD PSYCHOS NOS-ACTIVE	91
29991	CHILD PSYCHOS NOS-RESID	91
30000	ANXIETY STATE NOS	91
30001	PANIC DISORDER	91
30002	GENERALIZED ANXIETY DIS	91
30009	ANXIETY STATE NEC	91
30010	HYSTERIA NOS	91
30011	CONVERSION DISORDER	91
30012	PSYCHOGENIC AMNESIA	91
30013	PSYCHOGENIC FUGUE	91
30014	MULTIPLE PERSONALITY	91
30015	DISSOCIATIVE REACT NOS	91
30016	FACTITIOUS ILL W SYMPTOM	91
30019	FACTITIOUS ILL NEC/NOS	91
30020	PHOBIA NOS	91
30021	AGORAPHOBIA WITH PANIC	91
30022	AGORAPHOBIA W/O PANIC	91
30023	SOCIAL PHOBIA	91
30029	ISOLATED PHOBIAS NEC	91
3003	OBSESSIVE-COMPULSIVE DIS	91
3004	NEUROTIC DEPRESSION	91
3005	NEURASTHENIA	91
3006	DEPERSONALIZATION SYND	91
3007	HYPOCHONDRIASIS	91
30081	SOMATIZATION DISORDER	91
30089	NEUROTIC DISORDERS NEC	91
3009	NEUROTIC DISORDER NOS	91
3010	PARANOID PERSONALITY	91
30110	AFFECTIV PERSONALITY NOS	91
30111	CHRONIC HYPOMANIC PERSON	91
30112	CHR DEPRESSIVE PERSON	91
30113	CYCLOTHYMIC DISORDER	91
30120	SCHIZOID PERSONALITY NOS	91
30121	INTROVERTED PERSONALITY	91
30122	SCHIZOTYPAL PERSONALITY	91
3013	EXPLOSIVE PERSONALITY	91
3014	COMPULSIVE PERSONALITY	91
30150	HISTRIONIC PERSON NOS	91
30151	CHR FACTITIOUS ILLNESS	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
30159	HISTRIONIC PERSON NEC	91
3016	DEPENDENT PERSONALITY	91
3017	ANTISOCIAL PERSONALITY	91
30181	NARCISSISTIC PERSONALITY	91
30182	AVOIDANT PERSONALITY	91
30183	BORDERLINE PERSONALITY	91
30184	PASSIVE-AGGRESSIV PERSON	91
30189	PERSONALITY DISORDER NEC	91
3019	PERSONALITY DISORDER NOS	91
3020	EGO-DYSTONIC HOMOSEXLTY	91
3021	ZOOPHILIA	91
3022	PEDOPHILIA	91
3023	TRANVESTISM	91
3024	EXHIBITIONISM	91
30250	TRANS-SEXUALISM NOS	91
30251	TRANS-SEXUALISM, ASEXUAL	91
30252	TRANS-SEXUAL, HOMOSEXUAL	91
30253	TRANS-SEX, HETEROSEXUAL	91
3026	PSYCHOSEX IDENTITY DIS	91
30270	PSYCHOSEXUAL DYSFUNC NOS	91
30271	INHIBITED SEXUAL DESIRE	91
30272	INHIBITED SEX EXCITEMENT	91
30273	INHIBITED FEMALE ORGASM	91
30274	INHIBITED MALE ORGASM	91
30275	PREMATURE EJACULATION	91
30276	FUNCTIONAL DYSpareunia	91
30279	PSYCHOSEXUAL DYSFUNC NEC	91
30281	FETISHISM	91
30282	VOYEURISM	91
30283	SEXUAL MASOCHISM	91
30284	SEXUAL SADISM	91
30285	GEND IDEN DIS, ADOL/ADULT	91
30289	PSYCHOSEXUAL DIS NEC	91
3029	PSYCHOSEXUAL DIS NOS	91
30300	AC ALCOHOL INTOX-UNSPEC	91
30301	AC ALCOHOL INTOX-CONTIN	91
30302	AC ALCOHOL INTOX-EPIsOD	91
30303	AC ALCOHOL INTOX-REMISS	91
30390	ALCOH DEP NEC/NOS-UNSPEC	91
30391	ALCOH DEP NEC/NOS-CONTIN	91
30392	ALCOH DEP NEC/NOS-EPIsOD	91
30393	ALCOH DEP NEC/NOS-REMISS	91
30400	OPIOID DEPENDENCE-UNSPEC	91
30401	OPIOID DEPENDENCE-CONTIN	91
30402	OPIOID DEPENDENCE-EPIsOD	91
30403	OPIOID DEPENDENCE-REMISS	91
30410	BARBITURAT DEPEND-UNSPEC	91
30411	BARBITURAT DEPEND-CONTIN	91
30412	BARBITURAT DEPEND-EPIsOD	91
30413	BARBITURAT DEPEND-REMISS	91
30420	COCAINE DEPEND-UNSPEC	91
30421	COCAINE DEPEND-CONTIN	91
30422	COCAINE DEPEND-EPIsODIC	91
30423	COCAINE DEPEND-REMISS	91
30430	CANNABIS DEPEND-UNSPEC	91
30431	CANNABIS DEPEND-CONTIN	91
30432	CANNABIS DEPEND-EPIsODIC	91
30433	CANNABIS DEPEND-REMISS	91
30440	AMPHETAMIN DEPEND-UNSPEC	91
30441	AMPHETAMIN DEPEND-CONTIN	91
30442	AMPHETAMIN DEPEND-EPIsOD	91
30443	AMPHETAMIN DEPEND-REMISS	91
30450	HALLUCINOGEN DEP-UNSPEC	91
30451	HALLUCINOGEN DEP-CONTIN	91
30452	HALLUCINOGEN DEP-EPIsOD	91
30453	HALLUCINOGEN DEP-REMISS	91
30460	DRUG DEPEND NEC-UNSPEC	91
30461	DRUG DEPEND NEC-CONTIN	91
30462	DRUG DEPEND NEC-EPIsODIC	91
30463	DRUG DEPEND NEC-IN REM	91
30470	OPIOID/OTHER DEP-UNSPEC	91
30471	OPIOID/OTHER DEP-CONTIN	91
30472	OPIOID/OTHER DEP-EPIsOD	91
30473	OPIOID/OTHER DEP-REMISS	91
30480	COMB DRUG DEP NEC-UNSPEC	91
30481	COMB DRUG DEP NEC-CONTIN	91

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
30482	COMB DRUG DEP NEC-EPISOD	91
30483	COMB DRUG DEP NEC-REMISS	91
30490	DRUG DEPEND NOS-UNSPEC	91
30491	DRUG DEPEND NOS-CONTIN	91
30492	DRUG DEPEND NOS-EPISODIC	91
30493	DRUG DEPEND NOS-REMISS	91
30500	ALCOHOL ABUSE-UNSPEC	91
30501	ALCOHOL ABUSE-CONTINUOUS	91
30502	ALCOHOL ABUSE-EPISODIC	91
30503	ALCOHOL ABUSE-IN REMISS	91
3051	TOBACCO USE DISORDER	11
30510	TOBACCO USE DISORDER	11
30511	TOBACCO USE DISORDER	11
30512	TOBACCO USE DISORDER	11
30513	TOBACCO USE DISORDER	11
30520	CANNABIS ABUSE-UNSPEC	91
30521	CANNABIS ABUSE-CONTIN	91
30522	CANNABIS ABUSE-EPISODIC	91
30523	CANNABIS ABUSE-IN REMISS	91
30530	HALLUCINOGEN ABUSE-UNSPEC	91
30531	HALLUCINOGEN ABUSE-CONTIN	91
30532	HALLUCINOGEN ABUSE-EPISOD	91
30533	HALLUCINOGEN ABUSE-REMISS	91
30540	BARBITURATE ABUSE-UNSPEC	91
30541	BARBITURATE ABUSE-CONTIN	91
30542	BARBITURATE ABUSE-EPISOD	91
30543	BARBITURATE ABUSE-REMISS	91
30550	OPIOID ABUSE-UNSPEC	91
30551	OPIOID ABUSE-CONTINUOUS	91
30552	OPIOID ABUSE-EPISODIC	91
30553	OPIOID ABUSE-IN REMISS	91
30560	COCAINE ABUSE-UNSPEC	91
30561	COCAINE ABUSE-CONTINUOUS	91
30562	COCAINE ABUSE-EPISODIC	91
30563	COCAINE ABUSE-IN REMISS	91
30570	AMPHETAMINE ABUSE-UNSPEC	91
30571	AMPHETAMINE ABUSE-CONTIN	91
30572	AMPHETAMINE ABUSE-EPISOD	91
30573	AMPHETAMINE ABUSE-REMISS	91
30580	ANTIDEPRESS ABUSE-UNSPEC	91
30581	ANTIDEPRESS ABUSE-CONTIN	91
30582	ANTIDEPRESS ABUSE-EPISOD	91
30583	ANTIDEPRESS ABUSE-REMISS	91
30590	DRUG ABUSE NEC-UNSPEC	91
30591	DRUG ABUSE NEC-CONTIN	91
30592	DRUG ABUSE NEC-EPISODIC	91
30593	DRUG ABUSE NEC-IN REMISS	91
3060	PSYCHOGENIC MUSCULOSKELETAL DIS	24
3061	PSYCHOGENIC RESPIRATORY DIS	33
3062	PSYCHOGENIC CARDIOVASCULAR DIS	36
3063	PSYCHOGENIC SKIN DISEASE	18
3064	PSYCHOGENIC GI DISEASE	41
30650	PSYCHOGENIC GU DIS NOS	53
30651	PSYCHOGENIC VAGINISMUS	56
30652	PSYCHOGENIC DYSMENORRHEA	56
30653	PSYCHOGENIC DYSURIA	53
30659	PSYCHOGENIC GU DIS NEC	53
3066	PSYCHOGENIC ENDOCRINE DIS	82
3067	PSYCHOGENIC SENSORY DIS	91
3068	PSYCHOGENIC DISORDER NEC	91
3069	PSYCHOGENIC DISORDER NOS	91
3070	STAMMERING & STUTTERING	91
3071	ANOREXIA NERVOSA	91
30720	TIC DISORDER NOS	63
30721	TRANSIENT TIC, CHILDHOOD	63
30722	CHRONIC MOTOR TIC DIS	63
30723	GILLES DE LA TOURETTE DISORDER	63
3073	STEREOTYPED MOVEMENTS	91
30740	NONORGANIC SLEEP DIS NOS	91
30741	TRANSIENT INSOMNIA	91
30742	PERSISTENT INSOMNIA	91
30743	TRANSIENT HYPERSONNIA	91
30744	PERSISTENT HYPERSONNIA	91
30745	DISRUPT SLEEP-WAKE CYCLE	91
30746	SOMNAMBULISM/NIGHT TERROR	91
30747	SLEEP STAGE DYSFUNCTION NEC	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
30748	REPETIT SLEEP INTRUSION	91
30749	NONORGANIC SLEEP DIS NEC	91
30750	EATING DISORDER NOS	91
30751	BULIMIA	91
30752	PICA	91
30753	PSYCHOGENIC RUMINATION	91
30754	PSYCHOGENIC VOMITING	91
30759	EATING DISORDER NEC	91
3076	ENURESIS	91
3077	ENCOPRESIS	91
30780	PSYCHOGENIC PAIN NOS	91
30781	TENSION HEADACHE	63
30789	PSYCHOGENIC PAIN NEC	91
3079	SPECIAL SYMPTOM NEC/NOS	91
3080	STRESS REACT, EMOTIONAL	91
3081	STRESS REACTION, FUGUE	91
3082	STRESS REACT, PSYCHOMOT	91
3083	ACUTE STRESS REACT NEC	91
3084	STRESS REACT, MIXED DIS	91
3089	ACUTE STRESS REACT NOS	91
3090	BRIEF DEPRESSIVE REACT	91
3091	PROLONG DEPRESSIVE REACT	91
30921	SEPARATION ANXIETY	91
30922	EMANCIPATION DISORDER	91
30923	ACADEMIC/WORK INHIBITION	91
30924	ADJ REACT-ANXIOUS MOOD	91
30928	ADJ REACT-MIXED EMOTION	91
30929	ADJ REACT-EMOTION NEC	91
3093	ADJUST REACT-CONDUCT DIS	91
3094	ADJ REACT-EMOTION/CONDUCT	91
30981	PROLONG POSTTRAUM STRESS	91
30982	ADJUST REACT-PHYS SYMPT	91
30983	ADJUST REACT-WITHDRAWAL	91
30989	ADJUSTMENT REACTION NEC	91
3099	ADJUSTMENT REACTION NOS	91
3100	FRONTAL LOBE SYNDROME	91
3101	ORGANIC PERSONALITY SYND	91
3102	POSTCONCUSSION SYNDROME	63
3108	NONPSYCHOT BRAIN SYN NEC	91
3109	NONPSYCHOT BRAIN SYN NOS	91
311	DEPRESSIVE DISORDER NEC	91
31200	UNSOCIAL AGGRESS-UNSPEC	91
31201	UNSOCIAL AGGRESSION-MILD	91
31202	UNSOCIAL AGGRESSION-MOD	91
31203	UNSOCIAL AGGRESS-SEVERE	91
31210	UNSOCIAL UNAGGRESS-UNSP	91
31211	UNSOCIAL UNAGGRESS-MILD	91
31212	UNSOCIAL UNAGGRESS-MOD	91
31213	UNSOCIAL UNAGGR-SEVERE	91
31220	SOCIAL CONDUCT DIS-UNSP	91
31221	SOCIAL CONDUCT DIS-MILD	91
31222	SOCIAL CONDUCT DIS-MOD	91
31223	SOCIAL CONDUCT DIS-SEV	91
31230	IMPULSE CONTROL DIS NOS	91
31231	PATHOLOGICAL GAMBLING	91
31232	KLEPTOMANIA	91
31233	PYROMANIA	91
31234	INTERMITT EXPLOSIVE DIS	91
31235	ISOLATED EXPLOSIVE DIS	91
31239	IMPULSE CONTROL DIS NEC	91
3124	MIX DIS CONDUCT/EMOTION	91
3128	OTHER CONDUCT DISTURB*	91
31281	CNDCT DSRDR CHLDHND ONST	63
31282	CNDCT DSRDR ADLSCNT ONST	63
31289	OTHER CONDUCT DISORDER	63
3129	CONDUCT DISTURBANCE NOS	91
3130	OVERANXIOUS DISORDER	91
3131	MISERY & UNHAPPINESS DIS	91
31321	SHYNESS DISORDER-CHILD	91
31322	INTROVERTED DIS-CHILD	91
31323	ELECTIVE MUTISM	91
3133	RELATIONSHIP PROBLEMS	91
31381	OPPOSITIONAL DISORDER	91
31382	IDENTITY DISORDER	91
31383	ACADEMIC UNDERACHIEVMENT	91
31389	EMOTIONAL DIS CHILD NEC	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
3139	EMOTIONAL DIS CHILD NOS	91
31400	ATTN DEFIC NONHYPERACT	91
31401	ATTN DEFICIT W HYPERACT	91
3141	HYPERKINET W DEVEL DELAY	91
3142	HYPERKINETIC CONDUCT DIS	91
3148	OTHER HYPERKINETIC SYND	91
3149	HYPERKINETIC SYND NOS	91
31500	READING DISORDER NOS	91
31501	ALEXIA	91
31502	DEVELOPMENTAL DYSLEXIA	91
31509	READING DISORDER NEC	91
3151	ARITHMETICAL DISORDER	91
3152	OTH LEARNING DIFFICULTY	91
31531	DEVELOPMENT LANGUAGE DIS	91
31539	SPEECH/LANGUAGE DIS NEC	91
3154	COORDINATION DISORDER	91
3155	MIXED DEVELOPMENT DIS	91
3158	DEVELOPMENT DELAYS NEC	91
3159	DEVELOPMENT DELAY NOS	91
316	PSYCHIC FACTOR W OTH DIS	91
317	MILD MENTAL RETARDATION	91
3180	MOD MENTAL RETARDATION	91
3181	SEVERE MENTAL RETARDAT	91
3182	PROFOUND MENTAL RETARDAT	91
319	MENTAL RETARDATION NOS	91
3200	HEMOPHILUS MENINGITIS	63
3201	PNEUMOCOCCAL MENINGITIS	63
3202	STREPTOCOCCAL MENINGITIS	63
3203	STAPHYLOCOCC MENINGITIS	63
3207	MENING IN OTH BACT DIS	63
3208	BACTERIAL MENINGITIS NEC*	63
32081	ANAEROBIC MENINGITIS	63
32082	MNINGITS GRAM-NEG BCT NEC	63
32089	MENINGITIS OTH SPCF BACT	63
3209	BACTERIAL MENINGITIS NOS	63
3210	CRYPTOCOCCAL MENINGITIS	63
3211	MENING IN OTH FUNGAL DIS	63
3212	MENING IN OTH VIRAL DIS	63
3213	TRYPANOSOMIASIS MENINGIT	63
3214	MENINGIT D/T SARCOIDOSIS	63
3218	MENING IN OTH NONBAC DIS	63
3220	NONPYOGENIC MENINGITIS	63
3221	EOSINOPHILIC MENINGITIS	63
3222	CHRONIC MENINGITIS	63
3229	MENINGITIS NOS	63
3230	ENCEPHALIT IN VIRAL DIS	63
3231	RICKETTSIAL ENCEPHALITIS	63
3232	PROTOZOAL ENCEPHALITIS	63
3234	OTH ENCEPHALIT D/T INFEC	63
3235	POSTIMMUNIZAT ENCEPHALIT	63
3236	POSTINFECT ENCEPHALITIS	63
3237	TOXIC ENCEPHALITIS	63
3238	ENCEPHALITIS NEC	63
3239	ENCEPHALITIS NOS	63
3240	INTRACRANIAL ABSCESS	63
3241	INTRASPINAL ABSCESS	63
3249	CNS ABSCESS NOS	63
325	PHLEBITIS INTRCRAN SINUS	63
326	LATE EFF CNS ABSCESS	63
3300	LEUKODYSTROPHY	63
3301	CEREBRAL LIPIDOSES	63
3302	CEREB DEGEN IN LIPIDOSIS	63
3303	CEREB DEG CHLD IN OTH DIS	63
3308	CEREB DEGEN IN CHILD NEC	63
3309	CEREB DEGEN IN CHILD NOS	63
3310	ALZHEIMER'S DISEASE	91
3311	PICK'S DISEASE	91
3312	SENILE DEGENERAT BRAIN	91
3313	COMMUNICAT HYDROCEPHALUS	63
3314	OBSTRUCTIV HYDROCEPHALUS	63
3317	CEREB DEGEN IN OTH DIS	63
33181	REYE'S SYNDROME	63
33189	CEREB DEGENERATION NEC	63
3319	CEREB DEGENERATION NOS	63
3320	PARALYSIS AGITANS	63
3321	SECONDARY PARKINSONISM	63

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
3330	DEGEN BASAL GANGLIA NEC	63
3331	TREMOR NEC	63
3332	MYOCLONUS	63
3333	TICS OF ORGANIC ORIGIN	63
3334	HUNTINGTON'S CHOREA	63
3335	CHOREA NEC	63
3336	IDIOPAT TORSION DYSTONIA	63
3337	SYMPTOM TORSION DYSTONIA	63
33381	BLEPHAROSPASM	68
33382	OROFACIAL DYSKINESIA	63
33383	SPASMODIC TORTICOLLIS	63
33384	ORGANIC WRITERS' CRAMP	63
33389	FRAGM TORSION DYSTON NEC	63
33390	EXTRAPYRAMIDAL DIS NOS	63
33391	STIFF-MAN SYNDROME	63
33392	NEUROLEPTIC MALGNT SYND	63
33393	BNIGN SHUDDERING ATTACKS	63
33399	EXTRAPYRAMIDAL DIS NEC	63
3340	FRIEDREICH'S ATAXIA	63
3341	HERED SPASTIC PARAPLEGIA	63
3342	PRIMARY CEREBELLAR DEGEN	63
3343	CEREBELLAR ATAXIA NEC	63
3344	CEREBEL ATAX IN OTH DIS	63
3348	SPINOCEREBELLAR DIS NEC	63
3349	SPINOCEREBELLAR DIS NOS	63
3350	WERDNIG-HOFFMANN DISEASE	63
33510	SPINAL MUSCL ATROPHY NOS	63
33511	KUGELBERG-WELANDER DIS	63
33519	SPINAL MUSCL ATROPHY NEC	63
33520	AMYOTROPHIC SCLEROSIS	63
33521	PROG MUSCULAR ATROPHY	63
33522	PROGRESSIVE BULBAR PALSY	63
33523	PSEUDOBULBAR PALSY	63
33524	PRIM LATERAL SCLEROSIS	63
33529	MOTOR NEURON DISEASE NEC	63
3358	ANT HORN CELL DIS NEC	63
3359	ANT HORN CELL DIS NOS	63
3360	SYRINGOMYELIA	63
3361	VASCULAR MYELOPATHIES	63
3362	COMB DEG CORD IN OTH DIS	63
3363	MYELOPATHY IN OTH DIS	63
3368	MYELOPATHY NEC	63
3369	SPINAL CORD DISEASE NOS	63
3370	IDIOPATH AUTO NEUROPATHY	63
3371	AUT NEUROPTHY IN OTH DIS	63
33720	UNSP RFLX SYMPTH DYSTRPH	63
33721	RFLX SYM DYSTRPH UP LIMB	63
33722	RFLX SYM DYSTRPH LWR LMB	63
33729	RFLX SYM DYSTRPH OTH ST	63
3379	AUTONOMIC NERVE DIS NEC	63
340	MULTIPLE SCLEROSIS	63
3410	NEUROMYELITIS OPTICA	63
3411	SCHILDERS' DISEASE	63
3418	CNS DEMYELINATION NEC	63
3419	CNS DEMYELINATION NOS	63
3420	FLACCID HEMIPLEGIA*	63
34200	FLCCD HMIPLGA UNSPF SIDE	63
34201	FLCCD HMIPLGA DOMNT SIDE	63
34202	FLCCD HMIPLG NONDMNT SDE	63
3421	SPASTIC HEMIPLEGIA*	63
34210	SPSTC HMIPLGA UNSPF SIDE	63
34211	SPSTC HMIPLGA DOMNT SIDE	63
34212	SPSTC HMIPLG NONDMNT SDE	63
34280	OT SP HMIPLGA UNSPF SIDE	63
34281	OT SP HMIPLGA DOMNT SIDE	63
34282	OT SP HMIPLG NONDMNT SDE	63
3429	HEMIPLEGIA NOS*	63
34290	UNSP HEMIPLGA UNSPF SIDE	63
34291	UNSP HEMIPLGA DOMNT SIDE	63
34292	UNSP HMIPLGA NONDMNT SDE	63
3430	CONGENITAL DIPLEGIA	63
3431	CONGENITAL HEMIPLEGIA	63
3432	CONGENITAL QUADRIPEGIA	63
3433	CONGENITAL MONOPEGIA	63
3434	INFANTILE HEMIPLEGIA	63
3438	CEREBRAL PALSY NEC	63

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
3439	CEREBRAL PALSY NOS	63
3440	QUADRIPLEGIA NOS*	63
34400	QUADRIPLEGIA, UNSPECIFD	63
34401	QUADRPLG C1-C4, COMPLETE	63
34402	QUADRPLG C1-C4, INCOMPLT	63
34403	QUADRPLG C5-C7, COMPLETE	63
34404	QUADRPLG C5-C7, INCOMPLT	63
34409	OTHER QUADRIPLEGIA	63
3441	PARAPLEGIA NOS	63
3442	DIPLEGIA OF UPPER LIMBS	63
3443	MONOPLÉGIA OF LOWER LIMB*	63
34430	MONPLGA LWR LMB UNSP SDE	63
34431	MONPLGA LWR LMB DMNT SDE	63
34432	MNPLG LWR LMB NONDMNT SD	63
3444	MONOPLÉGIA OF UPPER LIMB*	63
34440	MONPLGA UPR LMB UNSP SDE	63
34441	MONPLGA UPR LMB DMNT SDE	63
34442	MNPLG UPR LMB NONDMNT SD	63
3445	MONOPLÉGIA NOS	63
34460	CAUDA EQUINA SYND NOS	63
34461	NEUROGENIC BLADDER	53
3448	PARALYTIC SYNDROMES NEC*	63
34481	LOCKED-IN STATE	78
34489	OTH SPCF PARALYTIC SYND	63
3449	PARALYSIS NOS	63
34500	GEN NONCV EP W/O INTR EP	63
34501	GEN NONCONV EP W INTR EP	63
34510	GEN CNV EPIL W/O INTR EP	63
34511	GEN CNV EPIL W INTR EPIL	63
3452	PETIT MAL STATUS	78
3453	GRAND MAL STATUS	78
34540	PSYMOTR EPIL W/O INT EPI	63
34541	PSYMOTR EPIL W INTR EPIL	63
34550	PART EPIL W/O INTR EPIL	63
34551	PART EPIL W INTR EPIL	63
34560	INF SPASM W/O INTR EPIL	63
34561	INF SPASM W INTRACT EPIL	63
34570	EPIL PAR CONT W/O INT EP	63
34571	EPIL PAR CONT W INTR EPI	63
34580	EPILEP NEC W/O INTR EPIL	63
34581	EPILEPSY NEC W INTR EPIL	63
34590	EPILEP NOS W/O INTR EPIL	63
34591	EPILEPSY NOS W INTR EPIL	63
3460	CLASSICAL MIGRAINE*	63
34600	CLSC MIGRNE WO NTRC MGRN	63
34601	CLSC MGRN W NTRC MGR STD	63
3461	COMMON MIGRAINE*	63
34610	COMN MIGRNE WO NTRC MGRN	63
34611	COMN MGRN W NTRC MGR STD	63
3462	VARIANTS OF MIGRAINE*	63
34620	VRNT MIGRNE WO NTRC MGRN	63
34621	VRNT MGRN W NTRC MGR STD	63
3468	MIGRAINE NEC*	63
34680	OTHR MIGRNE WO NTRC MGRN	63
34681	OTHR MGRN W NTRC MGR STD	63
3469	MIGRAINE NOS*	63
34690	MIGRNE UNSP WO NTRC MGRN	63
34691	MGRN UNSP W NTRC MGR STD	63
347	CATAPLEXY AND NARCOLEPSY	63
3480	CEREBRAL CYSTS	63
3481	ANOXIC BRAIN DAMAGE	63
3482	PSEUDOTUMOR CEREBRI	63
3483	ENCEPHALOPATHY NOS	63
3484	COMPRESSION OF BRAIN	63
3485	CEREBRAL EDEMA	63
3488	BRAIN CONDITIONS NEC	63
3489	BRAIN CONDITION NOS	63
3490	LUMBAR PUNCTURE REACTION	63
3491	COMPLICATION CNS DEVICE	63
3492	DISORDER OF MENINGES NEC	63
34981	CEREBROSPINAL RHINORRHEA	63
34982	TOXIC ENCEPHALOPATHY	63
34989	CNS DISORDER NEC	63
3499	CNS DISORDER NOS	63
3501	TRIGEMINAL NEURALGIA	63
3502	ATYPICAL FACE PAIN	63

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
3508	TRIGEMINAL NERVE DIS NEC	63
3509	TRIGEMINAL NERVE DIS NOS	63
3510	BELL'S PALSY	63
3511	GENICULATE GANGLIONITIS	63
3518	FACIAL NERVE DIS NEC	63
3519	FACIAL NERVE DIS NOS	63
3520	OLFACTORY NERVE DISORDER	63
3521	GLOSSOPHARYNG NEURALGIA	63
3522	GLOSSOPHAR NERVE DIS NEC	63
3523	PNEUMOGASTRIC NERVE DIS	63
3524	ACCESSORY NERVE DISORDER	63
3525	HYPOGLOSSAL NERVE DIS	63
3526	MULT CRANIAL NERVE PALSY	63
3529	CRANIAL NERVE DIS NOS	63
3530	BRACHIAL PLEXUS LESIONS	63
3531	LUMBOSACRAL PLEX LESION	63
3532	CERVICAL ROOT LESION NEC	63
3533	THORACIC ROOT LESION NEC	63
3534	LUMBSACRAL ROOT LES NEC	63
3535	NEURALGIC AMYOTROPHY	63
3536	PHANTOM LIMB (SYNDROME)	63
3538	NERV ROOT/PLEXUS DIS NEC	63
3539	NERV ROOT/PLEXUS DIS NOS	63
3540	CARPAL TUNNEL SYNDROME	63
3541	MEDIAN NERVE LESION NEC	63
3542	ULNAR NERVE LESION	63
3543	RADIAL NERVE LESION	63
3544	CAUSALGIA UPPER LIMB	63
3545	MONONEURITIS MULTIPLEX	63
3548	MONONEURITIS ARM NEC	63
3549	MONONEURITIS ARM NOS	63
3550	SCIATIC NERVE LESION	63
3551	MERALGIA PARESTHETICA	63
3552	FEMORAL NERVE LESION NEC	63
3553	LAT POPLITEAL NERVE LES	63
3554	MED POPLITEAL NERVE LES	63
3555	TARSAL TUNNEL SYNDROME	63
3556	PLANTAR NERVE LESION	63
3557	MONONEURITIS LEG NEC*	63
35571	CAUSALGIA LOWER LIMB	63
35579	OTH MONONEUR LOWER LIMB	63
3558	MONONEURITIS LEG NOS	63
3559	MONONEURITIS NOS	63
3560	HERED PERIPH NEUROPATHY	63
3561	PERONEAL MUSCLE ATROPHY	63
3562	HERED SENSORY NEUROPATHY	63
3563	REFSUM'S DISEASE	63
3564	IDIO PROG POLYNEUROPATHY	63
3568	IDIO PERIPH NEURPTHY NEC	63
3569	IDIO PERIPH NEURPTHY NOS	63
3570	AC INFECT POLYNEURITIS	63
3571	NEURPTHY IN COL VASC DIS	63
3572	NEUROPATHY IN DIABETES	63
3573	NEUROPATHY IN MALIG DIS	63
3574	NEUROPATHY IN OTHER DIS	63
3575	ALCOHOLIC POLYNEUROPATHY	63
3576	NEUROPATHY DUE TO DRUGS	63
3577	NEURPTHY TOXIC AGENT NEC	63
3578	INFLAM/TOX NEUROPTHY NEC	63
3579	INFLAM/TOX NEUROPTHY NOS	63
3580	MYASTHENIA GRAVIS	63
3581	MYASTHENIA IN OTH DIS	63
3582	TOXIC MYONEURAL DISORDER	63
3588	MYONEURAL DISORDERS NEC	63
3589	MYONEURAL DISORDERS NOS	63
3590	CONG HERED MUSC DYSTRPHY	63
3591	HERED PROG MUSC DYSTRPHY	63
3592	MYOTONIC DISORDERS	63
3593	FAMIL PERIODIC PARALYSIS	63
3594	TOXIC MYOPATHY	63
3595	MYOPATHY IN ENDOCRIN DIS	63
3596	INFL MYOPATHY IN OTH DIS	63
3598	MYOPATHY NEC	63
3599	MYOPATHY NOS	63
36000	PURULENT ENDOPHTHALM NOS	68
36001	ACUTE ENDOPHTHALMITIS	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
36002	PANOPHTHALMITIS	68
36003	CHRONIC ENDOPHTHALMITIS	68
36004	VITREOUS ABSCESS	68
36011	SYMPATHETIC UVEITIS	68
36012	PANUVEITIS	68
36013	PARASITIC ENDOPHTHAL NOS	68
36014	OPHTHALMIA NODOSA	68
36019	ENDOPHTHALMITIS NEC	68
36020	DEGENERAT GLOBE DIS NOS	68
36021	PROGRESSIVE HIGH MYOPIA	68
36023	SIDEROSIS	68
36024	OTHER METALLOSIS, EYE	68
36029	DEGENERATIVE GLOBE NEC	68
36030	HYPOTONY NOS, EYE	68
36031	PRIMARY HYPOTONY	68
36032	HYPOTONY DUE TO FISTULA	68
36033	HYPOTONY W EYE DIS NEC	68
36034	FLAT ANTERIOR CHAMBER	68
36040	DEGENERATION OF EYE NOS	68
36041	BLIND HYPOTENSIVE EYE	68
36042	BLIND HYPERTENSIVE EYE	68
36043	HEMOPHTHALMOS	68
36044	LEUCOCORIA	68
36050	OLD MAGNET FB, EYE NOS	68
36051	OLD MAGNET FB, ANT CHAMB	68
36052	OLD MAGNET FB, IRIS	68
36053	OLD MAGNET FB, LENS	68
36054	OLD MAGNET FB, VITREOUS	68
36055	OLD MAGNET FB, POST WALL	68
36059	OLD MAGNET FB, EYE NEC	68
36060	INTRAOCULAR FB NOS	68
36061	FB IN ANTERIOR CHAMBER	68
36062	FB IN IRIS OR CILIARY	68
36063	FOREIGN BODY IN LENS	68
36064	FOREIGN BODY IN VITREOUS	68
36065	FB IN POSTERIOR WALL	68
36069	INTRAOCULAR FB NEC	68
36081	LUXATION OF GLOBE	68
36089	DISORDER OF GLOBE NEC	68
3609	DISORDER OF GLOBE NOS	68
36100	DETACHMNT W DEFECT NOS	68
36101	PART DETACH-SINGL DEFEC	68
36102	PART DETACH-MULT DEFECT	68
36103	PART DETACH-GIANT TEAR	68
36104	PART DETACH-DIALYSIS	68
36105	RECENT DETACHMENT, TOTAL	68
36106	OLD DETACHMENT, PARTIAL	68
36107	OLD DETACHMENT, TOTAL	68
36110	RETINOSCHISIS NOS	68
36111	FLAT RETINOSCHISIS	68
36112	BULLOUS RETINOSCHISIS	68
36113	PRIMARY RETINAL CYSTS	68
36114	SECONDARY RETINAL CYSTS	68
36119	RETINOSHISIS OR CYST NEC	68
3612	SEROUS RETINA DETACHMENT	68
36130	RETINAL DEFECT NOS	68
36131	ROUND HOLE OF RETINA	68
36132	HORSESHOE TEAR OF RETINA	68
36133	MULT DEFECTS OF RETINA	68
36181	RETINAL TRACTION DETACH	68
36189	RETINAL DETACHMENT NEC	68
3619	RETINAL DETACHMENT NOS	68
36201	DIABETIC RETINOPATHY NOS	68
36202	PROLIF DIAB RETINOPATHY	68
36210	BACKGRND RETINOPATHY NOS	68
36211	HYPERTENSIVE RETINOPATHY	68
36212	EXUDATIVE RETINOPATHY	68
36213	RETINAL VASCULAR CHANGES	68
36214	RETINA MICROANEURYSM NOS	68
36215	RETINAL TELANGIECTASIA	68
36216	RETINAL NEOVASCULAR NOS	68
36217	RETINAL VARICES	68
36218	RETINAL VASCULITIS	68
36221	RETROLENTAL FIBROPLASIA	68
36229	PROLIF RETINOPATHY NEC	68
36230	RETINAL VASC OCCLUS NOS	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
36231	CENT RETINA ARTERY OCCLU	68
36232	ARTERIAL BRANCH OCCLUS	68
36233	PART ARTERIAL OCCLUSION	68
36234	TRANSIENT ARTERIAL OCCLU	68
36235	CENT RETINAL VEIN OCCLUS	68
36236	VENOUS TRIBUTARY OCCLUS	68
36237	RETINA VENOUS ENGORGEMNT	68
36240	RETINA LAYER SEPARAT NOS	68
36241	CENT SEROUS RETINOPATHY	68
36242	SEROUS DETACH PIGM EPITH	68
36243	HEM DETACH PIGMNT EPITH	68
36250	MACULAR DEGENERATION NOS	68
36251	NONEXUDAT MACULAR DEGEN	68
36252	EXUDATIVE MACULAR DEGEN	68
36253	CYSTOID MACULAR DEGEN	68
36254	MACULAR CYST OR HOLE	68
36255	TOXIC MACULOPATHY	68
36256	MACULAR PUCKERING	68
36257	DRUSEN (DEGENERATIVE)	68
36260	PERIPH RETINA DEGEN NOS	68
36261	PAVING STONE DEGENERAT	68
36262	MICROCYSTOID DEGENERAT	68
36263	LATTICE DEGENERATION	68
36264	SENILE RETICULAR DEGEN	68
36265	SECONDARY PIGMENT DEGEN	68
36266	SEC VITREORETINA DEGEN	68
36270	HERED RETIN DYSTRPHY NOS	68
36271	RET DYSTRPH IN LIPIDOSES	68
36272	RET DYSTRPH IN SYST DIS	68
36273	VITREORETINAL DYSTROPHY	68
36274	PIGMENT RETINA DYSTROPHY	68
36275	SENSORY RETINA DYSTROPHY	68
36276	VITELLIFORM DYSTROPHY	68
36277	BRUCH MEMBRANE DYSTROPHY	68
36281	RETINAL HEMORRHAGE	68
36282	RETINA EXUDATES/DEPOSITS	68
36283	RETINAL EDEMA	68
36284	RETINAL ISCHEMIA	68
36285	RETINAL NERV FIBER DEFEC	68
36289	RETINAL DISORDERS NEC	68
3629	RETINAL DISORDER NOS	68
36300	FOCAL CHORIORETINIT NOS	68
36301	JUXTAPAP FOC CHOROIDITIS	68
36303	FOC CHOROIDITIS POST NEC	68
36304	PERIPH FOCAL CHOROIDITIS	68
36305	JUXTAPAP FOCAL RETINITIS	68
36306	MACULAR FOCAL RETINITIS	68
36307	FOC RETINITIS POST NEC	68
36308	PERIPH FOCAL RETINITIS	68
36310	DISSEM CHORIORETINIT NOS	68
36311	DISSEM CHOROIDITIS, POST	68
36312	PERIPH DISEM CHOROIDITIS	68
36313	GEN DISSEM CHOROIDITIS	68
36314	METASTAT DISSEM RETINIT	68
36315	PIGMENT EPITHELIOPATHY	68
36320	CHORIORETINITIS NOS	68
36321	PARS PLANITIS	68
36322	HARADA'S DISEASE	68
36330	CHORIORETINAL SCAR NOS	68
36331	SOLAR RETINOPATHY	68
36332	MACULAR SCARS NEC	68
36333	POSTERIOR POLE SCAR NEC	68
36334	PERIPHERAL RETINAL SCARS	68
36335	DISSEMINATED RETINA SCAR	68
36340	CHOROIDAL DEGEN NOS	68
36341	SENILE ATROPHY, CHOROID	68
36342	DIFUS SEC ATROPH CHOROID	68
36343	ANGIOID STREAKS, CHOROID	68
36350	HERED CHOROID ATROPH NOS	68
36351	PRT CIRCMPAP CHOROID DYS	68
36352	TOT CIRCMPAP CHOROID DYS	68
36353	PART CENT CHOROID DYSTR	68
36354	TOT CENT CHOROID ATROPHY	68
36355	CHOROIDEREMIA	68
36356	PRT GEN CHOROID DYST NEC	68
36357	TOT GEN CHOROID DYST NEC	68

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
36361	CHOROIDAL HEMORRHAGE NOS	68
36362	EXPULSIVE CHOROID HEMORR	68
36363	CHOROIDAL RUPTURE	68
36370	CHOROIDAL DETACHMENT NOS	68
36371	SEROUS CHOROID DETACHMNT	68
36372	HEMORR CHOROID DETACHMNT	68
3638	DISORDERS OF CHOROID NEC	68
3639	CHOROIDAL DISORDER NOS	68
36400	ACUTE IRIDOCYCLITIS NOS	68
36401	PRIMARY IRIDOCYCLITIS	68
36402	RECURRENT IRIDOCYCLITIS	68
36403	SECONDARY IRITIS, INFECT	68
36404	SECOND IRITIS, NONINFEC	68
36405	HYPOPYON	68
36410	CHR IRIDOCYCLITIS NOS	68
36411	CHR IRIDOCYL IN OTH DIS	68
36421	FUCH HETROCHROM CYCLITIS	68
36422	GLAUCOMATOCYCLIT CRISES	68
36423	LENS-INDUCED IRIDOCYCLIT	68
36424	VOGT-KOYANAGI SYNDROME	68
3643	IRIDOCYCLITIS NOS	68
36441	HYPHEMA	68
36442	RUBEOSIS IRIDIS	68
36451	PROGRESSIVE IRIS ATROPHY	68
36452	IRIDOSCHISIS	68
36453	PIGMENT IRIS DEGENERAT	68
36454	PUPILLARY MARGIN DEGEN	68
36455	MIOTIC CYST PUPIL MARGIN	68
36456	DEGEN CHAMBER ANGLE	68
36457	DEGEN CILIARY BODY	68
36459	IRIS ATROPHY NEC	68
36460	IDIOPATHIC CYSTS	68
36461	IMPLANTATION CYSTS	68
36462	EXUD CYST IRIS/ANT CHAMB	68
36463	PRIMARY CYST PARS PLANA	68
36464	EXUDAT CYST PARS PLANA	68
36470	ADHESIONS OF IRIS NOS	68
36471	POSTERIOR SYNECHIAE	68
36472	ANTERIOR SYNECHIAE	68
36473	GONIOSYNECHIAE	68
36474	PUPILLARY MEMBRANES	68
36475	PUPILLARY ABNORMALITIES	68
36476	IRIDODIALYSIS	68
36477	RECESSION, CHAMBER ANGLE	68
3648	IRIS/CILIARY DIS NEC	68
3649	IRIS/CILIARY DIS NOS	68
36500	PREGLAUCOMA NOS	68
36501	OPN ANGL W BORDERLN FIND	68
36502	ANATOMICAL NARROW ANGLE	68
36503	STEROID RESPONDERS	68
36504	OCULAR HYPERTENSION	68
36510	OPEN-ANGLE GLAUCOMA NOS	68
36511	PRIM OPEN ANGLE GLAUCOMA	68
36512	LOW TENSION GLAUCOMA	68
36513	PIGMENTARY GLAUCOMA	68
36514	GLAUCOMA OF CHILDHOOD	68
36515	RESIDUAL OPN ANG GLAUCMA	68
36520	PRIM ANGL-CLOS GLAUC NOS	68
36521	INTERMIT ANGL-CLOS GLAUC	68
36522	ACUTE ANGL-CLOS GLAUCOMA	68
36523	CHR ANGLE-CLOS GLAUCOMA	68
36524	RESIDUAL ANGL-CLOS GLAUC	68
36531	GLAUC STAGE-STER INDUCED	68
36532	GLAUC RESID-STER INDUCED	68
36541	GLAUC W CHAMB ANGLE ANOM	68
36542	GLAUCOMA W IRIS ANOMALY	68
36543	GLAUC W ANT SEG ANOM NEC	68
36544	GLAUCOMA W SYSTEMIC SYND	68
36551	PHACOLYTIC GLAUCOMA	68
36552	PSEUDOEXFOLIAT GLAUCOMA	68
36559	GLAUCOMA W LENS DIS NEC	68
36560	GLAUC W OCULAR DIS NOS	68
36561	GLAUC W PUPILLARY BLOCK	68
36562	GLAUCOMA W OCULAR INFLAM	68
36563	GLAUCOMA W VASCULAR DIS	68
36564	GLAUCOMA W TUMOR OR CYST	68

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
36565	GLAUCOMA W OCULAR TRAUMA	68
36581	HYPERSECRETION GLAUCOMA	68
36582	GLAUC W INC EPISCL PRESS	68
36589	GLAUCOMA NEC	68
3659	GLAUCOMA NOS	68
36600	NONSENILE CATARACT NOS	68
36601	ANT SUBCAPS POL CATARACT	68
36602	POST SUBCAPS POL CATARCT	68
36603	CORTICAL CATARACT	68
36604	NUCLEAR CATARACT	68
36609	NONSENILE CATARACT NEC	68
36610	SENILE CATARACT NOS	68
36611	PSEUDOEXFOL LENS CAPSULE	68
36612	INCIPIENT CATARACT	68
36613	ANT SUBCAPS SENILE CATAR	68
36614	POST SUBCAP SENILE CATAR	68
36615	CORTICAL SENILE CATARACT	68
36616	SENILE NUCLEAR CATARACT	68
36617	MATURE CATARACT	68
36618	HYPERMATURE CATARACT	68
36619	SENILE CATARACT NEC	68
36620	TRAUMATIC CATARACT NOS	68
36621	LOCAL TRAUMATIC OPACITY	68
36622	TOTAL TRAUMATIC CATARACT	68
36623	PART RESOLV TRAUM CATAR	68
36630	CATARACTA COMPLICATA NOS	68
36631	GLAUCOMATOUS FLECKS	68
36632	CATARACT IN INFLAM DIS	68
36633	CATARACT W NEOVASCULIZAT	68
36634	CATARACT IN DEGEN DIS	68
36641	DIABETIC CATARACT	68
36642	TETANIC CATARACT	68
36643	MYOTONIC CATARACT	68
36644	CATARACT W SYNDROME NEC	68
36645	TOXIC CATARACT	68
36646	CATARACT W RADIATION	68
36650	AFTER-CATARACT NOS	68
36651	SOEMMERING'S RING	68
36652	AFTER-CATARACT NEC	68
36653	AFTR-CATAR OBSCUR VISION	68
3668	CATARACT NEC	68
3669	CATARACT NOS	68
3670	HYPERMETROPIA	68
3671	MYOPIA	68
36720	ASTIGMATISM NOS	68
36721	REGULAR ASTIGMATISM	68
36722	IRREGULAR ASTIGMATISM	68
36731	ANISOMETROPIA	68
36732	ANISEIKONIA	68
3674	PRESBYOPIA	68
36751	PARESIS OF ACCOMMODATION	68
36752	TOT INTERN OPHTHALMOPLLEG	68
36753	SPASM OF ACCOMMODATION	68
36781	TRANSIENT REFRACT CHANGE	68
36789	REFRACTION DISORDER NEC	68
3679	REFRACTION DISORDER NOS	68
36800	AMBLYOPIA NOS	68
36801	STRABISMIC AMBLYOPIA	68
36802	DEPRIVATION AMBLYOPIA	68
36803	REFRACTIVE AMBLYOPIA	68
36810	SUBJ VISUAL DISTURB NOS	68
36811	SUDDEN VISUAL LOSS	68
36812	TRANSIENT VISUAL LOSS	68
36813	VISUAL DISCOMFORT	68
36814	DISTORTION OF SHAPE/SIZE	68
36815	VISUAL DISTORTIONS NEC	68
36816	PSYCHOPHYSIC VISUAL DIST	68
3682	DIPLOPIA	68
36830	BINOCULAR VISION DIS NOS	68
36831	BINOCULAR VIS SUPPRESS	68
36832	VISUAL PERCEPT W/O FUSN	68
36833	FUSION W DEF STEREOPSIS	68
36834	ABN RETINA CORRESPOND	68
36840	VISUAL FIELD DEFECT NOS	68
36841	CENTRAL SCOTOMA	68
36842	SCOTOMA OF BLIND SPOT	68

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
36843	SECTOR OR ARCUATE DEFECT	68
36844	VISUAL FIELD DEFECT NEC	68
36845	GEN VISUAL CONTRACTION	68
36846	HOMONYMOUS HEMIANOPSIA	68
36847	HETERONYMOUS HEMIANOPSIA	68
36851	PROTAN DEFECT	68
36852	DEUTAN DEFECT	68
36853	TRITAN DEFECT	68
36854	ACHROMATOPSIA	68
36855	ACQ COLOR DEFICIENCY	68
36859	COLOR DEFICIENCY NEC	68
36860	NIGHT BLINDNESS NOS	68
36861	CONGEN NIGHT BLINDNESS	68
36862	ACQUIRED NIGHT BLINDNESS	68
36863	ABN DARK ADAPTAT CURVE	68
36869	NIGHT BLINDNESS NEC	68
3688	VISUAL DISTURBANCES NEC	68
3689	VISUAL DISTURBANCE NOS	68
36900	BOTH EYES BLIND-WHO DEF	68
36901	TOT IMPAIRMENT-BOTH EYES	68
36902	ONE EYE-NEAR TOT/OTH-NOS	68
36903	ONE EYE-NEAR TOT/OTH-TOT	68
36904	NEAR-TOT IMPAIR-BOTH EYE	68
36905	ONE EYE-PROFOUND/OTH-NOS	68
36906	ONE EYE-PROFOUND/OTH-TOT	68
36907	ONE EYE-PRFND/OTH-NR TOT	68
36908	PROFOUND IMPAIR BOTH EYE	68
36910	BLINDNESS/LOW VISION	68
36911	1 EYE-SEV/OTH-BLIND NOS	68
36912	ONE EYE-SEVERE/OTH-TOTAL	68
36913	ONE EYE-SEV/OTH-NEAR TOT	68
36914	ONE EYE-SEV/OTH-PRFND	68
36915	ONE EYE-MOD/OTH-BLIND	68
36916	ONE EYE-MODERATE/OTH-TOT	68
36917	ONE EYE-MOD/OTH-NEAR TOT	68
36918	ONE EYE-MOD/OTH-PROFOUND	68
36920	LOW VISION, 2 EYES NOS	68
36921	ONE EYE-SEVERE/OTH-NOS	68
36922	SEVERE IMPAIR-BOTH EYES	68
36923	ONE EYE-MODERATE/OTH-NOS	68
36924	ONE EYE-MODERATE/OTH-SEV	68
36925	MODERATE IMPAIR-BOTH EYE	68
3693	BLINDNESS NOS, BOTH EYES	68
3694	LEGAL BLINDNESS-USA DEF	68
36960	BLINDNESS, ONE EYE	68
36961	ONE EYE-TOTAL/OTH-UNKNWN	68
36962	ONE EYE-TOT/OTH-NEAR NOR	68
36963	ONE EYE-TOTAL/OTH-NORMAL	68
36964	ONE EYE-NEAR TOT/OTH-NOS	68
36965	NEAR-TOT IMP/NEAR-NORMAL	68
36966	NEAR-TOTAL IMPAIR/NORMAL	68
36967	ONE EYE-PRFOUND/OTH-UNKN	68
36968	PROFND IMPAIR/NEAR NORM	68
36969	PROFOUND IMPAIR/NORMAL	68
36970	LOW VISION, ONE EYE	68
36971	ONE EYE-SEVERE/OTH-UNKNW	68
36972	ONE EYE-SEV/OTH-NR NORM	68
36973	ONE EYE-SEVERE/OTH-NORM	68
36974	ONE EYE-MOD/OTHER-UNKNWN	68
36975	ONE EYE-MOD/OTH-NR NORM	68
36976	ONE EYE-MOD/OTH NORMAL	68
3698	VISUAL LOSS, ONE EYE NOS	68
3699	VISUAL LOSS NOS	68
37000	CORNEAL ULCER NOS	68
37001	MARGINAL CORNEAL ULCER	68
37002	RING CORNEAL ULCER	68
37003	CENTRAL CORNEAL ULCER	68
37004	HYPOPYON ULCER	68
37005	MYCOTIC CORNEAL ULCER	68
37006	PERFORATED CORNEAL ULCER	68
37007	MOOREN'S ULCER	68
37020	SUPERFIC KERATITIS NOS	68
37021	PUNCTATE KERATITIS	68
37022	MACULAR KERATITIS	68
37023	FILAMENTARY KERATITIS	68
37024	PHOTOKERATITIS	68

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
37031	PHLYCTEN KERATOCONJUNCT	68
37032	LIMBAR KERATOCONJUNCTIV	68
37033	KERATOCONJUNCTIVIT SICCA	68
37034	EXPSURE KERATOCONJUNCTIV	68
37035	NEUROTROPH KERATOCONJUNC	68
37040	KERATOCONJUNCTIVITIS NOS	68
37044	KERATITIS IN EXANTHEMA	68
37049	KERATOCONJUNCTIVITIS NEC	68
37050	INTERSTIT KERATITIS NOS	68
37052	DIFFUS INTERSTIT KERATIT	68
37054	SCLEROSING KERATITIS	68
37055	CORNEAL ABSCESS	68
37059	INTERSTIT KERATITIS NEC	68
37060	CORNEA NEOVASCULARIZ NOS	68
37061	LOCAL VASCULARIZA CORNEA	68
37062	CORNEAL PANNUS	68
37063	DEEP VASCULARIZA CORNEA	68
37064	CORNEAL GHOST VESSELS	68
3708	KERATITIS NEC	68
3709	KERATITIS NOS	68
37100	CORNEAL OPACITY NOS	68
37101	MINOR OPACITY OF CORNEA	68
37102	PERIPH OPACITY OF CORNEA	68
37103	CENTRAL OPACITY, CORNEA	68
37104	ADHERENT LEUCOMA	68
37105	PHTHISICAL CORNEA	68
37110	CORNEAL DEPOSIT NOS	68
37111	ANT CORNEA PIGMENTATION	68
37112	STROMAL CORNEA PIGMENT	68
37113	POST CORNEA PIGMENTATION	68
37114	KAYSER-FLEISCHER RING	68
37115	OTH DEPOSIT W METAB DIS	68
37116	ARGENTOUS CORNEA DEPOSIT	68
37120	CORNEAL EDEMA NOS	68
37121	IDIOPATHIC CORNEAL EDEMA	68
37122	SECONDARY CORNEAL EDEMA	68
37123	BULLOUS KERATOPATHY	68
37124	EDEMA D/T CONTACT LENS	68
37130	CORNEA MEMB CHANGE NOS	68
37131	FOLD OF BOWMAN MEMBRANE	68
37132	FOLD IN DESCOMET MEMBRAN	68
37133	RUPTURE DESCOMET MEMBRAN	68
37140	CORNEAL DEGENERATION NOS	68
37141	SENILE CORNEAL CHANGES	68
37142	RECURRENT CORNEA EROSION	68
37143	BAND-SHAPED KERATOPATHY	68
37144	CALCER CORNEA DEGEN NEC	68
37145	KERATOMALACIA NOS	68
37146	NODULAR CORNEA DEGEN	68
37148	PERIPHERAL CORNEA DEGEN	68
37149	CORNEA DEGENERATION NEC	68
37150	CORNEAL DYSTROPHY NOS	68
37151	JUV EPITH CORNEA DYSTRPH	68
37152	ANT CORNEA DYSTROPHY NEC	68
37153	GRANULAR CORNEA DYSTRPHY	68
37154	LATTICE CORNEA DYSTROPHY	68
37155	MACULAR CORNEA DYSTROPHY	68
37156	STROM CORNEA DYSTRPH NEC	68
37157	ENDOTHEL CORNEA DYSTRPHY	68
37158	POST CORNEA DYSTRPHY NEC	68
37160	KERATOCONUS NOS	68
37161	KERATOCONUS, STABLE	68
37162	KERATOCONUS, AC HYDROPS	68
37170	CORNEAL DEFORMITY NOS	68
37171	CORNEAL ECTASIA	68
37172	DESCEMETOCELE	68
37173	CORNEAL STAPHYLOMA	68
37181	CORNEAL ANESTHESIA	68
37182	CORNEAL DSDR CONTCT LENS	68
37189	CORNEAL DISORDER NEC	68
3719	CORNEAL DISORDER NOS	68
37200	ACUTE CONJUNCTIVITIS NOS	68
37201	SEROUS CONJUNCTIVITIS	68
37202	AC FOLLIC CONJUNCTIVITIS	68
37203	MUCOPUR CONJUNCTIVIT NEC	68
37204	PSEUDOMEMB CONJUNCTIVIT	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37205	AC ATOPIC CONJUNCTIVITIS	68
37210	CHR CONJUNCTIVITIS NOS	68
37211	SIMPL CHR CONJUNCTIVITIS	68
37212	CHR FOLLIC CONJUNCTIVIT	68
37213	VERNAL CONJUNCTIVITIS	68
37214	CHR ALLRG CONJUNCTIV NEC	68
37215	PARASITIC CONJUNCTIVITIS	68
37220	BLEPHAROCONJUNCTIVIT NOS	68
37221	ANGULAR BLEPHAROCONJUNCT	68
37222	CONTACT BLEPHAROCONJUNCT	68
37230	CONJUNCTIVITIS NOS	68
37231	ROSACEA CONJUNCTIVITIS	68
37233	MUCOCUTAN DIS CONJUNCTIV	68
37239	CONJUNCTIVITIS NEC	68
37240	PTERYGIUM NOS	68
37241	PERIPH STATION PTERYGIUM	68
37242	PERIPH PROGRESS PTERYGIUM	68
37243	CENTRAL PTERYGIUM	68
37244	DOUBLE PTERYGIUM	68
37245	RECURRENT PTERYGIUM	68
37250	CONJUNCTIVAL DEGEN NOS	68
37251	PINGUECULA	68
37252	PSEUDOPTERYGIUM	68
37253	CONJUNCTIVAL XEROSIS	68
37254	CONJUNCTIVAL CONCRETIONS	68
37255	CONJUNCTIVA PIGMENTATION	68
37256	CONJUNCTIVAL DEPOSITS	68
37261	GRANULOMA OF CONJUNCTIVA	68
37262	LOCAL CONJUNCTIVA ADHES	68
37263	SYMBLEPHARON	68
37264	SCARRING OF CONJUNCTIVA	68
37271	HYPEREMIA OF CONJUNCTIVA	68
37272	CONJUNCTIVAL HEMORRHAGE	68
37273	CONJUNCTIVAL EDEMA	68
37274	CONJUNCTIVA VASC ANOMALY	68
37275	CONJUNCTIVAL CYSTS	68
3728	CONJUNCTIVA DISORDER NEC	68
3729	CONJUNCTIVA DISORDER NOS	68
37300	BLEPHARITIS NOS	68
37301	ULCERATIVE BLEPHARITIS	68
37302	SQUAMOUS BLEPHARITIS	68
37311	HORDEOLUM EXTERNUM	68
37312	HORDEOLUM INTERNUM	68
37313	ABSCESS OF EYELID	68
3732	CHALAZION	68
37331	ECZEM DERMATITIS EYELID	68
37332	CONTACT DERMATIT EYELID	68
37333	XERODERMA OF EYELID	68
37334	DISC LUP ERYTHEMATOS LID	68
3734	INFECT DERM LID W DEFORM	68
3735	INFEC DERMATITIS LID NEC	68
3736	PARASITIC INFEST EYELID	68
3738	INFLAMMATION EYELID NEC	68
3739	INFLAMMATION EYELID NOS	68
37400	ENTROPION NOS	68
37401	SENILE ENTROPION	68
37402	MECHANICAL ENTROPION	68
37403	SPASTIC ENTROPION	68
37404	CICATRICIAL ENTROPION	68
37405	TRICHIASIS W/O ENTROPION	68
37410	ECTROPION NOS	68
37411	SENILE ECTROPION	68
37412	MECHANICAL ECTROPION	68
37413	SPASTIC ECTROPION	68
37414	CICATRICIAL ECTROPION	68
37420	LAGOPHTHALMOS NOS	68
37421	PARALYTIC LAGOPHTHALMOS	68
37422	MECHANICAL LAGOPHTHALMOS	68
37423	CICATRICIAL LAGOPHTHALM	68
37430	PTOSIS OF EYELID NOS	68
37431	PARALYTIC PTOSIS	68
37432	MYOGENIC PTOSIS	68
37433	MECHANICAL PTOSIS	68
37434	BLEPHAROCALASIS	68
37441	LID RETRACTION OR LAG	68
37443	ABNORM INNERVATION SYND	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37444	SENSORY DISORDERS, LID	68
37445	SENSORMOTR DISOR LID NEC	68
37446	BLEPHAROPHIMOSIS	68
37450	DEGEN DISORDER NOS, LID	68
37451	XANTHELASMA	18
37452	HYPERPIGMENTATION LID	68
37453	HYPOPIGMENTATION LID	68
37454	HYPERTRICHOSIS OF EYELID	68
37455	HYPOTRICHOSIS OF EYELID	68
37456	DEGEN DIS EYELID NEC	68
37481	HEMORRHAGE OF EYELID	68
37482	EDEMA OF EYELID	68
37483	ELEPHANTIASIS OF EYELID	68
37484	CYSTS OF EYELIDS	68
37485	VASCULAR ANOMALY, EYELID	68
37486	OLD FOREIGN BODY, EYELID	68
37487	DERMATOCHALASIS	68
37489	DISORDERS OF EYELID NEC	68
3749	DISORDER OF EYELID NOS	68
37500	DACRYOADENITIS NOS	68
37501	ACUTE DACRYOADENITIS	68
37502	CHRONIC DACRYOADENITIS	68
37503	CH ENLARGMNT LACRIM GLND	68
37511	DACRYOPS	68
37512	LACRIMAL GLAND CYST NEC	68
37513	PRIMARY LACRIMAL ATROPHY	68
37514	SECONDARY LACRIM ATROPHY	68
37515	TEAR FILM INSUFFIC NOS	68
37516	LACRIMAL GLAND DISLOCAT	68
37520	EPIPHORA NOS	68
37521	EPIPHORA D/T EXCESS TEAR	68
37522	EPIPHORA D/T INSUF DRAIN	68
37530	DACRYOCYSTITIS NOS	68
37531	ACUTE CANALICULITIS	68
37532	ACUTE DACRYOCYSTITIS	68
37533	PHLEGMON DACRYOCYSTITIS	68
37541	CHRONIC CANALICULITIS	68
37542	CHRONIC DACRYOCYSTITIS	68
37543	LACRIMAL MUCOCELE	68
37551	LACRIML PUNCTUM EVERSION	68
37552	LACRIML PUNCTUM STENOSIS	68
37553	LACRIM CANALIC STENOSIS	68
37554	LACRIMAL SAC STENOSIS	68
37555	NEONATAL NASOLACRML OBST	68
37556	ACQ NASOLACRML STENOSIS	68
37557	DACRYOLITH	68
37561	LACRIMAL FISTULA	68
37569	LACRIM PASSGE CHANGE NEC	68
37581	LACRIM PASSAGE GRANULOMA	68
37589	LACRIMAL SYST DIS NEC	68
3759	LACRIMAL SYST DIS NOS	68
37600	ACUTE INFLAM NOS, ORBIT	68
37601	ORBITAL CELLULITIS	68
37602	ORBITAL PERIOSTITIS	68
37603	ORBITAL OSTEOMYELITIS	68
37604	ORBITAL TENONITIS	68
37610	CHR INFLAM NOS, ORBIT	68
37611	ORBITAL GRANULOMA	68
37612	ORBITAL MYOSITIS	68
37613	PARASITE INFEST, ORBIT	68
37621	THYROTOXIC EXOPHTHALMOS	68
37622	EXOPHTHALM OPTHALMOPEG	68
37630	EXOPHTHALMOS NOS	68
37631	CONSTANT EXOPHTHALMOS	68
37632	ORBITAL HEMORRHAGE	68
37633	ORBITAL EDEMA	68
37634	INTERMITTNT EXOPHTHALMOS	68
37635	PULSATING EXOPHTHALMOS	68
37636	LATERAL GLOBE DISPLACMNT	68
37640	DEFORMITY OF ORBIT NOS	68
37641	HYPERTELORISM OF ORBIT	68
37642	EXOSTOSIS OF ORBIT	68
37643	ORBT DEFORM D/T BONE DIS	68
37644	CRANIOFACIAL-ORBIT DEFOR	68
37645	ATROPHY OF ORBIT	68
37646	ENLARGEMENT OF ORBIT	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37647	ORBIT DEFORM D/T TRAUMA	68
37650	ENOPHTHALMOS NOS	68
37651	ENOPHTH D/T ORBIT ATRPHY	68
37652	ENOPHTHALMOS D/T TRAUMA	68
3766	OLD FOREIGN BODY, ORBIT	68
37681	ORBITAL CYSTS	68
37682	EXTRAOCUL MUSCL MYOPATHY	68
37689	ORBITAL DISORDERS NEC	68
3769	ORBITAL DISORDER NOS	68
37700	PAPILLEDEMA NOS	68
37701	PAPILLEDEMA W INCR PRESS	68
37702	PAPILLEDEMA W DECR PRESS	68
37703	PAPILLEDEMA W RETINA DIS	68
37704	FOSTER-KENNEDY SYNDROME	63
37710	OPTIC ATROPHY NOS	63
37711	PRIMARY OPTIC ATROPHY	63
37712	POSTINFLAM OPTIC ATROPHY	63
37713	OPTIC ATRPH W RETIN DYST	63
37714	CUPPING OF OPTIC DISC	63
37715	PARTIAL OPTIC ATROPHY	63
37716	HEREDITARY OPTIC ATROPHY	63
37721	DRUSEN OF OPTIC DISC	68
37722	CRATER-LIKE HOLE OP DISC	68
37723	COLOBOMA OF OPTIC DISC	68
37724	PSEUDOPAPILLEDEMA	78
37730	OPTIC NEURITIS NOS	68
37731	OPTIC PAPILLITIS	68
37732	RETROBULBAR NEURITIS	68
37733	NUTRITION OPTC NEUROPTHY	68
37734	TOXIC OPTIC NEUROPATHY	68
37739	OPTIC NEURITIS NEC	68
37741	ISCHEMIC OPTIC NEUROPTHY	68
37742	OPTIC NERVE SHEATH HEMOR	68
37749	OPTIC NERVE DISORDER NEC	68
37751	OPT CHIASM W PITUIT DIS	63
37752	OPT CHIASM DIS/NEOPL NEC	63
37753	OPT CHIASM W VASCUL DIS	63
37754	OP CHIASM DIS W INFL DIS	63
37761	VIS PATH DIS W NEOPLASMS	63
37762	VIS PATH DIS W VASC DIS	63
37763	VIS PATH DIS W INFL DIS	63
37771	VIS CORTX DIS W NEOPLASM	63
37772	VIS CORTX DIS W VASC DIS	63
37773	VIS CORTEX DIS W INFLAM	63
37775	CORTICAL BLINDNESS	63
3779	OPTIC NERVE DISORDER NOS	63
37800	ESOTROPIA NOS	68
37801	MONOCULAR ESOTROPIA	68
37802	MONOC ESOTROP W A PATTRN	68
37803	MONOC ESOTROP W V PATTRN	68
37804	MONOC ESOTROP W X/Y PAT	68
37805	ALTERNATING ESOTROPIA	68
37806	ALT ESOTROPIA W A PATTRN	68
37807	ALT ESOTROPIA W V PATTRN	68
37808	ALT ESOTROP W X/Y PATTRN	68
37810	EXOTROPIA NOS	68
37811	MONOCULAR EXOTROPIA	68
37812	MONOC EXOTROP W A PATTRN	68
37813	MONOC EXOTROP W V PATTRN	68
37814	MONOC EXOTROP W X/Y PAT	68
37815	ALTERNATING EXOTROPIA	68
37816	ALT EXOTROPIA W A PATTRN	68
37817	ALT EXOTROPIA W V PATTRN	68
37818	ALT EXOTROP W X/Y PATTRN	68
37820	INTERMIT HETEROTROP NOS	68
37821	INTERMIT MONOC ESOTROPIA	68
37822	INTERMIT ALTRN ESOTROPIA	68
37823	INTERMIT MONOC EXOTROPIA	68
37824	INTERMIT ALTRN EXOTROPIA	68
37830	HETEROTROPIA NOS	68
37831	HYPERTROPIA	68
37832	HYPOTROPIA	68
37833	CYCLOTROPIA	68
37834	MONOFIXATION SYNDROME	68
37835	ACCOMMODATIVE ESOTROPIA	68
37840	HETEROPHORIA NOS	68

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
37841	ESOPHORIA	68
37842	EXOPHORIA	68
37843	VERTICAL HETEROPHORIA	68
37844	CYCLOPHORIA	68
37845	ALTERNATING HYPERPHORIA	68
37850	PARALYTIC STRABISMUS NOS	68
37851	PARTIAL THIRD NERV PALSY	68
37852	TOTAL THIRD NERVE PALSY	68
37853	FOURTH NERVE PALSY	68
37854	SIXTH NERVE PALSY	68
37855	EXTERNAL OPHTHALMOPLEGIA	68
37856	TOTAL OPHTHALMOPLEGIA	68
37860	MECHANICAL STRABISM NOS	68
37861	BROWN'S SHEATH SYNDROME	68
37862	MECH STRAB D/T MUSCL DIS	68
37863	MECH STRAB W OTH CONDITN	68
37871	DUANE'S SYNDROME	68
37872	PROG EXT OPHTHALMOPLEGIA	68
37873	NEUROMUSCLE DIS STRABISM	68
37881	PALSY OF CONJUGATE GAZE	68
37882	SPASM OF CONJUGATE GAZE	68
37883	CONVERGENC INSUFFICIENCY	68
37884	CONVERGENCE EXCESS	68
37885	ANOMALIES OF DIVERGENCE	68
37886	INTERNUCL OPHTHALMOPLG	63
37887	SKEW DEVIATION, EYE	68
3789	EYE MOVEMNT DISORDER NOS	68
37900	SCLERITIS NOS	68
37901	EPISCLERIT PERIODIC FUGX	68
37902	NODULAR EPISCLERITIS	68
37903	ANTERIOR SCLERITIS	68
37904	SCLEROMALACIA PERFORANS	68
37905	SCLERITIS W CORNEA INVOL	68
37906	BRAWNY SCLERITIS	68
37907	POSTERIOR SCLERITIS	68
37909	SCLERITIS NEC	68
37911	SCLERAL ECTASIA	68
37912	STAPHYLOMA POSTICUM	68
37913	EQUATORIAL STAPHYLOMA	68
37914	LOCAL ANTERIOR STAPHYLMA	68
37915	RING STAPHYLOMA	68
37916	SCLERAL DEGEN DIS NEC	68
37919	DISORDER OF SCLERA NEC	68
37921	VITREOUS DEGENERATION	68
37922	CRYSTAL DEPOSIT VITREOUS	68
37923	VITREOUS HEMORRHAGE	68
37924	VITREOUS OPACITIES NEC	68
37925	VITREOUS MEMBRANES	68
37926	VITREOUS PROLAPSE	68
37929	VITREOUS DISORDERS NEC	68
37931	APHAKIA	68
37932	SUBLUXATION OF LENS	68
37933	ANT DISLOCATION OF LENS	68
37934	POST DISLOCATION OF LENS	68
37939	DISORDERS OF LENS NEC	68
37940	ABN PUPIL FUNCTION NOS	68
37941	ANISOCORIA	68
37942	MIOSIS NOT D/T MIOTICS	68
37943	MYDRIASIS NOT D/T MYDRTC	68
37945	ARGYLL ROBERTSON PUPIL	68
37946	TONIC PUPILLARY REACTION	68
37949	PUPIL FUNCT ANOMALY NEC	68
37950	NYSTAGMUS NOS	68
37951	CONGENITAL NYSTAGMUS	68
37952	LATENT NYSTAGMUS	68
37953	VISUAL DEPRIVATN NYSTAGM	68
37954	NYSTAGMS W VESTIBULR DIS	68
37955	DISSOCIATED NYSTAGMUS	68
37956	NYSTAGMUS NEC	68
37957	SACCADIC EYE MOVMT DEF	68
37958	SMOOTH PURSUIT MVMNT DEF	68
37959	IRREGULAR EYE MVMNTS NEC	68
3798	EYE DISORDERS NEC	68
37990	EYE DISORDER NOS	68
37991	PAIN IN OR AROUND EYE	68
37992	SWELLING OR MASS OF EYE	68

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
37993	REDNESS/DISCHARGE OF EYE	68
37999	ILL-DEFINED EYE DIS NEC	68
38000	PERICHONDritis PINNA NOS	31
38001	AC PERICHONDritis PINNA	24
38002	CHR PERICHONDritis PINNA	24
38010	INFEC OTITIS EXTERNA NOS	31
38011	ACUTE INFECTION OF PINNA	31
38012	ACUTE SWIMMERS' EAR	31
38013	AC INFECT EXTERN EAR NEC	31
38014	MALIGNANT OTITIS EXTERNA	31
38015	CHR MYCOT OTITIS EXTERNA	31
38016	CHR INF OTIT EXTERNA NEC	31
38021	CHOLESTEATOMA EXTERN EAR	31
38022	ACUTE OTITIS EXTERNA NEC	31
38023	CHR OTITIS EXTERNA NEC	31
38030	DISORDER OF PINNA NOS	31
38031	HEMATOMA AURICLE/PINNA	31
38032	ACQ DEFORM AURICLE/PINNA	31
38039	NONINFECT DIS PINNA NEC	31
3804	IMPACTED CERUMEN	31
38050	ACQ STENOS EAR CANAL NOS	31
38051	STENOSIS EAR D/T TRAUMA	31
38052	STENOSIS EAR D/T SURGERY	31
38053	STENOSIS EAR D/T INFLAM	31
38081	EXOSTOSIS EXT EAR CANAL	31
38089	DIS EXTERNAL EAR NEC	31
3809	DIS EXTERNAL EAR NOS	31
38100	AC NONSUP OTITIS MED NOS	31
38101	AC SEROUS OTITIS MEDIA	31
38102	AC MUCOID OTITIS MEDIA	31
38103	AC SANGUIN OTITIS MEDIA	31
38104	AC ALLERGIC SEROUS OM	31
38105	AC ALLERGIC MUCOID OM	31
38106	AC ALLERG SANGUINOUS OM	31
38110	CHR SEROUS OM SIMP/NOS	31
38119	CHR SEROUS OM NEC	31
38120	CHR MUCOID OM SIMP/NOS	31
38129	CHR MUCOID OM NEC	31
3813	CHR NONSUP OM NOS/NEC	31
3814	NONSUPP OTITIS MEDIA NOS	31
38150	EUSTACHIAN SALPING NOS	31
38151	AC EUSTACHIAN SALPING	31
38152	CHR EUSTACHIAN SALPING	31
38160	OBSTR EUSTACH TUBE NOS	31
38161	OSSEOUS EUSTACHIAN OBSTR	31
38162	INTRINSIC EUSTACH OBSTR	31
38163	EXTRINSIC EUSTACH OBSTR	31
3817	PATULOUS EUSTACHIAN TUBE	31
38181	DYSFUNCT EUSTACHIAN TUBE	31
38189	EUSTACHIAN TUBE DIS NEC	31
3819	EUSTACHIAN TUBE DIS NOS	31
38200	AC SUPP OTITIS MEDIA NOS	31
38201	AC SUPP OM W DRUM RUPT	31
38202	AC SUPP OM IN OTH DIS	31
3821	CHR TUBOTYMPAN SUPPUR OM	31
3822	CHR ATTICOANTRAL SUP OM	31
3823	CHR SUP OTITIS MEDIA NOS	31
3824	SUPPUR OTITIS MEDIA NOS	31
3829	OTITIS MEDIA NOS	31
38300	AC MASTOIDITIS W/O COMPL	31
38301	SUBPERI MASTOID ABSCESS	31
38302	AC MASTOIDITIS-COMPL NEC	31
3831	CHRONIC MASTOIDITIS	31
38320	PETROSITIS NOS	31
38321	ACUTE PETROSITIS	31
38322	CHRONIC PETROSITIS	31
38330	POSTMASTOID COMPL NOS	31
38331	POSTMASTOID MUCOSAL CYST	31
38332	POSTMASTOID CHOLESTEATMA	31
38333	POSTMASTOID GRANULATIONS	31
38381	POSTAURICULAR FISTULA	31
38389	DISORDERS OF MASTOID NEC	31
3839	MASTOIDITIS NOS	31
38400	ACUTE MYRINGITIS NOS	31
38401	BULLOUS MYRINGITIS	31
38409	ACUTE MYRINGITIS NEC	31

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
3841	CHRONIC MYRINGITIS	31
38420	PERFORAT TYMPAN MEMB NOS	31
38421	CENT PERF TYMPANIC MEMB	31
38422	ATTIC PERF TYMPANIC MEMB	31
38423	MARGINAL PERF TYMP NEC	31
38424	MULT PERF TYMPANIC MEMB	31
38425	TOTAL PERF TYMPANIC MEMB	31
38481	ATROPHIC FLACCID TYMPAN	31
38482	ATROPHIC NONFLACCID TYMP	31
3849	DIS TYMPANIC MEMB NOS	31
38500	TYMPANOSCLEROSIS NOS	31
38501	TYMPANOSCL-TYMPANIC MEMB	31
38502	TYMPNOSCLER-TYMP/OSSICLE	31
38503	TYMPANOSCLER-ALL PARTS	31
38509	TYMPNSCLR-OTH SITE COMB	31
38510	ADHESIVE MID EAR DIS NOS	31
38511	ADHESION TYMPANUM-INCUS	31
38512	ADHESION TYMPANUM-STAPES	31
38513	ADHESION TYMP-PROMONTOR	31
38519	ADHESIVE MID EAR DIS NEC	31
38521	ANKYLOSIS MALLEUS	31
38522	ANKYLOSIS EAR OSSICL NEC	31
38523	DISLOCATION EAR OSSICLE	31
38524	PARTIAL LOSS EAR OSSICLE	31
38530	CHOLESTEATOMA NOS	31
38531	CHOLESTEATOMA OF ATTIC	31
38532	CHOLESTEATOMA MIDDLE EAR	31
38533	CHOLESTMA MID EAR/MSTOID	31
38535	DIFFUSE CHOLESTEATOSIS	31
38582	CHOLESTERIN GRANULOMA	31
38583	FOREIGN BODY MIDDLE EAR	31
38589	DIS MID EAR/MASTOID NEC	31
3859	DIS MID EAR/MASTOID NOS	31
38600	MENIERE'S DISEASE NOS	31
38601	MENIERE DIS COCHLVESTIB	31
38602	MENIERE DIS COCHLEAR	31
38603	MENIERE DIS VESTIBULAR	31
38604	INACTIVE MENIERE'S DIS	31
38610	PERIPHERAL VERTIGO NOS	31
38611	BENIGN PARXYSMAL VERTIGO	31
38612	VESTIBULAR NEURONITIS	31
38619	PERIPHERAL VERTIGO NEC	31
3862	CENTRAL ORIGIN VERTIGO	31
38630	LABYRINTHITIS NOS	31
38631	SEROUS LABYRINTHITIS	31
38632	CIRCUMSCRI LABYRINTHITIS	31
38633	SUPPURATIV LABYRINTHITIS	31
38634	TOXIC LABYRINTHITIS	31
38635	VIRAL LABYRINTHITIS	31
38640	LABYRINTHINE FISTULA NOS	31
38641	ROUND WINDOW FISTULA	31
38642	OVAL WINDOW FISTULA	31
38643	SEMICIRCUL CANAL FISTULA	31
38648	LABYRINTH FISTULA COMB	31
38650	LABYRINTHINE DYSFUNC NOS	31
38651	HYPRACT LABYRINTH UNILAT	31
38652	HYPERACT LABYRINTH BILAT	31
38653	HYPOACT LABYRINTH UNILAT	31
38654	HYPOACT LABYRINTH BILAT	31
38655	LOSS LABYRN REACT UNILAT	31
38656	LOSS LABYRN REACT BILAT	31
38658	LABYRINTHINE DYSFUNC NEC	31
3868	DISORDERS LABYRINTH NEC	31
3869	VERTIGINOUS SYND NOS	31
3870	OTOSCLER-OVAL WND NONOBL	31
3871	OTOSCLER-OVAL WNDW OBLIT	31
3872	COCHLEAR OTOSCLEROSIS	31
3878	OTOSCLEROSIS NEC	31
3879	OTOSCLEROSIS NOS	31
38800	DEGEN/VASCUL DIS EAR NOS	31
38801	PRESBYACUSIS	31
38802	TRANS ISCHEMIC DEAFNESS	31
38810	NOISE EFFECT-EAR/NOS	31
38811	ACOUSTIC TRAUMA	31
38812	HEARING LOSS D/T NOISE	31
3882	SUDDEN HEARING LOSS NOS	31

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
38830	TINNITUS NOS	31
38831	SUBJECTIVE TINNITUS	31
38832	OBJECTIVE TINNITUS	31
38840	ABN AUDITORY PERCEPT NOS	31
38841	DIPLACUSIS	31
38842	HYPERACUSIS	31
38843	IMPAIRM AUDITORY DISCRIM	31
38844	AUDITORY RECRUITMENT	31
3885	ACOUSTIC NERVE DISORDERS	31
38860	OTORRHEA NOS	31
38861	CEREBROSP FLUID OTORRHEA	63
38869	OTORRHEA NEC	31
38870	OTALGIA NOS	31
38871	OTOGENIC PAIN	31
38872	REFERRED PAIN OF EAR	31
3888	DISORDERS OF EAR NEC	31
3889	DISORDER OF EAR NOS	31
38900	CONDUCT HEARING LOSS NOS	31
38901	CONDUCT HEAR LOSS EXT EAR	31
38902	CONDUCT HEAR LOSS TYMPAN	31
38903	CONDUCT HEAR LOSS MID EAR	31
38904	COND HEAR LOSS INNER EAR	31
38908	COND HEAR LOSS COMB TYPE	31
38910	SENSORNEUR HEAR LOSS NOS	31
38911	SENSORY HEARING LOSS	31
38912	NEURAL HEARING LOSS	31
38914	CENTRAL HEARING LOSS	31
38918	SENSORNEUR LOSS COMB TYP	31
3892	MIXED HEARING LOSS	31
3897	DEAF MUTISM NEC	31
3898	HEARING LOSS NEC	31
3899	HEARING LOSS NOS	31
390	RHEUM FEV W/O HRT INVOLV	24
3910	ACUTE RHEUMATIC PERICARD	36
3911	ACUTE RHEUMATIC ENDOCARD	36
3912	AC RHEUMATIC MYOCARDITIS	36
3918	AC RHEUMAT HRT DIS NEC	36
3919	AC RHEUMAT HRT DIS NOS	36
3920	RHEUM CHOREA W HRT INVOL	36
3929	RHEUMATIC CHOREA NOS	36
393	CHR RHEUMATIC PERICARD	36
3940	MITRAL STENOSIS	36
3941	RHEUMATIC MITRAL INSUFF	36
3942	MITRAL STENOSIS W INSUFF	36
3949	MITRAL VALVE DIS NEC/NOS	36
3950	RHEUMAT AORTIC STENOSIS	36
3951	RHEUMATIC AORTIC INSUFF	36
3952	RHEUM AORTIC STEN/INSUFF	36
3959	RHEUM AORTIC DIS NEC/NOS	36
3960	MITRAL/AORTIC STENOSIS	36
3961	MITRAL STENOS/AORT INSUF	36
3962	MITRAL INSUF/AORT STENOS	36
3963	MITRAL/AORTIC VAL INSUFF	36
3968	MITR/AORTIC MULT INVOLV	36
3969	MITRAL/AORTIC V DIS NOS	36
3970	TRICUSPID VALVE DISEASE	36
3971	RHEUM PULMON VALVE DIS	36
3979	RHEUM ENDOCARDITIS NOS	36
3980	RHEUMATIC MYOCARDITIS	36
39890	RHEUMATIC HEART DIS NOS	36
39891	RHEUMATIC HEART FAILURE	36
39899	RHEUMATIC HEART DIS NEC	36
4010	MALIGNANT HYPERTENSION	36
4011	BENIGN HYPERTENSION	36
4019	HYPERTENSION NOS	36
40200	MAL HYPERTEN HRT DIS NOS	36
40201	MAL HYPERT HRT DIS W CHF	36
40210	BEN HYPERTEN HRT DIS NOS	36
40211	BENIGN HYP HRT DIS W CHF	36
40290	HYPERTENSIVE HRT DIS NOS	36
40291	HYPERTEN HEART DIS W CHF	36
40300	MAL HYP REN W/O REN FAIL	36
40301	MAL HYP REN W RENAL FAIL	53
40310	BEN HYP REN W/O REN FAIL	36
40311	BEN HYP RENAL W REN FAIL	53
40390	HYP REN NOS W/O REN FAIL	36

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
40391	HYP RENAL NOS W REN FAIL	53
40400	MAL HY HT/REN W/O CHF/RF	36
40401	MAL HYPER HRT/REN W CHF	36
40402	MAL HY HT/REN W REN FAIL	53
40403	MAL HYP HRT/REN W CHF&RF	36
40410	BEN HY HT/REN W/O CHF/RF	36
40411	BEN HYPER HRT/REN W CHF	36
40412	BEN HY HT/REN W REN FAIL	53
40413	BEN HYP HRT/REN W CHF&RF	36
40490	HY HT/REN NOS W/O CHF/RF	36
40491	HYPER HRT/REN NOS W CHF	36
40492	HY HT/REN NOS W REN FAIL	53
40493	HYP HT/REN NOS W CHF&RF	36
40501	MAL RENOVASC HYPERTENS	36
40509	MAL SECOND HYPERTEN NEC	36
40511	BENIGN RENOVASC HYPERTEN	36
40519	BENIGN SECOND HYPERT NEC	36
40591	RENOVASC HYPERTENSION	36
40599	SECOND HYPERTENSION NEC	36
41000	AMI ANTEROLATERAL, UNSPEC	36
41001	AMI ANTEROLATERAL, INIT	36
41002	AMI ANTEROLATERAL, SUBSEQ	36
41010	AMI ANTERIOR WALL, UNSPEC	36
41011	AMI ANTERIOR WALL, INIT	36
41012	AMI ANTERIOR WALL, SUBSEQ	36
41020	AMI INFEROLATERAL, UNSPEC	36
41021	AMI INFEROLATERAL, INIT	36
41022	AMI INFEROLATERAL, SUBSEQ	36
41030	AMI INFEROPOST, UNSPEC	36
41031	AMI INFEROPOST, INITIAL	36
41032	AMI INFEROPOST, SUBSEQ	36
41040	AMI INFERIOR WALL, UNSPEC	36
41041	AMI INFERIOR WALL, INIT	36
41042	AMI INFERIOR WALL, SUBSEQ	36
41050	AMI LATERAL NEC, UNSPEC	36
41051	AMI LATERAL NEC, INITIAL	36
41052	AMI LATERAL NEC, SUBSEQ	36
41060	TRUE POST INFARCT, UNSPEC	36
41061	TRUE POST INFARCT, INIT	36
41062	TRUE POST INFARCT, SUBSEQ	36
41070	SUBENDO INFARCT, UNSPEC	36
41071	SUBENDO INFARCT, INITIAL	36
41072	SUBENDO INFARCT, SUBSEQ	36
41080	AMI NEC, UNSPECIFIED	36
41081	AMI NEC, INITIAL	36
41082	AMI NEC, SUBSEQUENT	36
41090	AMI NOS, UNSPECIFIED	36
41091	AMI NOS, INITIAL	36
41092	AMI NOS, SUBSEQUENT	36
4110	POST MI SYNDROME	36
4111	INTERMED CORONARY SYND	36
41181	CORONARY OCCLSN W/O MI	36
41189	AC ISCHEMIC HRT DIS NEC	36
412	OLD MYOCARDIAL INFARCT	36
4130	ANGINA DECUBITUS	36
4131	PRINZMETAL ANGINA	36
4139	ANGINA PECTORIS NEC/NOS	36
41400	COR ATH UNSP VSL NTV/GFT	36
41401	CRNRY ATHRSCL NATVE VSSL	36
41402	CRN ATH ATLG VN BPS GRFT	36
41403	CRN ATH NONATLG BLG GRFT	36
41410	ANEURYSM, HEART (WALL)	36
41411	CORONARY VESSEL ANEURYSM	36
41419	ANEURYSM OF HEART NEC	36
4148	CHR ISCHEMIC HRT DIS NEC	36
4149	CHR ISCHEMIC HRT DIS NOS	36
4150	ACUTE COR PULMONALE	36
41511	IATROGEN PULM EMB/INFARC	33
41519	PULM EMBOL/INFARCT NEC	33
4160	PRIM PULM HYPERTENSION	36
4161	KYPHOSCOLIOTIC HEART DIS	36
4168	CHR PULMON HEART DIS NEC	36
4169	CHR PULMON HEART DIS NOS	36
4170	ARTERIOVEN FISTU PUL VES	36
4171	PULMON ARTERY ANEURYSM	36
4178	PULMON CIRCULAT DIS NEC	36

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE
HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
4179	PULMON CIRCULAT DIS NOS	36
4200	AC PERICARDIT IN OTH DIS	36
42090	ACUTE PERICARDITIS NOS	36
42091	AC IDIOPATH PERICARDITIS	36
42099	ACUTE PERICARDITIS NEC	36
4210	AC/SUBAC BACT ENDOCARD	36
4211	AC ENDOCARDIT IN OTH DIS	36
4219	AC/SUBAC ENDOCARDIT NOS	36
4220	AC MYOCARDIT IN OTH DIS	36
42290	ACUTE MYOCARDITIS NOS	36
42291	IDIOPATHIC MYOCARDITIS	36
42292	SEPTIC MYOCARDITIS	36
42293	TOXIC MYOCARDITIS	36
42299	ACUTE MYOCARDITIS NEC	36
4230	HEMOPERICARDIUM	36
4231	ADHESIVE PERICARDITIS	36
4232	CONSTRUCTIV PERICARDITIS	36
4238	PERICARDIAL DISEASE NEC	36
4239	PERICARDIAL DISEASE NOS	36
4240	MITRAL VALVE DISORDER	36
4241	AORTIC VALVE DISORDER	36
4242	NONRHEUM TRICUSP VAL DIS	36
4243	PULMONARY VALVE DISORDER	36
42490	ENDOCARDITIS NOS	36
42491	ENDOCARDITIS IN OTH DIS	36
42499	ENDOCARDITIS NEC	36
4250	ENDOMYOCARDIAL FIBROSIS	36
4251	HYPERTR OBSTR CARDIOMYOP	36
4252	OBSC AFRIC CARDIOMYOPATH	36
4253	ENDOCARD FIBROELASTOSIS	36
4254	PRIM CARDIOMYOPATHY NEC	36
4255	ALCOHOLIC CARDIOMYOPATHY	36
4257	METABOLIC CARDIOMYOPATHY	36
4258	CARDIOMYOPATH IN OTH DIS	36
4259	SECOND CARDIOMYOPATH NOS	36
4260	ATRIOVENT BLOCK COMPLETE	36
42610	ATRIOVENT BLOCK NOS	36
42611	ATRIOVENT BLOCK-1ST DEGR	36
42612	ATRIOVENT BLOCK-MOBITZ II	36
42613	AV BLOCK-2ND DEGREE NEC	36
4262	LEFT BB HEMIBLOCK	36
4263	LEFT BB BLOCK NEC	36
4264	RT BUNDLE BRANCH BLOCK	36
42650	BUNDLE BRANCH BLOCK NOS	36
42651	RT BBB/LFT POST FASC BLK	36
42652	RT BBB/LFT ANT FASC BLK	36
42653	BILAT BB BLOCK NEC	36
42654	TRIFASCICULAR BLOCK	36
4266	OTHER HEART BLOCK	36
4267	ANOMALOUS AV EXCITATION	36
42681	LOWN-GANONG-LEVINE SYND	36
42689	CONDUCTION DISORDER NEC	36
4269	CONDUCTION DISORDER NOS	36
4270	PAROX ATRIAL TACHYCARDIA	36
4271	PAROX VENTRIC TACHYCARD	78
4272	PAROX TACHYCARDIA NOS	36
42731	ATRIAL FIBRILLATION	36
42732	ATRIAL FLUTTER	36
42741	VENTRICULAR FIBRILLATION	78
42742	VENTRICULAR FLUTTER	78
4275	CARDIAC ARREST	78
42760	PREMATURE BEATS NOS	36
42761	ATRIAL PREMATURE BEATS	36
42769	PREMATURE BEATS NEC	36
42781	SINOATRIAL NODE DYSFUNCT	36
42789	CARDIAC DYSRHYTHMIAS NEC	36
4279	CARDIAC DYSRHYTHMIA NOS	36
4280	CONGESTIVE HEART FAILURE	36
4281	LEFT HEART FAILURE	36
4289	HEART FAILURE NOS	36
4290	MYOCARDITIS NOS	36
4291	MYOCARDIAL DEGENERATION	36
4292	ASCVD	36
4293	CARDIOMEGALY	36
4294	HRT DIS POSTCARDIAC SURG	36
4295	CHORDAE TENDINAE RUPTURE	36

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
4296	PAPILLARY MUSCLE RUPTURE	36
42971	ACQ CARDIAC SEPTL DEFECT	36
42979	OTHER SEQUELAE OF MI NEC	36
42981	PAPILLARY MUSCLE DIS NEC	36
42982	HYPERKINETIC HEART DIS	36
42989	ILL-DEFINED HRT DIS NEC	36
4299	HEART DISEASE NOS	36
430	SUBARACHNOID HEMORRHAGE	63
431	INTRACEREBRAL HEMORRHAGE	63
4320	NONTRAUM EXTRADURAL HEM	63
4321	SUBDURAL HEMORRHAGE	63
4329	INTRACRANIAL HEMORR NOS	63
43300	OCL BSLR ART WO INFRCT	63
43301	OCL BSLR ART W INFRCT	63
43310	OCL CRTD ART WO INFRCT	63
43311	OCL CRTD ART W INFRCT	63
43320	OCL VRTB ART WO INFRCT	63
43321	OCL VRTB ART W INFRCT	63
43330	OCL MLT BI ART WO INFRCT	63
43331	OCL MLT BI ART W INFRCT	63
43380	OCL SPCF ART WO INFRCT	63
43381	OCL SPCF ART W INFRCT	63
43390	OCL ART NOS WO INFRCT	63
43391	OCL ART NOS W INFRCT	63
43400	CRBL THRMBS WO INFRCT	63
43401	CRBL THRMBS W INFRCT	63
43410	CRBL EMBLSM WO INFRCT	63
43411	CRBL EMBLSM W INFRCT	63
43490	CRBL ART OC NOS WO INFRC	63
43491	CRBL ART OCL NOS W INFRC	63
4350	BASILAR ARTERY SYNDROME	63
4351	VERTEBRAL ARTERY SYNDROM	63
4352	SUBCLAVIAN STEAL SYNDROM	63
4353	VERTBROBASLR ARTERY SYND	63
4358	TRANS CEREB ISCHEMIA NEC	63
4359	TRANS CEREB ISCHEMIA NOS	63
436	CVA	63
4370	CEREBRAL ATHEROSCLEROSIS	63
4371	AC CEREBROVASC INSUF NOS	63
4372	HYPERTENS ENCEPHALOPATHY	63
4373	NONRUPT CEREBRAL ANEURYM	63
4374	CEREBRAL ARTERITIS	63
4375	MOYAMOYA DISEASE	63
4376	NONPYOGEN THROMBOS SINUS	63
4377	TRANSIENT GLOBAL AMNESIA	11
4378	CEREBROVASC DISEASE NEC	63
4379	CEREBROVASC DISEASE NOS	63
4400	AORTIC ATHEROSCLEROSIS	36
4401	RENAL ARTERY ATHEROSCLER	53
44020	ATHSCL EXTRM NTV ART NOS	36
44021	ATH EXT NTV AT W CLAUDCT	36
44022	ATH EXT NTV AT W RST PN	36
44023	ATH EXT NTV ART ULCRTION	36
44024	ATH EXT NTV ART GNGRENE	36
44029	ATHRSC EXTRM NTV ART OTH	36
44030	ATHSCL EXTRM BPS GFT NOS	36
44031	ATH EXT AUTOLOGS BPS GFT	36
44032	ATH EXT NONAUTLG BPS GFT	36
4408	ATHEROSCLEROSIS NEC	36
4409	ATHEROSCLEROSIS NOS	36
44100	DSCT OF AORTA UNSP SITE	78
44101	DSCT OF THORACIC AORTA	78
44102	DSCT OF ABDOMINAL AORTA	78
44103	DSCT OF THORACOABD AORTA	78
4411	RUPTUR THORACIC ANEURYSM	78
4412	THORACIC AORTIC ANEURYSM	36
4413	RUPT ABD AORTIC ANEURYSM	78
4414	ABDOM AORTIC ANEURYSM	36
4415	RUPT AORTIC ANEURYSM NOS	78
4416	THORACOABD ANEURYSM RUPT	78
4417	THRACABD ANURYSM WO RUPT	36
4419	AORTIC ANEURYSM NOS	36
4420	UPPER EXTREMITY ANEURYSM	36
4421	RENAL ARTERY ANEURYSM	53
4422	ILIAC ARTERY ANEURYSM	36
4423	LOWER EXTREMITY ANEURYSM	36

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
44281	ANEURYSM OF NECK	36
44282	SUBCLAVIAN ANEURYSM	36
44283	SPLenic ARTERY ANEURYSM	36
44284	VISCERAL ANEURYSM NEC	36
44289	ANEURYSM NEC	36
4429	ANEURYSM NOS	36
4430	RAYNAUD'S SYNDROME	86
4431	THROMBOANGIIT OBLITERANS	36
44381	ANGIOPATHY IN OTHER DIS	36
44389	PERIPH VASCULAR DIS NEC	36
4439	PERIPH VASCULAR DIS NOS	36
4440	ABD AORTIC EMBOLISM	36
4441	THORACIC AORTIC EMBOLISM	36
44421	UPPER EXTREMITY EMBOLISM	36
44422	LOWER EXTREMITY EMBOLISM	36
44481	ILIAC ARTERY EMBOLISM	36
44489	ARTERIAL EMBOLISM NEC	36
4449	ARTERIAL EMBOLISM NOS	36
4460	POLYARTERITIS NODOSA	86
4461	MUCOCUTAN LYMPH NODE SYN	86
4462	HYPERSENSITIV ANGIITIS*	86
44620	HYPERSENSIT ANGIITIS NOS	86
44621	GOODPASTURE'S SYNDROME	86
44629	HYPERSENSIT ANGIITIS NEC	86
4463	LETHAL MIDLINE GRANULOMA	86
4464	WEGENER'S GRANULOMATOSIS	86
4465	GIANT CELL ARTERITIS	86
4466	THROMBOT MICROANGIOPATHY	86
4467	TAKAYASU'S DISEASE	86
4470	ACQ ARTERIOVEN FISTULA	36
4471	STRICTURE OF ARTERY	36
4472	RUPTURE OF ARTERY	78
4473	RENAL ARTERY HYPERPLASIA	53
4474	CELIAC ART COMPRESS SYN	41
4475	NECROSIS OF ARTERY	36
4476	ARTERITIS NOS	24
4478	ARTERIAL DISEASE NEC	36
4479	ARTERIAL DISEASE NOS	36
4480	HEREDIT HEMORR TELANGIEC	36
4481	NEVUS, NON-NEOPLASTIC	18
4489	CAPILLARY DIS NEC/NOS	36
4510	SUPERFIC PHLEBITIS-LEG	36
45111	FEMORAL VEIN PHLEBITIS	36
45119	DEEP PHLEBITIS-LEG NEC	36
4512	THROMBOPHLEBITIS LEG NOS	36
45181	ILIAC THROMBOPHLEBITIS	36
45182	PHLBTS SPRFC VN UP EXTRM	36
45183	PHLBTS DEEP VN UP EXTRM	36
45184	PHLBTS VN NOS UP EXTRM	36
45189	THROMBOPHLEBITIS NEC	36
4519	THROMBOPHLEBITIS NOS	36
452	PORTAL VEIN THROMBOSIS	41
4530	BUDD-CHIARI SYNDROME	41
4531	THROMBOPHLEBITIS MIGRANS	36
4532	VENA CAVA THROMBOSIS	36
4533	RENAL VEIN THROMBOSIS	53
4538	VENOUS THROMBOSIS NEC	36
4539	VENOUS THROMBOSIS NOS	36
4540	LEG VARICOSITY W ULCER	36
4541	LEG VARICOSITY W INFLAM	36
4542	VARICOS LEG ULCER/INFLAM	36
4549	VARICOSE VEIN OF LEG NOS	36
4550	INT HEMORRHOID W/O COMPL	41
4551	INT THROMBOS HEMORRHOID	41
4552	INT HEMORRHOID W COMP NEC	41
4553	EXT HEMORRHOID W/O COMPL	41
4554	EXT THROMBOS HEMORRHOID	41
4555	EXT HEMORRHOID W COMP NEC	41
4556	HEMORRHOIDS NOS	41
4557	THROMBOS HEMORRHOIDS NOS	41
4558	HEMORRHOID NOS W COMP NEC	41
4559	RESIDUAL HEMORRHOID TAGS	41
4560	ESOPHAG VARICES W BLEED	41
4561	ESOPH VARICES W/O BLEED	41
45620	BLEED ESOPH VAR OTH DIS	41
45621	ESOPH VARICE OTH DIS NOS	41

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
4563	SUBLINGUAL VARICES	36
4564	SCROTAL VARICES	53
4565	PELVIC VARICES	53
4566	VULVAL VARICES	56
4568	VARICES OF OTHER SITES	36
4570	POSTMASTECT LYMPHEDEMA	18
4571	OTHER LYMPHEDEMA	18
4572	LYMPHANGITIS	18
4578	NONINFECT LYMPH DIS NEC	86
4579	NONINFECT LYMPH DIS NOS	86
4580	ORTHOSTATIC HYPOTENSION	36
4581	CHRONIC HYPOTENSION	36
4582	IATROGENIC HYPOTENSION	82
4589	HYPOTENSION NOS	36
4590	HEMORRHAGE NOS	11
4591	POSTPHLEBITIC SYNDROME	36
4592	COMPRESSION OF VEIN	36
45981	VENOUS INSUFFICIENCY NOS	36
45989	CIRCULATORY DISEASE NEC	36
4599	CIRCULATORY DISEASE NOS	36
460	ACUTE NASOPHARYNGITIS	31
4610	AC MAXILLARY SINUSITIS	31
4611	AC FRONTAL SINUSITIS	31
4612	AC ETHMOIDAL SINUSITIS	31
4613	AC SPHENOIDAL SINUSITIS	31
4618	OTHER ACUTE SINUSITIS	31
4619	ACUTE SINUSITIS NOS	31
462	ACUTE PHARYNGITIS	31
463	ACUTE TONSILLITIS	31
4640	ACUTE LARYNGITIS	31
46410	AC TRACHEITIS NO OBSTRUC	31
46411	AC TRACHEITIS W OBSTRUCT	31
46420	AC LARYNGOTRACH NO OBSTR	31
46421	AC LARYNGOTRACH W OBSTR	31
46430	AC EPIGLOTTITIS NO OBSTR	31
46431	AC EPIGLOTTITIS W OBSTR	78
4644	CROUP	31
4650	ACUTE LARYNGOPHARYNGITIS	31
4658	ACUTE URI MULT SITES NEC	31
4659	ACUTE URI NOS	31
4660	ACUTE BRONCHITIS	33
470	DEVIATED NASAL SEPTUM	31
4710	POLYP OF NASAL CAVITY	31
4711	POLYPOID SINUS DEGEN	31
4718	NASAL SINUS POLYP NEC	31
4719	NASAL POLYP NOS	31
4720	CHRONIC RHINITIS	31
4721	CHRONIC PHARYNGITIS	31
4722	CHRONIC NASOPHARYNGITIS	31
4730	CHR MAXILLARY SINUSITIS	31
4731	CHR FRONTAL SINUSITIS	31
4732	CHR ETHMOIDAL SINUSITIS	31
4733	CHR SPHENOIDAL SINUSITIS	31
4738	CHRONIC SINUSITIS NEC	31
4739	CHRONIC SINUSITIS NOS	31
4740	CHRONIC TONSILLITIS*	31
47410	HYPERTROPHY T AND A	31
47411	HYPERTROPHY TONSILS	31
47412	HYPERTROPHY ADENOIDS	31
4742	ADENOID VEGETATIONS	31
4748	CHR T & A DIS NEC	31
4749	CHR T & A DIS NOS	31
475	PERITONSILLAR ABSCESS	31
4760	CHRONIC LARYNGITIS	31
4761	CHR LARYNGOTRACHEITIS	31
4770	RHINITIS DUE TO POLLEN	31
4778	ALLERGIC RHINITIS NEC	31
4779	ALLERGIC RHINITIS NOS	31
4780	HYPERTRPH NASAL TURBINAT	31
4781	NASAL & SINUS DIS NEC	31
47820	DISEASE OF PHARYNX NOS	31
47821	CELLULITIS OF PHARYNX	31
47822	PARAPHARYNGEAL ABSCESS	31
47824	RETROPHARYNGEAL ABSCESS	31
47825	EDEMA PHARYNX/NASOPHARYX	31
47826	CYST PHARYNX/NASOPHARYNX	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
47829	DISEASE OF PHARYNX NEC	31
47830	VOCAL CORD PARALYSIS NOS	31
47831	VOCAL PARAL UNILAT PART	31
47832	VOCAL PARAL UNILAT TOTAL	31
47833	VOCAL PARAL BILAT PART	31
47834	VOCAL PARAL BILAT TOTAL	31
4784	VOCAL CORD/LARYNX POLYP	31
4785	VOCAL CORD DISEASE NEC	31
4786	EDEMA OF LARYNX	31
47870	DISEASE OF LARYNX NOS	31
47871	LARYNGEAL CELLULITIS	31
47874	STENOSIS OF LARYNX	31
47875	LARYNGEAL SPASM	31
47879	DISEASE OF LARYNX NEC	31
4788	URT HYPERSENS REACT NOS	31
4789	UPPER RESP DIS NEC/NOS	31
4800	ADENOVIRAL PNEUMONIA	33
4801	RESP SYNCYT VIRAL PNEUM	33
4802	PARINFLUENZA VIRAL PNEUM	33
4808	VIRAL PNEUMONIA NEC	33
4809	VIRAL PNEUMONIA NOS	33
481	PNEUMOCOCCAL PNEUMONIA	33
4820	K. PNEUMONIAE PNEUMONIA	33
4821	PSEUDOMONAL PNEUMONIA	33
4822	H. INFLUENZAE PNEUMONIA	33
48230	STREPTOCOCCAL PNEUMN NOS	33
48231	PNEUMONIA STRPTOCOCCUS A	33
48232	PNEUMONIA STRPTOCOCCUS B	33
48239	PNEUMONIA OTH STREP	33
4824	STAPHYLOCOCCAL PNEUMONIA	33
48281	PNEUMONIA ANAEROBES	33
48282	PNEUMONIA E COLI	33
48283	PNEUMO OTH GRM-NEG BACT	33
48289	PNEUMONIA OTH SPCF BACT	33
4829	BACTERIAL PNEUMONIA NOS	33
4830	PNEU MYCPLSM PNEUMONIAE	33
4838	PNEUMON OTH SPEC ORGNSM	33
4841	PNEUM W CYTOMEG INCL DIS	33
4843	PNEUMONIA IN WHOOP COUGH	33
4845	PNEUMONIA IN ANTHRAX	33
4846	PNEUM IN ASPERGILLOSIS	33
4847	PNEUM IN OTH SYS MYCOSES	33
4848	PNEUM IN INFECT DIS NEC	33
485	BRONCHOPNEUMONIA ORG NOS	33
486	PNEUMONIA, ORGANISM NOS	33
4870	INFLUENZA WITH PNEUMONIA	33
4871	FLU W RESP MANIFEST NEC	31
4878	FLU W MANIFESTATION NEC	31
490	BRONCHITIS NOS	33
4910	SIMPLE CHR BRONCHITIS	33
4911	MUCOPURUL CHR BRONCHITIS	33
4912	OBSTRUCT CHR BRONCHITIS*	33
49120	OBS CHR BRNC W/O ACT EXA	33
49121	OBS CHR BRNC W ACT EXA	33
4918	CHRONIC BRONCHITIS NEC	33
4919	CHRONIC BRONCHITIS NOS	33
4920	EMPHYSEMATOUS BLEB	33
4928	EMPHYSEMA NEC	33
49300	EXT ASTHMA W/O STAT ASTH	33
49301	EXT ASTHMA W STATUS ASTH	78
49310	INT ASTHMA W/O STAT ASTH	33
49311	INT ASTHMA W STATUS ASTH	78
49320	CH OB ASTH W/O STAT ASTH	33
49321	CH OB ASTHMA W STAT ASTH	78
49390	ASTHMA W/O STATUS ASTHM	33
49391	ASTHMA W STATUS ASTHMA	78
494	BRONCHIECTASIS	33
4950	FARMERS' LUNG	33
4951	BAGASSOSIS	33
4952	BIRD-FANCIERS' LUNG	33
4953	SUBEROSIS	33
4954	MALT WORKERS' LUNG	33
4955	MUSHROOM WORKERS' LUNG	33
4956	MAPL BARK-STRIPPRS' LUNG	33
4957	"VENTILATION" PNEUMONIT	33
4958	ALLERG ALVEOL/PNEUM NEC	33

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
4959	ALLERG ALVEOL/PNEUM NOS	33
496	CHR AIRWAY OBSTRUCT NEC	33
500	COAL WORKERS' PNEUMOCON	33
501	ASBESTOSIS	33
502	SILICA PNEUMOCON NEC	33
503	INORG DUST PNEUMOCON NEC	33
504	DUST PNEUMONOPATHY NEC	33
505	PNEUMOCONIOSIS NOS	33
5060	FUM/VAPOR BRONC/PNEUMON	33
5061	FUM/VAPOR AC PULM EDEMA	33
5062	FUM/VAPOR UP RESP INFLAM	33
5063	FUM/VAP AC RESP COND NEC	33
5064	FUM/VAPOR CHR RESP COND	33
5069	FUM/VAPOR RESP COND NOS	33
5070	FOOD/VOMIT PNEUMONITIS	33
5071	OIL/ESSENCE PNEUMONITIS	33
5078	SOLID/LIQ PNEUMONIT NEC	33
5080	AC PUL MANIF D/T RADIAT	33
5081	CHR PUL MANIF D/T RADIAT	33
5088	RESP COND: EXT AGENT NEC	33
5089	RESP COND: EXT AGENT NOS	33
5100	EMPHYEMA WITH FISTULA	33
5109	EMPHYEMA W/O FISTULA	33
5110	PLEURISY W/O EFFUS OR TB	33
5111	BACT PLEUR/EFFUS NOT TB	33
5118	PLEURAL EFFUS NEC NOT TB	33
5119	PLEURAL EFFUSION NOS	33
5120	SPONT TENS PNEUMOTHORAX	33
5121	IATROGENIC PNEUMOTHORAX	78
5128	SPONT PNEUMOTHORAX NEC	33
5130	ABSCESS OF LUNG	33
5131	ABSCESS OF MEDIASTINUM	33
514	PULM CONGEST/HYPOSTASIS	33
515	POSTINFLAM PULM FIBROSIS	33
5160	PUL ALVEOLAR PROTEINOSIS	33
5161	IDIO PULM HEMOSIDEROSIS	33
5162	PULM ALVEOLAR MICROLITH	33
5163	IDIO FIBROS ALVEOLITIS	33
5168	ALVEOL PNEUMONOPATHY NEC	33
5169	ALVEOL PNEUMONOPATHY NOS	33
5171	RHEUMATIC PNEUMONIA	33
5172	SYST SCLEROSIS LUNG DIS	33
5178	LUNG INVOLV IN OTH DIS	33
5180	PULMONARY COLLAPSE	33
5181	INTERSTITIAL EMPHYSEMA	33
5182	COMPENSATORY EMPHYSEMA	33
5183	PULMONARY EOSINOPHILIA	33
5184	ACUTE LUNG EDEMA NOS	33
5185	POST TRAUM PULM INSUFFIC	33
51881	RESPIRATORY FAILURE	33
51882	OTHER PULMONARY INSUFF	33
51889	OTHER LUNG DISEASE NEC	33
5190	TRACHEOSTOMY COMPLIC	33
5191	TRACHEA/BRONCHUS DIS NEC	33
5192	MEDIASTINITIS	33
5193	MEDIASTINUM DISEASE NEC	33
5194	DISORDERS OF DIAPHRAGM	33
5198	RESP SYSTEM DISEASE NEC	11
5199	RESP SYSTEM DISEASE NOS	11
5200	ANODONTIA	31
5201	SUPERNUMERARY TEETH	31
5202	ABNORMAL TOOTH SIZE/FORM	31
5203	MOTTLED TEETH	31
5204	TOOTH FORMATION DISTURB	31
5205	HEREDIT TOOTH STRUCT NEC	31
5206	TOOTH ERUPTION DISTURB	31
5207	TEETHING SYNDROME	31
5208	TOOTH DEVEL/ERUP DIS NEC	31
5209	TOOTH DEVEL/ERUP DIS NOS	31
5210	DENTAL CARIES	31
5211	EXCESS ATTRITION-TEETH	31
5212	ABRASION OF TEETH	31
5213	EROSION OF TEETH	31
5214	RESORPTION OF TEETH	31
5215	HYPERCEMENTOSIS	31
5216	ANKYLOSIS OF TEETH	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
5217	POSTERUPT COLOR CHANGE	31
5218	HARD TISS DIS TEETH NEC	31
5219	HARD TISS DIS TEETH NOS	31
5220	PULPITIS	31
5221	NECROSIS OF TOOTH PULP	31
5222	TOOTH PULP DEGENERATION	31
5223	ABN HARD TISS-TOOTH PULP	31
5224	AC APICAL PERIODONTITIS	31
5225	PERIAPICAL ABSCESS	31
5226	CHR APICAL PERIODONTITIS	31
5227	PERIAPICAL ABSC W SINUS	31
5228	RADICULAR CYST	31
5229	PULP/PERIAPICAL DIS NEC	31
5230	ACUTE GINGIVITIS	31
5231	CHRONIC GINGIVITIS	31
5232	GINGIVAL RECESSION	31
5233	ACUTE PERIODONTITIS	31
5234	CHRONIC PERIODONTITIS	31
5235	PERIODONTOSIS	31
5236	ACCRETIONS ON TEETH	31
5238	PERIODONTAL DISEASE NEC	31
5239	GINGIV/PERIODONT DIS NOS	31
52400	UNSPCF ANOMALY JAW SIZE	31
52401	MAXILLARY HYPERPLASIA	31
52402	MANDIBULAR HYPERPLASIA	31
52403	MAXILLARY HYPOPLASIA	31
52404	MANDIBULAR HYPOPLASIA	31
52405	MACROGENIA	31
52406	MICROGENIA	31
52409	OTH SPCF ANMLY JAW SIZE	31
52410	UNSPCF ANM JAW CRANL BSE	31
52411	MAXILLARY ASYMMETRY	31
52412	OTHER JAW ASYMMETRY	31
52419	SPCFD ANOM JAW CRANL BSE	31
5242	DENTAL ARCH ANOMALY	31
5243	TOOTH POSITION ANOMALY	31
5244	MALOCCLUSION NOS	31
5245	ABN DENTOFACIAL FUNCTION	31
52460	TMJ DISORDERS NOS	24
52461	ADHESNS/ANKYLOSIS—TMJ	24
52462	ARTHRALGIA TMJ	24
52463	ARTICULAR DISC DISORDER	24
52469	OTHER SPECF TMJ DISORDRS	24
52470	UNSPF DENT ALVELR ANMALY	31
52471	ALVEOLAR MAXIL HYPRPLSIA	31
52472	ALVEOLAR MANDIB HYPRPLAS	31
52473	ALVEOLAR MAXIL HYPOPLSIA	31
52474	ALVEOLAR MANDB HYPOPLSIA	31
52479	OTH SPCF ALVEOLAR ANMALY	31
5248	DENTOFACIAL ANOMALY NEC	31
5249	DENTOFACIAL ANOMALY NOS	31
5250	EXFOLIATION OF TEETH	31
5251	LOSS OF TEETH, ACQUIRED	31
5252	ATROPHY ALVEOLAR RIDGE	31
5253	RETAINED DENTAL ROOT	31
5258	DENTAL DISORDER NEC	31
5259	DENTAL DISORDER NOS	31
5260	DEVEL ODONTOGENIC CYSTS	31
5261	FISSURAL CYSTS OF JAW	31
5262	CYSTS OF JAWS NEC	31
5263	CENT GIANT CELL GRANULOM	31
5264	INFLAMMATION OF JAW	31
5265	ALVEOLITIS OF JAW	31
52681	EXOSTOSIS OF JAW	31
52689	JAW DISEASE NEC	31
5269	JAW DISEASE NOS	31
5270	SALIVARY GLAND ATROPHY	31
5271	SALIVARY GLND HYPRTROPHY	31
5272	SIALOADENITIS	31
5273	SALIVARY GLAND ABSCESS	31
5274	SALIVARY GLAND FISTULA	31
5275	SIALOLITHIASIS	31
5276	SALIVARY GLAND MUCOCELE	31
5277	SALIVARY SECRETION DIS	31
5278	SALIVARY GLAND DIS NEC	31
5279	SALIVARY GLAND DIS NOS	31

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
5280	STOMATITIS	31
5281	CANCER ORIS	31
5282	ORAL APHTHA	31
5283	CELLULITIS/ABSCESS MOUTH	31
5284	ORAL SOFT TISSUE CYST	31
5285	DISEASES OF LIPS	31
5286	LEUKOPLAKIA ORAL MUCOSA	31
5287	ORAL EPITHELIUM DIS NEC	31
5288	ORAL SUBMUCOSAL FIBROSIS	31
5289	ORAL SOFT TISSUE DIS NEC	31
5290	GLOSSITIS	31
5291	GEOGRAPHIC TONGUE	31
5292	MED RHOMBOID GLOSSITIS	31
5293	HYPERTROPH TONGUE PAPILL	31
5294	ATROPHY TONGUE PAPILLAE	31
5295	PLICATED TONGUE	31
5296	GLOSSODYNIA	31
5298	TONGUE DISORDER NEC	31
5299	TONGUE DISORDER NOS	31
5300	ACHALASIA & CARDIOSPASM	41
53010	ESOPHAGITIS, UNSPECIFIED	41
53011	REFLUX ESOPHAGITIS	41
53019	OTHER ESOPHAGITIS	41
5302	ULCER OF ESOPHAGUS	41
5303	ESOPHAGEAL STRICTURE	41
5304	PERFORATION OF ESOPHAGUS	41
5305	DYSKINESIA OF ESOPHAGUS	41
5306	ACQ ESOPHAG DIVERTICULUM	41
5307	MALLORY-WEISS SYNDROME	41
53081	ESOPHAGEAL REFLUX	41
53082	ESOPHAGEAL HEMORRHAGE	41
53083	ESOPHAGEAL LEUKOPLAKIA	41
53084	TRACHEOESOPHAGEAL FISTULA	41
53089	OTHER DSRDERS ESOPHAGUS	41
5309	ESOPHAGEAL DISORDER NOS	41
53100	AC STOMACH ULCER W HEM	41
53101	AC STOMACH ULC W HEM-OBST	41
53110	AC STOMACH ULCER W PERF	78
53111	AC STOM ULC W PERF-OBST	78
53120	AC STOMACH ULC W HEM/PERF	78
53121	AC STOM ULC HEM/PERF-OBS	78
53130	ACUTE STOMACH ULCER NOS	41
53131	AC STOMACH ULC NOS-OBSTR	41
53140	CHR STOMACH ULC W HEM	41
53141	CHR STOM ULC W HEM-OBSTR	41
53150	CHR STOMACH ULCER W PERF	78
53151	CHR STOM ULC W PERF-OBST	78
53160	CHR STOMACH ULC HEM/PERF	78
53161	CHR STOM ULC HEM/PERF-OB	78
53170	CHR STOMACH ULCER NOS	41
53171	CHR STOMACH ULC NOS-OBST	41
53190	STOMACH ULCER NOS	41
53191	STOMACH ULCER NOS-OBSTR	41
53200	AC DUODENAL ULCER W HEM	41
53201	AC DUODEN ULC W HEM-OBST	41
53210	AC DUODENAL ULCER W PERF	78
53211	AC DUODEN ULC PERF-OBSTR	78
53220	AC DUODEN ULC W HEM/PERF	78
53221	AC DUOD ULC HEM/PERF-OBS	78
53230	ACUTE DUODENAL ULCER NOS	41
53231	AC DUODENAL ULC NOS-OBST	41
53240	CHR DUODEN ULCER W HEM	41
53241	CHR DUODEN ULC HEM-OBSTR	41
53250	CHR DUODEN ULCER W PERF	78
53251	CHR DUODEN ULC PERF-OBST	78
53260	CHR DUODEN ULC HEM/PERF	78
53261	CHR DUOD ULC HEM/PERF-OB	78
53270	CHR DUODENAL ULCER NOS	41
53271	CHR DUODEN ULC NOS-OBSTR	41
53290	DUODENAL ULCER NOS	41
53291	DUODENAL ULCER NOS-OBSTR	41
53300	AC PEPTIC ULCER W HEMORR	41
53301	AC PEPTIC ULC W HEM-OBST	41
53310	AC PEPTIC ULCER W PERFOR	78
53311	AC PEPTIC ULC W PERF-OBS	78
53320	AC PEPTIC ULC W HEM/PERF	78

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
53321	AC PEPT ULC HEM/PERF-OBS	78
53330	ACUTE PEPTIC ULCER NOS	41
53331	AC PEPTIC ULCER NOS-OBST	41
53340	CHR PEPTIC ULCER W HEM	41
53341	CHR PEPTIC ULC W HEM-OBS	41
53350	CHR PEPTIC ULCER W PERF	78
53351	CHR PEPTIC ULC PERF-OBST	78
53360	CHR PEPT ULC W HEM/PERF	78
53361	CHR PEPT ULC HEM/PERF-OB	78
53370	CHRONIC PEPTIC ULCER NOS	41
53371	CHR PEPTIC ULCER NOS-OBS	41
53390	PEPTIC ULCER NOS	41
53391	PEPTIC ULCER NOS-OBSTRUC	41
53400	AC MARGINAL ULCER W HEM	41
53401	AC MARGIN ULC W HEM-OBST	41
53410	AC MARGINAL ULCER W PERF	78
53411	AC MARGIN ULC W PERF-OBS	78
53420	AC MARGIN ULC W HEM/PERF	78
53421	AC MARG ULC HEM/PERF-OBS	78
53430	AC MARGINAL ULCER NOS	41
53431	AC MARGINAL ULC NOS-OBST	41
53440	CHR MARGINAL ULCER W HEM	41
53441	CHR MARGIN ULC W HEM-OBS	41
53450	CHR MARGINAL ULC W PERF	78
53451	CHR MARGIN ULC PERF-OBST	78
53460	CHR MARGIN ULC HEM/PERF	78
53461	CHR MARG ULC HEM/PERF-OB	78
53470	CHR MARGINAL ULCER NOS	41
53471	CHR MARGINAL ULC NOS-OBS	41
53490	GASTROJEJUNAL ULCER NOS	41
53491	GASTROJEJUN ULC NOS-OBST	41
53500	ACUTE GASTRTIS W/O HMRHG	41
53501	ACUTE GASTRITIS W HMRHG	41
53510	ATRP H GASTRTIS W/O HMRHG	41
53511	ATRP H GASTRITIS W HMRHG	41
53520	GSTR MCSL HYPRT W/O HMRG	41
53521	GSTR MCSL HYPRT W HMRG	41
53530	ALCHL GASTRTIS W/O HMRHG	41
53531	ALCHL GSTRITIS W HMRHG	41
53540	OTH SPF GSTRT W/O HMRHG	41
53541	OTH SPF GASTRT W HMRHG	41
53550	GSTR/DDNTS NOS W/O HMRHG	41
53551	GSTR/DDNTS NOS W HMRHG	41
53560	DUODENITIS W/O HMRHG	41
53561	DUODENITIS W HMRHG	41
5360	ACHLORHYDRIA	41
5361	AC DILATION OF STOMACH	41
5362	PERSISTENT VOMITING	41
5363	GASTROPARESIS	41
5368	STOMACH FUNCTION DIS NEC	41
5369	STOMACH FUNCTION DIS NOS	41
5370	ACQ PYLORIC STENOSIS	41
5371	GASTRIC DIVERTICULUM	41
5372	CHRONIC DUODENAL ILEUS	41
5373	DUODENAL OBSTRUCTION NEC	41
5374	GASTRIC/DUODENAL FISTULA	41
5375	GASTROPTOSIS	41
5376	HOURLASS STRICTURE STOM	41
53781	PYLOROSPASM	41
53782	ANGIO STM/DUDN W/O HMRHG	41
53783	ANGIO STM/DUDN W HMRHG	41
53789	GASTRODUODENAL DIS NEC	41
5379	GASTRODUODENAL DIS NOS	41
5400	AC APPEND W PERITONITIS	41
5401	ABSCCESS OF APPENDIX	41
5409	ACUTE APPENDICITIS NOS	41
541	APPENDICITIS NOS	41
542	OTHER APPENDICITIS	41
5430	HYPERPLASIA OF APPENDIX	41
5439	DISEASES OF APPENDIX NEC	41
55000	UNILAT ING HERNIA W GANG	41
55001	RECUR UNIL ING HERN-GANG	41
55002	BILAT ING HERNIA W GANG	41
55003	RECUR BIL ING HERN-GANG	41
55010	UNILAT ING HERNIA W OBST	41
55011	RECUR UNIL ING HERN-OBST	41

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
55012	BILAT ING HERNIA W OBST	41
55013	RECUR BIL ING HERN-OBSTR	41
55090	UNILAT INGUINAL HERNIA	41
55091	RECUR UNILAT INGUIN HERN	41
55092	BILAT INGUINAL HERNIA	41
55093	RECUR BILAT INGUIN HERN	41
55100	UNIL FEMORAL HERN W GANG	41
55101	REC UNIL FEM HERN W GANG	41
55102	BILAT FEM HERN W GANG	41
55103	RECUR BIL FEM HERN-GANG	41
5511	UMBILICAL HERNIA W GANGR	41
55120	GANGR VENTRAL HERNIA NOS	41
55121	GANGR INCISIONAL HERNIA	41
55129	GANG VENTRAL HERNIA NEC	41
5513	DIAPHRAGM HERNIA W GANGR	78
5518	HERNIA, SITE NEC W GANGR	78
5519	HERNIA, SITE NOS W GANGR	78
55200	UNIL FEMORAL HERN W OBST	41
55201	REC UNIL FEM HERN W OBST	41
55202	BIL FEMORAL HERN W OBSTR	41
55203	REC BIL FEM HERN W OBSTR	41
5521	UMBILICAL HERNIA W OBSTR	41
55220	OBSTR VENTRAL HERNIA NOS	41
55221	OBSTR INCISIONAL HERNIA	41
55229	OBSTR VENTRAL HERNIA NEC	41
5523	DIAPHRAGM HERNIA W OBSTR	41
5528	HERNIA, SITE NEC W OBSTR	41
5529	HERNIA, SITE NOS W OBSTR	41
55300	UNILAT FEMORAL HERNIA	41
55301	RECUR UNIL FEMORAL HERN	41
55302	BILATERAL FEMORAL HERNIA	41
55303	RECUR BILAT FEMORAL HERN	41
5531	UMBILICAL HERNIA	41
55320	VENTRAL HERNIA NOS	41
55321	INCISIONAL HERNIA	41
55329	VENTRAL HERNIA NEC	41
5533	DIAPHRAGMATIC HERNIA	41
5538	HERNIA NEC	41
5539	HERNIA NOS	41
5550	REG ENTERITIS, SM INTEST	41
5551	REG ENTERITIS, LG INTEST	41
5552	REG ENTERIT SM/LG INTEST	41
5559	REGIONAL ENTERITIS NOS	41
5560	ULCERATIVE ENTEROCOLITIS	41
5561	ULCERATIVE ILEOCOLITIS	41
5562	ULCERATIVE PROCTITIS	41
5563	ULCERVTE PRCTOSIGMOIDITIS	41
5564	PSEUDOPOLYPOSIS COLON	41
5565	LFTSDED ULCERVTE COLITIS	41
5566	UNIVRSL ULCERVTE COLITIS	41
5568	OTHER ULCERATIVE COLITIS	41
5569	ULCERVTE COLITIS UNSPCF	41
5570	AC VASC INSUFF INTESTINE	41
5571	CHR VASC INSUFF INTEST	41
5579	VASC INSUFF INTEST NOS	41
5581	RADIATION GASTROENTERIT	41
5582	TOXIC GASTROENTERITIS	41
5589	NONINF GASTROENTERIT NEC	41
5600	INTUSSUSCEPTION	41
5601	PARALYTIC ILEUS	41
5602	VOLVULUS OF INTESTINE	41
56030	IMPACTION INTESTINE NOS	41
56031	GALLSTONE ILEUS	41
56039	IMPACTION INTESTINE NEC	41
56081	INTESTINAL ADHES W OBSTR	41
56089	INTESTINAL OBSTRUCT NEC	41
5609	INTESTINAL OBSTRUCT NOS	41
56200	DVRTCLO SML INT W/O HMRG	41
56201	DVRTCLI SML INT W/O HMRG	41
56202	DVRTCLO SML INT W HMRHG	41
56203	DVRTCLI SML INT W HMRHG	41
56210	DVRTCLO COLON W/O HMRHG	41
56211	DVRTCLI COLON W/O HMRHG	41
56212	DVRTCLO COLON W HMRHG	41
56213	DVRTCLI COLON W HMRHG	41
5640	CONSTIPATION	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
5641	IRRITABLE COLON	41
5642	POSTGASTRIC SURGERY SYND	41
5643	VOMITING POST-GI SURGERY	41
5644	POSTOP GI FUNCT DIS NEC	41
5645	FUNCTIONAL DIARRHEA	41
5646	ANAL SPASM	41
5647	MEGACOLON NEC	41
5648	FUNCT DIS INTESTINE NEC	41
5649	FUNCT DIS INTESTINE NOS	41
5650	ANAL FISSURE	41
5651	ANAL FISTULA	41
566	ANAL & RECTAL ABSCESS	41
5670	PERITONITIS IN INFECTION	41
5671	PNEUMOCOCCAL PERITONITIS	41
5672	SUPPURAT PERITONITIS NEC	41
5678	PERITONITIS NEC	41
5679	PERITONITIS NOS	41
5680	PERITONEAL ADHESIONS	41
56881	HEMOPERITONEUM	78
56882	PERITONEAL EFFUSION	41
56889	PERITONEAL DISORDER NEC	41
5689	PERITONEAL DISORDER NOS	41
5690	ANAL & RECTAL POLYP	41
5691	RECTAL PROLAPSE	41
5692	RECTAL & ANAL STENOSIS	41
5693	RECTAL & ANAL HEMORRHAGE	41
56941	RECTAL & ANAL ULCER	41
56942	ANAL OR RECTAL PAIN	41
56949	RECTAL & ANAL DIS NEC	41
5695	INTESTINAL ABSCESS	41
56960	COLSTOMY/ENTER COMP NOS	41
56961	COLOSTY/ENTEROST INFECTION	41
56969	COLSTOMY/ENTEROS COMP NEC	41
56981	INTESTINAL FISTULA	41
56982	ULCERATION OF INTESTINE	41
56983	PERFORATION OF INTESTINE	41
56984	ANGIO INTES W/O HMRHG	41
56985	ANGIO INTES W HMRHG	41
56989	INTESTINAL DISORDERS NEC	41
5699	INTESTINAL DISORDER NOS	41
570	ACUTE NECROSIS OF LIVER	41
5710	ALCOHOLIC FATTY LIVER	41
5711	AC ALCOHOLIC HEPATITIS	41
5712	ALCOHOL CIRRHOSIS LIVER	41
5713	ALCOHOL LIVER DAMAGE NOS	41
57140	CHRONIC HEPATITIS NOS	41
57141	CHR PERSISTENT HEPATITIS	41
57149	CHRONIC HEPATITIS NEC	41
5715	CIRRHOSIS OF LIVER NOS	41
5716	BILIARY CIRRHOSIS	41
5718	CHRONIC LIVER DIS NEC	41
5719	CHRONIC LIVER DIS NOS	41
5720	ABSCESS OF LIVER	41
5721	PORTAL PYEMIA	41
5722	HEPATIC COMA	78
5723	PORTAL HYPERTENSION	41
5724	HEPATORENAL SYNDROME	41
5728	OTH SEQUELA, CHR LIV DIS	41
5730	CHR PASSIV CONGEST LIVER	41
5731	HEPATITIS IN VIRAL DIS	41
5732	HEPATITIS IN OTH INF DIS	41
5733	HEPATITIS NOS	41
5734	HEPATIC INFARCTION	41
5738	LIVER DISORDERS NEC	41
5739	LIVER DISORDER NOS	41
57400	CHOLELITH W AC CHOLECYST	41
57401	CHOLELITH/AC GB INF-OBST	41
57410	CHOLELITH W CHOLECYS NEC	41
57411	CHOLELITH/GB INF NEC-OBS	41
57420	CHOLELITHIASIS NOS	41
57421	CHOLELITHIAS NOS W OBSTR	41
57430	CHOLEDOCHOLITH/AC GB INF	41
57431	CHOLEDOCHLITH/AC GB-OBST	41
57440	CHOLEDOCHLITH/GB INF NEC	41
57441	CHOLEDOCHLITH/GB NEC-OBS	41
57450	CHOLEDOCHOLITHIASIS NOS	41

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
57451	CHOLEDOCHLITH NOS W OBST	41
5750	ACUTE CHOLECYSTITIS	41
5752	OBSTRUCTION GALLBLADDER	41
5753	HYDROPS OF GALLBLADDER	41
5754	PERFORATION GALLBLADDER	41
5755	FISTULA OF GALLBLADDER	41
5756	GB CHOLESTEROSIS	41
5758	DIS OF GALLBLADDER NEC	41
5759	DIS OF GALLBLADDER NOS	41
5760	POSTCHOLECYSTECTOMY SYND	41
5761	CHOLANGITIS	41
5762	OBSTRUCTION OF BILE DUCT	41
5763	PERFORATION OF BILE DUCT	41
5764	FISTULA OF BILE DUCT	41
5765	SPASM SPHINCTER OF ODDI	41
5768	DIS OF BILIARY TRACT NEC	41
5769	DIS OF BILIARY TRACT NOS	41
5770	ACUTE PANCREATITIS	41
5771	CHRONIC PANCREATITIS	41
5772	PANCREAT CYST/PSEUDOCYST	41
5778	PANCREATIC DISEASE NEC	41
5779	PANCREATIC DISEASE NOS	41
5780	HEMATEMESIS	41
5781	BLOOD IN STOOL	41
5789	GASTROINTEST HEMORR NOS	41
5790	CELIAC DISEASE	41
5791	TROPICAL SPRUE	41
5792	BLIND LOOP SYNDROME	41
5793	INTEST POSTOP NONABSORB	41
5794	PANCREATIC STEATORRHEA	41
5798	INTEST MALABSORPTION NEC	41
5799	INTEST MALABSORPTION NOS	41
5800	AC PROLIFERAT NEPHRITIS	53
5804	AC RAPIDLY PROGR NEPHRIT	53
58081	AC NEPHRITIS IN OTH DIS	53
58089	ACUTE NEPHRITIS NEC	53
5809	ACUTE NEPHRITIS NOS	53
5810	NEPHROTIC SYN, PROLIFER	53
5811	EPIMEMBRANOUS NEPHRITIS	53
5812	MEMBRANOPROLIF NEPHROSIS	53
5813	MINIMAL CHANGE NEPHROSIS	53
58181	NEPHROTIC SYN IN OTH DIS	53
58189	NEPHROTIC SYNDROME NEC	53
5819	NEPHROTIC SYNDROME NOS	53
5820	CHR PROLIFERAT NEPHRITIS	53
5821	CHR MEMBRANOUS NEPHRITIS	53
5822	CHR MEMBRANOPROLIF NEPHR	53
5824	CHR RAPID PROGR NEPHRIT	53
58281	CHR NEPHRITIS IN OTH DIS	53
58289	CHRONIC NEPHRITIS NEC	53
5829	CHRONIC NEPHRITIS NOS	53
5830	PROLIFERAT NEPHRITIS NOS	53
5831	MEMBRANOUS NEPHRITIS NOS	53
5832	MEMBRANOPROLIF NEPHR NOS	53
5834	RAPIDLY PROG NEPHRIT NOS	53
5836	RENAL CORT NECROSIS NOS	53
5837	NEPHR NOS/MEDULL NECROS	53
58381	NEPHRITIS NOS IN OTH DIS	53
58389	NEPHRITIS NEC	53
5839	NEPHRITIS NOS	53
5845	LOWER NEPHRON NEPHROSIS	53
5846	AC RENAL FAIL, CORT NECR	53
5847	AC REN FAIL, MEDULL NECR	53
5848	AC RENAL FAILURE NEC	53
5849	ACUTE RENAL FAILURE NOS	53
585	CHRONIC RENAL FAILURE	53
586	RENAL FAILURE NOS	53
587	RENAL SCLEROSIS NOS	53
5880	RENAL OSTEODYSTROPHY	53
5881	NEPHROGEN DIABETES INSIP	53
5888	IMPAIRED RENAL FUNCT NEC	53
5889	IMPAIRED RENAL FUNCT NOS	53
5890	UNILATERAL SMALL KIDNEY	53
5891	BILATERAL SMALL KIDNEYS	53
5899	SMALL KIDNEY NOS	53
59000	CHR PYELONEPHRITIS NOS	53

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
59001	CHR PYELONEPH W MED NECR	53
59010	AC PYELONEPHRITIS NOS	53
59011	AC PYELONEPHR W MED NECR	53
5902	RENAL/PERIRENAL ABSCESS	53
5903	PYELOURETERITIS CYSTICA	53
59080	PYELONEPHRITIS NOS	53
59081	PYELONEPHRIT IN OTH DIS	53
5909	INFECTION OF KIDNEY NOS	53
591	HYDRONEPHROSIS	53
5920	CALCULUS OF KIDNEY	53
5921	CALCULUS OF URETER	53
5929	URINARY CALCULUS NOS	53
5930	NEPHROPTOSIS	53
5931	HYPERTROPHY OF KIDNEY	53
5932	CYST OF KIDNEY, ACQUIRED	53
5933	STRICTURE OF URETER	53
5934	URETERIC OBSTRUCTION NEC	53
5935	HYDROURETER	53
5936	POSTURAL PROTEINURIA	53
59370	VESCOURETRL RFLUX UNSPCF	53
59371	VSCURT RFLX NPHT UNILTRL	53
59372	VSCOURTL RFLX NPHT BLTRL	53
59373	VSCOURTL RFLX W NPHT NOS	53
59381	RENAL VASCULAR DISORDER	53
59382	URETERAL FISTULA	53
59389	RENAL & URETERAL DIS NEC	53
5939	RENAL & URETERAL DIS NOS	53
5940	BLAD DIVERTICULUM CALCUL	53
5941	BLADDER CALCULUS NEC	53
5942	URETHRAL CALCULUS	53
5948	LOWER URIN CALCUL NEC	53
5949	LOWER URIN CALCUL NOS	53
5950	ACUTE CYSTITIS	53
5951	CHR INTERSTIT CYSTITIS	53
5952	CHRONIC CYSTITIS NEC	53
5953	TRIGONITIS	53
5954	CYSTITIS IN OTH DIS	53
59581	CYSTITIS CYSTICA	53
59582	IRRADIATION CYSTITIS	53
59589	CYSTITIS NEC	53
5959	CYSTITIS NOS	53
5960	BLADDER NECK OBSTRUCTION	53
5961	INTESTINOVESICAL FISTULA	53
5962	VESICAL FISTULA NEC	53
5963	DIVERTICULUM OF BLADDER	53
5964	ATONY OF BLADDER	53
59651	HYPERTONICITY OF BLADDER	53
59652	LOW BLADDER COMPLIANCE	53
59653	PARALYSIS OF BLADDER	53
59654	NEUROGENIC BLADDER NOS	53
59655	DETRUSR SPHINC DYSSNRGIA	53
59659	OTH FUNC DSDR BLADDER	53
5966	BLADDER RUPT, NONTRAUM	53
5967	BLADDER WALL HEMORRHAGE	53
5968	BLADDER DISORDER NEC	53
5969	BLADDER DISORDER NOS	53
5970	URETHRAL ABSCESS	53
59780	URETHRITIS NOS	53
59781	URETHRAL SYNDROME NOS	53
59789	URETHRITIS NEC	53
59800	URETHR STRICT:INFECT NOS	53
59801	URETH STRICT:OTH INFECT	53
5981	TRAUM URETHRAL STRICTURE	53
5982	POSTOP URETHRAL STRICTUR	53
5988	URETHRAL STRICTURE NEC	53
5989	URETHRAL STRICTURE NOS	53
5990	URIN TRACT INFECTION NOS	53
5991	URETHRAL FISTULA	53
5992	URETHRAL DIVERTICULUM	53
5993	URETHRAL CARUNCLE	53
5994	URETHRAL FALSE PASSAGE	53
5995	PROLAPSE URETHRAL MUCOSA	53
5996	URINARY OBSTRUCTION NOS	53
5997	HEMATURIA	53
5998	URINARY TRACT DIS NEC*	53
59981	URETHRAL HYPERMOBILITY	53

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
59982	INTRINSC SPHNCTR DFCNCY	53
59983	URETHRAL INSTABILITY	53
59984	OTH SPCF DSDR URETHRA	53
59989	OTH SPCF DSDR URNRY TRCT	53
5999	URINARY TRACT DIS NOS	53
600	HYPERPLASIA OF PROSTATE	53
6010	ACUTE PROSTATITIS	53
6011	CHRONIC PROSTATITIS	53
6012	ABSCCESS OF PROSTATE	53
6013	PROSTATOCYSTITIS	53
6014	PROSTATITIS IN OTH DIS	53
6018	PROSTATIC INFLAM DIS NEC	53
6019	PROSTATITIS NOS	53
6020	CALCULUS OF PROSTATE	53
6021	PROSTATIC CONGEST/HEMORR	53
6022	ATROPHY OF PROSTATE	53
6028	PROSTATIC DISORDERS NEC	53
6029	PROSTATIC DISORDER NOS	53
6030	ENCYSTED HYDROCELE	53
6031	INFECTED HYDROCELE	53
6038	HYDROCELE NEC	53
6039	HYDROCELE NOS	53
6040	ORCHITIS WITH ABSCESS	53
60490	ORCHITIS/EPIDIDYMIT NOS	53
60491	ORCHITIS IN OTH DISEASE	53
60499	ORCHITIS/EPIDIDYMIT NEC	53
605	REDUN PREPUCE & PHIMOSIS	53
6060	AZOOSPERMIA	53
6061	OLIGOSPERMIA	53
6068	MALE INFERTILITY NEC	53
6069	MALE INFERTILITY NOS	53
6070	LEUKOPLAKIA OF PENIS	53
6071	BALANOPOSTHITIS	53
6072	INFLAM DIS, PENIS NEC	53
6073	PRIAPISM	53
60781	BALANITIS XEROTICA OBLIT	53
60782	VASCULAR DISORDER, PENIS	53
60783	EDEMA OF PENIS	53
60784	IMPOTENCE, ORGANIC ORIGIN	53
60789	DISORDER OF PENIS NEC	53
6079	DISORDER OF PENIS NOS	53
6080	SEMINAL VESICULITIS	97
6081	SPERMATOCELE	53
6082	TORSION OF TESTIS	53
6083	ATROPHY OF TESTIS	53
6084	MALE GEN INFLAM DIS NEC	53
60881	MALE GEN DIS IN OTH DIS	53
60883	MALE GEN VASCUL DIS NEC	53
60884	CHYLOCELE, TUNIC VAGINAL	53
60885	STRICTURE, MALE GEN ORGN	53
60886	EDEMA, MALE GENITAL ORGN	53
60889	MALE GENITAL DIS NEC	53
6089	MALE GENITAL DIS NOS	53
6100	SOLITARY CYST OF BREAST	18
6101	DIFFUS CYSTIC MASTOPATHY	18
6102	FIBROADENOSIS OF BREAST	18
6103	FIBROSCLEROSIS OF BREAST	18
6104	MAMMARY DUCT ECTASIA	18
6108	BENIGN MAMM DYSPLAS NEC	18
6109	BENIGN MAMM DYSPLAS NOS	18
6110	INFLAM DISEASE OF BREAST	18
6111	HYPERTROPHY OF BREAST	18
6112	FISSURE OF NIPPLE	18
6113	FAT NECROSIS OF BREAST	18
6114	ATROPHY OF BREAST	18
6115	GALACTOCELE	18
6116	GALACTORRHEA-NONOBSTET	18
61171	MASTODYNIA	18
61172	LUMP OR MASS IN BREAST	18
61179	SYMPTOMS IN BREAST NEC	18
6118	BREAST DISORDERS NEC	18
6119	BREAST DISORDER NOS	18
6140	AC SALPINGO-OOPHORITIS	97
6141	CHR SALPINGO-OOPHORITIS	97
6142	SALPINGO-OOPHORITIS NOS	97
6143	ACUTE PARAMETRITIS	56

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
6144	CHRONIC PARAMETRITIS	56
6145	AC PELV PERITONITIS-FEM	56
6146	FEM PELVIC PERITON ADHES	56
6147	CHR PELV PERITON NEC-FEM	56
6148	FEM PELV INFLAM DIS NEC	97
6149	FEM PELV INFLAM DIS NOS	97
6150	AC UTERINE INFLAMMATION	56
6151	CHR UTERINE INFLAMMATION	56
6159	UTERINE INFLAM DIS NOS	56
6160	CERVICITIS	97
61610	VAGINITIS NOS	97
61611	VAGINITIS IN OTH DISEASE	97
6162	BARTHOLIN'S GLAND CYST	56
6163	BARTHOLIN'S GLND ABSCESS	56
6164	ABSCESS OF VULVA NEC	56
61650	ULCERATION OF VULVA NOS	56
61651	VULVAR ULCER IN OTH DIS	56
6168	FEMALE GEN INFLAM NEC	56
6169	FEMALE GEN INFLAM NOS	56
6170	UTERINE ENDOMETRIOSIS	56
6171	OVARIAN ENDOMETRIOSIS	56
6172	TUBAL ENDOMETRIOSIS	56
6173	PELV PERIT ENDOMETRIOSIS	56
6174	VAGINAL ENDOMETRIOSIS	56
6175	INTESTINAL ENDOMETRIOSIS	41
6176	ENDOMETRIOSIS IN SCAR	18
6178	ENDOMETRIOSIS NEC	56
6179	ENDOMETRIOSIS NOS	56
6180	PROLAPSE OF VAGINAL WALL	56
6181	UTERINE PROLAPSE	56
6182	UTEROVAG PROLAPS-INCOMPL	56
6183	UTEROVAG PROLAPS-COMPLET	56
6184	UTERVAGINAL PROLAPSE NOS	56
6185	POSTOP VAGINAL PROLAPSE	56
6186	VAGINAL ENTEROCELE	56
6187	OLD LACER PELVIC MUSCLE	56
6188	GENITAL PROLAPSE NEC	56
6189	GENITAL PROLAPSE NOS	56
6190	URIN-GENITAL FISTUL, FEM	56
6191	DIGEST-GENIT FISTUL, FEM	41
6192	GENITAL-SKIN FISTUL, FEM	56
6198	FEM GENITAL FISTULA NEC	56
6199	FEM GENITAL FISTULA NOS	56
6200	FOLLICULAR CYST OF OVARY	56
6201	CORPUS LUTEUM CYST	56
6202	OVARIAN CYST NEC/NOS	56
6203	ACQ ATROPHY OVARY & TUBE	56
6204	PROLAPSE OF OVARY & TUBE	56
6205	TORSION OF OVARY OR TUBE	56
6206	BROAD LIGAMENT LACER SYN	56
6207	BROAD LIGAMENT HEMATOMA	56
6208	NONINFL DIS OVA/ADNX NEC	56
6209	NONINFL DIS OVA/ADNX NOS	56
6210	POLYP OF CORPUS UTERI	56
6211	CHR UTERINE SUBINVOLUTN	56
6212	HYPERTROPHY OF UTERUS	56
6213	ENDOMETRIAL HYPERPLASIA	56
6214	HEMATOMETRA	56
6215	INTRAUTERINE SYNECHIAE	56
6216	MALPOSITION OF UTERUS	56
6217	CHR INVERSION OF UTERUS	56
6218	DISORDERS OF UTERUS NEC	56
6219	DISORDER OF UTERUS NOS	56
6220	EROSION/ECTROPION CERVIX	56
6221	DYSPLASIA OF CERVIX	56
6222	LEUKOPLAKIA OF CERVIX	56
6223	OLD LACERATION OF CERVIX	56
6224	STRICTURE OF CERVIX	56
6225	INCOMPETENCE OF CERVIX	56
6226	HYPERTROPHIC ELONG CERVX	56
6227	MUCOUS POLYP OF CERVIX	56
6228	NONINFLAM DIS CERVIX NEC	56
6229	NONINFLAM DIS CERVIX NOS	56
6230	DYSPLASIA OF VAGINA	56
6231	LEUKOPLAKIA OF VAGINA	56
6232	STRICTURE OF VAGINA	56

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
6233	TIGHT HYMENAL RING	56
6234	OLD VAGINAL LACERATION	56
6235	NONINFECT VAG LEUKORRHEA	56
6236	VAGINAL HEMATOMA	56
6237	POLYP OF VAGINA	56
6238	NONINFLAM DIS VAGINA NEC	56
6239	NONINFLAM DIS VAGINA NOS	56
6240	DYSTROPHY OF VULVA	56
6241	ATROPHY OF VULVA	56
6242	HYPERTROPHY OF CLITORIS	56
6243	HYPERTROPHY OF LABIA	56
6244	OLD LACERATION OF VULVA	56
6245	HEMATOMA OF VULVA	56
6246	POLYP OF LABIA AND VULVA	56
6248	NONINFLAM DIS VULVA NEC	56
6249	NONINFLAM DIS VULVA NOS	56
6250	DYSPAREUNIA	56
6251	VAGINISMUS	56
6252	MITTELSCHMERZ	56
6253	DYSMENORRHEA	56
6254	PREMENSTRUAL TENSION	56
6255	PELVIC CONGESTION SYND	56
6256	FEM STRESS INCONTINENCE	56
6258	FEM GENITAL SYMPTOMS NEC	56
6259	FEM GENITAL SYMPTOMS NOS	56
6260	ABSENCE OF MENSTRUATION	56
6261	SCANTY MENSTRUATION	56
6262	EXCESSIVE MENSTRUATION	56
6263	PUBERTAL MENORRHAGIA	56
6264	IRREGULAR MENSTRUATION	56
6265	OVULATION BLEEDING	56
6266	METrorrhagia	56
6267	POSTCOITAL BLEEDING	56
6268	MENSTRUAL DISORDER NEC	56
6269	MENSTRUAL DISORDER NOS	56
6270	PREMENOPAUSE MENORRHAGIA	56
6271	POSTMENOPAUSAL BLEEDING	56
6272	FEMALE CLIMACTERIC STATE	56
6273	ATROPHIC VAGINITIS	56
6274	ARTIFIC MENOPAUSE STATES	56
6278	MENOPAUSAL DISORDER NEC	56
6279	MENOPAUSAL DISORDER NOS	56
6280	INFERTILITY-ANOVULATION	56
6281	INFERTIL-PITUITARY ORIG	56
6282	INFERTILITY-TUBAL ORIGIN	56
6283	INFERTILITY-UTERINE ORIG	56
6284	INFERTIL-CERVICAL ORIG	56
6288	FEMALE INFERTILITY NEC	56
6289	FEMALE INFERTILITY NOS	56
6290	HEMATOCELE, FEMALE NEC	56
6291	HYDROCELE CANAL NUCK-FEM	56
6298	FEMALE GENITAL DIS NEC	56
6299	FEMALE GENITAL DIS NOS	56
630	HYDATIDIFORM MOLE	57
631	OTH ABN PROD CONCEPTION	57
632	MISSED ABORTION	57
6330	ABDOMINAL PREGNANCY	57
6331	TUBAL PREGNANCY	57
6332	OVARIAN PREGNANCY	57
6338	ECTOPIC PREGNANCY NEC	57
6339	ECTOPIC PREGNANCY NOS	57
63400	SPON ABOR W PEL INF-UNSP	57
63401	SPON ABOR W PELV INF-INC	57
63402	SPON ABOR W PEL INF-COMP	57
63410	SPON ABORT W HEMORR-UNSP	57
63411	SPON ABORT W HEMORR-INC	57
63412	SPON ABORT W HEMORR-COMP	57
63420	SPON AB W PEL DAMAG-UNSP	57
63421	SPON AB W PELV DAMAG-INC	57
63422	SPON AB W PEL DAMAG-COMP	57
63430	SPON AB W REN FAIL-UNSP	57
63431	SPON AB W REN FAIL-INC	57
63432	SPON AB W REN FAIL-COMP	57
63440	SPON AB W METAB DIS-UNSP	57
63441	SPON AB W METAB DIS-INC	57
63442	SPON AB W METAB DIS-COMP	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
63450	SPON ABORT W SHOCK-UNSP	57
63451	SPON ABORT W SHOCK-INC	57
63452	SPON ABORT W SHOCK-COMP	57
63460	SPON ABORT W EMBOL-UNSP	57
63461	SPON ABORT W EMBOL-INC	57
63462	SPON ABORT W EMBOL-COMP	57
63470	SPON AB W COMPL NEC-UNSP	57
63471	SPON AB W COMPL NEC-INC	57
63472	SPON AB W COMPL NEC-COMP	57
63480	SPON AB W COMPL NOS-UNSP	57
63481	SPON AB W COMPL NOS-INC	57
63482	SPON AB W COMPL NOS-COMP	57
63490	SPON ABORT UNCOMPL-UNSP	57
63491	SPON ABORT UNCOMPL-INC	57
63492	SPON ABORT UNCOMPL-COMP	57
63500	LEG ABOR W PELV INF-UNSP	57
63501	LEG ABOR W PELV INF-INC	57
63502	LEG ABOR W PELV INF-COMP	57
63510	LEGAL ABOR W HEMORR-UNSP	57
63511	LEGAL ABORT W HEMORR-INC	57
63512	LEGAL ABOR W HEMORR-COMP	57
63520	LEG AB W PELV DAMAG-UNSP	57
63521	LEG AB W PELV DAMAG-INC	57
63522	LEG AB W PELV DAMAG-COMP	57
63530	LEG ABOR W REN FAIL-UNSP	57
63531	LEG ABOR W REN FAIL-INC	57
63532	LEG ABOR W REN FAIL-COMP	57
63540	LEG AB W METAB DIS-UNSP	57
63541	LEG AB W METAB DIS-INC	57
63542	LEG AB W METAB DIS-COMP	57
63550	LEGAL ABORT W SHOCK-UNSP	57
63551	LEGAL ABORT W SHOCK-INC	57
63552	LEGAL ABORT W SHOCK-COMP	57
63560	LEGAL ABORT W EMBOL-UNSP	57
63561	LEGAL ABORT W EMBOL-INC	57
63562	LEGAL ABORT W EMBOL-COMP	57
63570	LEG AB W COMPL NEC-UNSP	57
63571	LEG AB W COMPL NEC-INC	57
63572	LEG AB W COMPL NEC-COMP	57
63580	LEG AB W COMPL NOS-UNSP	57
63581	LEG AB W COMPL NOS-INC	57
63582	LEG AB W COMPL NOS-COMP	57
63590	LEGAL ABORT UNCOMPL-UNSP	57
63591	LEGAL ABORT UNCOMPL-INC	57
63592	LEGAL ABORT UNCOMPL-COMP	57
63600	ILLEG AB W PELV INF-UNSP	57
63601	ILLEG AB W PELV INF-INC	57
63602	ILLEG AB W PELV INF-COMP	57
63610	ILLEG AB W HEMORR-UNSPEC	57
63611	ILLEG AB W HEMORR-INC	57
63612	ILLEG AB W HEMORR-COMP	57
63620	ILLEG AB W PEL DAMG-UNSP	57
63621	ILLEG AB W PEL DAMAG-INC	57
63622	ILLEG AB W PEL DAMG-COMP	57
63630	ILLEG AB W REN FAIL-UNSP	57
63631	ILLEG AB W REN FAIL-INC	57
63632	ILLEG AB W REN FAIL-COMP	57
63640	ILLEG AB W MET DIS-UNSP	57
63641	ILLEG AB W METAB DIS-INC	57
63642	ILLEG AB W MET DIS-COMP	57
63650	ILLEG ABORT W SHOCK-UNSP	57
63651	ILLEG ABORT W SHOCK-INC	57
63652	ILLEG ABORT W SHOCK-COMP	57
63660	ILLEG AB W EMBOLISM-UNSP	57
63661	ILLEG AB W EMBOLISM-INC	57
63662	ILLEG AB W EMBOLISM-COMP	57
63670	ILLG AB W COMPL NEC-UNSP	57
63671	ILLEG AB W COMPL NEC-INC	57
63672	ILLG AB W COMPL NEC-COMP	57
63680	ILLG AB W COMPL NOS-UNSP	57
63681	ILLEG AB W COMPL NOS-INC	57
63682	ILLG AB W COMPL NOS-COMP	57
63690	ILLEG ABORT UNCOMPL-UNSP	57
63691	ILLEG ABORT UNCOMPL-INC	57
63692	ILLEG ABORT UNCOMPL-COMP	57
63700	ABORT NOS W PEL INF-UNSP	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
63701	ABORT NOS W PEL INF-INC	57
63702	ABORT NOS W PEL INF-COMP	57
63710	ABORT NOS W HEMORR-UNSP	57
63711	ABORT NOS W HEMORR-INC	57
63712	ABORT NOS W HEMORR-COMP	57
63720	AB NOS W PELV DAMAG-UNSP	57
63721	AB NOS W PELV DAMAG-INC	57
63722	AB NOS W PELV DAMAG-COMP	57
63730	AB NOS W RENAL FAIL-UNSP	57
63731	AB NOS W RENAL FAIL-INC	57
63732	AB NOS W RENAL FAIL-COMP	57
63740	AB NOS W METAB DIS-UNSP	57
63741	AB NOS W METAB DIS-INC	57
63742	AB NOS W METAB DIS-COMP	57
63750	ABORT NOS W SHOCK-UNSP	57
63751	ABORT NOS W SHOCK-INC	57
63752	ABORT NOS W SHOCK-COMP	57
63760	AB NOS W EMBOLISM-UNSP	57
63761	AB NOS W EMBOLISM-INC	57
63762	AB NOS W EMBOLISM-COMP	57
63770	AB NOS W COMPL NEC-UNSP	57
63771	AB NOS W COMPL NEC-INC	57
63772	AB NOS W COMPL NEC-COMP	57
63780	AB NOS W COMPL NOS-UNSP	57
63781	AB NOS W COMPL NOS-INC	57
63782	AB NOS W COMPL NOS-COMP	57
63790	AB NOS UNCOMPLICAT-UNSP	57
63791	AB NOS UNCOMPLICAT-INC	57
63792	AB NOS UNCOMPLICAT-COMP	57
6380	ATTEM ABORT W PELVIC INF	57
6381	ATTEM ABORT W HEMORRHAGE	57
6382	ATTEM ABORT W PELV DAMAG	57
6383	ATTEM ABORT W RENAL FAIL	57
6384	ATTEM ABOR W METABOL DIS	57
6385	ATTEM ABORTION W SHOCK	57
6386	ATTEMP ABORT W EMBOLISM	57
6387	ATTEMP ABORT W COMPL NEC	57
6388	ATTEMP ABORT W COMPL NOS	57
6389	ATTEMPTED ABORT UNCOMPL	57
6390	POSTABORTION GU INFECT	57
6391	POSTABORTION HEMORRHAGE	57
6392	POSTABORT PELVIC DAMAGE	57
6393	POSTABORT RENAL FAILURE	57
6394	POSTABORT METABOLIC DIS	57
6395	POSTABORTION SHOCK	57
6396	POSTABORTION EMBOLISM	57
6398	POSTABORTION COMPL NEC	57
6399	POSTABORTION COMPL NOS	57
64000	THREATENED ABORT-UNSPEC	57
*64001	THREATENED ABORT-DELIVER	57
64003	THREATEN ABORT-ANTEPART	57
64080	HEM EARLY PREG NEC-UNSP	57
*64081	HEM EARLY PREG NEC-DELIV	57
64083	HEM EARLY PG NEC-ANTEPAR	57
64090	HEMORR EARLY PREG-UNSPEC	57
*64091	HEM EARLY PREG-DELIVERED	57
64093	HEM EARLY PREG-ANTEPART	57
64100	PLACENTA PREVIA-UNSPEC	57
*64101	PLACENTA PREVIA-DELIVER	57
64103	PLACENTA PREVIA-ANTEPART	57
64110	PLACENTA PREV HEM-UNSPEC	57
*64111	PLACENTA PREV HEM-DELIV	57
64113	PLACEN PREV HEM-ANTEPART	57
64120	PREM SEPAR PLACEN-UNSPEC	57
64121	PREM SEPAR PLACEN-DELIV	57
64123	PREM SEPAR PLAC-ANTEPART	57
64130	COAG DEF HEMORR-UNSPEC	57
64131	COAG DEF HEMORR-DELIVER	57
64133	COAG DEF HEMORR-ANTEPART	57
64180	ANTEPART HEM NEC-UNSPEC	57
*64181	ANTEPARTUM HEM NEC-DELIV	57
64183	ANTEPART HEM NEC-ANTEPAR	57
64190	ANTEPART HEM NOS-UNSPEC	57
*64191	ANTEPARTUM HEM NOS-DELIV	57
64193	ANTEPART HEM NOS-ANTEPAR	57
64200	ESSEN HYPERTEN PREG-UNSP	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*64201	ESSEN HYPERTEN-DELIVERED .....	.....
*64202	ESSEN HYPERTEN-DEL W P/P .....	.....
64203	ESSEN HYPERTEN-ANTEPART	57
64204	ESSEN HYPERTEN-POSTPART	57
64210	RENAL HYPERTEN PREG-UNSP	57
*64211	RENAL HYPERTEN PG-DELIV .....	.....
*64212	RENAL HYPERTEN-DEL P/P .....	.....
64213	RENAL HYPERTEN-ANTEPART	57
64214	RENAL HYPERTEN-POSTPART	57
64220	OLD HYPERTEN PREG-UNSPEC	57
*64221	OLD HYPERTEN NEC-DELIVER .....	.....
*64222	OLD HYPERTEN-DELIV W P/P .....	.....
64223	OLD HYPERTEN NEC-ANTEPAR	57
64224	OLD HYPERTEN NEC-POSTPAR	57
64230	TRANS HYPERTEN PREG-UNSP	57
*64231	TRANS HYPERTEN-DELIVERED .....	.....
*64232	TRANS HYPERTEN-DEL W P/P .....	.....
64233	TRANS HYPERTEN-ANTEPART	57
64234	TRANS HYPERTEN-POSTPART	57
64240	MILD/NOS PREECLAMP-UNSP	57
*64241	MILD/NOS PREECLAMP-DELIV .....	.....
*64242	MILD PREECLAMP-DEL W P/P .....	.....
64243	MILD/NOS PREECLAMP-ANTEP	57
64244	MILD/NOS PREECLAMP-P/P	57
64250	SEVERE PREECLAMP-UNSPEC	57
*64251	SEVERE PREECLAMP-DELIVER .....	.....
*64252	SEV PREECLAMP-DEL W P/P .....	.....
64253	SEV PREECLAMP-ANTEPARTUM	57
64254	SEV PREECLAMP-POSTPARTUM	57
64260	ECLAMPSIA-UNSPECIFIED	57
*64261	ECLAMPSIA-DELIVERED .....	.....
*64262	ECLAMPSIA-DELIV W P/P .....	.....
64263	ECLAMPSIA-ANTEPARTUM	57
64264	ECLAMPSIA-POSTPARTUM	57
64270	TOX W OLD HYPERTEN-UNSP	57
*64271	TOX W OLD HYPERTEN-DELIV .....	.....
*64272	TOX W OLD HYP-DEL W P/P .....	.....
64273	TOX W OLD HYPER-ANTEPART	57
64274	TOX W OLD HYPER-POSTPART	57
64290	HYPERTEN PREG NOS-UNSPEC	57
*64291	HYPERTENS NOS-DELIVERED .....	.....
*64292	HYPERTENS NOS-DEL W P/P .....	.....
64293	HYPERTENS NOS-ANTEPARTUM	57
64294	HYPERTENS NOS-POSTPARTUM	57
64300	MILD HYPEREM GRAV-UNSPEC	57
*64301	MILD HYPEREM GRAV-DELIV .....	.....
64303	MILD HYPEREMESIS-ANTEPAR	57
64310	HYPEREM W METAB DIS-UNSP	57
*64311	HYPEREM W METAB DIS-DEL .....	.....
64313	HYPEREM W METAB-ANTEPART	57
64320	LATE VOMIT OF PREG-UNSP	57
*64321	LATE VOMIT OF PREG-DELIV .....	.....
64323	LATE VOMIT PREG-ANTEPART	57
64380	VOMIT COMPL PREG-UNSPEC	57
*64381	VOMIT COMPL PREG-DELIVER .....	.....
*64383	VOMIT COMPL PREG-ANTEPAR	57
64390	VOMIT OF PREG NOS-UNSPEC	57
*64391	VOMIT OF PREG NOS-DELIV .....	.....
*64393	VOMIT OF PG NOS-ANTEPART	57
64400	THREAT PREM LABOR-UNSPEC	57
64403	THRT PREM LABOR-ANTEPART	57
*64410	THREAT LABOR NEC-UNSPEC	57
64413	THREAT LABOR NEC-ANTEPAR	57
64420	EARLY ONSET DELIV-UNSPEC	57
*64421	EARLY ONSET DELIVERY-DEL .....	.....
64500	PROLONGED PREG-UNSPEC	57
*64501	PROLONGED PREG-DELIVERED .....	.....
64503	PROLONGED PREG-ANTEPART	57
64600	PAPYRACEOUS FETUS-UNSPEC	57
*64601	PAPYRACEOUS FETUS-DELIV .....	.....
64603	PAPYRACEOUS FET-ANTEPAR	57
64610	EDEMA IN PREG-UNSPEC	57
*64611	EDEMA IN PREG-DELIVERED .....	.....
*64612	EDEMA IN PREG-DEL W P/P .....	.....
64613	EDEMA IN PREG-ANTEPARTUM	57
64614	EDEMA IN PREG-POSTPARTUM	57

*ICD-9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
64620	RENAL DIS PREG NOS-UNSP	57
*64621	RENAL DIS NOS-DELIVERED	
*64622	RENAL DIS NOS-DEL W P/P	
*64623	RENAL DIS NOS-ANTEPARTUM	57
64624	RENAL DIS NOS-POSTPARTUM	57
64630	HABITUAL ABORTER-UNSPEC	57
*64631	HABITUAL ABORTER-DELIVER	
64633	HABITUAL ABORT-ANTEPART	57
64640	NEURITIS OF PREG-UNSPEC	57
*64641	NEURITIS-DELIVERED	
*64642	NEURITIS-DELIVERED W P/P	
64643	NEURITIS OF PREG-ANTEPAR	57
64644	NEURITIS OF PREG-POSTPAR	57
64650	BACTERIURIA PREG-UNSPEC	57
*64651	ASYM BACTERIURIA-DELIVER	
*64652	ASY BACTERURIA-DEL W P/P	
64653	ASY BACTERIURIA-ANTEPART	57
64654	ASY BACTERIURIA-POSTPART	57
64660	GU INFECT IN PREG-UNSPEC	57
*64661	GU INFECTION-DELIVERED	
*64662	GU INFECTION-DELIV W P/P	
64663	GU INFECTION-ANTEPARTUM	57
64664	GU INFECTION-POSTPARTUM	57
64670	LIVER DIS IN PREG-UNSPEC	57
*64671	LIVER DISORDER-DELIVERED	
64673	LIVER DISORDER-ANTEPART	57
64680	PREG COMPL NEC-UNSPEC	57
*64681	PREG COMPL NEC-DELIVERED	
*64682	PREG COMPL NEC-DEL W P/P	
64683	PREG COMPL NEC-ANTEPART	57
64684	PREG COMPL NEC-POSTPART	57
64690	PREG COMPL NOS-UNSPEC	57
*64691	PREG COMPL NOS-DELIVERED	
64693	PREG COMPL NOS-ANTEPART	57
64700	SYPHILIS IN PREG-UNSPEC	57
*64701	SYPHILIS-DELIVERED	
*64702	SYPHILIS-DELIVERED W P/P	
64703	SYPHILIS-ANTEPARTUM	57
64704	SYPHILIS-POSTPARTUM	57
64710	GONORRHEA IN PREG-UNSPEC	57
*64711	GONORRHEA-DELIVERED	
*64712	GONORRHEA-DELIVER W P/P	
64713	GONORRHEA-ANTEPARTUM	57
64714	GONORRHEA-POSTPARTUM	57
64720	OTHER VD IN PREG-UNSPEC	57
*64721	OTHER VD-DELIVERED	
*64722	OTHER VD-DELIVERED W P/P	
64723	OTHER VD-ANTEPARTUM	57
64724	OTHER VD-POSTPARTUM	57
64730	TB IN PREG-UNSPECIFIED	57
*64731	TUBERCULOSIS-DELIVERED	
*64732	TUBERCULOSIS-DELIV W P/P	
64733	TUBERCULOSIS-ANTEPARTUM	57
64734	TUBERCULOSIS-POSTPARTUM	57
64740	MALARIA IN PREG-UNSPEC	57
*64741	MALARIA-DELIVERED	
*64742	MALARIA-DELIVERED W P/P	
64743	MALARIA-ANTEPARTUM	57
64744	MALARIA-POSTPARTUM	57
64750	RUBELLA IN PREG-UNSPEC	57
*64751	RUBELLA-DELIVERED	
*64752	RUBELLA-DELIVERED W P/P	
64753	RUBELLA-ANTEPARTUM	57
64754	RUBELLA-POSTPARTUM	57
64760	OTH VIRUS IN PREG-UNSPEC	57
*64761	OTH VIRAL DIS-DELIVERED	
*64762	OTH VIRAL DIS-DEL W P/P	
64763	OTH VIRAL DIS-ANTEPARTUM	57
64764	OTH VIRAL DIS-POSTPARTUM	57
64780	INF DIS IN PREG NEC-UNSP	57
*64781	INFECT DIS NEC-DELIVERED	
*64782	INFECT DIS NEC-DEL W P/P	
64783	INFECT DIS NEC-ANTEPART	57
64784	INFECT DIS NEC-POSTPART	57
64790	INFECT IN PREG NOS-UNSP	57
*64791	INFECT NOS-DELIVERED	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*64792	INFECT NOS-DELIVER W P/P	57
64793	INFECT NOS-ANTEPARTUM	57
64794	INFECT NOS-POSTPARTUM	57
64800	DIABETES IN PREG-UNSPEC	57
*64801	DIABETES-DELIVERED	57
*64802	DIABETES-DELIVERED W P/P	57
64803	DIABETES-ANTEPARTUM	57
64804	DIABETES-POSTPARTUM	57
64810	THYROID DYSFUN PREG-UNSP	57
*64811	THYROID DYSFUNC-DELIVER	57
*64812	THYROID DYSFUN-DEL W P/P	57
64813	THYROID DYSFUNC-ANTEPART	57
64814	THYROID DYSFUNC-POSTPART	57
64820	ANEMIA IN PREG-UNSPEC	57
*64821	ANEMIA-DELIVERED	57
*64822	ANEMIA-DELIVERED W P/P	57
64823	ANEMIA-ANTEPARTUM	57
64824	ANEMIA-POSTPARTUM	57
64830	DRUG DEPEND PREG-UNSPEC	57
*64831	DRUG DEPENDENCE-DELIVER	57
*64832	DRUG DEPENDEN-DEL W P/P	57
64833	DRUG DEPENDENCE-ANTEPART	57
64834	DRUG DEPENDENCE-POSTPART	57
64840	MENTAL DIS PREG-UNSPEC	57
*64841	MENTAL DISORDER-DELIVER	57
*64842	MENTAL DIS-DELIV W P/P	57
64843	MENTAL DISORDER-ANTEPART	57
64844	MENTAL DISORDER-POSTPART	57
64850	CONGEN CV DIS PREG-UNSP	57
*64851	CONGEN CV DIS-DELIVERED	57
*64852	CONGEN CV DIS-DEL W P/P	57
64853	CONGEN CV DIS-ANTEPARTUM	57
64854	CONGEN CV DIS-POSTPARTUM	57
64860	CV DIS NEC PREG-UNSPEC	57
*64861	CV DIS NEC PREG-DELIVER	57
*64862	CV DIS NEC-DELIVER W P/P	57
64863	CV DIS NEC-ANTEPARTUM	57
64864	CV DIS NEC-POSTPARTUM	57
64870	BONE DISORD IN PREG-UNSP	57
*64871	BONE DISORDER-DELIVERED	57
*64872	BONE DISORDER-DEL W P/P	57
64873	BONE DISORDER-ANTEPARTUM	57
64874	BONE DISORDER-POSTPARTUM	57
64880	ABN GLUCOSE IN PREG-UNSP	57
*64881	ABN GLUCOSE TOLER-DELIV	57
*64882	ABN GLUCOSE-DELIV W P/P	57
64883	ABN GLUCOSE-ANTEPARTUM	57
64884	ABN GLUCOSE-POSTPARTUM	57
64890	OTH CURR COND PREG-UNSP	57
*64891	OTH CURR COND-DELIVERED	57
*64892	OTH CURR COND-DEL W P/P	57
64893	OTH CURR COND-ANTEPARTUM	57
64894	OTH CURR COND-POSTPARTUM	57
*650	NORMAL DELIVERY	57
65100	TWIN PREGNANCY-UNSPEC	57
*65101	TWIN PREGNANCY-DELIVERED	57
65103	TWIN PREGNANCY-ANTEPART	57
65110	TRIPLT PREGNANCY-UNSPEC	57
*65111	TRIPLT PREGNANCY-DELIV	57
65113	TRIPLT PREG-ANTEPARTUM	57
65120	QUADRUPLT PREG-UNSPEC	57
*65121	QUADRUPLT PREG-DELIVER	57
65123	QUADRUPLT PREG-ANTEPART	57
65130	TWINS W FETAL LOSS-UNSP	57
*65131	TWINS W FETAL LOSS-DEL	57
65133	TWINS W FETAL LOSS-ANTE	57
65140	TRIPLETS W FET LOSS-UNSP	57
*65141	TRIPLETS W FET LOSS-DEL	57
65143	TRIPLETS W FET LOSS-ANTE	57
65150	QUADS W FETAL LOSS-UNSP	57
*65151	QUADS W FETAL LOSS-DEL	57
65153	QUADS W FETAL LOSS-ANTE	57
65160	MULT GES W FET LOSS-UNSP	57
*65161	MULT GES W FET LOSS-DEL	57
65163	MULT GES W FET LOSS-ANTE	57
65180	MULTI GESTAT NEC-UNSPEC	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*65181	MULTI GESTAT NEC-DELIVER	57
65183	MULTI GEST NEC-ANTEPART	57
65190	MULTI GESTAT NOS-UNSPEC	57
*65191	MULT GESTATION NOS-DELIV	57
65193	MULTI GEST NOS-ANTEPART	57
65200	UNSTABLE LIE-UNSPECIFIED	57
*65201	UNSTABLE LIE-DELIVERED	57
65203	UNSTABLE LIE-ANTEPARTUM	57
65210	CEPHALIC VERS NOS-UNSPEC	57
*65211	CEPHALIC VERS NOS-DELIV	57
65213	CEPHAL VERS NOS-ANTEPART	57
65220	BREECH PRESENTAT-UNSPEC	57
*65221	BREECH PRESENTAT-DELIVER	57
65223	BREECH PRESENT-ANTEPART	57
65230	TRANSV/OBLIQ LIE-UNSPEC	57
*65231	TRANSVER/OBLIQ LIE-DELIV	57
65233	TRANSV/OBLIQ LIE-ANTEPAR	57
65240	FACE/BROW PRESENT-UNSPEC	57
*65241	FACE/BROW PRESENT-DELIV	57
65243	FACE/BROW PRES-ANTEPART	57
65250	HIGH HEAD AT TERM-UNSPEC	57
*65251	HIGH HEAD AT TERM-DELIV	57
65253	HIGH HEAD TERM-ANTEPART	57
65260	MULT GEST MALPRES-UNSP	57
*65261	MULT GEST MALPRES-DELIV	57
65263	MULT GES MALPRES-ANTEPAR	57
65270	PROLAPSED ARM-UNSPEC	57
*65271	PROLAPSED ARM-DELIVERED	57
65273	PROLAPSED ARM-ANTEPART	57
65280	MALPOSITION NEC-UNSPEC	57
*65281	MALPOSITION NEC-DELIVER	57
65283	MALPOSITION NEC-ANTEPART	57
65290	MALPOSITION NOS-UNSPEC	57
*65291	MALPOSITION NOS-DELIVER	57
65293	MALPOSITION NOS-ANTEPART	57
65300	PELVIC DEFORM NOS-UNSPEC	57
*65301	PELVIC DEFORM NOS-DELIV	57
65303	PELV DEFORM NOS-ANTEPART	57
65310	CONTRACT PELV NOS-UNSPEC	57
*65311	CONTRACT PELV NOS-DELIV	57
65313	CONTRAC PELV NOS-ANTEPAR	57
65320	INLET CONTRACTION-UNSPEC	57
*65321	INLET CONTRACTION-DELIV	57
65323	INLET CONTRACT-ANTEPART	57
65330	OUTLET CONTRACTION-UNSP	57
*65331	OUTLET CONTRACTION-DELIV	57
65333	OUTLET CONTRACT-ANTEPART	57
65340	FETOPELV DISPROP-UNSPEC	57
*65341	FETOPELV DISPROP-DELIV	57
65343	FETOPELV DISPROP-ANTEPART	57
65350	FETAL DISPROP NOS-UNSPEC	57
*65351	FETAL DISPROP NOS-DELIV	57
65353	FETAL DISPRO NOS-ANTEPAR	57
65360	HYDROCEPHAL FETUS-UNSPEC	57
*65361	HYDROCEPH FETUS-DELIVER	57
65363	HYDROCEPH FETUS-ANTEPART	57
65370	OTH ABN FET DISPROP-UNSP	57
*65371	OTH ABN FET DISPRO-DELIV	57
65373	OTH ABN FET DISPRO-ANTEP	57
65380	DISPROPORTION NEC-UNSPEC	57
*65381	DISPROPORTION NEC-DELIV	57
65383	DISPROPOR NEC-ANTEPARTUM	57
*65390	DISPROPORTION NOS-UNSPEC	57
*65391	DISPROPORTION NOS-DELIV	57
65393	DISPROPOR NOS-ANTEPARTUM	57
65400	CONG ABN UTER PREG-UNSP	57
*65401	CONGEN ABN UTERUS-DELIV	57
*65402	CONG ABN UTER-DEL W P/P	57
65403	CONGEN ABN UTER-ANTEPART	57
65404	CONGEN ABN UTER-POSTPART	57
65410	UTER TUMOR IN PREG-UNSP	57
*65411	UTERINE TUMOR-DELIVERED	57
*65412	UTERINE TUMOR-DEL W P/P	57
65413	UTERINE TUMOR-ANTEPARTUM	57
65414	UTERINE TUMOR-POSTPARTUM	57
65420	PREV C-DELIVERY UNSPEC	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*65421	PREV C-DELIVERY-DELIVRD .....	.....
65423	PREV C-DELIVERY-ANTEPART	57
65430	RETROVERT UTERUS-UNSPEC	57
*65431	RETROVERT UTERUS-DELIVER .....	.....
*65432	RETROVERT UTER-DEL W P/P .....	.....
65433	RETROVERT UTER-ANTEPART	57
65434	RETROVERT UTER-POSTPART	57
65440	ABN GRAV UTERUS NEC-UNSP	57
*65441	ABN UTERUS NEC-DELIVERED .....	.....
*65442	ABN UTERUS NEC-DEL W P/P .....	.....
65443	ABN UTERUS NEC-ANTEPART	57
65444	ABN UTERUS NEC-POSTPART	57
65450	CERV INCOMPET PREG-UNSP	57
*65451	CERVICAL INCOMPET-DELIV .....	.....
*65452	CERV INCOMPET-DEL W P/P .....	.....
65453	CERV INCOMPET-ANTEPARTUM	57
65454	CERV INCOMPET-POSTPARTUM	57
65460	ABN CERVIX NEC PREG-UNSP	57
*65461	ABN CERVIX NEC-DELIVERED .....	.....
*65462	ABN CERVIX NEC-DEL W P/P .....	.....
65463	ABN CERVIX NEC-ANTEPART	57
65464	ABN CERVIX NEC-POSTPART	57
65470	ABN VAGINA IN PREG-UNSP	57
*65471	ABNORM VAGINA-DELIVERED .....	.....
*65472	ABNORM VAGINA-DEL W P/P .....	.....
65473	ABNORM VAGINA-ANTEPARTUM	57
65474	ABNORM VAGINA-POSTPARTUM	57
65480	ABN VULVA IN PREG-UNSPEC	57
*65481	ABNORMAL VULVA-DELIVERED .....	.....
*65482	ABNORMAL VULVA-DEL W P/P .....	.....
65483	ABNORMAL VULVA-ANTEPART	57
65484	ABNORMAL VULVA-POSTPART	57
65490	ABN PEL NEC IN PREG-UNSP	57
*65491	ABN PELV ORG NEC-DELIVER .....	.....
*65492	ABN PELV NEC-DELIV W P/P .....	.....
65493	ABN PELV ORG NEC-ANTEPAR	57
65494	ABN PELV ORG NEC-POSTPAR	57
65500	FETAL CNS MALFORM-UNSPEC	57
*65501	FETAL CNS MALFORM-DELIV .....	.....
65503	FETAL CNS MALFOR-ANTEPAR	57
65510	FETAL CHROMOS ABN-UNSPEC	57
*65511	FETAL CHROMOSO ABN-DELIV .....	.....
65513	FET CHROMO ABN-ANTEPART	57
65520	FAMIL HEREDIT DIS-UNSPEC	57
*65521	FAMIL HEREDIT DIS-DELIV .....	.....
65523	FAMIL HERED DIS-ANTEPART	57
65530	FET DAMG D/T VIRUS-UNSP	57
*65531	FET DAMG D/T VIRUS-DELIV .....	.....
65533	FET DAMG D/T VIRUS-ANTEP	57
65540	FET DAMG D/T DIS-UNSPEC	57
*65541	FET DAMG D/T DIS-DELIVER .....	.....
65543	FET DAMG D/T DIS-ANTEPAR	57
65550	FETAL DAMG D/T DRUG-UNSP	57
*65551	FET DAMAG D/T DRUG-DELIV .....	.....
65553	FET DAMG D/T DRUG-ANTEPA	57
65560	RADIAT FETAL DAMAG-UNSP	57
*65561	RADIAT FETAL DAMAG-DELIV .....	.....
65563	RADIAT FET DAMAG-ANTEPAR	57
65580	FETAL ABNORM NEC-UNSPEC	57
*65581	FETAL ABNORM NEC-DELIVER .....	.....
65583	FETAL ABNORM NEC-ANTEPAR	57
65590	FETAL ABNORM NOS-UNSPEC	57
*65591	FETAL ABNORM NOS-DELIVER .....	.....
65593	FETAL ABNORM NOS-ANTEPAR	57
65600	FETAL-MATERNAL HEM-UNSP	57
*65601	FETAL-MATERNAL HEM-DELIV .....	.....
65603	FETAL-MATERN HEM-ANTEPAR	57
65610	RH ISOIMMUNIZATION-UNSP	57
*65611	RH ISOIMMUNIZAT-DELIVER .....	.....
65613	RH ISOIMMUNIZAT-ANTEPART	57
65620	ABO ISOIMMUNIZATION-UNSP	57
*65621	ABO ISOIMMUNIZAT-DELIVER .....	.....
65623	ABO ISOIMMUNIZAT-ANTEPAR	57
65630	FETAL DISTRESS-UNSPEC	57
*65631	FETAL DISTRESS-DELIVERED	
65633	FETAL DISTRESS-ANTEPART	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
65640	INTRAUTERINE DEATH-UNSP	57
*65641	INTRAUTER DEATH-DELIVER	57
65643	INTRAUTER DEATH-ANTEPART	57
65650	POOR FETAL GROWTH-UNSPEC	57
*65651	POOR FETAL GROWTH-DELIV	57
65653	POOR FETAL GRTH-ANTEPART	57
65660	EXCESS FETAL GRTH-UNSPEC	57
*65661	EXCESS FETAL GRTH-DELIV	57
65663	EXCESS FET GRTH-ANTEPART	57
65670	OTH PLACENT COND-UNSPEC	57
*65671	OTH PLACENT COND-DELIVER	57
65673	OTH PLACENT COND-ANTEPART	57
65680	FET/PLAC PROB NEC-UNSPEC	57
*65681	FET/PLAC PROB NEC-DELIV	57
65683	FET/PLAC PROB NEC-ANTEPA	57
65690	FET/PLAC PROB NOS-UNSPEC	57
*65691	FET/PLAC PROB NOS-DELIV	57
65693	FET/PLAC PROB NOS-ANTEPA	57
65700	POLYHYDRAMNIOS-UNSPEC	57
*65701	POLYHYDRAMNIOS-DELIVERED	57
65703	POLYHYDRAMNIOS-ANTEPART	57
65800	OLIGOHYDRAMNIOS-UNSPEC	57
*65801	OLIGOHYDRAMNIOS-DELIVER	57
65803	OLIGOHYDRAMNIOS-ANTEPART	57
65810	PREM RUPT MEMBRAN-UNSPEC	57
*65811	PREM RUPT MEMBRAN-DELIV	57
65813	PREM RUPT MEMB-ANTEPART	57
65820	PROLONG RUPT MEMB-UNSPEC	57
65821	PROLONG RUPT MEMB-DELIV	57
65823	PROLONG RUP MEMB-ANTEPART	57
65830	ARTIFIC RUPT MEMBR-UNSP	57
*65831	ARTIFIC RUPT MEMBR-DELIV	57
65833	ARTIF RUPT MEMB-ANTEPART	57
65840	AMNIOTIC INFECTION-UNSP	57
*65841	AMNIOTIC INFECTION-DELIV	57
65843	AMNIOTIC INFECT-ANTEPART	57
65880	AMNIOTIC PROB NEC-UNSPEC	57
*65881	AMNIOTIC PROB NEC-DELIV	57
65883	AMNION PROB NEC-ANTEPART	57
65890	AMNIOTIC PROB NOS-UNSPEC	57
65891	AMNIOTIC PROB NOS-DELIV	57
65893	AMNION PROB NOS-ANTEPART	57
65900	FAIL MECHAN INDUCT-UNSP	57
*65901	FAIL MECH INDUCT-DELIVER	57
65903	FAIL MECH INDUCT-ANTEPART	57
65910	FAIL INDUCTION NOS-UNSP	57
*65911	FAIL INDUCTION NOS-DELIV	57
65913	FAIL INDUCT NOS-ANTEPART	57
65920	PYREXIA IN LABOR-UNSPEC	57
*65921	PYREXIA IN LABOR-DELIVER	57
65923	PYREXIA IN LABOR-ANTEPART	57
65930	SEPTICEMIA IN LABOR-UNSP	57
*65931	SEPTICEM IN LABOR-DELIV	57
65933	SEPTICEM IN LABOR-ANTEPA	57
65940	GRAND MULTIPARITY-UNSPEC	57
*65941	GRAND MULTIPARITY-DELIV	57
65943	GRAND MULTIPARITY-ANTEPA	57
65950	ELDERLY PRIMIGRAVID-UNSP	57
*65951	ELDERLY PRIMIGRAVIDA-DEL	57
65953	ELDER PRIMIGRAVID-ANTEPA	57
65960	OTH ADVNCD MTRNL AGE UNS	57
*65961	OTH ADVNCD MTRNL AGE DEL	57
65963	OTH ADVNCD MTRNL AGE ANT	57
65980	COMPLIC LABOR NEC-UNSP	57
*65981	COMPLIC LABOR NEC-DELIV	57
65983	COMPL LABOR NEC-ANTEPART	57
65990	COMPLIC LABOR NOS-UNSP	57
*65991	COMPLIC LABOR NOS-DELIV	57
65993	COMPL LABOR NOS-ANTEPART	57
66000	OBSTRUCT/FET MALPOS-UNSP	57
*66001	OBSTRUC/FET MALPOS-DELIV	57
66003	OBSTRUC/FET MALPOS-ANTEP	57
66010	BONY PELV OBSTRUC-UNSPEC	57
*66011	BONY PELV OBSTRUC-DELIV	57
66013	BONY PELV OBSTRUC-ANTEPA	57
66020	ABN PELV TISS OBSTR-UNSP	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
66021	ABN PELV TIS OBSTR-DELIV	57
66023	ABN PELV TIS OBSTR-ANTEP	57
66030	PERSIST OCCIPITPOST-UNSP	57
*66031	PERSIST OCCIPTPOST-DELIV	
66033	PERSIST OCCIPTPOST-ANTEP	57
66040	SHOULDER DYSTOCIA-UNSPEC	57
*66041	SHOULDER DYSTOCIA-DELIV	
66043	SHOULDER DYSTOCIA-ANTEPA	57
66050	LOCKED TWINS-UNSPECIFIED	57
*66051	LOCKED TWINS-DELIVERED	
66053	LOCKED TWINS-ANTEPARTUM	57
66060	FAIL TRIAL LAB NOS-UNSP	57
*66061	FAIL TRIAL LAB NOS-DELIV	
66063	FAIL TRIAL LAB NOS-ANTEP	57
66070	FAILED FORCEP NOS-UNSPEC	57
*66071	FAILED FORCEPS NOS-DELIV	
66073	FAIL FORCEPS NOS-ANTEPAR	57
66080	OBSTRUC LABOR NEC-UNSPEC	57
*66081	OBSTRUCT LABOR NEC-DELIV	
66083	OBSTRUC LABOR NEC-ANTEPA	57
66090	OBSTRUC LABOR NOS-UNSPEC	57
*66091	OBSTRUCT LABOR NOS-DELIV	
66093	OBSTRUC LABOR NOS-ANTEPA	57
66100	PRIM UTERINE INERT-UNSP	57
*66101	PRIM UTERINE INERT-DELIV	
66103	PRIM UTER INERT-ANTEPART	57
66110	SEC UTERINE INERT-UNSPEC	57
*66111	SEC UTERINE INERT-DELIV	
66113	SEC UTERINE INERT-ANTEPA	57
66120	UTERINE INERTIA NEC-UNSP	57
*66121	UTERINE INERT NEC-DELIV	
66123	UTERINE INERT NEC-ANTEPA	57
66130	PRECIPITATE LABOR-UNSPEC	57
*66131	PRECIPITATE LABOR-DELIV	
66133	PRECIPITATE LABOR-ANTEPA	57
66140	UTER DYSTOCIA NOS-UNSPEC	57
*66141	UTER DYSTOCIA NOS-DELIV	
66143	UTER DYSTOCIA NOS-ANTEPA	57
66190	ABNORMAL LABOR NOS-UNSP	57
*66191	ABNORMAL LABOR NOS-DELIV	
66193	ABNORM LABOR NOS-ANTEPAR	57
66200	PROLONGED 1ST STAGE-UNSP	57
*66201	PROLONG 1ST STAGE-DELIV	
66203	PROLONG 1ST STAGE-ANTEPA	57
66210	PROLONGED LABOR NOS-UNSP	57
*66211	PROLONG LABOR NOS-DELIV	
66213	PROLONG LABOR NOS-ANTEPA	57
66220	PROLONGED 2ND STAGE-UNSP	57
*66221	PROLONG 2ND STAGE-DELIV	
66223	PROLONG 2ND STAGE-ANTEPA	57
66230	DELAY DEL 2ND TWIN-UNSP	57
*66231	DELAY DEL 2ND TWIN-DELIV	
66233	DELAY DEL 2 TWIN-ANTEPAR	57
66300	CORD PROLAPSE-UNSPEC	57
*66301	CORD PROLAPSE-DELIVERED	
66303	CORD PROLAPSE-ANTEPARTUM	57
66310	CORD AROUND NECK-UNSPEC	57
*66311	CORD AROUND NECK-DELIVER	
66313	CORD AROUND NECK-ANTEPAR	57
66320	CORD COMPRESS NEC-UNSPEC	57
*66321	CORD COMPRESS NEC-DELIV	
66323	CORD COMPRES NEC-ANTEPAR	57
66330	CORD ENTANGLE NEC-UNSPEC	57
*66331	CORD ENTANGLE NEC-DELIV	
66333	CORD ENTANGL NEC-ANTEPAR	57
66340	SHORT CORD-UNSPECIFIED	57
*66341	SHORT CORD-DELIVERED	
66343	SHORT CORD-ANTEPARTUM	57
66350	VASA PREVIA-UNSPECIFIED	57
*66351	VASA PREVIA-DELIVERED	
66353	VASA PREVIA-ANTEPARTUM	57
66360	VASC LESION CORD-UNSPEC	57
*66361	VASC LESION CORD-DELIVER	
66363	VASC LESION CORD-ANTEPAR	57
66380	CORD COMPLICAT NEC-UNSP	57
*66381	CORD COMPLICAT NEC-DELIV	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
66383	CORD COMPL NEC-ANTEPART	57
66390	CORD COMPLICAT NOS-UNSP	57
*66391	CORD COMPLICAT NOS-DELIV	
66393	CORD COMPL NOS-ANTEPART	57
66400	DEL W 1 DEG LACERAT-UNSP	57
*66401	DEL W 1 DEG LACERAT-DEL	
66404	DEL W 1 DEG LAC-POSTPART	57
66410	DEL W 2 DEG LACERAT-UNSP	57
*66411	DEL W 2 DEG LACERAT-DEL	
66414	DEL W 2 DEG LAC-POSTPART	57
66420	DEL W 3 DEG LACERAT-UNSP	57
*66421	DEL W 3 DEG LACERAT-DEL	
66424	DEL W 3 DEG LAC-POSTPART	57
66430	DEL W 4 DEG LACERAT-UNSP	57
*66431	DEL W 4 DEG LACERAT-DEL	
66434	DEL W 4 DEG LAC-POSTPART	57
66440	OB PERINEAL LAC NOS-UNSP	57
*66441	OB PERINEAL LAC NOS-DEL	
66444	PERINEAL LAC NOS-POSTPAR	57
66450	OB PERINEAL HEMATOM-UNSP	57
*66451	OB PERINEAL HEMATOMA-DEL	
66454	PERIN HEMATOMA-POSTPART	57
66480	OB PERIN TRAUM NEC-UNSP	57
*66481	OB PERINEAL TRAU NEC-DEL	
66484	PERIN TRAUM NEC-POSTPART	57
66490	OB PERIN TRAUM NOS-UNSP	57
*66491	OB PERINEAL TRAU NOS-DEL	
66494	PERIN TRAUM NOS-POSTPART	57
66500	PRELABOR RUPT UTER-UNSP	57
*66501	PRELABOR RUPT UTERUS-DEL	
66503	PRELAB RUPT UTER-ANTEPAR	57
66510	RUPTURE UTERUS NOS-UNSP	57
*66511	RUPTURE UTERUS NOS-DELIV	
66520	INVERSION OF UTERUS-UNSP	57
*66522	INVERS UTERUS-DEL W P/P	
66524	INVERS UTERUS-POSTPART	57
66530	LACERAT OF CERVIX-UNSPEC	57
*66531	LACERAT OF CERVIX-DELIV	
66534	LACER OF CERVIX-POSTPART	57
66540	HIGH VAGINAL LACER-UNSP	57
*66541	HIGH VAGINAL LACER-DELIV	
66544	HIGH VAGINAL LAC-POSTPAR	57
66550	OB INJ PELV ORG NEC-UNSP	57
*66551	OB INJ PELV ORG NEC-DEL	
66554	INJ PELV ORG NEC-POSTPAR	57
66560	DAMAGE TO PELVIC JT-UNSP	57
*66561	DAMAGE TO PELVIC JT-DEL	
66564	DAMAGE PELVIC JT-POSTPAR	57
66570	OB PELVIC HEMATOMA-UNSP	57
*66571	OB PELVIC HEMATOMA-DELIV	
*66572	PELVIC HEMATOM-DEL W PP	
66574	PELVIC HEMATOMA-POSTPART	57
66580	OB TRAUMA NEC-UNSPEC	57
*66581	OB TRAUMA NEC-DELIVERED	
*66582	OB TRAUMA NEC-DEL W P/P	
66583	OB TRAUMA NEC-ANTEPARTUM	57
66584	OB TRAUMA NEC-POSTPARTUM	57
66590	OB TRAUMA NOS-UNSPEC	57
*66591	OB TRAUMA NOS-DELIVERED	
*66592	OB TRAUMA NOS-DEL W P/P	
66593	OB TRAUMA NOS-ANTEPARTUM	57
66594	OB TRAUMA NOS-POSTPARTUM	57
66600	THIRD-STAGE HEM-UNSPEC	57
*66602	THRD-STAGE HEM-DEL W P/P	
66604	THIRD-STAGE HEM-POSTPART	57
66610	POSTPARTUM HEM NEC-UNSP	57
*66612	POSTPA HEM NEC-DEL W P/P	
66614	POSTPART HEM NEC-POSTPAR	57
66620	DELAY P/PART HEM-UNSPEC	57
*66622	DELAY P/P HEM-DEL W P/P	
66624	DELAY P/PART HEM-POSTPAR	57
66630	POSTPART COAGUL DEF-UNSP	57
*66632	P/P COAG DEF-DEL W P/P	
66634	POSTPART COAG DEF-POSTPA	57
66700	RETAIN PLACENTA NOS-UNSP	57
*66702	RETND PLAC NOS-DEL W P/P	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
66704	RETAIN PLAC NOS-POSTPART	57
66710	RETAIN PROD CONCEPT-UNSP	57
*66712	RET PROD CONC-DEL W P/P	
66714	RET PROD CONCEPT-POSTPAR	57
66800	PULM COMPL IN DEL-UNSPEC	57
*66801	PULM COMPL IN DEL-DELIV	
*66802	PULM COMPLIC-DEL W P/P	
66803	PULM COMPLICAT-ANTEPART	57
66804	PULM COMPLICAT-POSTPART	57
66810	HEART COMPL IN DEL-UNSP	57
*66811	HEART COMPL IN DEL-DELIV	
*66812	HEART COMPL-DEL W P/P	
66813	HEART COMPLIC-ANTEPART	57
66814	HEART COMPLIC-POSTPART	57
66820	CNS COMPL LABOR/DEL-UNSP	57
*66821	CNS COMPL LAB/DEL-DELIV	
*66822	CNS COMPLIC-DEL W P/P	
66823	CNS COMPL IN DEL-ANTEPAR	57
66824	CNS COMPL IN DEL-POSTPAR	57
66880	ANESTH COMP DEL NEC-UNSP	57
*66881	ANESTH COMPL NEC-DELIVER	
*66882	ANESTH COMPL NEC-DEL P/P	
66883	ANESTH COMPL ANTEPARTUM	57
66884	ANESTH COMPL-POSTPARTUM	57
66890	ANESTH COMP DEL NOS-UNSP	57
*66891	ANESTH COMPL NOS-DELIVER	
*66892	ANESTH COMPL NOS-DEL P/P	
66893	ANESTH COMPL-ANTEPARTUM	57
66894	ANESTH COMPL-POSTPARTUM	57
66900	MATERNAL DISTRESS-UNSPEC	57
*66901	MATERNAL DISTRESS-DELIV	
*66902	MATERN DISTRES-DEL W P/P	
66903	MATERN DISTRESS-ANTEPAR	57
66904	MATERN DISTRESS-POSTPART	57
66910	OBSTETRIC SHOCK-UNSPEC	57
*66911	OBSTETRIC SHOCK-DELIVER	
*66912	OBSTET SHOCK-DELIV W P/P	
66913	OBSTETRIC SHOCK-ANTEPAR	57
66914	OBSTETRIC SHOCK-POSTPART	57
66920	MATERN HYPOTENS SYN-UNSP	57
*66921	MATERN HYPOTEN SYN-DELIV	
*66922	MATERN HYPOTEN-DEL W P/P	
66923	MATERN HYPOTENS-ANTEPAR	57
66924	MATERN HYPOTENS-POSTPART	57
66930	AC REN FAIL W DELIV-UNSP	57
*66932	AC REN FAIL-DELIV W P/P	
66934	AC RENAL FAILURE-POSTPAR	57
66940	OTH OB SURG COMPL-UNSPEC	57
*66941	OTH OB COMPL-DELIVERED	
*66942	OTH OB COMPL-DELIV W P/P	
66943	COMPLC OB SURG ANTEPTM	56
66944	OTH OB SURG COMPL-POSTPA	57
66950	FORCEP DELIV NOS-UNSPEC	57
*66951	FORCEP DELIV NOS-DELIVER	
66960	BREECH EXTR NOS-UNSPEC	57
*66961	BREECH EXTR NOS-DELIVER	
66970	CESAREAN DELIV NOS-UNSP	57
*66971	CESAREAN DELIVERY NOS	
*66980	COMPL LAB/DELIV NEC-UNSP	
*66981	COMPL LAB/DELIV NEC-DELIV	
*66982	COMPL DEL NEC-DEL W P/P	
66983	COMPL DELIV NEC-ANTEPAR	57
66984	COMPL DELIV NEC-POSTPART	57
66990	COMPL LAB/DELIV NOS-UNSP	57
*66991	COMPL LAB/DELIV NOS-DELIV	
*66992	COMPL DEL NOS-DEL W P/P	
66993	COMPL DELIV NOS-ANTEPAR	57
66994	COMPL DELIV NOS-POSTPART	57
67000	MAJOR PUERP INFECT-UNSP	57
*67002	MAJOR PUERP INF-DEL P/P	
67004	MAJOR PUERP INF-POSTPART	57
67100	VARIC VEIN LEG PREG-UNSP	57
*67101	VARICOSE VEIN LEG-DELIV	
*67102	VARIC VEIN LEG-DEL W P/P	
67103	VARIC VEIN LEG-ANTEPART	57
67104	VARIC VEIN LEG-POSTPART	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
67110	VARIC VULVA PREG-UNSPEC	57
*67111	VARICOSE VULVA-DELIVERED	
*67112	VARICOSE VULVA-DEL W P/P	
67113	VARICOSE VULVA-ANTEPART	57
67114	VARICOSE VULVA-POSTPART	57
67120	THROMBOPHLEB PREG-UNSPEC	57
*67121	THROMBOPHLEBITIS-DELIVER	
*67122	THROMBOPHLEB-DELIV W P/P	
67123	THROMBOPHLEBIT-ANTEPART	57
67124	THROMBOPHLEBIT-POSTPART	57
67130	DEEP THROMB ANTEPAR-UNSP	57
*67131	DEEP THROM ANTEPAR-DELIV	
67133	DEEP VEIN THROMB-ANTEPAR	57
67140	DEEP THROMB POSTPAR-UNSP	57
*67142	THROMB POSTPAR-DEL W P/P	
67144	DEEP VEIN THROMB-POSTPAR	57
67150	THROMBOSIS NEC PREG-UNSP	57
*67151	THROMBOSIS NEC-DELIVERED	
*67152	THROMB NEC-DELIV W P/P	
67153	THROMBOSIS NEC-ANTEPART	57
67154	THROMBOSIS NEC-POSTPART	57
67180	VEN COMPL PREG NEC-UNSP	57
*67181	VENOUS COMPL NEC-DELIVER	
*67182	VEN COMP NEC-DELIV W P/P	
67183	VENOUS COMPL NEC-ANTEPAR	57
67184	VENOUS COMPL NEC-POSTPAR	57
67190	VEN COMPL PREG NOS-UNSP	57
*67191	VENOUS COMPL NOS-DELIVER	
*67192	VEN COMP NOS-DELIV W P/P	
67193	VENOUS COMPL NOS-ANTEPAR	57
67194	VENOUS COMPL NOS-POSTPAR	57
67200	PUERPERAL PYREXIA-UNSPEC	57
*67202	PUERP PYREXIA-DEL W P/P	
67204	PUERP PYREXIA-POSTPARTUM	57
67300	OB AIR EMBOLISM-UNSPEC	57
*67301	OB AIR EMBOLISM-DELIVER	
*67302	OB AIR EMBOL-DELIV W P/P	
67303	OB AIR EMBOLISM-ANTEPART	57
67304	OB AIR EMBOLISM-POSTPART	57
67310	AMNIOTIC EMBOLISM-UNSPEC	57
*67311	AMNIOTIC EMBOLISM-DELIV	
*67312	AMNIOT EMBOL-DELIV W P/P	
67313	AMNIOTIC EMBOL-ANTEPART	57
67314	AMNIOTIC EMBOL-POSTPART	57
67320	OB PULM EMBOL NOS-UNSPEC	57
*67321	PULM EMBOL NOS-DELIVERED	
*67322	PULM EMBOL NOS-DEL W P/P	
67323	PULM EMBOL NOS-ANTEPART	57
67324	PULM EMBOL NOS-POSTPART	57
67330	OB PYEMIC EMBOL-UNSPEC	57
*67331	OB PYEMIC EMBOL-DELIVER	
*67332	OB PYEM EMBOL-DEL W P/P	
67333	OB PYEMIC EMBOL-ANTEPART	57
67334	OB PYEMIC EMBOL-POSTPART	57
67380	OB PULMON EMBOL NEC-UNSP	57
*67381	PULMON EMBOL NEC-DELIVER	
*67382	PULM EMBOL NEC-DEL W P/P	
67383	PULMON EMBOL NEC-ANTEPAR	57
67384	PULMON EMBOL NEC-POSTPAR	57
67400	PUERP CEREBVASC DIS-UNSP	57
*67401	PUERP CEREBVAS DIS-DELIV	
*67402	CEREBVAS DIS-DELIV W P/P	
67403	CEREBROVASC DIS-ANTEPART	57
67404	CEREBROVASC DIS-POSTPART	57
67410	DISRUPT C-SECT WND-UNSP	57
*67412	DISRUPT C-SECT-DEL W P/P	
67414	DISRUPT C-SECT-POSTPART	57
67420	DISRUPT PERINEUM-UNSPEC	57
*67422	DISRUPT PERIN-DEL W P/P	
67424	DISRUPT PERINEUM-POSTPAR	57
67430	OB SURG COMPL NEC-UNSPEC	57
*67432	OB SURG COMPL-DEL W P/P	
67434	OB SURG COMP NEC-POSTPAR	57
67440	PLACENTAL POLYP-UNSPEC	57
67442	PLACENT POLYP-DEL W P/P	
67444	PLACENTAL POLYP-POSTPART	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
67480	PUERP COMPL NEC-UNSPEC	57
*67482	PUERP COMP NEC-DEL W P/P	57
67484	PUERP COMPL NEC-POSTPART	57
67490	PUERP COMPL NOS-UNSPEC	57
*67492	PUERP COMP NOS-DEL W P/P	57
67494	PUERP COMPL NOS-POSTPART	57
67500	INFECT NIPPLE PREG-UNSP	57
67501	INFECT NIPPLE-DELIVERED	57
67502	INFECT NIPPLE-DEL W P/P	57
67503	INFECT NIPPLE-ANTEPARTUM	57
67504	INFECT NIPPLE-POSTPARTUM	57
67510	BREAST ABSCESS PREG-UNSP	57
67511	BREAST ABSCESS-DELIVERED	57
67512	BREAST ABSCESS-DEL W P/P	57
67513	BREAST ABSCESS-ANTEPART	57
67514	BREAST ABSCESS-POSTPART	57
67520	MASTITIS IN PREG-UNSPEC	57
67521	MASTITIS-DELIVERED	57
67522	MASTITIS-DELIV W P/P	57
67523	MASTITIS-ANTEPARTUM	57
67524	MASTITIS-POSTPARTUM	57
67580	BREAST INF PREG NEC-UNSP	57
67581	BREAST INFECT NEC-DELIV	57
67582	BREAST INF NEC-DEL W P/P	57
67583	BREAST INF NEC-ANTEPART	57
67584	BREAST INF NEC-POSTPART	57
67590	BREAST INF PREG NOS-UNSP	57
67591	BREAST INFECT NOS-DELIV	57
67592	BREAST INF NOS-DEL W P/P	57
67593	BREAST INF NOS-ANTEPART	57
67594	BREAST INF NOS-POSTPART	57
67600	RETRACT NIPPLE PREG-UNSP	57
67601	RETRACTED NIPPLE-DELIVER	57
67602	RETRACT NIPPLE-DEL W P/P	57
67603	RETRACT NIPPLE-ANTEPART	57
67604	RETRACT NIPPLE-POSTPART	57
67610	CRACKED NIPPLE PREG-UNSP	57
67611	CRACKED NIPPLE-DELIVERED	57
67612	CRACKED NIPPLE-DEL W P/P	57
67613	CRACKED NIPPLE-ANTEPART	57
67614	CRACKED NIPPLE-POSTPART	57
67620	BREAST ENGORGE-UNSPEC	57
67621	BREAST ENGORGE-DELIVERED	57
67622	BREAST ENGORGE-DEL W P/P	57
67623	BREAST ENGORGE-ANTEPART	57
67624	BREAST ENGORGE-POSTPART	57
67630	BREAST DIS PREG NEC-UNSP	57
67631	BREAST DIS NEC-DELIVERED	57
67632	BREAST DIS NEC-DEL W P/P	57
67633	BREAST DIS NEC-ANTEPART	57
67634	BREAST DIS NEC-POSTPART	57
67640	LACTATION FAIL-UNSPEC	57
67641	LACTATION FAIL-DELIVERED	57
67642	LACTATION FAIL-DEL W P/P	57
67643	LACTATION FAIL-ANTEPART	57
67644	LACTATION FAIL-POSTPART	57
67650	SUPPR LACTATION-UNSPEC	57
67651	SUPPR LACTATION-DELIVER	57
67652	SUPPR LACTAT-DEL W P/P	57
67653	SUPPR LACTATION-ANTEPAR	57
67654	SUPPR LACTATION-POSTPART	57
67660	GALACTORRHEA PREG-UNSPEC	57
67661	GALACTORRHEA-DELIVERED	57
67662	GALACTORRHEA-DEL W P/P	57
67663	GALACTORRHEA-ANTEPARTUM	57
67664	GALACTORRHEA-POSTPARTUM	57
67680	LACTATION DIS NEC-UNSPEC	57
67681	LACTATION DIS NEC-DELIV	57
67682	LACTAT DIS NEC-DEL W P/P	57
67683	LACTAT DIS NEC-ANTEPART	57
67684	LACTAT DIS NEC-POSTPART	57
67690	LACTATION DIS NOS-UNSPEC	57
67691	LACTATION DIS NOS-DELIV	57
67692	LACTAT DIS NOS-DEL W P/P	57
67693	LACTAT DIS NOS-ANTEPART	57
67694	LACTAT DIS NOS-POSTPART	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
677	LATE EFFECT CMPLCATN PREG	11
6800	CARBUNCLE OF FACE	18
6801	CARBUNCLE OF NECK	18
6802	CARBUNCLE OF TRUNK	18
6803	CARBUNCLE OF ARM	18
6804	CARBUNCLE OF HAND	18
6805	CARBUNCLE OF BUTTOCK	18
6806	CARBUNCLE OF LEG	18
6807	CARBUNCLE OF FOOT	18
6808	CARBUNCLE, SITE NEC	18
6809	CARBUNCLE NOS	18
68100	CELLULITIS, FINGER NOS	18
68101	FELON	18
68102	ONYCHIA OF FINGER	18
68110	CELLULITIS, TOE NOS	18
68111	ONYCHIA OF TOE	18
6819	CELLULITIS OF DIGIT NOS	18
6820	CELLULITIS OF FACE	18
6821	CELLULITIS OF NECK	18
6822	CELLULITIS OF TRUNK	18
6823	CELLULITIS OF ARM	18
6824	CELLULITIS OF HAND	18
6825	CELLULITIS OF BUTTOCK	18
6826	CELLULITIS OF LEG	18
6827	CELLULITIS OF FOOT	18
6828	CELLULITIS, SITE NEC	18
6829	CELLULITIS NOS	18
683	ACUTE LYMPHADENITIS	86
684	IMPETIGO	18
6850	PILONIDAL CYST W ABSCESS	18
6851	PILONIDAL CYST W/O ABSC	18
6861	PYOGENIC GRANULOMA	18
6868	LOCAL SKIN INFECTION NEC	18
6869	LOCAL SKIN INFECTION NOS	18
69010	SEBRRHEIC DERMATITIS NOS	18
69011	SEBORRHEA CAPITIS	18
69012	SBRHEIC INFANTL DRMTITIS	18
69018	SEBRRHEIC DERMATITIS NEC	18
6908	ERYTHMTSQUAMOUS DERM NEC	18
6910	DIAPER OR NAPKIN RASH	18
6918	OTHER ATOPIC DERMATITIS	18
6920	DETERGENT DERMATITIS	18
6921	OIL & GREASE DERMATITIS	18
6922	SOLVENT DERMATITIS	18
6923	TOPICAL MED DERMATITIS	18
6924	CHEMICAL DERMATITIS NEC	18
6925	TOPICAL FOOD DERMATITIS	18
6926	DERMATITIS DUE TO PLANT	18
69270	SOLAR DERMATITIS NOS	18
69271	SUNBURN	18
69272	ACT DRMTITIS SOLAR RDIAT	18
69273	ACTNC RETIC ACTNC GRNLMA	18
69274	OTH CHR DRMTIT SOLAR RAD	18
69279	OTH DERMATITIS SOLAR RAD	18
69281	COSMETIC DERMATITIS	18
69282	DERMATITIS OTH RADIATION	18
69283	DERMATITIS METALS	18
69289	DERMATITIS NEC	18
6929	DERMATITIS NOS	18
6930	DRUG DERMATITIS NOS	18
6931	DERMAT D/T FOOD INGEST	18
6938	DERMAT D/T INT AGENT NEC	18
6939	DERMAT D/T INT AGENT NOS	18
6940	DERMATITIS HERPETIFORMIS	18
6941	SUBCORNEAL PUST DERMATOS	68
6942	JUVEN DERMAT HERPETIFORM	18
6943	IMPETIGO HERPETIFORMIS	18
6944	PEMPHIGUS	18
6945	PEMPHIGOID	18
69460	BN MUCOUS MEMB PEMPH NOS	18
69461	OCULAR PEMPHIGUS	68
6948	BULLOUS DERMATOSES NEC	18
6949	BULLOUS DERMATOSES NOS	18
6950	TOXIC ERYTHEMA	18
6951	ERYTHEMA MULTIFORME	18
6952	ERYTHEMA NODOSUM	18

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
6953	ROSACEA	18
6954	LUPUS ERYTHEMATOSUS	18
69581	RITTER'S DISEASE	18
69589	ERYTHEMATOUS COND NEC	18
6959	ERYTHEMATOUS COND NOS	18
6960	PSORIATIC ARTHROPATHY	24
6961	OTHER PSORIASIS	18
6962	PARAPSORIASIS	18
6963	PITYRIASIS ROSEA	18
6964	PITYRIASIS RUBRA PILARIS	18
6965	PITYRIASIS NEC & NOS	18
6968	PSORIAS RELATED DIS NEC	18
6970	LICHEN PLANUS	18
6971	LICHEN NITIDUS	18
6978	LICHEN NEC	18
6979	LICHEN NOS	18
6980	PRURITUS ANI	18
6981	PRURITUS OF GENITALIA	53
6982	PRURIGO	18
6983	LICHENIFICATION	18
6984	DERMATITIS FACTITIA	18
6988	PRURITIC CONDITIONS NEC	18
6989	PRURITIC DISORDER NOS	18
700	CORNS AND CALLOSITIES	18
7010	CIRCUMSCRIBE SCLERODERMA	18
7011	KERATODERMA, ACQUIRED	18
7012	ACQ ACANTHOSIS NIGRICANS	18
7013	STRIAE ATROPHICAE	18
7014	KELOID SCAR	18
7015	ABNORMAL GRANULATION NEC	18
7018	SKIN HYPERTRO/ATROPH NEC	18
7019	SKIN HYPERTRO/ATROPH NOS	18
7020	ACTINIC KERATOSIS	18
70211	INFLAMED SBRHEIC KERATOS	18
70219	OTHER SBORHEIC KERATOSIS	18
7028	OTHER SPECF DERMATOSES	18
7030	INGROWING NAIL	18
7038	DISEASES OF NAIL NEC	18
7039	DISEASE OF NAIL NOS	18
70400	ALOPECIA NOS	18
70401	ALOPECIA AREATA	18
70402	TELOGEN EFFLUVIUM	18
70409	ALOPECIA NEC	18
7041	HIRSUTISM	18
7042	ABNORMALITIES OF HAIR	18
7043	VARIATIONS IN HAIR COLOR	18
7048	HAIR DISEASES NEC	18
7049	HAIR DISEASE NOS	18
7050	ANHIDROSIS	18
7051	PRICKLY HEAT	18
70581	DYSHIDROSIS	18
70582	FOX-FORDYCE DISEASE	18
70583	HIDRADENITIS	18
70589	SWEAT GLAND DISORDER NEC	18
7059	SWEAT GLAND DISORDER NOS	18
7060	ACNE VARIOLIFORMIS	18
7061	ACNE NEC	18
7062	SEBACEOUS CYST	18
7063	SEBORRHEA	18
7068	SEBACEOUS GLAND DIS NEC	18
7069	SEBACEOUS GLAND DIS NOS	18
7070	DECUBITUS ULCER	18
7071	CHRONIC ULCER OF LEG	18
7078	CHRONIC SKIN ULCER NEC	18
7079	CHRONIC SKIN ULCER NOS	18
7080	ALLERGIC URTICARIA	18
7081	IDIOPATHIC URTICARIA	18
7082	URTICARIA FROM COLD/HEAT	18
7083	DERMATOGRAPHIC URTICARIA	18
7084	VIBRATORY URTICARIA	18
7085	CHOLINERGIC URTICARIA	18
7088	URTICARIA NEC	18
7089	URTICARIA NOS	18
70900	DYSCHROMIA, UNSPECIFIED	18
70901	VITILIGO	18
70909	OTHER DYSCHROMIA	18

*ICD-9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7091	VASCULAR DISORD OF SKIN	18
7092	SCAR & FIBROSIS OF SKIN	18
7093	DEGENERATIVE SKIN DISORD	18
7094	FOREIGN BODY GRANUL-SKIN	18
7098	SKIN DISORDERS NEC	18
7099	SKIN DISORDER NOS	18
7100	SYST LUPUS ERYTHEMATOSUS	86
7101	SYSTEMIC SCLEROSIS	86
7102	SICCA SYNDROME	86
7103	DERMATOMYOSITIS	86
7104	POLYMYOSITIS	86
7105	EOSINOPHILIA MYALGIA SND	24
7108	DIFF CONNECT TIS DIS NEC	24
7109	DIFF CONNECT TIS DIS NOS	24
71100	PYOGEN ARTHRITIS-UNSPEC	24
71101	PYOGEN ARTHRITIS-SHLDER	24
71102	PYOGEN ARTHRITIS-UP/ARM	24
71103	PYOGEN ARTHRITIS-FOREARM	24
71104	PYOGEN ARTHRITIS-HAND	24
71105	PYOGEN ARTHRITIS-PELVIS	24
71106	PYOGEN ARTHRITIS-L/LEG	24
71107	PYOGEN ARTHRITIS-ANKLE	24
71108	PYOGEN ARTHRITIS NEC	24
71109	PYOGEN ARTHRITIS-MULT	24
71110	REITER ARTHRITIS-UNSPEC	24
71111	REITER ARTHRITIS-SHLDER	24
71112	REITER ARTHRITIS-UP/ARM	24
71113	REITER ARTHRITIS-FOREARM	24
71114	REITER ARTHRITIS-HAND	24
71115	REITER ARTHRITIS-PELVIS	24
71116	REITER ARTHRITIS-L/LEG	24
71117	REITER ARTHRITIS-ANKLE	24
71118	REITER ARTHRITIS NEC	24
71119	REITER ARTHRITIS-MULT	24
71120	BEHCET ARTHRITIS-UNSPEC	24
71121	BEHCET ARTHRITIS-SHLDER	24
71122	BEHCET ARTHRITIS-UP/ARM	24
71123	BEHCET ARTHRITIS-FOREARM	24
71124	BEHCET ARTHRITIS-HAND	24
71125	BEHCET ARTHRITIS-PELVIS	24
71126	BEHCET ARTHRITIS-L/LEG	24
71127	BEHCET ARTHRITIS-ANKLE	24
71128	BEHCET ARTHRITIS NEC	24
71129	BEHCET ARTHRITIS-MULT	24
71130	DYSENTER ARTHRIT-UNSPEC	24
71131	DYSENTER ARTHRIT-SHLDER	24
71132	DYSENTER ARTHRIT-UP/ARM	24
71133	DYSENTER ARTHRIT-FOREARM	24
71134	DYSENTER ARTHRIT-HAND	24
71135	DYSENTER ARTHRIT-PELVIS	24
71136	DYSENTER ARTHRIT-L/LEG	24
71137	DYSENTER ARTHRIT-ANKLE	24
71138	DYSENTER ARTHRIT NEC	24
71139	DYSENTER ARTHRIT-MULT	24
71140	BACT ARTHRITIS-UNSPEC	24
71141	BACT ARTHRITIS-SHLDER	24
71142	BACT ARTHRITIS-UP/ARM	24
71143	BACT ARTHRITIS-FOREARM	24
71144	BACT ARTHRITIS-HAND	24
71145	BACT ARTHRITIS-PELVIS	24
71146	BACT ARTHRITIS-L/LEG	24
71147	BACT ARTHRITIS-ANKLE	24
71148	BACT ARTHRITIS NEC	24
71149	BACT ARTHRITIS-MULT	24
71150	VIRAL ARTHRITIS-UNSPEC	24
71151	VIRAL ARTHRITIS-SHLDER	24
71152	VIRAL ARTHRITIS-UP/ARM	24
71153	VIRAL ARTHRITIS-FOREARM	24
71154	VIRAL ARTHRITIS-HAND	24
71155	VIRAL ARTHRITIS-PELVIS	24
71156	VIRAL ARTHRITIS-L/LEG	24
71157	VIRAL ARTHRITIS-ANKLE	24
71158	VIRAL ARTHRITIS NEC	24
71159	VIRAL ARTHRITIS-MULT	24
71160	MYCOTIC ARTHRITIS-UNSPEC	24
71161	MYCOTIC ARTHRITIS-SHLDER	24

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
71162	MYCOTIC ARTHRITIS-UP/ARM	24
71163	MYCOTIC ARTHRITIS-FOREARM	24
71164	MYCOTIC ARTHRITIS-HAND	24
71165	MYCOTIC ARTHRITIS-PELVIS	24
71166	MYCOTIC ARTHRITIS-L/LEG	24
71167	MYCOTIC ARTHRITIS-ANKLE	24
71168	MYCOTIC ARTHRITIS NEC	24
71169	MYCOTIC ARTHRITIS-MULT	24
71170	HELMINTH ARTHRITIS-UNSPEC	24
71171	HELMINTH ARTHRITIS-SHLDER	24
71172	HELMINTH ARTHRITIS-UP/ARM	24
71173	HELMINTH ARTHRITIS-FOREARM	24
71174	HELMINTH ARTHRITIS-HAND	24
71175	HELMINTH ARTHRITIS-PELVIS	24
71176	HELMINTH ARTHRITIS-L/LEG	24
71177	HELMINTH ARTHRITIS-ANKLE	24
71178	HELMINTH ARTHRITIS NEC	24
71179	HELMINTH ARTHRITIS-MULT	24
71180	INF ARTHRITIS NEC-UNSPEC	24
71181	INF ARTHRITIS NEC-SHLDER	24
71182	INF ARTHRITIS NEC-UP/ARM	24
71183	INF ARTHRITIS NEC-FOREARM	24
71184	INF ARTHRITIS NEC-HAND	24
71185	INF ARTHRITIS NEC-PELVIS	24
71186	INF ARTHRITIS NEC-L/LEG	24
71187	INF ARTHRITIS NEC-ANKLE	24
71188	INF ARTHRITIS NEC-OTH SITE	24
71189	INF ARTHRITIS NEC-MULT	24
71190	INF ARTHRITIS NOS-UNSPEC	24
71191	INF ARTHRITIS NOS-SHLDER	24
71192	INF ARTHRITIS NOS-UP/ARM	24
71193	INF ARTHRITIS NOS-FOREARM	24
71194	INF ARTHRITIS NOS-HAND	24
71195	INF ARTHRITIS NOS-PELVIS	24
71196	INF ARTHRITIS NOS-L/LEG	24
71197	INF ARTHRITIS NOS-ANKLE	24
71198	INF ARTHRITIS NOS-OTH SITE	24
71199	INF ARTHRITIS NOS-MULT	24
71210	DICALC PHOS CRYST-UNSPEC	24
71211	DICALC PHOS CRYST-SHLDER	24
71212	DICALC PHOS CRYST-UP/ARM	24
71213	DICALC PHOS CRYST-FOREARM	24
71214	DICALC PHOS CRYST-HAND	24
71215	DICALC PHOS CRYST-PELVIS	24
71216	DICALC PHOS CRYST-L/LEG	24
71217	DICALC PHOS CRYST-ANKLE	24
71218	DICALC PHOS CRYST-SITE NEC	24
71219	DICALC PHOS CRYST-MULT	24
71220	PYROPHOSPH CRYST-UNSPEC	24
71221	PYROPHOSPH CRYST-SHLDER	24
71222	PYROPHOSPH CRYST-UP/ARM	24
71223	PYROPHOSPH CRYST-FOREARM	24
71224	PYROPHOSPH CRYST-HAND	24
71225	PYROPHOSPH CRYST-PELVIS	24
71226	PYROPHOSPH CRYST-L/LEG	24
71227	PYROPHOSPH CRYST-ANKLE	24
71228	PYROPHOSPH CRYST-SITE NEC	24
71229	PYROPHOSPH CRYST-MULT	24
71230	CHONDROCALCIN NOS-UNSPEC	24
71231	CHONDROCALCIN NOS-SHLDER	24
71232	CHONDROCALCIN NOS-UP/ARM	24
71233	CHONDROCALCIN NOS-FOREARM	24
71234	CHONDROCALCIN NOS-HAND	24
71235	CHONDROCALCIN NOS-PELVIS	24
71236	CHONDROCALCIN NOS-L/LEG	24
71237	CHONDROCALCIN NOS-ANKLE	24
71238	CHONDROCALCIN NOS-OTH SITE	24
71239	CHONDROCALCIN NOS-MULT	24
71280	CRYST ARTHROP NEC-UNSPEC	24
71281	CRYST ARTHROP NEC-SHLDER	24
71282	CRYST ARTHROP NEC-UP/ARM	24
71283	CRYST ARTHROP NEC-FOREARM	24
71284	CRYST ARTHROP NEC-HAND	24
71285	CRYST ARTHROP NEC-PELVIS	24
71286	CRYST ARTHROP NEC-L/LEG	24
71287	CRYST ARTHROP NEC-ANKLE	24

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
71288	CRY ARTHROP NEC-OTH SITE	24
71289	CRYST ARTHROP NEC-MULT	24
71290	CRYST ARTHROP NOS-UNSPEC	24
71291	CRYST ARTHROP NOS-SHLDR	24
71292	CRYST ARTHROP NOS-UP/ARM	24
71293	CRYST ARTHROP NOS-FOREARM	24
71294	CRYST ARTHROP NOS-HAND	24
71295	CRYST ARTHROP NOS-PELVIS	24
71296	CRYST ARTHROP NOS-L/LEG	24
71297	CRYST ARTHROP NOS-ANKLE	24
71298	CRY ARTHROP NOS-OTH SITE	24
71299	CRYST ARTHROP NOS-MULT	24
7130	ARTHROP W ENDOCR/MET DIS	24
7131	ARTHROP W NONINF GI DIS	24
7132	ARTHROPATH W HEMATOL DIS	24
7133	ARTHROPATHY W SKIN DIS	24
7134	ARTHROPATHY W RESP DIS	24
7135	ARTHROPATHY W NERVE DIS	24
7136	ARTHROP W HYPERSEN REACT	24
7137	ARTHROP W SYSTEM DIS NEC	24
7138	ARTHROP W OTH DIS NEC	24
7140	RHEUMATOID ARTHRITIS	24
7141	FELTY'S SYNDROME	24
7142	SYST RHEUM ARTHRITIS NEC	24
71430	JUV RHEUM ARTHRITIS NOS	24
71431	POLYART JUV RHEUM ARTHR	24
71432	PAUCIART JUV RHEUM ARTHR	24
71433	MONOART JUV RHEUM ARTHR	24
7144	CHR POSTRHEUM ARTHRITIS	24
71481	RHEUMATOID LUNG	33
71489	INFLAMM POLYARTHROP NEC	24
7149	INFLAMM POLYARTHROP NOS	24
71500	GENERAL OSTEOARTHRITIS	24
71504	GEN OSTEOARTHRITIS-HAND	24
71509	GENERAL OSTEOARTHRITIS	24
71510	LOC PRIM OSTEOART-UNSPEC	24
71511	LOC PRIM OSTEOART-SHLDER	24
71512	LOC PRIM OSTEOART-UP/ARM	24
71513	LOC PRIM OSTEOART-FORARM	24
71514	LOC PRIM OSTEOARTH-HAND	24
71515	LOC PRIM OSTEOART-PELVIS	24
71516	LOC PRIM OSTEOART-L/LEG	24
71517	LOC PRIM OSTEOARTH-ANKLE	24
71518	LOC PRIM OSTEOARTH NEC	24
71520	LOC 2ND OSTEOARTH-UNSPEC	24
71521	LOC 2ND OSTEOARTH-SHLDER	24
71522	LOC 2ND OSTEOARTH-UP/ARM	24
71523	LOC 2ND OSTEOART-FOREARM	24
71524	LOC 2ND OSTEOARTHRO-HAND	24
71525	LOC 2ND OSTEOARTH-PELVIS	24
71526	LOC 2ND OSTEOARTH-L/LEG	24
71527	LOC 2ND OSTEOARTH-ANKLE	24
71528	LOC 2ND OSTEOARTHROS NEC	24
71530	LOC OSTEOARTH NOS-UNSPEC	24
71531	LOC OSTEOARTH NOS-SHLDER	24
71532	LOC OSTEOARTH NOS-UP/ARM	24
71533	LOC OSTEOART NOS-FOREARM	24
71534	LOC OSTEOARTH NOS-HAND	24
71535	LOC OSTEOARTH NOS-PELVIS	24
71536	LOC OSTEOARTH NOS-L/LEG	24
71537	LOC OSTEOARTH NOS-ANKLE	24
71538	LOC OSTEOAR NOS-SITE NEC	24
71580	OSTEOARTHROSIS-MULT SITE	24
71589	OSTEOARTHROSIS-MULT SITE	24
71590	OSTEOARTHROS NOS-UNSPEC	24
71591	OSTEOARTHROS NOS-SHLDER	24
71592	OSTEOARTHROS NOS-UP/ARM	24
71593	OSTEOARTHROS NOS-FOREARM	24
71594	OSTEOARTHROS NOS-HAND	24
71595	OSTEOARTHROS NOS-PELVIS	24
71596	OSTEOARTHROS NOS-L/LEG	24
71597	OSTEOARTHROS NOS-ANKLE	24
71598	OSTEOARTHRO NOS-OTH SITE	24
71600	KASCHIN-BECK DIS-UNSPEC	24
71601	KASCHIN-BECK DIS-SHLDER	24
71602	KASCHIN-BECK DIS-UP/ARM	24

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
71603	KASCHIN-BECK DIS-FOREARM	24
71604	KASCHIN-BECK DIS-HAND	24
71605	KASCHIN-BECK DIS-PELVIS	24
71606	KASCHIN-BECK DIS-L/LEG	24
71607	KASCHIN-BECK DIS-ANKLE	24
71608	KASCHIN-BECK DIS NEC	24
71609	KASCHIN-BECK DIS-MULT	24
71610	TRAUM ARTHROPATHY-UNSPEC	24
71611	TRAUM ARTHROPATHY-SHLDER	24
71612	TRAUM ARTHROPATHY-UP/ARM	24
71613	TRAUM ARTHROPATH-FOREARM	24
71614	TRAUM ARTHROPATHY-HAND	24
71615	TRAUM ARTHROPATHY-PELVIS	24
71616	TRAUM ARTHROPATHY-L/LEG	24
71617	TRAUM ARTHROPATHY-ANKLE	24
71618	TRAUM ARTHROPATHY NEC	24
71619	TRAUM ARTHROPATHY-MULT	24
71620	ALLERG ARTHRITIS-UNSPEC	24
71621	ALLERG ARTHRITIS-SHLDER	24
71622	ALLERG ARTHRITIS-UP/ARM	24
71623	ALLERG ARTHRITIS-FOREARM	24
71624	ALLERG ARTHRITIS-HAND	24
71625	ALLERG ARTHRITIS-PELVIS	24
71626	ALLERG ARTHRITIS-L/LEG	24
71627	ALLERG ARTHRITIS-ANKLE	24
71628	ALLERG ARTHRITIS NEC	24
71629	ALLERG ARTHRITIS-MULT	24
71630	CLIMACT ARTHRITIS-UNSPEC	24
71631	CLIMACT ARTHRITIS-SHLDER	24
71632	CLIMACT ARTHRITIS-UP/ARM	24
71633	CLIMACT ARTHRIT-FOREARM	24
71634	CLIMACT ARTHRITIS-HAND	24
71635	CLIMACT ARTHRITIS-PELVIS	24
71636	CLIMACT ARTHRITIS-L/LEG	24
71637	CLIMACT ARTHRITIS-ANKLE	24
71638	CLIMACT ARTHRITIS NEC	24
71639	CLIMACT ARTHRITIS-MULT	24
71640	TRANS ARTHROPATHY-UNSPEC	24
71641	TRANS ARTHROPATHY-SHLDER	24
71642	TRANS ARTHROPATHY-UP/ARM	24
71643	TRANS ARTHROPATH-FOREARM	24
71644	TRANS ARTHROPATHY-HAND	24
71645	TRANS ARTHROPATHY-PELVIS	24
71646	TRANS ARTHROPATHY-L/LEG	24
71647	TRANS ARTHROPATHY-ANKLE	24
71648	TRANS ARTHROPATHY NEC	24
71649	TRANS ARTHROPATHY-MULT	24
71650	POLYARTHRITIS NOS-UNSPEC	24
71651	POLYARTHRITIS NOS-SHLDER	24
71652	POLYARTHRITIS NOS-UP/ARM	24
71653	POLYARTHRIT NOS-FOREARM	24
71654	POLYARTHRITIS NOS-HAND	24
71655	POLYARTHRITIS NOS-PELVIS	24
71656	POLYARTHRITIS NOS-L/LEG	24
71657	POLYARTHRITIS NOS-ANKLE	24
71658	POLYARTHRIT NOS-OTH SITE	24
71659	POLYARTHRITIS NOS-MULT	24
71660	MONOARTHRITIS NOS-UNSPEC	24
71661	MONOARTHRITIS NOS-SHLDER	24
71662	MONOARTHRITIS NOS-UP/ARM	24
71663	MONOARTHRIT NOS-FOREARM	24
71664	MONOARTHRITIS NOS-HAND	24
71665	MONOARTHRITIS NOS-PELVIS	24
71666	MONOARTHRITIS NOS-L/LEG	24
71667	MONOARTHRITIS NOS-ANKLE	24
71668	MONOARTHRIT NOS-OTH SITE	24
71680	ARTHROPATHY NEC-UNSPEC	24
71681	ARTHROPATHY NEC-SHLDER	24
71682	ARTHROPATHY NEC-UP/ARM	24
71683	ARTHROPATHY NEC-FOREARM	24
71684	ARTHROPATHY NEC-HAND	24
71685	ARTHROPATHY NEC-PELVIS	24
71686	ARTHROPATHY NEC-L/LEG	24
71687	ARTHROPATHY NEC-ANKLE	24
71688	ARTHROPATHY NEC-OTH SITE	24
71689	ARTHROPATHY NEC-MULT	24

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
71690	ARTHROPATHY NOS-UNSPEC	24
71691	ARTHROPATHY NOS-SHLDER	24
71692	ARTHROPATHY NOS-UP/ARM	24
71693	ARTHROPATHY NOS-FOREARM	24
71694	ARTHROPATHY NOS-HAND	24
71695	ARTHROPATHY NOS-PELVIS	24
71696	ARTHROPATHY NOS-L/LEG	24
71697	ARTHROPATHY NOS-ANKLE	24
71698	ARTHROPATHY NOS-OTH SITE	24
71699	ARTHROPATHY NOS-MULT	24
7170	OLD BUCKET TEAR MED MEN	24
7171	DERANG ANT MED MENISCUS	24
7172	DERANG POST MED MENISCUS	24
7173	DERANG MED MENISCUS NEC	24
71740	DERANG LAT MENISCUS NOS	24
71741	OLD BUCKET TEAR LAT MEN	24
71742	DERANGE ANT LAT MENISCUS	24
71743	DERANG POST LAT MENISCUS	24
71749	DERANG LAT MENISCUS NEC	24
7175	DERANGEMENT MENISCUS NEC	24
7176	LOOSE BODY IN KNEE	24
7177	CHONDROMALACIA PATELLAE	24
71781	OLD DISRUPT LAT COLLAT	24
71782	OLD DISRUPT MED COLLAT	24
71783	OLD DISRUPT ANT CRUCIATE	24
71784	OLD DISRUPT POST CRUCIAT	24
71785	OLD DISRUPT KNEE LIG NEC	24
71789	INT DERANGEMENT KNEE NEC	24
7179	INT DERANGEMENT KNEE NOS	24
71800	ARTIC CARTIL DIS-UNSPEC	24
71801	ARTIC CARTIL DIS-SHLDER	24
71802	ARTIC CARTIL DIS-UP/ARM	24
71803	ARTIC CARTIL DIS-FOREARM	24
71804	ARTIC CARTIL DIS-HAND	24
71805	ARTIC CARTIL DIS-PELVIS	24
71807	ARTIC CARTIL DIS-ANKLE	24
71808	ARTIC CARTIL DIS-JT NEC	24
71809	ARTIC CARTIL DIS-MULT JT	24
71810	LOOSE BODY-UNSPEC	24
71811	LOOSE BODY-SHLDER	24
71812	LOOSE BODY-UP/ARM	24
71813	LOOSE BODY-FOREARM	24
71814	LOOSE BODY-HAND	24
71815	LOOSE BODY-PELVIS	24
71817	LOOSE BODY-ANKLE	24
71818	LOOSE BODY-JOINT NEC	24
71819	LOOSE BODY-MULT JOINTS	24
71820	PATHOL DISLOCAT-UNSPEC	24
71821	PATHOL DISLOCAT-SHLDER	24
71822	PATHOL DISLOCAT-UP/ARM	24
71823	PATHOL DISLOCAT-FOREARM	24
71824	PATHOL DISLOCAT-HAND	24
71825	PATHOL DISLOCAT-PELVIS	24
71826	PATHOL DISLOCAT-L/LEG	24
71827	PATHOL DISLOCAT-ANKLE	24
71828	PATHOL DISLOCAT-JT NEC	24
71829	PATHOL DISLOCAT-MULT JTS	24
71830	RECUR DISLOCAT-UNSPEC	24
71831	RECUR DISLOCAT-SHLDER	24
71832	RECUR DISLOCAT-UP/ARM	24
71833	RECUR DISLOCAT-FOREARM	24
71834	RECUR DISLOCAT-HAND	24
71835	RECUR DISLOCAT-PELVIS	24
71836	RECUR DISLOCAT-L/LEG	24
71837	RECUR DISLOCAT-ANKLE	24
71838	RECUR DISLOCAT-JT NEC	24
71839	RECUR DISLOCAT-MULT JTS	24
71840	JT CONTRACTURE-UNSPEC	24
71841	JT CONTRACTURE-SHLDER	24
71842	JT CONTRACTURE-UP/ARM	24
71843	JT CONTRACTURE-FOREARM	24
71844	JT CONTRACTURE-HAND	24
71845	JT CONTRACTURE-PELVIS	24
71846	JT CONTRACTURE-L/LEG	24
71847	JT CONTRACTURE-ANKLE	24
71848	JT CONTRACTURE-JT NEC	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
71849	JT CONTRACTURE-MULT JTS	24
71850	ANKYLOSIS-UNSPEC	24
71851	ANKYLOSIS-SHOULDER	24
71852	ANKYLOSIS-UPPER/ARM	24
71853	ANKYLOSIS-FOREARM	24
71854	ANKYLOSIS-HAND	24
71855	ANKYLOSIS-PELVIS	24
71856	ANKYLOSIS-LOWER/LEG	24
71857	ANKYLOSIS-ANKLE	24
71858	ANKYLOSIS-JOINT NEC	24
71859	ANKYLOSIS-MULT JOINTS	24
71860	PROTRUSIO ACETAB-UNSPEC	24
71865	PROTRUSIO ACETABULI NOS	24
71880	JT DERANGMNT NEC-UNSP JT	24
71881	JT DERANGMENT NEC-SHLDER	24
71882	JT DERANGMENT NEC-UP/ARM	24
71883	JT DERANGMNT NEC-FOREARM	24
71884	JT DERANGEMENT NEC-HAND	24
71885	JT DERANGMENT NEC-PELVIS	24
71886	JT DERANGEMENT NEC-L/LEG	24
71887	JT DERANGEMENT NEC-ANKLE	24
71888	JT DERANGMENT NEC-OTH JT	24
71889	JT DERANGEMENT NEC-MULT	24
71890	JT DERANGMNT NOS-UNSP JT	24
71891	JT DERANGMENT NOS-SHLDER	24
71892	JT DERANGMENT NOS-UP/ARM	24
71893	JT DERANGMNT NOS-FOREARM	24
71894	JT DERANGEMENT NOS-HAND	24
71895	JT DERANGMENT NOS-PELVIS	24
71897	JT DERANGEMENT NOS-ANKLE	24
71898	JT DERANGMENT NOS-OTH JT	24
71899	JT DERANGEMENT NOS-MULT	24
71900	JOINT EFFUSION-UNSPEC	24
71901	JOINT EFFUSION-SHLDER	24
71902	JOINT EFFUSION-UP/ARM	24
71903	JOINT EFFUSION-FOREARM	24
71904	JOINT EFFUSION-HAND	24
71905	JOINT EFFUSION-PELVIS	24
71906	JOINT EFFUSION-L/LEG	24
71907	JOINT EFFUSION-ANKLE	24
71908	JOINT EFFUSION-JT NEC	24
71909	JOINT EFFUSION-MULT JTS	24
71910	HEMARTHROSIS-UNSPEC	24
71911	HEMARTHROSIS-SHLDER	24
71912	HEMARTHROSIS-UP/ARM	24
71913	HEMARTHROSIS-FOREARM	24
71914	HEMARTHROSIS-HAND	24
71915	HEMARTHROSIS-PELVIS	24
71916	HEMARTHROSIS-L/LEG	24
71917	HEMARTHROSIS-ANKLE	24
71918	HEMARTHROSIS-JT NEC	24
71919	HEMARTHROSIS-MULT JTS	24
71920	VILLONOD SYNOVIT-UNSPEC	24
71921	VILLONOD SYNOVIT-SHLDER	24
71922	VILLONOD SYNOVIT-UP/ARM	24
71923	VILLONOD SYNOVIT-FOREARM	24
71924	VILLONOD SYNOVIT-HAND	24
71925	VILLONOD SYNOVIT-PELVIS	24
71926	VILLONOD SYNOVIT-L/LEG	24
71927	VILLONOD SYNOVIT-ANKLE	24
71928	VILLONOD SYNOVIT-JT NEC	24
71929	VILLONOD SYNOVIT-MULT JT	24
71930	PALINDROM RHEUM-UNSPEC	24
71931	PALINDROM RHEUM-SHLDER	24
71932	PALINDROM RHEUM-UP/ARM	24
71933	PALINDROM RHEUM-FOREARM	24
71934	PALINDROM RHEUM-HAND	24
71935	PALINDROM RHEUM-PELVIS	24
71936	PALINDROM RHEUM-L/LEG	24
71937	PALINDROM RHEUM-ANKLE	24
71938	PALINDROM RHEUM-JT NEC	24
71939	PALINDROM RHEUM-MULT JTS	24
71940	JOINT PAIN-UNSPEC	24
71941	JOINT PAIN-SHLDER	24
71942	JOINT PAIN-UP/ARM	24
71943	JOINT PAIN-FOREARM	24

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
71944	JOINT PAIN-HAND	24
71945	JOINT PAIN-PELVIS	24
71946	JOINT PAIN-L/LEG	24
71947	JOINT PAIN-ANKLE	24
71948	JOINT PAIN-JT NEC	24
71949	JOINT PAIN-MULT JTS	24
71950	JT STIFFNESS NEC-UNSPEC	24
71951	JT STIFFNESS NEC-SHLDER	24
71952	JT STIFFNESS NEC-UP/ARM	24
71953	JT STIFFNES NEC-FOREARM	24
71954	JT STIFFNESS NEC-HAND	24
71955	JT STIFFNESS NEC-PELVIS	24
71956	JT STIFFNESS NEC-L/LEG	24
71957	JT STIFFNESS NEC-ANKLE	24
71958	JT STIFFNESS NEC-OTH JT	24
71959	JT STIFFNESS NEC-MULT JT	24
71960	JOINT SYMPT NEC-UNSP JT	24
71961	JOINT SYMPTOM NEC-SHLDER	24
71962	JOINT SYMPTOM NEC-UP/ARM	24
71963	JOINT SYMPT NEC-FOREARM	24
71964	JOINT SYMPTOM NEC-HAND	24
71965	JOINT SYMPTOM NEC-PELVIS	24
71966	JOINT SYMPTOM NEC-L/LEG	24
71967	JOINT SYMPTOM NEC-ANKLE	24
71968	JOINT SYMPTOM NEC-OTH JT	24
71969	JOINT SYMPT NEC-MULT JTS	24
71970	DIFFICULT WALK-UNSPEC	24
71975	DIFFICULT WALK-PELVIS	24
71976	DIFFICULT WALK-LO/LEG	24
71977	DIFFICULT WALK-FOOT	24
71978	DIFFICULT WALK NEC	24
71979	DIFFICULT WALK-MULT	24
71980	JOINT DIS NEC-UNSPEC	24
71981	JOINT DIS NEC-SHLDER	24
71982	JOINT DIS NEC-UP/ARM	24
71983	JOINT DIS NEC-FOREARM	24
71984	JOINT DIS NEC-HAND	24
71985	JOINT DIS NEC-PELVIS	24
71986	JOINT DIS NEC-L/LEG	24
71987	JOINT DIS NEC-ANKLE	24
71988	JOINT DIS NEC-OTH JT	24
71989	JOINT DIS NEC-MULT JTS	24
71990	JOINT DIS NOS-UNSPEC JT	24
71991	JOINT DIS NOS-SHLDER	24
71992	JOINT DIS NOS-UP/ARM	24
71993	JOINT DIS NOS-FOREARM	24
71994	JOINT DIS NOS-HAND	24
71995	JOINT DIS NOS-PELVIS	24
71996	JOINT DIS NOS-L/LEG	24
71997	JOINT DIS NOS-ANKLE	24
71998	JOINT DIS NOS-OTH JT	24
71999	JOINT DIS NOS-MULT JTS	24
7200	ANKYLOSING SPONDYLITIS	24
7201	SPINAL ENTHESOPATHY	24
7202	SACROILIITIS NEC	24
72081	SPONDYLOPATHY IN OTH DIS	24
72089	INFLAM SPONDYLOPATHY NEC	24
7209	INFLAM SPONDYLOPATHY NOS	24
7210	CERVICAL SPONDYLOSIS	24
7211	CERV SPONDYL W MYELOPATH	24
7212	THORACIC SPONDYLOSIS	24
7213	LUMBOSACRAL SPONDYLOSIS	24
72141	SPOND COMPR THOR SP CORD	24
72142	SPOND COMPR LUMB SP CORD	24
7215	KISSING SPINE	24
7216	ANKYL VERT HYPEROSTOSIS	24
7217	TRAUMATIC SPONDYLOPATHY	24
7218	SPINAL DISORDERS NEC	24
72190	SPONDYLOS NOS W/O MYEOP	24
72191	SPONDYLOSIS NOS W MYEOP	24
7220	CERVICAL DISC DISPLACMNT	24
72210	LUMBAR DISC DISPLACEMENT	24
72211	THORACIC DISC DISPLACMNT	24
7222	DISC DISPLACEMENT NOS	24
72230	SCHMORL'S NODES NOS	24
72231	SCHMORLS NODE-THORACIC	24

*ICD-9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE
HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
72232	SCHMORLS NODE-LUMBAR	24
72239	SCHMORLS NODE-REGION NEC	24
7224	CERVICAL DISC DEGEN	24
72251	THORACIC DISC DEGEN	24
72252	LUMB/LUMBOSAC DISC DEGEN	24
7226	DISC DEGENERATION NOS	24
72270	DISC DIS W MYELOPATH NOS	24
72271	CERV DISC DIS W MYELOPAT	24
72272	THOR DISC DIS W MYELOPAT	24
72273	LUMB DISC DIS W MYELOPAT	24
72280	POSTLAMINECTOMY SYND NOS	24
72281	POSTLAMINECT SYND-CERV	24
72282	POSTLAMINECT SYND-THORAC	24
72283	POSTLAMINECT SYND-LUMBAR	24
72290	DISC DIS NEC/NOS-UNSPEC	24
72291	DISC DIS NEC/NOS-CERV	24
72292	DISC DIS NEC/NOS-THORAC	24
72293	DISC DIS NEC/NOS-LUMBAR	24
7230	CERVICAL SPINAL STENOSIS	24
7231	CERVICALGIA	24
7232	CERVICOCRANIAL SYNDROME	63
7233	CERVICOBRACHIAL SYNDROME	63
7234	BRACHIAL NEURITIS NOS	63
7235	TORTICOLLIS NOS	24
7236	PANNICULITIS OF NECK	18
7237	OSSIFICATION CERV LIG	24
7238	CERVICAL SYNDROME NEC	24
7239	NECK DISORDER/SYMPT NOS	24
72400	SPINAL STENOSIS NOS	24
72401	SPINAL STENOSIS-THORACIC	24
72402	SPINAL STENOSIS-LUMBAR	24
72409	SPINAL STENOSIS-OTH SITE	24
7241	PAIN IN THORACIC SPINE	24
7242	LUMBAGO	24
7243	SCIATICA	24
7244	LUMBOSACRAL NEURITIS NOS	24
7245	BACKACHE NOS	24
7246	DISORDERS OF SACRUM	24
72470	DISORDER OF COCCYX NOS	24
72471	HYPERMOBILITY OF COCCYX	24
72479	DISORDER OF COCCYX NEC	24
7248	OTHER BACK SYMPTOMS	24
7249	BACK DISORDER NOS	24
725	POLYMYALGIA RHEUMATICA	24
7260	ADHESIVE CAPSULIT SHLDER	24
72610	ROTATOR CUFF SYND NOS	24
72611	CALCIF TENDINITIS SHLDER	24
72612	BICIPITAL TENOSYNOVITIS	24
72619	ROTATOR CUFF DIS NEC	24
7262	SHOULDER REGION DIS NEC	24
72630	ELBOW ENTHESOPATHY NOS	24
72631	MEDIAL EPICONDYLITIS	24
72632	LATERAL EPICONDYLITIS	24
72633	OLECRANON BURSITIS	24
72639	ELBOW ENTHESOPATHY NEC	24
7264	ENTHESOPATHY OF WRIST	24
7265	ENTHESOPATHY OF HIP	24
72660	ENTHESOPATHY OF KNEE NOS	24
72661	PES ANSERINUS TENDINITIS	24
72662	TIBIAL COLL LIG BURSITIS	24
72663	FIBULA COLL LIG BURSITIS	24
72664	PATELLAR TENDINITIS	24
72665	PREPATELLAR BURSITIS	24
72669	ENTHESOPATHY OF KNEE NEC	24
72670	ANKLE ENTHESOPATHY NOS	24
72671	ACHILLES TENDINITIS	24
72672	TIBIALIS TENDINITIS	24
72673	CALCANEAL SPUR	24
72679	ANKLE ENTHESOPATHY NEC	24
7268	PERIPH ENTHESOPATHY NEC	24
72690	ENTHESOPATHY, SITE NOS	24
72691	EXOSTOSIS, SITE NOS	24
72700	SYNOVITIS NOS	24
72701	SYNOVITIS IN OTH DIS	24
72702	GIANT CELL TUMOR TENDON	24
72703	TRIGGER FINGER	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
72704	RADIAL STYLOID TENOSYNOV	24
72705	TENOSYNOV HAND/WRIST NEC	24
72706	TENOSYNOVITIS FOOT/ANKLE	24
72709	SYNOVITIS NEC	24
7271	BUNION	24
7272	OCCUPATIONAL BURSTITIS	24
7273	BURSTITIS NEC	24
72740	SYNOVIAL CYST NOS	24
72741	GANGLION OF JOINT	24
72742	GANGLION OF TENDON	24
72743	GANGLION NOS	24
72749	BURSAL CYST NEC	24
72750	RUPTURE OF SYNOVIUM NOS	24
72751	POPLITEAL SYNOVIAL CYST	24
72759	RUPTURE OF SYNOVIUM NEC	24
72760	NONTRAUM TENDON RUPT NOS	24
72761	ROTATOR CUFF RUPTURE	24
72762	BICEPS TENDON RUPTURE	24
72763	RUPT EXTEN TENDON HAND	24
72764	RUPT FLEXOR TENDON HAND	24
72765	RUPTURE QUADRICEP TENDON	24
72766	RUPTURE PATELLAR TENDON	24
72767	RUPTURE ACHILLES TENDON	24
72768	RUPTURE TENDON FOOT NEC	24
72769	NONTRAUM TENDON RUPT NEC	24
72781	CONTRACTURE OF TENDON	24
72782	CALCIUM DEPOSIT TENDON	24
72789	SYNOV/TEND/BURSA DIS NEC	24
7279	SYNOV/TEND/BURSA DIS NOS	24
7280	INFECTIVE MYOSITIS	24
72810	MUSCULAR CALCIFICAT NOS	24
72811	PROG MYOSITIS OSSIFICANS	24
72812	TRAUM MYOSITIS OSSIFICAN	24
72813	POSTOP HETEROTOPIC CALC	24
72819	MUSCULAR CALCIFICAT NEC	24
7282	MUSC DISUSE ATROPHY NEC	24
7283	MUSCLE DISORDERS NEC	24
7284	LAXITY OF LIGAMENT	24
7285	HYPERMOBILITY SYNDROME	24
7286	CONTRACTED PALMAR FASCIA	24
72871	PLANTAR FIBROMATOSIS	24
72879	FIBROMATOSES NEC	24
72881	INTERSTITIAL MYOSITIS	24
72882	FB GRANULOMA OF MUSCLE	24
72883	NONTRAUM MUSCLE RUPTURE	24
72884	DIASTASIS OF MUSCLE	24
72885	SPASM OF MUSCLE	24
72886	NECROTIZING FASCIITIS	97
72889	MUSCLE/LIGAMENT DIS NEC	24
7289	MUSCLE/LIGAMENT DIS NOS	24
7290	RHEUMATISM NOS	24
7291	MYALGIA AND MYOSITIS NOS	24
7292	NEURALGIA/NEURITIS NOS	63
72930	PANNICULITIS, UNSP SITE	18
72931	HYPERTROPHY OF FAT PAD	18
72939	PANNICULITIS, SITE NEC	18
7294	FASCIITIS NOS	24
7295	PAIN IN LIMB	24
7296	OLD FB IN SOFT TISSUE	72
72981	SWELLING OF LIMB	24
72982	CRAMP IN LIMB	24
72989	MUSCSKEL SYMPT LIMB NEC	24
7299	SOFT TISSUE DIS NEC/NOS	24
73000	AC OSTEOMYELITIS-UNSPEC	24
73001	AC OSTEOMYELITIS-SHLDER	24
73002	AC OSTEOMYELITIS-UP/ARM	24
73003	AC OSTEOMYELITIS-FOREARM	24
73004	AC OSTEOMYELITIS-HAND	24
73005	AC OSTEOMYELITIS-PELVIS	24
73006	AC OSTEOMYELITIS-L/LEG	24
73007	AC OSTEOMYELITIS-ANKLE	24
73008	AC OSTEOMYELITIS NEC	24
73009	AC OSTEOMYELITIS-MULT	24
73010	CHR OSTEOMYELITIS-UNSP	24
73011	CHR OSTEOMYELIT-SHLDER	24
73012	CHR OSTEOMYELIT-UP/ARM	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
73013	CHR OSTEOMYELIT-FOREARM	24
73014	CHR OSTEOMYELIT-HAND	24
73015	CHR OSTEOMYELIT-PELVIS	24
73016	CHR OSTEOMYELIT-L/LEG	24
73017	CHR OSTEOMYELIT-ANKLE	24
73018	CHR OSTEOMYELIT NEC	24
73019	CHR OSTEOMYELIT-MULT	24
73020	OSTEOMYELITIS NOS-UNSPEC	24
73021	OSTEOMYELITIS NOS-SHLDER	24
73022	OSTEOMYELITIS NOS-UP/ARM	24
73023	OSTEOMYELIT NOS-FOREARM	24
73024	OSTEOMYELITIS NOS-HAND	24
73025	OSTEOMYELITIS NOS-PELVIS	24
73026	OSTEOMYELITIS NOS-L/LEG	24
73027	OSTEOMYELITIS NOS-ANKLE	24
73028	OSTEOMYELIT NOS-OTH SITE	24
73029	OSTEOMYELITIS NOS-MULT	24
73030	PERIOSTITIS-UNSPEC	24
73031	PERIOSTITIS-SHLDER	24
73032	PERIOSTITIS-UP/ARM	24
73033	PERIOSTITIS-FOREARM	24
73034	PERIOSTITIS-HAND	24
73035	PERIOSTITIS-PELVIS	24
73036	PERIOSTITIS-L/LEG	24
73037	PERIOSTITIS-ANKLE	24
73038	PERIOSTITIS NEC	24
73039	PERIOSTITIS-MULT	24
73070	POLIO OSTEOPATHY-UNSPEC	24
73071	POLIO OSTEOPATHY-SHLDER	24
73072	POLIO OSTEOPATHY-UP/ARM	24
73073	POLIO OSTEOPATHY-FOREARM	24
73074	POLIO OSTEOPATHY-HAND	24
73075	POLIO OSTEOPATHY-PELVIS	24
73076	POLIO OSTEOPATHY-L/LEG	24
73077	POLIO OSTEOPATHY-ANKLE	24
73078	POLIO OSTEOPATHY NEC	24
73079	POLIO OSTEOPATHY-MULT	24
73080	BONE INFECT NEC-UNSPEC	24
73081	BONE INFECT NEC-SHLDER	24
73082	BONE INFECT NEC-UP/ARM	24
73083	BONE INFECT NEC-FOREARM	24
73084	BONE INFECT NEC-HAND	24
73085	BONE INFECT NEC-PELVIS	24
73086	BONE INFECT NEC-L/LEG	24
73087	BONE INFECT NEC-ANKLE	24
73088	BONE INFECT NEC-OTH SITE	24
73089	BONE INFECT NEC-MULT	24
73090	BONE INFEC NOS-UNSP SITE	24
73091	BONE INFECT NOS-SHLDER	24
73092	BONE INFECT NOS-UP/ARM	24
73093	BONE INFECT NOS-FOREARM	24
73094	BONE INFECT NOS-HAND	24
73095	BONE INFECT NOS-PELVIS	24
73096	BONE INFECT NOS-L/LEG	24
73097	BONE INFECT NOS-ANKLE	24
73098	BONE INFECT NOS-OTH SITE	24
73099	BONE INFECT NOS-MULT	24
7310	OSTEITIS DEFORMANS NOS	24
7311	OSTEITIS DEF IN OTH DIS	24
7312	HYPERTROPH OSTEOARTHROP	24
7318	BONE INVOLV IN OTH DIS	24
7320	JUV OSTEOCHONDROS SPINE	24
7321	JUV OSTEOCHONDROS PELVIS	24
7322	FEMORAL EPIPHYSIOLYSIS	24
7323	JUV OSTEOCHONDROSIS ARM	24
7324	JUV OSTEOCHONDROSIS LEG	24
7325	JUV OSTEOCHONDROSIS FOOT	24
7326	JUV OSTEOCHONDROSIS NEC	24
7327	OSTEOCHONDROIT DISSECANS	24
7328	OSTEOCHONDROPATHY NEC	24
7329	OSTEOCHONDROPATHY NOS	24
73300	OSTEOPOROSIS NOS	24
73301	SENILE OSTEOPOROSIS	24
73302	IDIOPATHIC OSTEOPOROSIS	24
73303	DISUSE OSTEOPOROSIS	24
73309	OSTEOPOROSIS NEC	24

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
73310	PATH FX UNSPECIFIED SITE	72
73311	PATH FX HUMERUS	72
73312	PATH FX DSTL RADIUS ULNA	72
73313	PATH FX VERTEBRAE	72
73314	PATH FX NECK OF FEMUR	72
73315	PATH FX OTH SPCF PRT FMR	72
73316	PATH FX TIBIA FIBULA	72
73319	PATH FX OTH SPECIF SITE	72
73320	CYST OF BONE NOS	24
73321	SOLITARY BONE CYST	24
73322	ANEURYSMAL BONE CYST	24
73329	BONE CYST NEC	24
7333	HYPEROSTOSIS OF SKULL	24
73340	ASEPT NECROSIS BONE NOS	24
73341	ASEPTIC NECROSIS HUMERUS	24
73342	ASEPTIC NECROSIS FEMUR	24
73343	ASEPT NECRO FEMUR CONDYL	24
73344	ASEPTIC NECROSIS TALUS	24
73349	ASEPT NECROSIS BONE NEC	24
7335	OSTEITIS CONDENSANS	24
7336	TIETZE'S DISEASE	33
7337	ALGONEURODYSTROPHY	24
73381	MALUNION OF FRACTURE	72
73382	NONUNION OF FRACTURE	72
74742	PART ANOM PULM VEN CONN	36
74749	GREAT VEIN ANOMALY NEC	36
7475	UMBILICAL ARTERY ABSENCE	36
74760	UNSP PRPHERL VASC ANOMAL	36
74761	GSTRONTEST VESL ANOMALY	36
74762	RENAL VESSEL ANOMALY	36
74763	UPR LIMB VESSEL ANOMALY	36
74764	LWR LIMB VESSEL ANOMALY	36
74769	OTH SPCF PRPH VSCL ANOML	36
74781	CEREBROVASCULAR ANOMALY	11
74782	SPINAL VESSEL ANOMALY	36
74789	CIRCULATORY ANOMALY NEC	36
7479	CIRCULATORY ANOMALY NOS	11
7480	CHOANAL ATRESIA	31
7481	NOSE ANOMALY NEC	31
7482	LARYNGEAL WEB	31
7483	LARYNGOTRACH ANOMALY NEC	31
7484	CONGENITAL CYSTIC LUNG	33
7485	AGENESIS OF LUNG	33
74860	LUNG ANOMALY NOS	33
74861	CONGEN BRONCHIECTASIS	33
74869	LUNG ANOMALY NEC	33
7488	RESPIRATORY ANOMALY NEC	11
7489	RESPIRATORY ANOMALY NOS	11
74900	CLEFT PALATE NOS	31
74901	UNILAT CLEFT PALATE-COMP	31
74902	UNILAT CLEFT PALATE-INC	31
74903	BILAT CLEFT PALATE-COMPL	31
74904	BILAT CLEFT PALATE-INC	31
74910	CLEFT LIP NOS	31
74911	UNILAT CLEFT LIP-COMPL	31
74912	UNILAT CLEFT LIP-IMCOMPL	31
74913	BILAT CLEFT LIP-COMplete	31
74914	BILAT CLEFT LIP-INCOMPL	31
74920	CLEFT PALATE & LIP NOS	31
74921	UNIL CLEFT PALAT/LIP-COM	31
74922	UNIL CLEFT PALAT/LIP-INC	31
74923	BILAT CLFT PALAT/LIP-COM	31
74924	BILAT CLFT PALAT/LIP-INC	31
74925	CLEFT PALATE & LIP NEC	31
7500	TONGUE TIE	31
75010	TONGUE ANOMALY NOS	31
75011	AGLOSSIA	31
75012	CONG ADHESIONS OF TONGUE	31
75013	CONG FISSURE OF TONGUE	31
75015	CONG MACROGLOSSIA	31
75016	MICROGLOSSIA	31
75019	TONGUE ANOMALY NEC	31
75021	SALIVARY GLAND ABSENCE	31
75022	ACCESSORY SALIVARY GLAND	31
75023	CONG ATRESIA, SALIV DUCT	31
75024	CONG SALIVARY FISTULA	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
75025	CONGENITAL LIP FISTULA	31
75026	MOUTH ANOMALY NEC	11
75027	DIVERTICULUM OF PHARYNX	31
75029	PHARYNGEAL ANOMALY NEC	11
7503	CONG ESOPH FISTULA/ATRES	41
7504	ESOPHAGEAL ANOMALY NEC	41
7505	CONG PYLORIC STENOSIS	41
7506	CONGENITAL HIATUS HERNIA	41
7507	GASTRIC ANOMALY NEC	41
7508	UPPER GI ANOMALY NEC	41
7509	UPPER GI ANOMALY NOS	41
7510	MECKEL'S DIVERTICULUM	41
7511	ATRESIA SMALL INTESTINE	41
7512	ATRESIA LARGE INTESTINE	41
7513	HIRSCHSPRUNG'S DISEASE	41
7514	INTESTINAL FIXATION ANOM	41
7515	INTESTINAL ANOMALY NEC	41
75160	BILIARY & LIVER ANOM NOS	41
75161	BILIARY ATRESIA	41
75162	CONG CYSTIC LIVER DIS	41
75169	BILIARY & LIVER ANOM NEC	41
7517	PANCREAS ANOMALIES	41
7518	ANOM DIGESTIVE SYST NEC	41
7519	ANOM DIGESTIVE SYST NOS	41
7520	ANOMALIES OF OVARIES	56
75210	TUBAL/BROAD LIG ANOM NOS	56
75211	EMBRYONIC CYST OF ADNEXA	56
75219	TUBAL/BROAD LIG ANOM NEC	56
7522	DOUBLING OF UTERUS	56
7523	UTERINE ANOMALY NEC	56
75240	CERVIX/FEM GEN ANOM NOS	56
75241	EMBRYON CYST FEM GEN NEC	56
75242	IMPERFORATE HYMEN	56
75249	CERVIX/FEM GEN ANOM NEC	56
7527	INDETERMINATE SEX	53
7528	GENITAL ORGAN ANOM NEC	53
7529	GENITAL ORGAN ANOM NOS	53
7530	RENAL AGENESIS	53
75310	CYSTIC KIDNEY DISEAS NOS	53
75311	CONGENITAL RENAL CYST	53
75312	POLYCYSTIC KIDNEY NOS	53
75313	POLYCYST KID-AUTOSOM DOM	53
75314	POLYCYST KID-AUTOSOM REC	53
75315	RENAL DYSPLASIA	53
75316	MEDULLARY CYSTIC KIDNEY	53
75317	MEDULLARY SPONGE KIDNEY	53
75319	CYSTIC KIDNEY DISEAS NEC	53
7533	KIDNEY ANOMALY NEC	53
7534	URETERAL ANOMALY NEC	53
7535	BLADDER EXSTROPHY	53
7536	CONGEN URETHRAL STENOSIS	53
7537	ANOMALIES OF URACHUS	53
7538	CYSTOURETHRAL ANOM NEC	53
7539	URINARY ANOMALY NOS	53
7540	CONG SKULL/FACE/JAW DEF	24
7541	CONGENITAL TORTICOLLIS	24
7542	CONG POSTURAL DEFORMITY	24
75430	CONG HIP DISLOC, UNILAT	24
75431	CONGEN HIP DISLOC, BILAT	24
75432	CONG HIP SUBLUX, UNILAT	24
75433	CONG HIP SUBLUX, BILAT	24
75435	CONG HIP DISLOC W SUBLUX	24
75440	CONG GENU RECURVATUM	24
75441	CONG KNEE DISLOCATION	24
75442	CONGEN BOWING OF FEMUR	24
75443	CONG BOWING TIBIA/FIBULA	24
75444	CONG BOWING LEG NOS	24
75450	TALIPES VARUS	24
75451	TALIPES EQUINOVARUS	24
75452	METATARSUS PRIMUS VARUS	24
75453	METATARSUS VARUS	24
75459	CONG VARUS FOOT DEF NEC	24
75460	TALIPES VALGUS	24
75461	CONGENITAL PES PLANUS	24
75462	TALIPES CALCANEVALGUS	24
75469	CONG VALGUS FOOT DEF NEC	24

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
75470	TALIPES NOS	24
75471	TALIPES CAVUS	24
75479	CONG FOOT DEFORM NEC	24
75481	PECTUS EXCAVATUM	11
75482	PECTUS CARINATUM	11
75489	NONTERATOGENIC ANOM NEC	24
75500	POLYDACTYLY NOS	24
75501	POLYDACTYLY, FINGERS	24
75502	POLYDACTYLY, TOES	24
75510	SYNDACTYLY, MULTIPLE/NOS	24
75511	SYNDACTYL FING-NO FUSION	24
75512	SYNDACTYL FING W FUSION	24
75513	SYNDACTYL TOE-NO FUSION	24
75514	SYNDACTYL TOE W FUSION	24
75520	REDUC DEFORM UP LIMB NOS	24
75521	TRANSVERSE DEFIC ARM	24
75522	LONGITUD DEFIC ARM NEC	24
75523	COMBIN LONGIT DEFIC ARM	24
75524	LONGITUDIN DEFIC HUMERUS	24
75525	LONGITUD DEFIC RADIOULNA	24
75526	LONGITUD DEFIC RADIUS	24
75527	LONGITUDINAL DEFIC ULNA	24
75528	LONGITUDINAL DEFIC HAND	24
75529	LONGITUD DEFIC PHALANGES	24
75530	REDUCTION DEFORM LEG NOS	24
75531	TRANSVERSE DEFIC LEG	24
75532	LONGITUDIN DEFIC LEG NEC	24
75533	COMB LONGITUDIN DEF LEG	24
75534	LONGITUDINAL DEFIC FEMUR	24
75535	TIBIOFIBULA LONGIT DEFIC	24
75536	LONGITUDINAL DEFIC TIBIA	24
75537	LONGITUDIN DEFIC FIBULA	24
75538	LONGITUDINAL DEFIC FOOT	24
75539	LONGITUD DEFIC PHALANGES	24
7554	REDUCT DEFORM LIMB NOS	24
75550	UPPER LIMB ANOMALY NOS	24
75551	CONG DEFORMITY-CLAVICLE	24
75552	CONG ELEVATION-SCAPULA	24
75553	RADIOULNAR SYNOSTOSIS	24
75554	MADDELUNG'S DEFORMITY	24
75555	ACROCEPHALOSYNDACTYLY	24
75556	ACCESSORY CARPAL BONES	24
75557	MACRODACTYLIA (FINGERS)	24
75558	CONGENITAL CLEFT HAND	24
75559	UPPER LIMB ANOMALY NEC	24
75560	LOWER LIMB ANOMALY NOS	24
75561	CONGENITAL COXA VALGA	24
75562	CONGENITAL COXA VARA	24
75563	CONG HIP DEFORMITY NEC	24
75564	CONG KNEE DEFORMITY	24
75565	MACRODACTYLIA OF TOES	24
75566	ANOMALIES OF TOES NEC	24
75567	ANOMALIES OF FOOT NEC	24
75569	LOWER LIMB ANOMALY NEC	24
7558	CONGEN LIMB ANOMALY NEC	24
7559	CONGEN LIMB ANOMALY NOS	24
7560	ANOMAL SKULL/FACE BONES	24
75610	ANOMALY OF SPINE NOS	24
75611	LUMBOSACR SPONDYLOLYSIS	24
75612	SPONDYLOLISTHESIS	24
75613	CONG ABSENCE OF VERTEBRA	24
75614	HEMIVERTEBRA	24
75615	CONGEN FUSION OF SPINE	24
75616	KLIPEL-FEIL SYNDROME	24
75617	SPINA BIFIDA OCCULTA	63
75619	ANOMALY OF SPINE NEC	24
7562	CERVICAL RIB	24
7563	RIB & STERNUM ANOMAL NEC	11
7564	CHONDRODYSSTROPHY	24
75650	OSTEODYSTROPHY NOS	24
75651	OSTEOGENESIS IMPERFECTA	24
75652	OSTEOPETROSIS	24
75653	OSTEOPOIKILOYSIS	24
75654	POLYOSTOTIC FIBROS DYSPL	24
75655	CHONDROECTODERM DYSPLAS	24
75656	MULT EPIPHYSEAL DYSPLAS	24

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
75659	OSTEODYSTROPHY NEC	24
7566	ANOMALIES OF DIAPHRAGM	11
75681	ABSENCE OF MUSCLE/TENDON	24
75682	ACCESSORY MUSCLE	24
75683	EHLERS-DANLOS SYNDROME	24
75689	SOFT TISSUE ANOMALY NEC	24
7569	MUSCULOSKEL ANOM NEC/NOS	24
7570	HEREDITARY EDEMA OF LEGS	18
7571	ICHTHYOSIS CONGENITA	18
7572	DERMATOGLYPHIC ANOMALIES	18
75731	CONG ECTODERMAL DYSPLAS	18
75732	VASCULAR HAMARTOMAS	18
75733	CONG SKIN PIGMENT ANOMAL	18
75739	SKIN ANOMALY NEC	18
7574	HAIR ANOMALIES NEC	18
7575	NAIL ANOMALIES NEC	18
7576	BREAST ANOMALIES NEC	18
7578	OTH INTEGUMENT ANOMALIES	18
7579	INTEGUMENT ANOMALY NOS	18
7580	DOWN'S SYNDROME	91
7581	PATAU'S SYNDROME	91
7582	EDWARDS' SYNDROME	91
7583	AUTOSOMAL DELETION SYND	91
7584	BALANCE AUTOSOM TRANSLOC	11
7585	AUTOSOMAL ANOMALIES NEC	11
7586	GONADAL DYSGENESIS	53
7587	KLINEFELTER'S SYNDROME	53
7589	CHROMOSOME ANOMALY NOS	57
7590	ANOMALIES OF SPLEEN	86
7591	ADRENAL GLAND ANOMALY	82
7592	ENDOCRINE ANOMALY NEC	82
7593	SITUS INVERSUS	41
7594	CONJOINED TWINS	57
7595	TUBEROUS SCLEROSIS	63
7596	HAMARTOSES NEC	18
7597	MULT CONGEN ANOMAL NEC	57
75981	PRADER-WILLI SYNDROME	57
75982	MARFAN SYNDROME	57
75983	FRAGILE X SYNDROME	82
75989	SPECIFIED CONG ANOMAL NEC	57
7599	CONGENITAL ANOMALY NOS	57
7600	MATERN HYPERTEN AFF NB	57
7601	MATERN URINE DIS AFF NB	57
7602	MATERNAL INFEC AFF NB	57
7603	MATERN CARDIORESP AFF NB	57
7604	MATERN NUTRIT DIS AFF NB	57
7605	MATERNAL INJURY AFF NB	57
7606	SURG OP ON MOTHER AFF NB	57
76070	NOXIOUS SUBST NOS AFF NB	57
76071	MATERNAL ALCOHOL AFF NB	57
76072	MATERNAL NARCOTIC AFF NB	57
76073	MATERNAL HALLUCIN AFF NB	57
76074	MATERNAL ANTI-INF AFF NB	57
76075	COCAINE - NXs INFL FETUS	57
76076	FTS/NB AFCTD MTRNL DES	56
76079	NOXIOUS SUBST NEC AFF NB	57
7608	MATERNAL COND NEC AFF NB	57
7609	MATERNAL COND NOS AFF NB	57
7610	INCOMPETNT CERVIX AFF NB	57
7611	PREMAT RUPT MEMB AFF NB	57
7612	OLIGOHYDRAMNIOS AFF NB	57
7613	POLYHYDRAMNIOS AFF NB	57
7614	ECTOPIC PREGNANCY AFF NB	57
7615	MULT PREGNANCY AFF NB	57
7616	MATERNAL DEATH AFF NB	57
7617	ANTEPART MALPRES AFF NB	57
7618	MATERN COMPL NEC AFF NB	57
7619	MATERN COMPL NOS AFF NB	57
7620	PLACENTA PREVIA AFF NB	57
7621	PLACENTA HEM NEC AFF NB	57
7622	ABN PLAC NEC/NOS AFF NB	57
7623	PLACENT TRANSFUSION SYN	57
7624	PROLAPSED CORD AFF NB	57
7625	OTH UMBIL CORD COMPRESS	57
7626	UMBIL COND NEC AFF NB	57
7627	CHORIOAMNIONITIS AFF NB	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7628	ABN AMNION NEC AFF NB	57
7629	ABN AMNION NOS AFF NB	57
7630	BREECH DEL/EXTRAC AFF NB	57
7631	MALPOS/DISPRO NEC AFF NB	57
7632	FORCEPS DELIVERY AFF NB	57
7633	VACUUM EXTRAC DEL AFF NB	57
7634	CESAREAN DELIVERY AFF NB	57
7635	MAT ANESTH/ANALG AFF NB	57
7636	PRECIPITATE DEL AFF NB	57
7637	ABN UTERINE CONTR AFF NB	57
7638	COMPL DELIV NEC AFF NB	57
7639	COMPL DELIV NOS AFF NB	57
76400	LIGHT-FOR-DATES WTNOS	57
76401	LIGHT-FOR-DATES <500G	57
76402	LT-FOR-DATES 500-749G	57
76403	LT-FOR-DATES 750-999G	57
76404	LT-FOR-DATES 1000-1249G	57
76405	LT-FOR-DATES 1250-1499G	57
76406	LT-FOR-DATES 1500-1749G	57
76407	LT-FOR-DATES 1750-1999G	57
76408	LT-FOR-DATES 2000-2499G	57
76409	LT-FOR-DATES 2500+G	57
76410	LT-FOR-DATE W/MAL WTNOS	57
76411	LT-FOR-DATE W/MAL <500G	57
76412	LT-DATE W/MAL 500-749G	57
76413	LT-DATE W/MAL 750-999G	57
76414	LT-DATE W/MAL 1000-1249G	57
76415	LT-DATE W/MAL 1250-1499G	57
76416	LT-DATE W/MAL 1500-1749G	57
76417	LT-DATE W/MAL 1750-1999G	57
76418	LT-DATE W/MAL 2000-2499G	57
76419	LT-FOR-DATE W/MAL 2500+G	57
76420	FETAL MALNUTRITION WTNOS	57
76421	FETAL MALNUTRITION <500G	57
76422	FETAL MALNUTR 500-749G	57
76423	FETAL MAL 750-999G	57
76424	FETAL MAL 1000-1249G	57
76425	FETAL MAL 1250-1499G	57
76426	FETAL MAL 1500-1749G	57
76427	FETAL MALNUTR 1750-1999G	57
76428	FETAL MALNUTR 2000-2499G	57
76429	FETAL MALNUTR 2500+G	57
76490	FET GROWTH RETARD WTNOS	57
76491	FET GROWTH RETARD <500G	57
76492	FET GROWTH RET 500-749G	57
76493	FET GROWTH RET 750-999G	57
76494	FET GRWTH RET 1000-1249G	57
76495	FET GRWTH RET 1250-1499G	57
76496	FET GRWTH RET 1500-1749G	57
76497	FET GRWTH RET 1750-1999G	57
76498	FET GRWTH RET 2000-2499G	57
76499	FET GROWTH RET 2500+G	57
76500	EXTREME IMMATUR WTNOS	57
76501	EXTREME IMMATUR <500G	57
76502	EXTREME IMMATUR 500-749G	57
76503	EXTREME IMMATUR 750-999G	57
76504	EXTREME IMMAT 1000-1249G	57
76505	EXTREME IMMAT 1250-1499G	57
76506	EXTREME IMMAT 1500-1749G	57
76507	EXTREME IMMAT 1750-1999G	57
76508	EXTREME IMMAT 2000-2499G	57
76509	EXTREME IMMAT 2500+G	57
76510	PRETERM INFANT NEC WTNOS	57
76511	PRETERM NEC <500G	57
76512	PRETERM NEC 500-749G	57
76513	PRETERM NEC 750-999G	57
76514	PRETERM NEC 1000-1249G	57
76515	PRETERM NEC 1250-1499G	57
76516	PRETERM NEC 1500-1749G	57
76517	PRETERM NEC 1750-1999G	57
76518	PRETERM NEC 2000-2499G	57
76519	PRETERM NEC 2500+G	57
7660	EXCEPTIONALLY LARGE BABY	57
7661	HEAVY-FOR-DATE INFAN NEC	57
7662	POST-TERM INFANT NOS	57
7670	CEREBRAL HEM AT BIRTH	57

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
7671	SCALP INJURY AT BIRTH	57
7672	CLAVICLE FX AT BIRTH	57
7673	BONE INJURY NEC AT BIRTH	57
7674	SPINAL CORD INJ AT BIRTH	57
7675	FACIAL NERVE INJ-BIRTH	57
7676	BRACH PLEXUS INJ-BIRTH	57
7677	NERVE INJ NEC AT BIRTH	57
7678	BIRTH TRAUMA NEC	57
7679	BIRTH TRAUMA NOS	57
7680	FETAL DEATH-ANOXIA NOS	57
7681	FET DEATH-ANOXIA DUR LAB	57
7682	FET DISTRESS BEFOR LABOR	57
7683	FETAL DISTRESS DUR LABOR	57
7684	FETAL DISTRESS NOS	57
7685	SEVERE BIRTH ASPHYXIA	57
7686	MILD/MOD BIRTH ASPHYXIA	57
7689	BIRTH ASPHYXIA NOS	57
769	RESPIRATORY DISTRESS SYN	57
7700	CONGENITAL PNEUMONIA	57
7701	MECONIUM ASPIRATN SYNDRM	57
7702	NB INTERSTIT EMPHYSEMA	57
7703	NB PULMONARY HEMORRHAGE	57
7704	PRIMARY ATELECTASIS	57
7705	NB ATELECTASIS NEC/NOS	57
7706	NB TRANSITORY TACHYPNEA	57
7707	PERINATAL CHR RESP DIS	57
7708	POST-BIRTH RESP PROB NEC	57
7709	NB RESPIRATORY COND NOS	57
7710	CONGENITAL RUBELLA	57
7711	CONG CYTOMEGALOVIRUS INF	57
7712	CONGENITAL INFEC NEC	57
7713	TETANUS NEONATORUM	57
7714	OMPHALITIS OF NEWBORN	57
7715	NEONATAL INFEC MASTITIS	57
7716	NEONATAL CONJUNCTIVITIS	57
7717	NEONATAL CANDIDA INFECT	57
7718	PERINATAL INFECTION NEC	57
7720	FETAL BLOOD LOSS NEC	57
7721	NB INTRAVENTRICULAR HEM	57
7722	NB SUBARACHNOID HEMORR	57
7723	POST-BIRTH UMBIL HEMORR	57
7724	NB GI HEMORRHAGE	57
7725	NB ADRENAL HEMORRHAGE	57
7726	NB CUTANEOUS HEMORRHAGE	57
7728	NEONATAL HEMORRHAGE NEC	57
7729	NEONATAL HEMORRHAGE NOS	57
7730	NB HEMOLYT DIS:RH ISOIMM	57
7731	NB HEMOLYT DIS-ABO ISOIM	57
7732	NB HEMOLYT DIS-ISOIM NEC	57
7733	HYDROPS FETALIS:ISOIMM	57
7734	NB KERNICTERUS:ISOIMMUN	57
7735	NB LATE ANEMIA:ISOIMMUN	57
7740	PERINAT JAUND-HERED ANEM	57
7741	PERINAT JAUND:HEMOLYSIS	57
7742	NEONAT JAUND PRETERM DEL	57
77430	DELAY CONJUGAT JAUND NOS	57
77431	NEONAT JAUND IN OTH DIS	57
77439	DELAY CONJUGAT JAUND NEC	57
7744	FETAL/NEONATAL HEPATITIS	57
7745	PERINATAL JAUNDICE NEC	57
7746	FETAL/NEONATAL JAUND NOS	57
7747	NB KERNICTERUS	57
7750	INFANT DIABET MOTHER SYN	57
7751	NEONAT DIABETES MELLITUS	57
7752	NEONAT MYASTHENIA GRAVIS	57
7753	NEONATAL THYROTOXICOSIS	57
7754	HYPOCALCEM/HYPOMAGNES NB	57
7755	NEONATAL DEHYDRATION	57
7756	NEONATAL HYPOGLYCEMIA	57
7757	LATE METAB ACIDOSIS NB	57
7758	TRANSIENT MET DIS NB NEC	57
7759	TRANSIENT MET DIS NB NOS	57
7760	NB HEMORRHAGIC DISEASE	57
7761	NEONATAL THROMBOCYTOPEN	57
7762	DISSEM INTRAVASC COAG NB	57
7763	OTH NEONATAL COAG DIS	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7764	POLYCYTHEMIA NEONATORUM	57
7765	CONGENITAL ANEMIA	57
7766	ANEMIA OF PREMATURITY	57
7767	NEONATAL NEUTROPENIA	57
7768	TRANSIENT HEMAT DIS NEC	57
7769	NB HEMATOLOGICAL DIS NOS	57
7771	MECONIUM OBSTRUCTION	57
7772	INTEST OBST-INSPISS MILK	57
7773	SWALLOWED BLOOD SYNDROME	57
7774	TRANSITORY ILEUS OF NB	57
7775	NECROT ENTEROCOLITIS NB	57
7776	PERINATAL INTEST PERFOR	57
7778	PERINAT GI SYS DIS NEC	57
7779	PERINAT GI SYS DIS NOS	57
7780	HYDROPS FETALIS NO ISOIM	57
7781	SCLEREMA NEONATORUM	57
7782	NB COLD INJURY SYNDROME	57
7783	NB HYPOTHERMIA NEC	57
7784	NB TEMP REGULAT DIS NEC	57
7785	EDEMA OF NEWBORN NEC/NOS	57
7786	CONGENITAL HYDROCELE	57
7787	NB BREAST ENGORGEMENT	57
7788	NB INTEGUMENT COND NEC	57
7789	NB INTEGUMENT COND NOS	57
7790	CONVULSIONS IN NEWBORN	57
7791	NB CEREB IRRIT NEC/NOS	57
7792	CNS DYSFUNCTION SYN NB	57
7793	NB FEEDING PROBLEMS	57
7794	NB DRUG REACTION/INTOXIC	57
7795	NB DRUG WITHDRAWAL SYNDR	57
*7796	TERMINATION OF PREGNANCY .....	.....
7798	PERINATAL CONDITION NEC	57
7799	PERINATAL CONDITION NOS	57
78001	COMA	78
78002	TRANS ALTER AWARENESS	63
78003	PERSISTENT VEGTV STATE	78
78009	OTHER ALTER CONSCIOUSNES	63
7801	HALLUCINATIONS	91
7802	SYNCOPE AND COLLAPSE	63
7804	DIZZINESS AND GIDDINESS	11
78050	SLEEP DISTURBANCE NOS	91
78051	INSOMNIA W SLEEP APNEA	63
78052	INSOMNIA NEC	91
78053	HYPERMOMNI W SLEEP APNEA	63
78054	HYPERMOMNIA NEC	91
78055	IRREG SLEEP-WAKE RHY NOS	91
78056	SLEEP STAGE DYSFUNCTIONS	91
78057	OTH UNSPCF SLEEP APNEA	91
78059	SLEEP DISTURBANCES NEC	91
7806	FEVER	97
7807	MALAISE AND FATIGUE	11
7808	HYPERHIDROSIS	99
7809	GENERAL SYMPTOMS NEC	11
7810	ABN INVOLUN MOVEMENT NEC	63
7811	SMELL & TASTE DISTURB	63
7812	ABNORMALITY OF GAIT	63
7813	LACK OF COORDINATION	11
7814	TRANSIENT LIMB PARALYSIS	63
7815	CLUBBING OF FINGERS	33
7816	MENINGISMUS	78
7817	TETANY	82
7818	NEUROLOGIC NEGLECT SYNDR	63
7819	NERV/MUSCULSKEL SYM NEC	11
7820	SKIN SENSATION DISTURB	11
7821	NONSPECIF SKIN ERUPT NEC	18
7822	LOCAL SUPRFICIAL SWELLNG	11
7823	EDEMA	11
7824	JAUNDICE NOS	41
7825	CYANOSIS	36
78261	PALLOR	11
78262	FLUSHING	11
7827	SPONTANEOUS ECCHYMOSES	86
7828	CHANGES IN SKIN TEXTURE	11
7829	INTEGUMENT TISS SYMP NEC	11
7830	ANOREXIA	41
7831	ABNORMAL WEIGHT GAIN	82

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7832	ABNORMAL LOSS OF WEIGHT	82
7833	FEEDING PROBLEM	41
7834	LACK NORM PHYSIOL DEVEL	82
7835	POLYDIPSIA	82
7836	POLYPHAGIA	82
7839	NUTR/METAB/DEVEL SYM NEC	82
7840	HEADACHE	63
7841	THROAT PAIN	11
7842	SWELLING IN HEAD & NECK	11
7843	APHASIA	63
78440	VOICE DISTURBANCE NOS	11
78441	APHONIA	11
78449	VOICE DISTURBANCE NEC	11
7845	SPEECH DISTURBANCE NEC	11
78460	SYMBOLIC DYSFUNCTION NOS	91
78461	ALEXIA AND DYSLEXIA	91
78469	SYMBOLIC DYSFUNCTION NEC	91
7847	EPISTAXIS	31
7848	HEMORRHAGE FROM THROAT	41
7849	SYMP INVOL HEAD/NECK NEC	11
7850	TACHYCARDIA NOS	36
7851	PALPITATIONS	36
7852	CARDIAC MURMURS NEC	36
7853	ABNORM HEART SOUNDS NEC	36
7854	GANGRENE	36
78550	SHOCK NOS	78
78551	CARDIOGENIC SHOCK	78
78559	SHOCK W/O TRAUMA NEC	97
7856	ENLARGEMENT LYMPH NODES	86
7859	CARDIOVAS SYS SYMP NEC	36
78600	RESPIRATORY ABNORM NOS	33
78601	HYPERVENTILATION	11
78602	ORTHOPNEA	36
78609	RESPIRATORY ABNORM NEC	33
7861	STRIDOR	33
7862	COUGH	31
7863	HEMOPTYSIS	33
7864	ABNORMAL SPUTUM	11
78650	CHEST PAIN NOS	36
78651	PRECARDIAL PAIN	36
78652	PAINFUL RESPIRATION	36
78659	CHEST PAIN NEC	36
7866	CHEST SWELLING/MASS/LUMP	24
7867	ABNORMAL CHEST SOUNDS	11
7868	HICCOUGH	11
7869	RESP SYS/CHEST SYMP NEC	11
7870	NAUSEA AND VOMITING*	41
78701	NAUSEA WITH VOMITING	41
78702	NAUSEA ALONE	41
78703	VOMITING ALONE	41
7871	HEARTBURN	41
7872	DYSPHAGIA	41
7873	FLATUL/ERUCTAT/GAS PAIN	41
7874	VISIBLE PERISTALSIS	41
7875	ABNORMAL BOWEL SOUNDS	41
7876	INCONTINENCE OF FECES	41
7877	ABNORMAL FECES	41
78791	DIARRHEA	41
78799	DIGESTVE SYST SYMPTM NEC	41
7880	RENAL COLIC	53
7881	DYSURIA	53
78820	RETENTION URINE NOS	53
78821	INCMPLET BLDDER EMPTYING	53
78829	OTH SPCF RETENTION URINE	53
7883	INCONTINENCE OF URINE*	53
78830	URINARY INCONTINENCE NOS	53
78831	URGE INCONTINENCE	53
78832	STRESS INCONTINENCE MALE	53
78833	MIXED INCONTINENCE	53
78834	INCONTNCE WO SENSR AWARE	53
78835	POST-VOID DRIBBLING	53
78836	NOCTURNAL ENURESIS	53
78837	CONTINUOUS LEAKAGE	53
78839	OTH URINRY INCONTINENCE	53
78841	URINARY FREQUENCY	53
78842	POLYURIA	53

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
78843	NOCTURIA	53
7885	OLIGURIA & ANURIA	53
78861	SPLITTING URINARY STREAM	53
78862	SLOWING URINARY STREAM	53
78869	OTH ABNORMALT URINATION	53
7887	URETHRAL DISCHARGE	97
7888	EXTRAVASATION OF URINE	53
7889	URINARY SYS SYMPTOM NEC	53
78900	ABDMNAL PAIN UNSPCF SITE	41
78901	ABDMNAL PAIN RT UPR QUAD	41
78902	ABDMNAL PAIN LFT UP QUAD	41
78903	ABDMNAL PAIN RT LWR QUAD	41
78904	ABDMNAL PAIN LT LWR QUAD	41
78905	ABDMNAL PAIN PERIUMBILIC	41
78906	ABDMNAL PAIN EPIGASTRIC	41
78907	ABDMNAL PAIN GENERALIZED	41
78909	ABDMNAL PAIN OTH SPCF ST	41
7891	HEPATOMEGALY	41
7892	SPLENOMEGALY	86
78930	ABDMNAL MASS UNSPCF SITE	41
78931	ABDMNAL MASS RT UPR QUAD	41
78932	ABDMNAL MASS LFT UP QUAD	41
78933	ABDMNAL MASS RT LWR QUAD	41
78934	ABDMNAL MASS LT LWR QUAD	41
78935	ABDMNAL MASS PERIUMBILIC	41
78936	ABDMNAL MASS EPIGASTRIC	41
78937	ABDMNAL MASS GENERALIZED	41
78939	ABDMNAL MASS OTH SPCF ST	41
78940	ABDMNAL RGDT UNSPCF SITE	41
78941	ABDMNAL RGDT RT UPR QUAD	41
78942	ABDMNAL RGDT LFT UP QUAD	41
78943	ABDMNAL RGDT RT LWR QUAD	41
78944	ABDMNAL RGDT LT LWR QUAD	41
78945	ABDMNAL RGDT PERIUMBILIC	41
78946	ABDMNAL RGDT EPIGASTRIC	41
78947	ABDMNAL RGDT GENERALIZED	41
78949	ABDMNAL RGDT OTH SPCF ST	41
7895	ASCITES	41
78960	ABDMNAL TNDR UNSPCF SITE	41
78961	ABDMNAL TNDR RT UPR QUAD	41
78962	ABDMNAL TNDR LFT UP QUAD	41
78963	ABDMNAL TNDR RT LWR QUAD	41
78964	ABDMNAL TNDR LT LWR QUAD	41
78965	ABDMNAL TNDR PERIUMBILIC	41
78966	ABDMNAL TNDR EPIGASTRIC	41
78967	ABDMNAL TNDR GENERALIZED	41
78969	ABDMNAL TNDR OTH SPCF ST	41
7899	ABDOMEN/PELVIS SYMP NEC	11
7900	ABNORM RED BLOOD CELL	86
7901	ELEVATED SEDIMENT RATE	11
7902	ABN GLUCOSE TOLERAN TEST	11
7903	EXCESS BLOOD-ALCOHOL LEV	91
7904	ELEV TRANSAMINASE/LDH	11
7905	ABN SERUM ENZY LEVEL NEC	11
7906	ABN BLOOD CHEMISTRY NEC	11
7907	BACTEREMIA	97
7908	VIREMIA NOS	97
79091	ABNRML ART BLOOD GASES	11
79092	ABNRML COAGULTION PRFILE	11
79093	ELVTD PRSTATE SPCF ANTGN	11
79099	OTH NSPCF FINDING BLOOD	11
7910	PROTEINURIA	53
7911	CHYLURIA	78
7912	HEMOGLOBINURIA	53
7913	MYOGLOBINURIA	53
7914	BILIURIA	53
7915	GLYCOSURIA	53
7916	ACETONURIA	53
7917	OTH CELLS/CASTS IN URINE	53
7919	ABN URINE FINDINGS NEC	53
7920	ABN FND-CEREBROSPINAL FL	11
7921	ABN FIND-STOOL CONTENTS	11
7922	ABN FINDINGS-SEMIN	53
7923	ABN FIND-AMNIOTIC FLUID	57
7924	ABN FINDINGS-SALIVA	11
7929	ABN FIND-BODY SUBST NEC	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7930	ABN FINDING-SKULL & HEAD	11
7931	ABN FINDINGS-LUNG FIELD	11
7932	ABN FD-INTRATHOR ORG NEC	11
7933	ABN FIND-BILIARY TRACT	41
7934	ABN FINDINGS-GI TRACT	11
7935	ABN FINDINGS-GU ORGANS	53
7936	ABN FIND-ABDOMINAL AREA	11
7937	ABN FIND-MUSCULOSKEL SYS	11
7938	ABNORMAL FINDINGS-BREAST	18
7939	ABN FIND-BODY STRUCT NEC	11
79400	ABN CNS FUNCT STUDY NOS	11
79401	ABNORM ECHOENCEPHALOGRAM	11
79402	ABN ELECTROENCEPHALOGRAM	11
79409	ABN CNS FUNCT STUDY NEC	11
79410	ABN STIMUL RESPONSE NOS	11
79411	ABN RETINAL FUNCT STUDY	68
79412	ABNORM ELECTRO-OCULOGRAM	68
79413	ABNORMAL VEP	68
79414	ABN OCULOMOTOR STUDIES	68
79415	ABN AUDITORY FUNCT STUDY	31
79416	ABN VESTIBULAR FUNC STUD	21
79417	ABNORM ELECTROMYOGRAM	24
79419	ABN PERIPH NERV STUD NEC	11
7942	ABN PULMONARY FUNC STUDY	11
79430	ABN CARDIOVASC STUDY NOS	11
79431	ABNORM ELECTROCARDIOGRAM	11
79439	ABN CARDIOVASC STUDY NEC	11
7944	ABN KIDNEY FUNCT STUDY	53
7945	ABN THYROID FUNCT STUDY	82
7946	ABN ENDOCRINE STUDY NEC	82
7947	ABN BASAL METABOL STUDY	82
7948	ABN LIVER FUNCTION STUDY	41
7949	ABN FUNCTION STUDY NEC	53
7950	ABN PAP SMEAR-CERVIX	56
7951	ABN PAP SMEAR-OTH SITE	56
7952	ABN CHROMOSOMAL ANALYSIS	57
7953	POSITIVE CULTURE FINDING	97
7954	ABN HISTOLOGIC FIND NEC	11
7955	TUBERCULIN TEST REACTION	11
7956	FALSE POS SERO TEST-SYPH	11
79571	NONSPCF SERLGC EVDNC HIV	86
79579	OTH UNSPCF NSPF IMUN FND	86
7960	ABN TOXICOLOGIC FINDING	11
7961	ABNORMAL REFLEX	11
7962	ELEV BL PRES W/O HYPERTN	36
7963	LOW BLOOD PRESS READING	36
7964	ABN CLINICAL FINDING NEC	11
7969	ABNORMAL FINDINGS NEC	11
797	SENILITY W/O PSYCHOSIS	91
7980	SUDDEN INFANT DEATH SYND	99
7981	INSTANTANEOUS DEATH	99
7982	DEATH WITHIN 24 HR SYMPT	99
7989	UNATTENDED DEATH	99
7990	ASPHYXIA	78
7991	RESPIRATORY ARREST	78
7992	NERVOUSNESS	91
7993	DEBILITY NOS	11
7994	CACHEXIA	41
7998	ILL-DEFINE CONDITION NEC	11
7999	UNKN CAUSE MORB/MORT NEC	11
80000	CLOSED SKULL VAULT FX	72
80001	CL SKULL VLT FX W/O COMA	72
80002	CL SKULL VLT FX-BRF COMA	72
80003	CL SKULL VLT FX-MOD COMA	72
80004	CL SKL VLT FX-PROLN COMA	72
80005	CL SKUL VLT FX-DEEP COMA	72
80006	CL SKULL VLT FX-COMA NOS	72
80009	CL SKL VLT FX-CONCUS NOS	72
80010	CL SKL VLT FX/CEREBR LAC	72
80011	CL SKULL VLT FX W/O COMA	72
80012	CL SKULL VLT FX-BRF COMA	72
80013	CL SKULL VLT FX-MOD COMA	72
80014	CL SKL VLT FX-PROLN COMA	72
80015	CL SKUL VLT FX-DEEP COMA	72
80016	CL SKULL VLT FX-COMA NOS	72
80019	CL SKL VLT FX-CONCUS NOS	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
80020	CL SKL VLT FX/MENING HEM	72
80021	CL SKULL VLT FX W/O COMA	72
80022	CL SKULL VLT FX-BRF COMA	72
80023	CL SKULL VLT FX-MOD COMA	72
80024	CL SKL VLT FX-PROLN COMA	72
80025	CL SKUL VLT FX-DEEP COMA	72
80026	CL SKULL VLT FX-COMA NOS	72
80029	CL SKL VLT FX-CONCUS NOS	72
80030	CL SKULL VLT FX/HEM NEC	72
80031	CL SKULL VLT FX W/O COMA	72
80032	CL SKULL VLT FX-BRF COMA	72
80033	CL SKULL VLT FX-MOD COMA	72
80034	CL SKL VLT FX-PROLN COMA	72
80035	CL SKUL VLT FX-DEEP COMA	72
80036	CL SKULL VLT FX-COMA NOS	72
80039	CL SKL VLT FX-CONCUS NOS	72
80040	CL SKL VLT FX/BR INJ NEC	72
80041	CL SKULL VLT FX W/O COMA	72
80042	CL SKULL VLT FX-BRF COMA	72
80043	CL SKULL VLT FX-MOD COMA	72
80044	CL SKL VLT FX-PROLN COMA	72
80045	CL SKUL VLT FX-DEEP COMA	72
80046	CL SKULL VLT FX-COMA NOS	72
80049	CL SKL VLT FX-CONCUS NOS	72
80050	OPN SKULL VAULT FRACTURE	72
80051	OPN SKUL VLT FX W/O COMA	72
80052	OPN SKUL VLT FX-BRF COMA	72
80053	OPN SKUL VLT FX-MOD COMA	72
80054	OPN SKL VLT FX-PROLN COM	72
80055	OPN SKL VLT FX-DEEP COMA	72
80056	OPN SKUL VLT FX-COMA NOS	72
80059	OP SKL VLT FX-CONCUS NOS	72
80060	OPN SKL VLT FX/CEREB LAC	72
80061	OPN SKUL VLT FX W/O COMA	72
80062	OPN SKUL VLT FX-BRF COMA	72
80063	OPN SKUL VLT FX-MOD COMA	72
80064	OPN SKL VLT FX-PROLN COM	72
80065	OPN SKL VLT FX-DEEP COMA	72
80066	OPN SKUL VLT FX-COMA NOS	72
80069	OP SKL VLT FX-CONCUS NOS	72
80070	OPN SKL VLT FX/MENIN HEM	72
80071	OPN SKUL VLT FX W/O COMA	72
80072	OPN SKUL VLT FX-BRF COMA	72
80073	OPN SKUL VLT FX-MOD COMA	72
80074	OPN SKL VLT FX-PROLN COM	72
80075	OPN SKL VLT FX-DEEP COMA	72
80076	OPN SKUL VLT FX-COMA NOS	72
80079	OP SKL VLT FX-CONCUS NOS	72
80080	OPN SKULL VLT FX/HEM NEC	72
80081	OPN SKUL VLT FX W/O COMA	72
80082	OPN SKUL VLT FX-BRF COMA	72
80083	OPN SKUL VLT FX-MOD COMA	72
80084	OPN SKL VLT FX-PROLN COM	72
80085	OPN SKL VLT FX-DEEP COMA	72
80086	OPN SKUL VLT FX-COMA NOS	72
80089	OP SKL VLT FX-CONCUS NOS	72
80090	OP SKL VLT FX/BR INJ NEC	72
80091	OPN SKUL VLT FX W/O COMA	72
80092	OPN SKUL VLT FX-BRF COMA	72
80093	OPN SKUL VLT FX-MOD COMA	72
80094	OPN SKL VLT FX-PROLN COM	72
80095	OP SKUL VLT FX-DEEP COMA	72
80096	OPN SKUL VLT FX-COMA NOS	72
80099	OP SKL VLT FX-CONCUS NOS	72
80100	CLOS SKULL BASE FRACTURE	72
80101	CL SKUL BASE FX W/O COMA	72
80102	CL SKUL BASE FX-BRF COMA	72
80103	CL SKUL BASE FX-MOD COMA	72
80104	CL SKL BASE FX-PROL COMA	72
80105	CL SKL BASE FX-DEEP COMA	72
80106	CL SKUL BASE FX-COMA NOS	72
80109	CL SKULL BASE FX-CONCUSS	72
80110	CL SKL BASE FX/CEREB LAC	72
80111	CL SKUL BASE FX W/O COMA	72
80112	CL SKUL BASE FX-BRF COMA	72
80113	CL SKUL BASE FX-MOD COMA	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
80114	CL SKL BASE FX-PROL COMA	72
80115	CL SKL BASE FX-DEEP COMA	72
80116	CL SKUL BASE FX-COMA NOS	72
80119	CL SKULL BASE FX-CONCUSS	72
80120	CL SKL BASE FX/MENIN HEM	72
80121	CL SKUL BASE FX W/O COMA	72
80122	CL SKUL BASE FX/BRF COMA	72
80123	CL SKUL BASE FX-MOD COMA	72
80124	CL SKL BASE FX-PROL COMA	72
80125	CL SKL BASE FX-DEEP COMA	72
80126	CL SKUL BASE FX-COMA NOS	72
80129	CL SKULL BASE FX-CONCUSS	72
80130	CL SKULL BASE FX/HEM NEC	72
80131	CL SKUL BASE FX W/O COMA	72
80132	CL SKUL BASE FX-BRF COMA	72
80133	CL SKUL BASE FX-MOD COMA	72
80134	CL SKL BASE FX-PROL COMA	72
80135	CL SKL BASE FX-DEEP COMA	72
80136	CL SKUL BASE FX-COMA NOS	72
80139	CL SKULL BASE FX-CONCUSS	72
80140	CL SK BASE FX/BR INJ NEC	72
80141	CL SKUL BASE FX W/O COMA	72
80142	CL SKUL BASE FX-BRF COMA	72
80143	CL SKUL BASE FX-MOD COMA	72
80144	CL SKL BASE FX-PROL COMA	72
80145	CL SKL BASE FX-DEEP COMA	72
80146	CL SKUL BASE FX-COMA NOS	72
80149	CL SKULL BASE FX-CONCUSS	72
80150	OPEN SKULL BASE FRACTURE	72
80151	OPN SKL BASE FX W/O COMA	72
80152	OPN SKL BASE FX-BRF COMA	72
80153	OPN SKL BASE FX-MOD COMA	72
80154	OP SKL BASE FX-PROL COMA	72
80155	OP SKL BASE FX-DEEP COMA	72
80156	OPN SKL BASE FX-COMA NOS	72
80159	OPN SKUL BASE FX-CONCUSS	72
80160	OP SKL BASE FX/CEREB LAC	72
80161	OPN SKL BASE FX W/O COMA	72
80162	OPN SKL BASE FX-BRF COMA	72
80163	OPN SKL BASE FX-MOD COMA	72
80164	OP SKL BASE FX-PROL COMA	72
80165	OP SKL BASE FX-DEEP COMA	72
80166	OPN SKL BASE FX-COMA NOS	72
80169	OPN SKUL BASE FX-CONCUSS	72
80170	OP SKL BASE FX/MENIN HEM	72
80171	OPN SKL BASE FX W/O COMA	72
80172	OPN SKL BASE FX-BRF COMA	72
80173	OPN SKL BASE FX-MOD COMA	72
80174	OP SKL BASE FX-PROL COMA	72
80175	OP SKL BASE FX-DEEP COMA	72
80176	OPN SKL BASE FX-COMA NOS	72
80179	OPN SKUL BASE FX-CONCUSS	72
80180	OPN SKUL BASE FX/HEM NEC	72
80181	OPN SKL BASE FX W/O COMA	72
80182	OPN SKL BASE FX-BRF COMA	72
80183	OPN SKL BASE FX-MOD COMA	72
80184	OP SKL BASE FX-PROL COMA	72
80185	OP SKL BASE FX-DEEP COMA	72
80186	OPN SKL BASE FX-COMA NOS	72
80189	OPN SKUL BASE FX-CONCUSS	72
80190	OP SK BASE FX/BR INJ NEC	72
80191	OP SKUL BASE FX W/O COMA	72
80192	OPN SKL BASE FX-BRF COMA	72
80193	OPN SKL BASE FX-MOD COMA	72
80194	OP SKL BASE FX-PROL COMA	72
80195	OP SKL BASE FX-DEEP COMA	72
80196	OPN SKL BASE FX-COMA NOS	72
80199	OPN SKUL BASE FX-CONCUSS	72
8020	NASAL BONE FX-CLOSED	72
8021	NASAL BONE FX-OPEN	72
80220	MANDIBLE FX NOS-CLOSED	72
80221	FX CONDYL PROC MANDIB-CL	72
80222	SUBCONDYLAR FX MANDIB-CL	72
80223	FX CORON PROC MANDIB-CL	72
80224	FX RAMUS NOS-CLOSED	72
80225	FX ANGLE OF JAW-CLOSED	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
80226	FX SYMPHY MANDIB BODY-CL	72
80227	FX ALVEOLAR BORD MAND-CL	72
80228	FX MANDIBLE BODY NEC-CL	72
80229	MULT FX MANDIBLE-CLOSED	72
80230	MANDIBLE FX NOS-OPEN	72
80231	FX CONDYL PROC MAND-OPEN	72
80232	SUBCONDYL FX MANDIB-OPEN	72
80233	FX CORON PROC MANDIB-OPN	72
80234	FX RAMUS NOS-OPEN	72
80235	FX ANGLE OF JAW-OPEN	72
80236	FX SYMPHY MANDIB BDY-OPN	72
80237	FX ALV BORD MAND BDY-OPN	72
80238	FX MANDIBLE BODY NEC-OPN	72
80239	MULT FX MANDIBLE-OPEN	72
8024	FX MALAR/MAXILLARY-CLOSE	72
8025	FX MALAR/MAXILLARY-OPEN	72
8026	FX ORBITAL FLOOR-CLOSED	72
8027	FX ORBITAL FLOOR-OPEN	72
8028	FX FACIAL BONE NEC-CLOSE	72
8029	FX FACIAL BONE NEC-OPEN	72
80300	CLOSE SKULL FRACTURE NEC	72
80301	CL SKULL FX NEC W/O COMA	72
80302	CL SKULL FX NEC-BRF COMA	72
80303	CL SKULL FX NEC-MOD COMA	72
80304	CL SKL FX NEC-PROLN COMA	72
80305	CL SKUL FX NEC-DEEP COMA	72
80306	CL SKULL FX NEC-COMA NOS	72
80309	CL SKULL FX NEC-CONCUSS	72
80310	CL SKL FX NEC/CEREBR LAC	72
80311	CL SKULL FX NEC W/O COMA	72
80312	CL SKULL FX NEC-BRF COMA	72
80313	CL SKULL FX NEC-MOD COMA	72
80314	CL SKL FX NEC-PROLN COMA	72
80315	CL SKUL FX NEC-DEEP COMA	72
80316	CL SKULL FX NEC-COMA NOS	72
80319	CL SKULL FX NEC-CONCUSS	72
80320	CL SKL FX NEC/MENING HEM	72
80321	CL SKULL FX NEC W/O COMA	72
80322	CL SKULL FX NEC-BRF COMA	72
80323	CL SKULL FX NEC-MOD COMA	72
80324	CL SKL FX NEC-PROLN COMA	72
80325	CL SKUL FX NEC-DEEP COMA	72
80326	CL SKULL FX NEC-COMA NOS	72
80329	CL SKULL FX NEC-CONCUSS	72
80330	CL SKULL FX NEC/HEM NEC	72
80331	CL SKULL FX NEC W/O COMA	72
80332	CL SKULL FX NEC-BRF COMA	72
80333	CL SKULL FX NEC-MOD COMA	72
80334	CL SKL FX NEC-PROLN COMA	72
80335	CL SKUL FX NEC-DEEP COMA	72
80336	CL SKULL FX NEC-COMA NOS	72
80339	CL SKULL FX NEC-CONCUSS	72
80340	CL SKL FX NEC/BR INJ NEC	72
80341	CL SKULL FX NEC W/O COMA	72
80342	CL SKULL FX NEC-BRF COMA	72
80343	CL SKULL FX NEC-MOD COMA	72
80344	CL SKL FX NEC-PROLN COMA	72
80345	CL SKUL FX NEC-DEEP COMA	72
80346	CL SKULL FX NEC-COMA NOS	72
80349	CL SKULL FX NEC-CONCUSS	72
80350	OPEN SKULL FRACTURE NEC	72
80351	OPN SKUL FX NEC W/O COMA	72
80352	OPN SKUL FX NEC-BRF COMA	72
80353	OPN SKUL FX NEC-MOD COMA	72
80354	OPN SKL FX NEC-PROL COMA	72
80355	OPN SKL FX NEC-DEEP COMA	72
80356	OPN SKUL FX NEC-COMA NOS	72
80359	OPN SKULL FX NEC-CONCUSS	72
80360	OPN SKL FX NEC/CEREB LAC	72
80361	OPN SKUL FX NEC W/O COMA	72
80362	OPN SKUL FX NEC-BRF COMA	72
80363	OPN SKUL FX NEC-MOD COMA	72
80364	OPN SKL FX NEC-PROLN COM	72
80365	OPN SKL FX NEC-DEEP COMA	72
80366	OPN SKUL FX NEC-COMA NOS	72
80369	OPN SKULL FX NEC-CONCUSS	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
80370	OPN SKL FX NEC/MENIN HEM	72
80371	OPN SKUL FX NEC W/O COMA	72
80372	OPN SKUL FX NEC-BRF COMA	72
80373	OPN SKUL FX NEC-MOD COMA	72
80374	OPN SKL FX NEC-PROL COMA	72
80375	OPN SKL FX NEC-DEEP COMA	72
80376	OPN SKUL FX NEC-COMA NOS	72
80379	OPN SKULL FX NEC-CONCUSS	72
80380	OPN SKULL FX NEC/HEM NEC	72
80381	OPN SKUL FX NEC W/O COMA	72
80382	OPN SKUL FX NEC-BRF COMA	72
80383	OPN SKUL FX NEC-MOD COMA	72
80384	OPN SKL FX NEC-PROL COMA	72
80385	OPN SKL FX NEC-DEEP COMA	72
80386	OPN SKUL FX NEC-COMA NOS	72
80389	OPN SKULL FX NEC-CONCUSS	72
80390	OP SKL FX NEC/BR INJ NEC	72
80391	OPN SKUL FX NEC W/O COMA	72
80392	OPN SKUL FX NEC-BRF COMA	72
80393	OPN SKUL FX NEC-MOD COMA	72
80394	OPN SKL FX NEC-PROL COMA	72
80395	OPN SKL FX NEC-DEEP COMA	72
80396	OPN SKUL FX NEC-COMA NOS	72
80399	OPN SKULL FX NEC-CONCUSS	72
80400	CL SKUL FX W OTH BONE FX	72
80401	CL SKL W OTH FX W/O COMA	72
80402	CL SKL W OTH FX-BRF COMA	72
80403	CL SKL W OTH FX-MOD COMA	72
80404	CL SKL/OTH FX-PROLN COMA	72
80405	CL SKUL/OTH FX-DEEP COMA	72
80406	CL SKL W OTH FX-COMA NOS	72
80409	CL SKUL W OTH FX-CONCUSS	72
80410	CL SK W OTH FX/CEREB LAC	72
80411	CL SKL W OTH FX W/O COMA	72
80412	CL SKL W OTH FX-BRF COMA	72
80413	CL SKL W OTH FX-MOD COMA	72
80414	CL SKL/OTH FX-PROLN COMA	72
80415	CL SKUL/OTH FX-DEEP COMA	72
80416	CL SKL W OTH FX-COMA NOS	72
80419	CL SKUL W OTH FX-CONCUSS	72
80420	CL SKL/OTH FX/MENING HEM	72
80421	CL SKL W OTH FX W/O COMA	72
80422	CL SKL W OTH FX-BRF COMA	72
80423	CL SKL W OTH FX-MOD COMA	72
80424	CL SKL/OTH FX-PROLN COMA	72
80425	CL SKUL/OTH FX-DEEP COMA	72
80426	CL SKL W OTH FX-COMA NOS	72
80429	CL SKUL W OTH FX-CONCUSS	72
80430	CL SKUL W OTH FX/HEM NEC	72
80431	CL SKL W OTH FX W/O COMA	72
80432	CL SKL W OTH FX-BRF COMA	72
80433	CL SKL W OTH FX-MOD COMA	72
80434	CL SKL/OTH FX-PROLN COMA	72
80435	CL SKUL/OTH FX-DEEP COMA	72
80436	CL SKL W OTH FX-COMA NOS	72
80439	CL SKUL W OTH FX-CONCUSS	72
80440	CL SKL/OTH FX/BR INJ NEC	72
80441	CL SKL W OTH FX W/O COMA	72
80442	CL SKL W OTH FX-BRF COMA	72
80443	CL SKL W OTH FX-MOD COMA	72
80444	CL SKL/OTH FX-PROLN COMA	72
80445	CL SKUL/OTH FX-DEEP COMA	72
80446	CL SKL W OTH FX-COMA NOS	72
80449	CL SKUL W OTH FX-CONCUSS	72
80450	OPN SKULL FX/OTH BONE FX	72
80451	OPN SKUL/OTH FX W/O COMA	72
80452	OPN SKUL/OTH FX-BRF COMA	72
80453	OPN SKUL/OTH FX-MOD COMA	72
80454	OPN SKL/OTH FX-PROL COMA	72
80455	OPN SKL/OTH FX-DEEP COMA	72
80456	OPN SKUL/OTH FX-COMA NOS	72
80459	OPN SKULL/OTH FX-CONCUSS	72
80460	OPN SKL/OTH FX/CEREB LAC	72
80461	OPN SKUL/OTH FX W/O COMA	72
80462	OPN SKUL/OTH FX-BRF COMA	72
80463	OPN SKUL/OTH FX-MOD COMA	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
80464	OPN SKL/OTH FX-PROL COMA	72
80465	OPN SKL/OTH FX-DEEP COMA	72
80466	OPN SKUL/OTH FX-COMA NOS	72
80469	OPN SKULL/OTH FX-CONCUSS	72
80470	OPN SKL/OTH FX/MENIN HEM	72
80471	OPN SKUL/OTH FX W/O COMA	72
80472	OPN SKUL/OTH FX-BRF COMA	72
80473	OPN SKUL/OTH FX-MOD COMA	72
80474	OPN SKL/OTH FX-PROL COMA	72
80475	OPN SKL/OTH FX-DEEP COMA	72
80476	OPN SKUL/OTH FX-COMA NOS	72
80479	OPN SKULL/OTH FX-CONCUSS	72
80480	OPN SKL W OTH FX/HEM NEC	72
80481	OPN SKUL/OTH FX W/O COMA	72
80482	OPN SKUL/OTH FX-BRF COMA	72
80483	OPN SKUL/OTH FX-MOD COMA	72
80484	OPN SKL/OTH FX-PROL COMA	72
80485	OPN SKL/OTH FX-DEEP COMA	72
80486	OPN SKUL/OTH FX-COMA NOS	72
80489	OPN SKULL/OTH FX-CONCUSS	72
80490	OP SKL/OTH FX/BR INJ NEC	72
80491	OPN SKUL/OTH FX W/O COMA	72
80492	OPN SKUL/OTH FX-BRF COMA	72
80493	OPN SKUL/OTH FX-MOD COMA	72
80494	OPN SKL/OTH FX-PROL COMA	72
80495	OPN SKL/OTH FX-DEEP COMA	72
80496	OPN SKUL/OTH FX-COMA NOS	72
80499	OPN SKULL/OTH FX-CONCUSS	72
80500	FX CERVICAL VERT NOS-CL	72
80501	FX C1 VERTEBRA-CLOSED	72
80502	FX C2 VERTEBRA-CLOSED	72
80503	FX C3 VERTEBRA-CLOSED	72
80504	FX C4 VERTEBRA-CLOSED	72
80505	FX C5 VERTEBRA-CLOSED	72
80506	FX C6 VERTEBRA-CLOSED	72
80507	FX C7 VERTEBRA-CLOSED	72
80508	FX MULT CERVICAL VERT-CL	72
80510	FX CERVICAL VERT NOS-OPN	72
80511	FX C1 VERTEBRA-OPEN	72
80512	FX C2 VERTEBRA-OPEN	72
80513	FX C3 VERTEBRA-OPEN	72
80514	FX C4 VERTEBRA-OPEN	72
80515	FX C5 VERTEBRA-OPEN	72
80516	FX C6 VERTEBRA-OPEN	72
80517	FX C7 VERTEBRA-OPEN	72
80518	FX MLT CERVICAL VERT-OPN	72
8052	FX DORSAL VERTEBRA-CLOSE	72
8053	FX DORSAL VERTEBRA-OPEN	72
8054	FX LUMBAR VERTEBRA-CLOSE	72
8055	FX LUMBAR VERTEBRA-OPEN	72
8056	FX SACRUM/COCCYX-CLOSED	24
8057	FX SACRUM/COCCYX-OPEN	24
8058	VERTEBRAL FX NOS-CLOSED	72
8059	VERTEBRAL FX NOS-OPEN	72
80600	C1-C4 FX-CL/CORD INJ NOS	72
80601	C1-C4 FX-CL/COM CORD LES	72
80602	C1-C4 FX-CL/ANT CORD SYN	72
80603	C1-C4 FX-CL/CEN CORD SYN	72
80604	C1-C4 FX-CL/CORD INJ NEC	72
80605	C5-C7 FX-CL/CORD INJ NOS	72
80606	C5-C7 FX-CL/COM CORD LES	72
80607	C5-C7 FX-CL/ANT CORD SYN	72
80608	C5-C7 FX-CL/CEN CORD SYN	72
80609	C5-C7 FX-CL/CORD INJ NEC	72
80610	C1-C4 FX-OP/CORD INJ NOS	72
80611	C1-C4 FX-OP/COM CORD LES	72
80612	C1-C4 FX-OP/ANT CORD SYN	72
80613	C1-C4 FX-OP/CEN CORD SYN	72
80614	C1-C4 FX-OP/CORD INJ NEC	72
0615	C5-C7 FX-OP/CORD INJ NOS	72
80616	C5-C7 FX-OP/COM CORD LES	72
80617	C5-C7 FX-OP/ANT CORD SYN	72
80618	C5-C7 FX-OP/CEN CORD SYN	72
80619	C5-C7 FX-OP/CORD INJ NEC	72
80620	T1-T6 FX-CL/CORD INJ NOS	72
80621	T1-T6 FX-CL/COM CORD LES	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
80622	T1-T6 FX-CL/ANT CORD SYN	72
80623	T1-T6 FX-CL/CEN CORD SYN	72
80624	T1-T6 FX-CL/CORD INJ NEC	72
80625	T7-T12 FX-CL/CRD INJ NOS	72
80626	T7-T12 FX-CL/COM CRD LES	72
80627	T7-T12 FX-CL/ANT CRD SYN	72
80628	T7-T12 FX-CL/CEN CRD SYN	72
80629	T7-T12 FX-CL/CRD INJ NEC	72
80630	T1-T6 FX-OP/CORD INJ NOS	72
80631	T1-T6 FX-OP/COM CORD LES	72
80632	T1-T6 FX-OP/ANT CORD SYN	72
80633	T1-T6 FX-OP/CEN CORD SYN	72
80634	T1-T6 FX-OP/CORD INJ NEC	72
80635	T7-T12 FX-OP/CRD INJ NOS	72
80636	T7-T12 FX-OP/COM CRD LES	72
80637	T7-T12 FX-OP/ANT CRD SYN	72
80638	T7-T12 FX-OP/CEN CRD SYN	72
80639	T7-T12 FX-OP/CRD INJ NEC	72
8064	CL LUMBAR FX W CORD INJ	72
8065	OPN LUMBAR FX W CORD INJ	72
80660	FX SACRUM-CL/CRD INJ NOS	72
80661	FX SACR-CL/CAUDA EQU LES	72
80662	FX SACR-CL/CAUDA INJ NEC	72
80669	FX SACRUM-CL/CRD INJ NEC	72
80670	FX SACRUM-OP/CRD INJ NOS	72
80671	FX SACR-OP/CAUDA EQU LES	72
80672	FX SACR-OP/CAUDA INJ NEC	72
80679	FX SACRUM-OP/CRD INJ NEC	72
8068	VERT FX NOS-CL W CRD INJ	72
8069	VERT FX NOS-OP W CRD INJ	72
80700	FRACTURE RIB NOS-CLOSED	72
80701	FRACTURE ONE RIB-CLOSED	72
80702	FRACTURE TWO RIBS-CLOSED	72
80703	FRACTURE THREE RIBS-CLOS	72
80704	FRACTURE FOUR RIBS-CLOSE	72
80705	FRACTURE FIVE RIBS-CLOSE	72
80706	FRACTURE SIX RIBS-CLOSED	72
80707	FRACTURE SEVEN RIBS-CLOS	72
80708	FX EIGHT/MORE RIB-CLOSED	72
80709	FX MULT RIBS NOS-CLOSED	72
80710	FRACTURE RIB NOS-OPEN	72
80711	FRACTURE ONE RIB-OPEN	72
80712	FRACTURE TWO RIBS-OPEN	72
80713	FRACTURE THREE RIBS-OPEN	72
80714	FRACTURE FOUR RIBS-OPEN	72
80715	FRACTURE FIVE RIBS-OPEN	72
80716	FRACTURE SIX RIBS-OPEN	72
80717	FRACTURE SEVEN RIBS-OPEN	72
80718	FX EIGHT/MORE RIBS-OPEN	72
80719	FX MULT RIBS NOS-OPEN	72
8072	FRACTURE OF STERNUM-CLOS	72
8073	FRACTURE OF STERNUM-OPEN	72
8074	FLAIL CHEST	72
8075	FX LARYNX/TRACHEA-CLOSED	72
8076	FX LARYNX/TRACHEA-OPEN	72
8080	FRACTURE ACETABULUM-CLOS	72
8081	FRACTURE ACETABULUM-OPEN	72
8082	FRACTURE OF PUBIS-CLOSED	72
8083	FRACTURE OF PUBIS-OPEN	72
80841	FRACTURE OF ILIUM-CLOSED	72
80842	FRACTURE ISCHIUM-CLOSED	72
80843	PELV FX-CLOS/PELV DISRUP	72
80849	PELVIC FRACTURE NEC-CLOS	72
80851	FRACTURE OF ILIUM-OPEN	72
80852	FRACTURE OF ISCHIUM-OPEN	72
80853	PELV FX-OPEN/PELV DISRUP	72
80859	PELVIC FRACTURE NEC-OPEN	72
8088	PELVIC FRACTURE NOS-CLOS	72
8089	PELVIC FRACTURE NOS-OPEN	72
8090	FRACTURE TRUNK BONE-CLOS	72
8091	FRACTURE TRUNK BONE-OPEN	72
81000	FX CLAVICLE NOS-CLOSED	72
81001	FX CLAVICL, STERN END-CL	72
81002	FX CLAVICLE SHAFT-CLOSED	72
81003	FX CLAVICL, ACROM END-CL	72
81010	FX CLAVICLE NOS-OPEN	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
81011	FX CLAVIC, STERN END-OPN	72
81012	FX CLAVICLE SHAFT-OPEN	72
81013	FX CLAVIC, ACROM END-OPN	72
81100	FX SCAPULA NOS-CLOSED	72
81101	FX SCAPUL, ACROM PROC-CL	72
81102	FX SCAPUL, CORAC PROC-CL	72
81103	FX SCAP, GLEN CAV/NCK-CL	72
81109	FX SCAPULA NEC-CLOSED	72
81110	FX SCAPULA NOS-OPEN	72
81111	FX SCAPUL, ACROM PROC-OP	72
81112	FX SCAPUL, CORAC PROC-OP	72
81113	FX SCAP, GLEN CAV/NCK-OP	72
81119	FX SCAPULA NEC-OPEN	72
81200	FX UP END HUMERUS NOS-CL	72
81201	FX SURG NCK HUMERUS-CLOS	72
81202	FX ANATOM NCK HUMERUS-CL	72
81203	FX GR TUBEROS HUMERUS-CL	72
81209	FX UPPER HUMERUS NEC-CL	72
81210	FX UPPER HUMERUS NOS-OPN	72
81211	FX SURG NECK HUMERUS-OPN	72
81212	FX ANAT NECK HUMERUS-OPN	72
81213	FX GR TUBEROS HUMER-OPEN	72
81219	FX UPPER HUMERUS NEC-OPN	72
81220	FX HUMERUS NOS-CLOSED	72
81221	FX HUMERUS SHAFT-CLOSED	72
81230	FX HUMERUS NOS-OPEN	72
81231	FX HUMERUS SHAFT-OPEN	72
81240	FX LOWER HUMERUS NOS-CL	72
81241	SUPRCONDYL FX HUMERUS-CL	72
81242	FX HUMER, LAT CONDYL-CL	72
81243	FX HUMER, MED CONDYL-CL	72
81244	FX HUMER, CONDYL NOS-CL	72
81249	FX LOWER HUMERUS NEC-CL	72
81250	FX LOWER HUMER NOS-OPEN	72
81251	SUPRACONDYL FX HUMER-OPN	72
81252	FX HUMER, LAT CONDYL-OPN	72
81253	FX HUMER, MED CONDYL-OPN	72
81254	FX HUMER, CONDYL NOS-OPN	72
81259	FX LOWER HUMER NEC-OPEN	72
81300	FX UPPER FOREARM NOS-CL	72
81301	FX OLECRAN PROC ULNA-CL	72
81302	FX CORONOID PROC ULNA-CL	72
81303	MONTEGGIA'S FX-CLOSED	72
81304	FX UPPER ULNA NEC/NOS-CL	72
81305	FX RADIUS HEAD-CLOSED	72
81306	FX RADIUS NECK-CLOSED	72
81307	FX UP RADIUS NEC/NOS-CL	72
81308	FX UP RADIUS W ULNA-CLOS	72
81310	FX UPPER FOREARM NOS-OPN	72
81311	FX OLECRAN PROC ULNA-OPN	72
81312	FX CORONOID PRO ULNA-OPN	72
81313	MONTEGGIA'S FX-OPEN	72
81314	FX UP ULNA NEC/NOS-OPEN	72
81315	FX RADIUS HEAD-OPEN	72
81316	FX RADIUS NECK-OPEN	72
81317	FX UP RADIUS NEC/NOS-OPN	72
81318	FX UP RADIUS W ULNA-OPEN	72
81320	FX SHAFT FOREARM NOS-CL	72
81321	FX RADIUS SHAFT-CLOSED	72
81322	FX ULNA SHAFT-CLOSED	72
81323	FX SHAFT RAD W ULNA-CLOS	72
81330	FX SHAFT FOREARM NOS-OPN	72
81331	FX RADIUS SHAFT-OPEN	72
81332	FX ULNA SHAFT-OPEN	72
81333	FX SHAFT RAD W ULNA-OPEN	72
81340	FX LOWER FOREARM NOS-CL	72
81341	COLLES' FRACTURE-CLOSED	72
81342	FX DISTAL RADIUS NEC-CL	72
81343	FX DISTAL ULNA-CLOSED	72
81344	FX LOW RADIUS W ULNA-CL	72
81350	FX LOWER FOREARM NOS-OPN	72
81351	COLLES' FRACTURE-OPEN	72
81352	FX DISTAL RADIUS NEC-OPN	72
81353	FX DISTAL ULNA-OPEN	72
81354	FX LOW RADIUS W ULNA-OPN	72
81380	FX FOREARM NOS-CLOSED	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
81381	FX RADIUS NOS-CLOSED	72
81382	FRACTURE ULNA NOS-CLOSED	72
81383	FX RADIUS W ULNA NOS-CL	72
81390	FX FOREARM NOS-OPEN	72
81391	FRACTURE RADIUS NOS-OPEN	72
81392	FRACTURE ULNA NOS-OPEN	72
81393	FX RADIUS W ULNA NOS-OPN	72
81400	FX CARPAL BONE NOS-CLOSE	72
81401	FX NAVICULAR, WRIST-CLOS	72
81402	FX LUNATE, WRIST-CLOSED	72
81403	FX TRIQUETRAL, WRIST-CL	72
81404	FX PISIFORM-CLOSED	72
81405	FX TRAPEZIUM BONE-CLOSED	72
81406	FX TRAPEZOID BONE-CLOSED	72
81407	FX CAPITATE BONE-CLOSED	72
81408	FX HAMATE BONE-CLOSED	72
81409	FX CARPAL BONE NEC-CLOSE	72
81410	FX CARPAL BONE NOS-OPEN	72
81411	FX NAVICULAR, WRIST-OPEN	72
81412	FX LUNATE, WRIST-OPEN	72
81413	FX TRIQUETRAL, WRIST-OPN	72
81414	FX PISIFORM-OPEN	72
81415	FX TRAPEZIUM BONE-OPEN	72
81416	FX TRAPEZOID BONE-OPEN	72
81417	FX CAPITATE BONE-OPEN	72
81418	FX HAMATE BONE-OPEN	72
81419	FX CARPAL BONE NEC-OPEN	72
81500	FX METACARPAL NOS-CLOSED	72
81501	FX 1ST METACARP BASE-CL	72
81502	FX METACARP BASE NEC-CL	72
81503	FX METACARPAL SHAFT-CLOS	72
81504	FX METACARPAL NECK-CLOSE	72
81509	MULT FX METACARPUS-CLOSE	72
81510	FX METACARPAL NOS-OPEN	72
81511	FX 1ST METACARP BASE-OPN	72
81512	FX METACARP BASE NEC-OPN	72
81513	FX METACARPAL SHAFT-OPEN	72
81514	FX METACARPAL NECK-OPEN	72
81519	MULT FX METACARPUS-OPEN	72
81600	FX PHALANX, HAND NOS-CL	72
81601	FX MID/PRX PHAL, HAND-CL	72
81602	FX DIST PHALANX, HAND-CL	72
81603	FX MULT PHALAN, HAND-CL	72
81610	FX PHALANX, HAND NOS-OPN	72
81611	FX MID/PRX PHAL, HAND-OP	72
81612	FX DISTAL PHAL, HAND-OPN	72
81613	FX MULT PHALAN, HAND-OPN	72
8170	MULTIPLE FX HAND-CLOSED	72
8171	MULTIPLE FX HAND-OPEN	72
8180	FX ARM MULT/NOS-CLOSED	72
8181	FX ARM MULT/NOS-OPEN	72
8190	FX ARMS W RIB/STERNUM-CL	72
8191	FX ARMS W RIB/STERN-OPEN	72
82000	FX FEMUR INTRCAPS NOS-CL	72
82001	FX UP FEMUR EPIPHY-CLOS	72
82002	FX FEMUR, MIDCERVIC-CLOS	72
82003	FX BASE FEMORAL NCK-CLOS	72
82009	FX FEMUR INTRCAPS NEC-CL	72
82010	FX FEMUR INTRCAP NOS-OPN	72
82011	FX UP FEMUR EPIPHY-OPEN	72
82012	FX FEMUR, MIDCERVIC-OPEN	72
82013	FX BASE FEMORAL NCK-OPEN	72
82019	FX FEMUR INTRCAP NEC-OPN	72
82020	TROCHANTERIC FX NOS-CLOS	72
82021	INTERTROCHANTERIC FX-CL	72
82022	SUBTROCHANTERIC FX-CLOSE	72
82030	TROCHANTERIC FX NOS-OPEN	72
82031	INTERTROCHANTERIC FX-OPN	72
82032	SUBTROCHANTERIC FX-OPEN	72
8208	FX NECK OF FEMUR NOS-CL	72
8209	FX NECK OF FEMUR NOS-OPN	72
82100	FX FEMUR NOS-CLOSED	72
82101	FX FEMUR SHAFT-CLOSED	72
82110	FX FEMUR NOS-OPEN	72
82111	FX FEMUR SHAFT-OPEN	72
82120	FX LOW END FEMUR NOS-CL	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
82121	FX FEMORAL CONDYLE-CLOSE	72
82122	FX LOW FEMUR EPIPHY-CLOS	72
82123	SUPRACONDYL FX FEMUR-CL	72
82129	FX LOW END FEMUR NEC-CL	72
82130	FX LOW END FEMUR NOS-OPN	72
82131	FX FEMORAL CONDYLE-OPEN	72
82132	FX LOW FEMUR EPIPHY-OPEN	72
82133	SUPRACONDYL FX FEMUR-OPN	72
82139	FX LOW END FEMUR NEC-OPN	72
8220	FRACTURE PATELLA-CLOSED	72
8221	FRACTURE PATELLA-OPEN	72
82300	FX UPPER END TIBIA-CLOSE	72
82301	FX UPPER END FIBULA-CLOS	72
82302	FX UP TIBIA W FIBULA-CL	72
82310	FX UPPER END TIBIA-OPEN	72
82311	FX UPPER END FIBULA-OPEN	72
82312	FX UP TIBIA W FIBULA-OPN	72
82320	FX SHAFT TIBIA-CLOSED	72
82321	FX SHAFT FIBULA-CLOSED	72
82322	FX SHAFT FIB W TIB-CLOS	72
82330	FX TIBIA SHAFT-OPEN	72
82331	FX FIBULA SHAFT-OPEN	72
82332	FX SHAFT TIBIA W FIB-OPN	72
82380	FX TIBIA NOS-CLOSED	72
82381	FX FIBULA NOS-CLOSED	72
82382	FX TIBIA W FIBULA NOS-CL	72
82390	FX TIBIA NOS-OPEN	72
82391	FX FIBULA NOS-OPEN	72
82392	FX TIBIA W FIB NOS-OPEN	72
8240	FX MEDIAL MALLEOLUS-CLOS	72
8241	FX MEDIAL MALLEOLUS-OPEN	72
8242	FX LATERAL MALLEOLUS-CL	72
8243	FX LATERAL MALLEOLUS-OPN	72
8244	FX BIMALLEOLAR-CLOSED	72
8245	FX BIMALLEOLAR-OPEN	72
8246	FX TRIMALLEOLAR-CLOSED	72
8247	FX TRIMALLEOLAR-OPEN	72
8248	FX ANKLE NOS-CLOSED	72
8249	FX ANKLE NOS-OPEN	72
8250	FRACTURE CALCANEUS-CLOSE	72
8251	FRACTURE CALCANEUS-OPEN	72
82520	FX FOOT BONE NOS-CLOSED	72
82521	FX ASTRAGALUS-CLOSED	72
82522	FX NAVICULAR, FOOT-CLOS	72
82523	FX CUBOID-CLOSED	72
82524	FX CUNEIFORM, FOOT-CLOS	72
82525	FX METATARSAL-CLOSED	72
82529	FX FOOT BONE NEC-CLOSED	72
82530	FX FOOT BONE NOS-OPEN	72
82531	FX ASTRAGALUS-OPEN	72
82532	FX NAVICULAR, FOOT-OPEN	72
82533	FX CUBOID-OPEN	72
82534	FX CUNEIFORM, FOOT-OPEN	72
82535	FX METATARSAL-OPEN	72
82539	FX FOOT BONE NEC-OPEN	72
8260	FX PHALANX, FOOT-CLOSED	72
8261	FX PHALANX, FOOT-OPEN	72
8270	FX LOWER LIMB NEC-CLOSED	72
8271	FX LOWER LIMB NEC-OPEN	72
8280	FX LEGS W ARM/RIB-CLOSED	72
8281	FX LEGS W ARM/RIB-OPEN	72
8290	FRACTURE NOS-CLOSED	72
8291	FRACTURE NOS-OPEN	72
8300	DISLOCATION JAW-CLOSED	72
8301	DISLOCATION JAW-OPEN	72
83100	DISLOC SHOULDER NOS-CLOS	72
83101	ANT DISLOC HUMERUS-CLOSE	72
83102	POST DISLOC HUMERUS-CLOS	72
83103	INFER DISLOC HUMERUS-CL	72
83104	DISLOC ACROMIOCLAVIC-CL	72
83109	DISLOC SHOULDER NEC-CLOS	72
83110	DISLOC SHOULDER NOS-OPEN	72
83111	ANT DISLOC HUMERUS-OPEN	72
83112	POST DISLOC HUMERUS-OPEN	72
83113	INFER DISLOC HUMERUS-OPN	72
83114	DISLOC ACROMIOCLAVIC-OPN	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
83119	DISLOC SHOULDER NEC-OPEN	72
83200	DISLOCAT ELBOW NOS-CLOSE	72
83201	ANT DISLOC ELBOW-CLOSED	72
83202	POST DISLOC ELBOW-CLOSED	72
83203	MED DISLOC ELBOW-CLOSED	72
83204	LAT DISLOC ELBOW-CLOSED	72
83209	DISLOCAT ELBOW NEC-CLOSE	72
83210	DISLOCAT ELBOW NOS-OPEN	72
83211	ANT DISLOC ELBOW-OPEN	72
83212	POST DISLOC ELBOW-OPEN	72
83213	MED DISLOC ELBOW-OPEN	72
83214	LAT DISLOCAT ELBOW-OPEN	72
83219	DISLOCAT ELBOW NEC-OPEN	72
83300	DISLOC WRIST NOS-CLOSED	72
83301	DISLOC DIST RADIOULN-CL	72
83302	DISLOC RADIOCARPAL-CLOS	72
83303	DISLOCA MIDCARPAL-CLOSED	72
83304	DISLOC CARPOMETACARP-CL	72
83305	DISLOC METACARPAL-CLOSED	72
83309	DISLOC WRIST NEC-CLOSED	72
83310	DISLOCAT WRIST NOS-OPEN	72
83311	DISLOC DIST RADIOULN-OPN	72
83312	DISLOC RADIOCARPAL-OPEN	72
83313	DISLOCAT MIDCARPAL-OPEN	72
83314	DISLOC CARPOMETACARP-OPN	72
83315	DISLOCAT METACARPAL-OPEN	72
83319	DISLOCAT WRIST NEC-OPEN	72
83400	DISL FINGER NOS-CLOSED	72
83401	DISLOC METACARPOPHALN-CL	72
83402	DISL INTERPHALN HAND-CL	72
83410	DISLOC FINGER NOS-OPEN	72
83411	DISL METACARPOPHALAN-OPN	72
83412	DISL INTERPHALN HAND-OPN	72
83500	DISLOCAT HIP NOS-CLOSED	72
83501	POSTERIOR DISLOC HIP-CL	72
83502	OBTURATOR DISLOC HIP-CL	72
83503	ANT DISLOC HIP NEC-CLOS	72
83510	DISLOCATION HIP NOS-OPEN	72
83511	POSTERIOR DISLOC HIP-OPN	72
83512	OBTURATOR DISLOC HIP-OPN	72
83513	ANT DISLOC HIP NEC-OPEN	72
8360	TEAR MED MENISC KNEE-CUR	72
8361	TEAR LAT MENISC KNEE-CUR	72
8362	TEAR MENISCUS NEC-CURREN	72
8363	DISLOCAT PATELLA-CLOSED	72
8364	DISLOCATION PATELLA-OPEN	72
83650	DISLOCAT KNEE NOS-CLOSED	72
83651	ANT DISLOC PROX TIBIA-CL	72
83652	POST DISL PROX TIBIA-CL	72
83653	MED DISLOC PROX TIBIA-CL	72
83654	LAT DISLOC PROX TIBIA-CL	72
83659	DISLOCAT KNEE NEC-CLOSED	72
83660	DISLOCAT KNEE NOS-OPEN	72
83661	ANT DISL PROX TIBIA-OPEN	72
83662	POST DISL PROX TIBIA-OPN	72
83663	MED DISL PROX TIBIA-OPEN	72
83664	LAT DISL PROX TIBIA-OPEN	72
83669	DISLOCAT KNEE NEC-OPEN	72
8370	DISLOCATION ANKLE-CLOSED	72
8371	DISLOCATION ANKLE-OPEN	72
83800	DISLOCAT FOOT NOS-CLOSED	72
83801	DISLOC TARSAL NOS-CLOSED	72
83802	DISLOC MIDTARSAL-CLOSED	72
83803	DISLOC TARSOMETATARS-CL	72
83804	DISLOC METATARSAL NOS-CL	72
83805	DISL METATARSOPHALANG-CL	72
83806	DISL INTERPHALAN FOOT-CL	72
83809	DISLOCAT FOOT NEC-CLOSED	72
83810	DISLOCAT FOOT NOS-OPEN	72
83811	DISLOC TARSAL NOS-OPEN	72
83812	DISLOC MIDTARSAL-OPEN	72
83813	DISL TARSOMETATARSAL-OPN	72
83814	DISL METATARSAL NOS-OPEN	72
83815	DISLOC METATARSOPHAL-OPN	72
83816	DIS INTERPHALAN FOOT-OPN	72
83819	DISLOCAT FOOT NEC-OPEN	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
83900	DISLOC CERV VERT NOS-CL	72
83901	DISLOC 1ST CERV VERT-CL	72
83902	DISLOC 2ND CERV VERT-CL	72
83903	DISLOC 3RD CERV VERT-CL	72
83904	DISLOC 4TH CERV VERT-CL	72
83905	DISLOC 5TH CERV VERT-CL	72
83906	DISLOC 6TH CERV VERT-CL	72
83907	DISLOC 7TH CERV VERT-CL	72
83908	DISLOC MULT CERV VERT-CL	72
83910	DISLOC CERV VERT NOS-OPN	72
83911	DISLOC LST CERV VERT-OPN	72
83912	DISLOC 2ND CERV VERT-OPN	72
83913	DISLOC 3RD CERV VERT-OPN	72
83914	DISLOC 4TH CERV VERT-OPN	72
83915	DISLOC 5TH CERV VERT-OPN	72
83916	DISLOC 6TH CERV VERT-OPN	72
83917	DISLOC 7TH CERV VERT-OPN	72
83918	DISLOC MLT CERV VERT-OPN	72
83920	DISLOCAT LUMBAR VERT-CL	72
83921	DISLOC THORACIC VERT-CL	72
83930	DISLOCAT LUMBAR VERT-OPN	72
83931	DISLOC THORACIC VERT-OPN	72
83940	DISLOCAT VERTEBRA NOS-CL	72
83941	DISLOCAT COCCYX-CLOSED	72
83942	DISLOCAT SACRUM-CLOSED	72
83949	DISLOCAT VERTEBRA NEC-CL	72
83950	DISLOC VERTEBRA NOS-OPEN	72
83951	DISLOCAT COCCYX-OPEN	72
83952	DISLOCAT SACRUM-OPEN	72
83959	DISLOC VERTEBRA NEC-OPEN	72
83961	DISLOCAT STERNUM-CLOSED	72
83969	DISLOCAT SITE NEC-CLOSED	72
83971	DISLOCATION STERNUM-OPEN	72
83979	DISLOCAT SITE NEC-OPEN	72
8398	DISLOCATION NEC-CLOSED	72
8399	DISLOCATION NEC-OPEN	72
8400	SPRAIN ACROMIOCLAVICULAR	72
8401	SPRAIN CORACOCLAVICULAR	72
8402	SPRAIN CORACOHUMERAL	72
8403	SPRAIN INFRASPINATUS	72
8404	SPRAIN ROTATOR CUFF	72
8405	SPRAIN SUBSCAPULARIS	72
8406	SPRAIN SUPRASPINATUS	72
8408	SPRAIN SHOULDER/ARM NEC	72
8409	SPRAIN SHOULDER/ARM NOS	72
8410	SPRAIN RADIAL COLLAT LIG	72
8411	SPRAIN ULNAR COLLAT LIG	72
8412	SPRAIN RADIOHUMERAL	72
8413	SPRAIN ULNOHUMERAL	72
8418	SPRAIN ELBOW/FOREARM NEC	72
8419	SPRAIN ELBOW/FOREARM NOS	72
84200	SPRAIN OF WRIST NOS	72
84201	SPRAIN CARPAL	72
84202	SPRAIN RADIOCARPAL	72
84209	SPRAIN OF WRIST NEC	72
84210	SPRAIN OF HAND NOS	72
84211	SPRAIN CARPOMETACARPAL	72
84212	SPRAIN METACARPOPHALANG	72
84213	SPRAIN INTERPHALANGEAL	72
84219	SPRAIN OF HAND NEC	72
8430	SPRAIN ILIOFEMORAL	72
8431	SPRAIN ISCHIOCAPSULAR	72
8438	SPRAIN HIP & THIGH NEC	72
8439	SPRAIN HIP & THIGH NOS	72
8440	SPRAIN LATERAL COLL LIG	72
8441	SPRAIN MEDIAL COLLAT LIG	72
8442	SPRAIN CRUCIATE LIG KNEE	72
8443	SPRAIN SUPER TIBIOFIBULA	72
8448	SPRAIN OF KNEE & LEG NEC	72
8449	SPRAIN OF KNEE & LEG NOS	72
84500	SPRAIN OF ANKLE NOS	72
84501	SPRAIN OF ANKLE DELTOID	72
84502	SPRAIN CALCANEOFIBULAR	72
84503	SPRAIN DISTAL TIBIOFIBUL	72
84509	SPRAIN OF ANKLE NEC	72
84510	SPRAIN OF FOOT NOS	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
84511	SPRAIN TARSMETATARSAL	72
84512	SPRAIN METATARSOPHALANG	72
84513	SPRAIN INTERPHALANG TOE	72
84519	SPRAIN OF FOOT NEC	72
8460	SPRAIN LUMBOSACRAL	72
8461	SPRAIN SACROILIAC	72
8462	SPRAIN SACROSPINATUS	72
8463	SPRAIN SACROTUBEROUS	72
8468	SPRAIN SACROILIAC NEC	72
8469	SPRAIN SACROILIAC NOS	72
8470	SPRAIN OF NECK	72
8471	SPRAIN THORACIC REGION	72
8472	SPRAIN LUMBAR REGION	72
8473	SPRAIN OF SACRUM	72
8474	SPRAIN OF COCCYX	72
8479	SPRAIN OF BACK NOS	72
8480	SPRAIN OF NASAL SEPTUM	72
8481	SPRAIN OF JAW	72
8482	SPRAIN OF THYROID REGION	72
8483	SPRAIN OF RIBS	72
84840	SPRAIN OF STERNUM NOS	72
84841	SPRAIN STERNOCLAVICULAR	72
84842	SPRAIN CHONDROSTERNAL	72
84849	SPRAIN OF STERNUM NEC	72
8485	SPRAIN OF PELVIS	72
8488	SPRAIN NEC	72
8489	SPRAIN NOS	72
8500	CONCUSSION W/O COMA	72
8501	CONCUSSION-BRIEF COMA	72
8502	CONCUSSION-MODERATE COMA	72
8503	CONCUSSION-PROLONG COMA	72
8504	CONCUSSION-DEEP COMA	72
8505	CONCUSSION W COMA NOS	72
8509	CONCUSSION NOS	72
85100	CEREBRAL CORTX CONTUSION	72
85101	CORTEX CONTUSION-NO COMA	72
85102	CORTEX CONTUS-BRIEF COMA	72
85103	CORTEX CONTUS-MOD COMA	72
85104	CORTEX CONTUS-PROLONG COMA	72
85105	CORTEX CONTUS-DEEP COMA	72
85106	CORTEX CONTUS-COMA NOS	72
85109	CORTEX CONTUS-CONCUS NOS	72
85110	CORTEX CONTUSION/OPN WND	72
85111	OPN CORTX CONTUS-NO COMA	72
85112	OPN CORTX CONTUS-BRF COMA	72
85113	OPN CORTX CONTUS-MOD COMA	72
85114	OPN CORTX CONTU-PROL COMA	72
85115	OPN CORTX CONTU-DEEP COMA	72
85116	OPN CORTX CONTUS-COMA NOS	72
85119	OPN CORTX CONTUS-CONCUSS	72
85120	CEREBRAL CORTEX LACERAT	72
85121	CORTEX LACERAT W/O COMA	72
85122	CORTEX LACERAT-BRIEF COMA	72
85123	CORTEX LACERAT-MOD COMA	72
85124	CORTEX LACERAT-PROL COMA	72
85125	CORTEX LACERAT-DEEP COMA	72
85126	CORTEX LACERAT-COMA NOS	72
85129	CORTEX LACERAT-CONCUSS	72
85130	CORTEX LACER W OPN WOUND	72
85131	OPN CORTEX LACER-NO COMA	72
85132	OPN CORTX LAC-BRIEF COMA	72
85133	OPN CORTX LACER-MOD COMA	72
85134	OPN CORTX LAC-PROLN COMA	72
85135	OPN CORTEX LAC-DEEP COMA	72
85136	OPN CORTX LACER-COMA NOS	72
85139	OPN CORTX LACER-CONCUSS	72
85140	CEREBEL/BRAIN STM CONTUS	72
85141	CEREBELL CONTUS W/O COMA	72
85142	CEREBELL CONTUS-BRF COMA	72
85143	CEREBELL CONTUS-MOD COMA	72
85144	CEREBEL CONTUS-PROL COMA	72
85145	CEREBEL CONTUS-DEEP COMA	72
85146	CEREBELL CONTUS-COMA NOS	72
85149	CEREBELL CONTUS-CONCUSS	72
85150	CEREBEL CONTUS W OPN WND	72
85151	OPN CEREBE CONT W/O COMA	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
85152	OPN CEREBE CONT-BRF COMA	72
85153	OPN CEREBE CONT-MOD COMA	72
85154	OPN CEREBE CONT-PROL COM	72
85155	OPN CEREBE CONT-DEEP COM	72
85156	OPN CEREBE CONT-COMA NOS	72
85159	OPN CEREBEL CONT-CONCUSS	72
85160	CEREBEL/BRAIN STEM LACER	72
85161	CEREBEL LACERAT W/O COMA	72
85162	CEREBEL LACER-BRIEF COMA	72
85163	CEREBEL LACERAT-MOD COMA	72
85164	CEREBEL LACER-PROLN COMA	72
85165	CEREBELL LACER-DEEP COMA	72
85166	CEREBEL LACERAT-COMA NOS	72
85169	CEREBEL LACER-CONCUSSION	72
85170	CEREBEL LACER W OPEN WND	72
85171	OPN CEREBEL LAC W/O COMA	72
85172	OPN CEREBEL LAC-BRF COMA	72
85173	OPN CEREBEL LAC-MOD COMA	72
85174	OPN CEREBE LAC-PROL COMA	72
85175	OPN CEREBE LAC-DEEP COMA	72
85176	OPN CEREBEL LAC-COMA NOS	72
85179	OPN CEREBELL LAC-CONCUSS	72
85180	BRAIN LACERATION NEC	72
85181	BRAIN LACER NEC W/O COMA	72
85182	BRAIN LAC NEC-BRIEF COMA	72
85183	BRAIN LACER NEC-MOD COMA	72
85184	BRAIN LAC NEC-PROLN COMA	72
85185	BRAIN LAC NEC-DEEP COMA	72
85186	BRAIN LACER NEC-COMA NOS	72
85189	BRAIN LACER NEC-CONCUSS	72
85190	BRAIN LAC NEC W OPEN WND	72
85191	OPN BRAIN LACER W/O COMA	72
85192	OPN BRAIN LAC-BRIEF COMA	72
85193	OPN BRAIN LACER-MOD COMA	72
85194	OPN BRAIN LAC-PROLN COMA	72
85195	OPEN BRAIN LAC-DEEP COMA	72
85196	OPN BRAIN LACER-COMA NOS	72
85199	OPEN BRAIN LACER-CONCUSS	72
85200	TRAUM SUBARACHNOID HEM	72
85201	SUBARACHNOID HEM-NO COMA	72
85202	SUBARACH HEM-BRIEF COMA	72
85203	SUBARACH HEM-MOD COMA	72
85204	SUBARACH HEM-PROLNG COMA	72
85205	SUBARACH HEM-DEEP COMA	72
85206	SUBARACH HEM-COMA NOS	72
85209	SUBARACH HEM-CONCUSSION	72
85210	SUBARACH HEM W OPN WOUND	72
85211	OPN SUBARACH HEM-NO COMA	72
85212	OP SUBARACH HEM-BRF COMA	72
85213	OP SUBARACH HEM-MOD COMA	72
85214	OP SUBARACH HEM-PROL COM	72
85215	OP SUBARACH HEM-DEEP COM	72
85216	OP SUBARACH HEM-COMA NOS	72
85219	OPN SUBARACH HEM-CONCUSS	72
85220	TRAUMATIC SUBDURAL HEM	72
85221	SUBDURAL HEM W/O COMA	72
85222	SUBDURAL HEM-BRIEF COMA	72
85223	SUBDURAL HEMORR-MOD COMA	72
85224	SUBDURAL HEM-PROLNG COMA	72
85225	SUBDURAL HEM-DEEP COMA	72
85226	SUBDURAL HEMORR-COMA NOS	72
85229	SUBDURAL HEM-CONCUSSION	72
85230	SUBDURAL HEM W OPN WOUND	72
85231	OPEN SUBDUR HEM W/O COMA	72
85232	OPN SUBDUR HEM-BRF COMA	72
85233	OPN SUBDUR HEM-MOD COMA	72
85234	OPN SUBDUR HEM-PROL COMA	72
85235	OPN SUBDUR HEM-DEEP COMA	72
85236	OPN SUBDUR HEM-COMA NOS	72
85239	OPN SUBDUR HEM-CONCUSS	72
85240	TRAUMATIC EXTRADURAL HEM	72
85241	EXTRADURAL HEM W/O COMA	72
85242	EXTRADUR HEM-BRIEF COMA	72
85243	EXTRADURAL HEM-MOD COMA	72
85244	EXTRADUR HEM-PROLN COMA	72
85245	EXTRADURAL HEM-DEEP COMA	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
85246	EXTRADURAL HEM-COMA NOS	72
85249	EXTADURAL HEM-CONCUSS	72
85250	EXTRADURAL HEM W OPN WND	72
85251	EXTRADURAL HEMOR-NO COMA	72
85252	EXTRADUR HEM-BRIEF COMA	72
85253	EXTRADURAL HEM-MOD COMA	72
85254	EXTRADUR HEM-PROLN COMA	72
85255	EXTRADUR HEM-DEEP COMA	72
85256	EXTRADURAL HEM-COMA NOS	72
85259	EXTRADURAL HEM-CONCUSS	72
85300	TRAUMATIC BRAIN HEM NEC	72
85301	BRAIN HEM NEC W/O COMA	72
85302	BRAIN HEM NEC-BRIEF COMA	72
85303	BRAIN HEM NEC-MOD COMA	72
85304	BRAIN HEM NEC-PROLN COMA	72
85305	BRAIN HEM NEC-DEEP COMA	72
85306	BRAIN HEM NEC-COMA NOS	72
85309	BRAIN HEM NEC-CONCUSSION	72
85310	BRAIN HEM NEC W OPN WND	72
85311	BRAIN HEM OPN W/O COMA	72
85312	BRAIN HEM OPN-BRF COMA	72
85313	BRAIN HEM OPEN-MOD COMA	72
85314	BRAIN HEM OPN-PROLN COMA	72
85315	BRAIN HEM OPEN-DEEP COMA	72
85316	BRAIN HEM OPEN-COMA NOS	72
85319	BRAIN HEM OPN-CONCUSSION	72
85400	BRAIN INJURY NEC	72
85401	BRAIN INJURY NEC-NO COMA	72
85402	BRAIN INJ NEC-BRIEF COMA	72
85403	BRAIN INJ NEC-MOD COMA	72
85404	BRAIN INJ NEC-PROLN COMA	72
85405	BRAIN INJ NEC-DEEP COMA	72
85406	BRAIN INJ NEC-COMA NOS	72
85409	BRAIN INJ NEC-CONCUSSION	72
85410	BRAIN INJURY W OPN WND	72
85411	OPN BRAIN INJ W/O COMA	72
85412	OPN BRAIN INJ-BRIEF COMA	72
85413	OPN BRAIN INJ-MOD COMA	72
85414	OPN BRAIN INJ-PROLN COMA	72
85415	OPN BRAIN INJ-DEEP COMA	72
85416	OPEN BRAIN INJ-COMA NOS	72
85419	OPN BRAIN INJ-CONCUSSION	72
8600	TRAUM PNEUMOTHORAX-CLOSE	72
8601	TRAUM PNEUMOTHORAX-OPEN	72
8602	TRAUM HEMOTHORAX-CLOSED	72
8603	TRAUM HEMOTHORAX-OPEN	72
8604	TRAUM PNEUMOHEMOTHOR-CL	72
8605	TRAUM PNEUMOHEMOTHOR-OPN	72
86100	HEART INJURY NOS-CLOSED	72
86101	HEART CONTUSION-CLOSED	72
86102	HEART LACERATION-CLOSED	72
86103	HEART CHAMBER LACERAT-CL	72
86110	HEART INJURY NOS-OPEN	72
86111	HEART CONTUSION-OPEN	72
86112	HEART LACERATION-OPEN	72
86113	HEART CHAMBER LACER-OPN	72
86120	LUNG INJURY NOS-CLOSED	72
86121	LUNG CONTUSION-CLOSED	72
86122	LUNG LACERATION-CLOSED	72
86130	LUNG INJURY NOS-OPEN	72
86131	LUNG CONTUSION-OPEN	72
86132	LUNG LACERATION-OPEN	72
8620	DIAPHRAGM INJURY-CLOSED	72
8621	DIAPHRAGM INJURY-OPEN	72
86221	BRONCHUS INJURY-CLOSED	72
86222	ESOPHAGUS INJURY-CLOSED	72
86229	INTRATHORACIC INJ NEC-CL	72
86231	BRONCHUS INJURY-OPEN	72
86232	ESOPHAGUS INJURY-OPEN	72
86239	INTRATHORAC INJ NEC-OPEN	72
8628	INTRATHORACIC INJ NOS-CL	72
8629	INTRATHORAC INJ NOS-OPEN	72
8630	STOMACH INJURY-CLOSED	72
8631	STOMACH INJURY-OPEN	72
86320	SMALL INTEST INJ NOS-CL	72
86321	DUODENUM INJURY-CLOSED	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
86329	SMALL INTEST INJ NEC-CL	72
86330	SMALL INTEST INJ NOS-OPN	72
86331	DUODENUM INJURY-OPEN	72
86339	SMALL INTEST INJ NEC-OPN	72
86340	COLON INJURY NOS-CLOSED	72
86341	ASCENDING COLON INJ-CLOS	72
86342	TRANSVERSE COLON INJ-CL	72
86343	DESCENDING COLON INJ-CL	72
86344	SIGMOID COLON INJ-CLOSED	72
86345	RECTUM INJURY-CLOSED	72
86346	COLON INJ MULT SITE-CLOS	72
86349	COLON INJURY NEC-CLOSED	72
86350	COLON INJURY NOS-OPEN	72
86351	ASCENDING COLON INJ-OPEN	72
86352	TRANSVERSE COLON INJ-OPN	72
86353	DESCENDING COLON INJ-OPN	72
86354	SIGMOID COLON INJ-OPEN	72
86355	RECTUM INJURY-OPEN	72
86356	COLON INJ MULT SITE-OPEN	72
86359	COLON INJURY NEC-OPEN	72
86380	GI INJURY NOS-CLOSED	72
86381	PANCREAS, HEAD INJ-CLOSE	72
86382	PANCREAS, BODY INJ-CLOSE	72
86383	PANCREAS, TAIL INJ-CLOSE	72
86384	PANCREAS INJURY NOS-CLOS	72
86385	APPENDIX INJURY-CLOSED	72
86389	GI INJURY NEC-CLOSED	72
86390	GI INJURY NOS-OPEN	72
86391	PANCREAS, HEAD INJ-OPEN	72
86392	PANCREAS, BODY INJ-OPEN	72
86393	PANCREAS, TAIL INJ-OPEN	72
86394	PANCREAS INJURY NOS-OPEN	72
86395	APPENDIX INJURY-OPEN	72
86399	GI INJURY NEC-OPEN	72
86400	LIVER INJURY NOS-CLOSED	72
86401	LIVER HEMATOMA/CONTUSION	72
86402	LIVER LACERATION, MINOR	72
86403	LIVER LACERATION, MOD	72
86404	LIVER LACERATION, MAJOR	72
86405	LIVER LACERAT UNSPCF CLS	72
86409	LIVER INJURY NEC-CLOSED	72
86410	LIVER INJURY NOS-OPEN	72
86411	LIVER HEMATOM/CONTUS-OPN	72
86412	LIVER LACERAT, MINOR-OPN	72
86413	LIVER LACERAT, MOD-OPEN	72
86414	LIVER LACERAT, MAJOR-OPN	72
86415	LIVER LACERAT UNSPCF OPN	72
86419	LIVER INJURY NEC-OPEN	72
86500	SPLEEN INJURY NOS-CLOSED	72
86501	SPLEEN HEMATOMA-CLOSED	72
86502	SPLEEN CAPSULAR TEAR	72
86503	SPLEEN PARENCHYMA LACER	72
86504	SPLEEN DISRUPTION-CLOS	72
86509	SPLEEN INJURY NEC-CLOSED	72
86510	SPLEEN INJURY NOS-OPEN	72
86511	SPLEEN HEMATOMA-OPEN	72
86512	SPLEEN CAPSULAR TEAR-OPN	72
86513	SPLEEN PARNCHYM LAC-OPN	72
86514	SPLEEN DISRUPTION-OPEN	72
86519	SPLEEN INJURY NEC-OPEN	72
86600	KIDNEY INJURY NOS-CLOSED	72
86601	KIDNEY HEMATOMA-CLOSED	72
86602	KIDNEY LACERATION-CLOSED	72
86603	KIDNEY DISRUPTION-CLOSED	72
86610	KIDNEY INJURY NOS-OPEN	72
86611	KIDNEY HEMATOMA-OPEN	72
86612	KIDNEY LACERATION-OPEN	72
86613	KIDNEY DISRUPTION-OPEN	72
8670	BLADDER/URETHRA INJ-CLOS	72
8671	BLADDER/URETHRA INJ-OPEN	72
8672	URETER INJURY-CLOSED	72
8673	URETER INJURY-OPEN	72
8674	UTERUS INJURY-CLOSED	72
8675	UTERUS INJURY-OPEN	72
8676	PELVIC ORGAN INJ NEC-CL	72
8677	PELVIC ORGAN INJ NEC-OPN	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
8678	PELVIC ORGAN INJ NOS-CL	72
8679	PELVIC ORGAN INJ NOS-OPN	72
86800	INTRA-ABDOM INJ NOS-CLOS	72
86801	ADRENAL GLAND INJURY-CL	72
86802	BILIARY TRACT INJURY-CL	72
86803	PERITONEUM INJURY-CLOSED	72
86804	RETROPERITONEUM INJ-CL	72
86809	INTRA-ABDOM INJ NEC-CLOS	72
86810	INTRA-ABDOM INJ NOS-OPEN	72
86811	ADRENAL GLAND INJURY-OPN	72
86812	BILIARY TRACT INJURY-OPN	72
86813	PERITONEUM INJURY-OPEN	72
86814	RETROPERITONEUM INJ-OPEN	72
86819	INTRA-ABDOM INJ NEC-OPEN	72
8690	INTERNAL INJ NOS-CLOSED	72
8691	INTERNAL INJURY NOS-OPEN	72
8700	LAC EYELID SKN/PERIOCLUR	72
8701	FULL-THICKNES LAC EYELID	72
8702	LAC EYELID INV LACRM PAS	72
8703	PENETR WND ORBIT W/O FB	72
8704	PENETRAT WND ORBIT W FB	72
8708	OPN WND OCULAR ADNEX NEC	72
8709	OPN WND OCULAR ADNEX NOS	72
8710	OCULAR LAC W/O PROLAPSE	72
8711	OCULAR LACERA W PROLAPSE	72
8712	RUPTURE EYE W TISSU LOSS	72
8713	AVULSION OF EYE	72
8714	LACERATION OF EYE NOS	72
8715	PENETRAT MAGNET FB EYE	72
8716	PENETRAT FB NEC EYE	72
8717	OCULAR PENETRATION NOS	72
8719	OPN WOUND OF EYEBALL NOS	72
87200	OPN WOUND EXTERN EAR NOS	72
87201	OPEN WOUND OF AURICLE	72
87202	OPN WOUND AUDITORY CANAL	72
87210	OPN WND EX EAR NOS-COMPL	72
87211	OPEN WOUND AURICLE-COMPL	72
87212	OPEN WND AUD CANAL-COMPL	72
87261	OPEN WOUND OF EAR DRUM	72
87262	OPEN WOUND OF OSSICLES	72
87263	OPEN WND EUSTACHIAN TUBE	72
87264	OPEN WOUND OF COCHLEA	72
87269	OPEN WOUND OF EAR NEC	72
87271	OPEN WND EAR DRUM-COMPL	72
87272	OPEN WND OSSICLES-COMPL	72
87273	OPN WND EUSTACH TB-COMPL	72
87274	OPEN WOUND COCHLEA-COMPL	72
87279	OPEN WOUND EAR NEC-COMPL	72
8728	OPEN WOUND OF EAR NOS	72
8729	OPEN WOUND EAR NOS-COMPL	72
8730	OPEN WOUND OF SCALP	72
8731	OPEN WOUND SCALP-COMPL	72
87320	OPEN WOUND OF NOSE NOS	72
87321	OPEN WOUND NASAL SEPTUM	72
87322	OPEN WOUND NASAL CAVITY	72
87323	OPEN WOUND NASAL SINUS	72
87329	MULT OPEN WOUND NOSE	72
87330	OPEN WND NOSE NOS-COMPL	72
87331	OPN WND NAS SEPTUM-COMPL	72
87332	OPEN WND NASAL CAV-COMPL	72
87333	OPEN WND NAS SINUS-COMPL	72
87339	MULT OPEN WND NOSE-COMPL	72
87340	OPEN WOUND OF FACE NOS	72
87341	OPEN WOUND OF CHEEK	72
87342	OPEN WOUND OF FOREHEAD	72
87343	OPEN WOUND OF LIP	72
87344	OPEN WOUND OF JAW	72
87349	OPEN WOUND OF FACE NEC	72
87350	OPEN WND FACE NOS-COMPL	72
87351	OPEN WOUND CHEEK-COMPL	72
87352	OPEN WND FOREHEAD-COMPL	72
87353	OPEN WOUND LIP-COMPLICAT	72
87354	OPEN WOUND JAW-COMPLICAT	72
87359	OPEN WND FACE NEC-COMPL	72
87360	OPEN WOUND OF MOUTH NOS	72
87361	OPEN WOUND BUCCAL MUCOSA	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
87362	OPEN WOUND OF GUM	72
87363	BROKEN TOOTH	31
87364	OPN WND TONGUE/MOUTH FLR	72
87365	OPEN WOUND OF PALATE	72
87369	OPEN WOUND MOUTH NEC	72
87370	OPEN WND MOUTH NOS-COMPL	72
87371	OPN WND BUC MUCOSA-COMPL	72
87372	OPEN WOUND GUM-COMPL	72
87373	BROKEN TOOTH-COMPLICATED	31
87374	OPEN WOUND TONGUE-COMPL	72
87375	OPEN WOUND PALATE-COMPL	72
87379	OPEN WND MOUTH NOS-COMPL	72
8738	OPEN WOUND OF HEAD NEC	72
8739	OPEN WND HEAD NEC-COMPL	72
87400	OPN WND LARYNX W TRACHEA	72
87401	OPEN WOUND OF LARYNX	72
87402	OPEN WOUND OF TRACHEA	72
87410	OPN WND LARY W TRAC-COMP	72
87411	OPEN WOUND LARYNX-COMPL	72
87412	OPEN WOUND TRACHEA-COMPL	72
8742	OPEN WOUND THYROID GLAND	72
8743	OPEN WOUND THYROID-COMPL	72
8744	OPEN WOUND OF PHARYNX	72
8745	OPEN WOUND PHARYNX-COMPL	72
8748	OPEN WOUND OF NECK NEC	72
8749	OPN WOUND NECK NEC-COMPL	72
8750	OPEN WOUND OF CHEST	72
8751	OPEN WOUND CHEST-COMPL	72
8760	OPEN WOUND OF BACK	72
8761	OPEN WOUND BACK-COMPL	72
8770	OPEN WOUND OF BUTTOCK	72
8771	OPEN WOUND BUTTOCK-COMPL	72
8780	OPEN WOUND OF PENIS	72
8781	OPEN WOUND PENIS-COMPL	72
8782	OPN WOUND SCROTUM/TESTES	72
8783	OPN WND SCROT/TEST-COMPL	72
8784	OPEN WOUND OF VULVA	72
8785	OPEN WOUND VULVA-COMPL	72
8786	OPEN WOUND OF VAGINA	72
8787	OPEN WOUND VAGINA-COMPL	72
8788	OPEN WOUND GENITAL NEC	72
8789	OPN WND GENITAL NEC-COMP	72
8790	OPEN WOUND OF BREAST	72
8791	OPEN WOUND BREAST-COMPL	72
8792	OPN WND ANTERIOR ABDOMEN	72
8793	OPN WND ANT ABDOMEN-COMP	72
8794	OPN WND LATERAL ABDOMEN	72
8795	OPN WND LAT ABDOMEN-COMP	72
8796	OPEN WOUND OF TRUNK NEC	72
8797	OPEN WND TRUNK NEC-COMPL	72
8798	OPEN WOUND SITE NOS	72
8799	OPN WOUND SITE NOS-COMPL	72
88000	OPEN WOUND OF SHOULDER	72
88001	OPEN WOUND OF SCAPULA	72
88002	OPEN WOUND OF AXILLA	72
88003	OPEN WOUND OF UPPER ARM	72
88009	MULT OPEN WOUND SHOULDER	72
88010	OPEN WND SHOULDER-COMPL	72
88011	OPEN WOUND SCAPULA-COMPL	72
88012	OPEN WOUND AXILLA-COMPL	72
88013	OPEN WND UPPER ARM-COMPL	72
88019	MULT OPN WND SHOULD-COMP	72
88020	OPN WND SHOULD W TENDON	72
88021	OPN WND SCAPULA W TENDON	72
88022	OPEN WND AXILLA W TENDON	72
88023	OPEN WND UP ARM W TENDON	72
88029	MLT OPN WND SHLDR W TEND	72
88100	OPEN WOUND OF FOREARM	72
88101	OPEN WOUND OF ELBOW	72
88102	OPEN WOUND OF WRIST	72
88110	OPEN WOUND FOREARM-COMPL	72
88111	OPEN WOUND ELBOW-COMPLIC	72
88112	OPEN WOUND WRIST-COMPLIC	72
88120	OPEN WND FOREARM W TENDN	72
88121	OPN WOUND ELBOW W TENDON	72
88122	OPN WOUND WRIST W TENDON	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
8820	OPEN WOUND OF HAND	72
8821	OPN WOUND HAND-COMPLICAT	72
8822	OPEN WOUND HAND W TENDON	72
8830	OPEN WOUND OF FINGER	72
8831	OPEN WOUND FINGER-COMPL	72
8832	OPEN WND FINGER W TENDON	72
8840	OPEN WOUND ARM MULT/NOS	72
8841	OPEN WOUND ARM NOS-COMPL	72
8842	OPN WND ARM NOS W TENDON	72
8850	AMPUTATION THUMB	72
8851	AMPUTATION THUMB-COMPL	72
8860	AMPUTATION FINGER	72
8861	AMPUTATION FINGER-COMPL	72
8870	AMPUT BELOW ELB, UNILAT	72
8871	AMP BELOW ELB, UNIL-COMP	72
8872	AMPUT ABV ELBOW, UNILAT	72
8873	AMPUT ABV ELB, UNIL-COMP	72
8874	AMPUTAT ARM, UNILAT NOS	72
8875	AMPUT ARM, UNIL NOS-COMP	72
8876	AMPUTATION ARM, BILAT	72
8877	AMPUTAT ARM, BILAT-COMPL	72
8900	OPEN WOUND OF HIP/THIGH	72
8901	OPEN WND HIP/THIGH-COMPL	72
8902	OPN WND HIP/THIGH W TEND	72
8910	OPEN WND KNEE/LEG/ANKLE	72
8911	OPEN WND KNEE/LEG-COMPL	72
8912	OPN WND KNEE/LEG W TENDN	72
8920	OPEN WOUND OF FOOT	72
8921	OPEN WOUND FOOT-COMPL	72
8922	OPEN WOUND FOOT W TENDON	72
8930	OPEN WOUND OF TOE	72
8931	OPEN WOUND TOE-COMPL	72
8932	OPEN WOUND TOE W TENDON	72
8940	OPEN WOUND OF LEG NEC	72
8941	OPEN WOUND LEG NEC-COMPL	72
8942	OPN WND LEG NEC W TENDON	72
8950	AMPUTATION TOE	72
8951	AMPUTATION TOE-COMPLICAT	72
8960	AMPUTATION FOOT, UNILAT	72
8961	AMPUT FOOT, UNILAT-COMPL	72
8962	AMPUTATION FOOT, BILAT	72
8963	AMPUTAT FOOT, BILAT-COMP	72
8970	AMPUT BELOW KNEE, UNILAT	72
8971	AMPUTAT BK, UNILAT-COMPL	72
8972	AMPUT ABOVE KNEE, UNILAT	72
8973	AMPUT ABV KN, UNIL-COMPL	72
8974	AMPUTAT LEG, UNILAT NOS	72
8975	AMPUT LEG, UNIL NOS-COMP	72
8976	AMPUTATION LEG, BILAT	72
8977	AMPUTAT LEG, BILAT-COMPL	72
90000	INJUR CAROTID ARTERY NOS	72
90001	INJ COMMON CAROTID ARTER	72
90002	INJ EXTERNAL CAROTID ART	72
90003	INJ INTERNAL CAROTID ART	72
9001	INJ INTERNL JUGULAR VEIN	72
90081	INJ EXTERN JUGULAR VEIN	72
90082	INJ MLT HEAD/NECK VESSEL	72
90089	INJ HEAD/NECK VESSEL NEC	72
9009	INJ HEAD/NECK VESSEL NOS	72
9010	INJURY THORACIC AORTA	72
9011	INJ INNOMIN/SUBCLAV ART	72
9012	INJ SUPERIOR VENA CAVA	72
9013	INJ INNOMIN/SUBCLAV VEIN	72
90140	INJ PULMONARY VESSEL NOS	72
90141	INJURY PULMONARY ARTERY	72
90142	INJURY PULMONARY VEIN	72
90181	INJ INTERCOSTAL ART/VEIN	72
90182	INJ INT MAMMARY ART/VEIN	72
90183	INJ MULT THORACIC VESSEL	72
90189	INJ THORACIC VESSEL NEC	72
9019	INJ THORACIC VESSEL NOS	72
9020	INJURY ABDOMINAL AORTA	72
90210	INJ INFER VENA CAVA NOS	72
90211	INJURY HEPATIC VEINS	72
90219	INJ INFER VENA CAVA NEC	72
90220	INJ CELIAC/MESEN ART NOS	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
90221	INJURY GASTRIC ARTERY	72
90222	INJURY HEPATIC ARTERY	72
90223	INJURY SPLENIC ARTERY	72
90224	INJURY CELIAC AXIS NEC	72
90225	INJ SUPER MESENTERIC ART	72
90226	INJ BRNCH SUP MESENT ART	72
90227	INJ INFER MESENTERIC ART	72
90229	INJ MESENTERIC VESS NEC	72
90231	INJ SUPERIOR MESENT VEIN	72
90232	INJ INFERIOR MESENT VEIN	72
90233	INJURY PORTAL VEIN	72
90234	INJURY SPLENIC VEIN	72
90239	INJ PORT/SPLEN VESS NEC	72
90240	INJURY RENAL VESSEL NOS	72
90241	INJURY RENAL ARTERY	72
90242	INJURY RENAL VEIN	72
90249	INJURY RENAL VESSEL NEC	72
90250	INJURY ILIAC VESSEL NOS	72
90251	INJ HYPOGASTRIC ARTERY	72
90252	INJURY HYPOGASTRIC VEIN	72
90253	INJURY ILIAC ARTERY	72
90254	INJURY ILIAC VEIN	72
90255	INJURY UTERINE ARTERY	72
90256	INJURY UTERINE VEIN	72
90259	INJURY ILIAC VESSEL NEC	72
90281	INJURY OVARIAN ARTERY	72
90282	INJURY OVARIAN VEIN	72
90287	INJ MULT ABD/PELV VESSEL	72
90289	INJ ABDOMINAL VESSEL NEC	72
9029	INJ ABDOMINAL VESSEL NOS	72
90300	INJ AXILLARY VESSEL NOS	72
90301	INJURY AXILLARY ARTERY	72
90302	INJURY AXILLARY VEIN	72
9031	INJURY BRACHIAL VESSELS	72
9032	INJURY RADIAL VESSELS	72
9033	INJURY ULNAR VESSELS	72
9034	INJURY PALMAR ARTERY	72
9035	INJURY FINGER VESSELS	72
9038	INJURY ARM VESSELS NEC	72
9039	INJURY ARM VESSEL NOS	72
9040	INJ COMMON FEMORAL ARTER	72
9041	INJ SUPERFIC FEMORAL ART	72
9042	INJURY FEMORAL VEIN	72
9043	INJURY SAPHENOUS VEIN	72
90440	INJ POPLITEAL VESSEL NOS	72
90441	INJURY POPLITEAL ARTERY	72
90442	INJURY POPLITEAL VEIN	72
90450	INJURY TIBIAL VESSEL NOS	72
90451	INJ ANTER TIBIAL ARTERY	72
90452	INJ ANTERIOR TIBIAL VEIN	72
90453	INJ POST TIBIAL ARTERY	72
90454	INJ POST TIBIAL VEIN	72
9046	INJ DEEP PLANTAR VESSEL	72
9047	INJURY LEG VESSELS NEC	72
9048	INJURY LEG VESSEL NOS	72
9049	BLOOD VESSEL INJURY NOS	72
9050	LATE EFFEC SKULL/FACE FX	72
9051	LATE EFF SPINE/TRUNK FX	72
9052	LATE EFFECT ARM FX	72
9053	LATE EFF FEMORAL NECK FX	72
9054	LATE EFFECT LEG FX	72
9055	LATE EFFECT FRACTURE NEC	72
9056	LATE EFFECT DISLOCATION	72
9057	LATE EFFEC SPRAIN/STRAIN	72
9058	LATE EFFEC TENDON INJURY	72
9059	LATE EFF TRAUMAT AMPUTAT	72
9060	LT EFF OPN WND HEAD/TRNK	72
9061	LATE EFF OPEN WND EXTREM	72
9062	LATE EFF SUPERFICIAL INJ	72
9063	LATE EFFECT OF CONTUSION	72
9064	LATE EFFECT OF CRUSHING	72
9065	LATE EFF HEAD/NECK BURN	72
9066	LATE EFF WRIST/HAND BURN	72
9067	LATE EFF BURN EXTREM NEC	72
9068	LATE EFFECT OF BURNS NEC	72
9069	LATE EFFECT OF BURN NOS	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
9070	LT EFF INTRACRANIAL INJ	72
9071	LATE EFF CRAN NERVE INJ	72
9072	LATE EFF SPINAL CORD INJ	72
9073	LT EFF NERV INJ TRNK NEC	72
9074	LT EFF NERV INJ SHLD/ARM	72
9075	LT EFF NERV INJ PELV/LEG	72
9079	LATE EFF NERVE INJ NEC	72
9080	LATE EFF INT INJUR CHEST	72
9081	LATE EFF INT INJ ABDOMEN	72
9082	LATE EFF INT INJURY NEC	72
9083	LATE EFF INJ PERIPH VESS	72
9084	LT EFF INJ THOR/ABD VESS	72
9085	LATE EFF FB IN ORIFICE	72
9086	LATE EFF COMPLIC TRAUMA	72
9089	LATE EFFECT INJURY NOS	72
9090	LATE EFF DRUG POISONING	72
9091	LATE EFF NONMED SUBSTANC	72
9092	LATE EFFECT OF RADIATION	72
9093	LATE EFF SURG/MED COMPL	11
9094	LATE EFF CERT EXT CAUSE	72
9095	LTE EFCT ADVRS EFCT DRUG	11
9099	LATE EFF EXTER CAUSE NEC	72
9100	ABRASION HEAD	72
9101	ABRASION HEAD-INFECTED	72
9102	BLISTER HEAD	72
9103	BLISTER HEAD-INFECTED	72
9104	INSECT BITE HEAD	72
9105	INSECT BITE HEAD-INFECT	72
9106	FOREIGN BODY HEAD	72
9107	FOREIGN BODY HEAD-INFECT	72
9108	SUPERFIC INJ HEAD NEC	72
9109	SUPERF INJ HEAD NEC-INF	72
9110	ABRASION TRUNK	72
9111	ABRASION TRUNK-INFECTED	72
9112	BLISTER TRUNK	72
9113	BLISTER TRUNK-INFECTED	72
9114	INSECT BITE TRUNK	72
9115	INSECT BITE TRUNK-INFEC	72
9116	FOREIGN BODY TRUNK	72
9117	FOREIGN BODY TRUNK-INFEC	72
9118	SUPERFIC INJ TRUNK NEC	72
9119	SUPERF INJ TRNK NEC-INF	72
9120	ABRASION SHOULDER/ARM	72
9121	ABRASION SHLDR/ARM-INFEC	72
9122	BLISTER SHOULDER & ARM	72
9123	BLISTER SHOULDER/ARM-INF	72
9124	INSECT BITE SHOULDER/ARM	72
9125	INSECT BITE SHLD/ARM-INF	72
9126	FOREIGN BODY SHOULDR/ARM	72
9127	FB SHOULDER/ARM-INFECT	72
9128	SUPERF INJ SHLDR/ARM NEC	72
9129	SUPERF INJ SHLDR NEC-INF	72
9130	ABRASION FOREARM	72
9131	ABRASION FOREARM-INFECT	72
9132	BLISTER FOREARM	72
9133	BLISTER FOREARM-INFECTED	72
9134	INSECT BITE FOREARM	72
9135	INSECT BITE FOREARM-INF	72
9136	FOREIGN BODY FOREARM	72
9137	FOREIGN BODY FOREARM-INF	72
9138	SUPERF INJ FOREARM NEC	72
9139	SUPRF INJ FORARM NEC-INF	72
9140	ABRASION HAND	72
9141	ABRASION HAND-INFECTED	72
9142	BLISTER HAND	72
9143	BLISTER HAND-INFECTED	72
9144	INSECT BITE HAND	72
9145	INSECT BITE HAND-INFECT	72
9146	FOREIGN BODY HAND	72
9147	FOREIGN BODY HAND-INFECT	72
9148	SUPERFICIAL INJ HAND NEC	72
9149	SUPERF INJ HAND NEC-INF	72
9150	ABRASION FINGER	72
9151	ABRASION FINGER-INFECTED	72
9152	BLISTER FINGER	72
9153	BLISTER FINGER-INFECTED	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9154	INSECT BITE FINGER	72
9155	INSECT BITE FINGER-INFEC	72
9156	FOREIGN BODY FINGER	72
9157	FOREIGN BODY FINGER-INF	72
9158	SUPERFIC INJ FINGER-NEC	72
9159	SUPRF INJ FINGER NEC-INF	72
9160	ABRASION HIP & LEG	72
9161	ABRASION HIP/LEG-INFECT	72
9162	BLISTER HIP & LEG	72
9163	BLISTER HIP & LEG-INFECT	72
9164	INSECT BITE HIP & LEG	72
9165	INSECT BITE HIP/LEG-INF	72
9166	FOREIGN BODY HIP/LEG	72
9167	FOREIGN BDY HIP/LEG-INF	72
9168	SUPERFIC INJ HIP/LEG NEC	72
9169	SUPERF INJ LEG NEC-INFEC	72
9170	ABRASION FOOT & TOE	72
9171	ABRASION FOOT/TOE-INFEC	72
9172	BLISTER FOOT & TOE	72
9173	BLISTER FOOT & TOE-INFEC	72
9174	INSECT BITE FOOT/TOE	72
9175	INSECT BITE FOOT/TOE-INF	72
9176	FOREIGN BODY FOOT & TOE	72
9177	FOREIGN BDY FOOT/TOE-INF	72
9178	SUPERF INJ FOOT/TOE NEC	72
9179	SUPERF INJ FOOT NEC-INF	72
9180	SUPERFIC INJ PERIOCLAR	68
9181	SUPERFICIAL INJ CORNEA	68
9182	SUPERFIC INJ CONJUNCTIVA	68
9189	SUPERFICIAL INJ EYE NEC	68
9190	ABRASION NEC	72
9191	ABRASION NEC-INFECTED	72
9192	BLISTER NEC	72
9193	BLISTER NEC-INFECTED	72
9194	INSECT BITE NEC	72
9195	INSECT BITE NEC-INFECTED	72
9196	SUPERFIC FOREIGN BDY NEC	72
9197	SUPERFICIAL FB NEC-INFEC	72
9198	SUPERFICIAL INJURY NEC	72
9199	SUPERFIC INJ NEC-INFECT	72
920	CONTUSION FACE/SCALP/NCK	72
9210	BLACK EYE NOS	72
9211	CONTUSION PERIOCLAR	72
9212	CONTUSION ORBITAL TISSUE	72
9213	CONTUSION OF EYEBALL	72
9219	CONTUSION OF EYE NOS	68
9220	CONTUSION OF BREAST	72
9221	CONTUSION OF CHEST WALL	72
9222	CONTUSION ABDOMINAL WALL	72
9224	CONTUSION GENITAL ORGANS	72
9228	MULTIPLE CONTUSION TRUNK	72
9229	CONTUSION TRUNK NOS	72
92300	CONTUSION SHOULDER REG	72
92301	CONTUSION SCAPUL REGION	72
92302	CONTUSION AXILLARY REG	72
92303	CONTUSION OF UPPER ARM	72
92309	CONTUSION SHOULDER & ARM	72
92310	CONTUSION OF FOREARM	72
92311	CONTUSION OF ELBOW	72
92320	CONTUSION OF HAND(S)	72
92321	CONTUSION OF WRIST	72
9233	CONTUSION OF FINGER	72
9238	MULTIPLE CONTUSION ARM	72
9239	CONTUSION UPPER LIMB NOS	72
92400	CONTUSION OF THIGH	72
92401	CONTUSION OF HIP	72
92410	CONTUSION OF LOWER LEG	72
92411	CONTUSION OF KNEE	72
92420	CONTUSION OF FOOT	72
92421	CONTUSION OF ANKLE	72
9243	CONTUSION OF TOE	72
9244	MULTIPLE CONTUSION LEG	72
9245	CONTUSION LEG NOS	72
9248	MULTIPLE CONTUSIONS NEC	72
9249	CONTUSION NOS	72
9251	CRUSH INJ FACE SCALP	72

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9252	CRUSH INJ NECK	72
9260	CRUSH INJ EXT GENITALIA	72
92611	CRUSHING INJURY BACK	72
92612	CRUSHING INJURY BUTTOCK	72
92619	CRUSHING INJ TRUNK NEC	72
9268	MULT CRUSHING INJ TRUNK	72
9269	CRUSHING INJ TRUNK NOS	72
92700	CRUSH INJ SHOULDER REG	72
92701	CRUSH INJ SCAPUL REGION	72
92702	CRUSH INJ AXILLARY REG	72
92703	CRUSHING INJ UPPER ARM	72
92709	CRUSH INJ SHOULDER & ARM	72
92710	CRUSHING INJURY FOREARM	72
92711	CRUSHING INJURY ELBOW	72
92720	CRUSHING INJURY OF HAND	72
92721	CRUSHING INJURY OF WRIST	72
9273	CRUSHING INJURY FINGER	72
9278	MULT CRUSHING INJURY ARM	72
9279	CRUSHING INJURY ARM NOS	72
92800	CRUSHING INJURY THIGH	72
92801	CRUSHING INJURY HIP	72
92810	CRUSHING INJ LOWER LEG	72
92811	CRUSHING INJURY KNEE	72
92820	CRUSHING INJURY FOOT	72
92821	CRUSHING INJURY ANKLE	72
9283	CRUSHING INJURY TOE	72
9288	MULT CRUSHING INJURY LEG	72
9289	CRUSHING INJURY LEG NOS	72
9290	CRUSH INJ MULT SITE NEC	72
9299	CRUSHING INJURY NOS	72
9300	CORNEAL FOREIGN BODY	68
9301	FB IN CONJUNCTIVAL SAC	72
9302	FB IN LACRIMAL PUNCTUM	72
9308	FOREIGN BDY EXT EYE NEC	68
9309	FOREIGN BDY EXT EYE NOS	68
931	FOREIGN BODY IN EAR	72
932	FOREIGN BODY IN NOSE	72
9330	FOREIGN BODY IN PHARYNX	72
9331	FOREIGN BODY IN LARYNX	72
9340	FOREIGN BODY IN TRACHEA	72
9341	FOREIGN BODY BRONCHUS	72
9348	FB TRACH/BRONCH/LUNG NEC	72
9349	FB RESPIRATORY TREE NOS	72
9350	FOREIGN BODY IN MOUTH	72
9351	FOREIGN BODY ESOPHAGUS	72
9352	FOREIGN BODY IN STOMACH	72
936	FB IN INTESTINE & COLON	72
937	FOREIGN BODY ANUS/RECTUM	72
938	FOREIGN BODY GI NOS	72
9390	FB BLADDER & URETHRA	72
9391	FOREIGN BODY UTERUS	56
9392	FOREIGN BDY VULVA/VAGINA	72
9393	FOREIGN BODY PENIS	72
9399	FOREIGN BDY GU TRACT NOS	72
9400	CHEMICAL BURN PERIOCLAR	72
9401	BURN PERIOCLAR AREA NEC	72
9402	ALKAL BURN CORNEA/CONJUN	72
9403	ACID BURN CORNEA/CONJUNC	72
9404	BURN CORNEA/CONJUNCT NEC	72
9405	BURN W EYEBALL DESTRUCT	72
9409	BURN EYE & ADNEXA NOS	72
94100	BURN NOS HEAD-UNSPEC	72
94101	BURN NOS EAR	72
94102	BURN NOS EYE	72
94103	BURN NOS LIP	72
94104	BURN NOS CHIN	72
94105	BURN NOS NOSE	72
94106	BURN NOS SCALP	72
94107	BURN NOS FACE NEC	72
94108	BURN NOS NECK	72
94109	BURN NOS HEAD-MULT	72
94110	1ST DEG BURN HEAD NOS	72
94111	1ST DEG BURN EAR	72
94112	1ST DEG BURN EYE	72
94113	1ST DEG BURN LIP	72
94114	1ST DEG BURN CHIN	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
94115	1ST DEG BURN NOSE	72
94116	1ST DEG BURN SCALP	72
94117	1ST DEG BURN FACE NEC	72
94118	1ST DEG BURN NECK	72
94119	1ST DEG BURN HEAD-MULT	72
94120	2ND DEG BURN HEAD NOS	72
94121	2ND DEG BURN EAR	72
94122	2ND DEG BURN EYE	72
94123	2ND DEG BURN LIP	72
94124	2ND DEG BURN CHIN	72
94125	2ND DEG BURN NOSE	72
94126	2ND DEG BURN SCALP	72
94127	2ND DEG BURN FACE NEC	72
94128	2ND DEG BURN NECK	72
94129	2ND DEG BURN HEAD-MULT	72
94130	3RD DEG BURN HEAD NOS	72
94131	3RD DEG BURN EAR	72
94132	3RD DEG BURN EYE	72
94133	3RD DEG BURN LIP	72
94134	3RD DEG BURN CHIN	72
94135	3RD DEG BURN NOSE	72
94136	3RD DEG BURN SCALP	72
94137	3RD DEG BURN FACE NEC	72
94138	3RD DEG BURN NECK	72
94139	3RD DEG BURN HEAD-MULT	72
94140	DEEP 3 DEG BURN HEAD NOS	72
94141	DEEP 3RD DEG BURN EAR	72
94142	DEEP 3RD DEG BURN EYE	72
94143	DEEP 3RD DEG BURN LIP	72
94144	DEEP 3RD DEG BURN CHIN	72
94145	DEEP 3RD DEG BURN NOSE	72
94146	DEEP 3RD DEG BURN SCALP	72
94147	DEEP 3RD BURN FACE NEC	72
94148	DEEP 3RD DEG BURN NECK	72
94149	DEEP 3 DEG BRN HEAD-MULT	72
94150	3RD BURN W LOSS-HEAD NOS	72
94151	3RD DEG BURN W LOSS-EAR	72
94152	3RD DEG BURN W LOSS-EYE	72
94153	3RD DEG BURN W LOSS-LIP	72
94154	3RD DEG BURN W LOSS-CHIN	72
94155	3RD DEG BURN W LOSS-NOSE	72
94156	3RD DEG BRN W LOSS-SCALP	72
94157	3RD BURN W LOSS-FACE NEC	72
94158	3RD DEG BURN W LOSS-NECK	72
94159	3RD BRN W LOSS-HEAD MULT	72
94200	BURN NOS TRUNK-UNSPEC	72
94201	BURN NOS BREAST	72
94202	BURN NOS CHEST WALL	72
94203	BURN NOS ABDOMINAL WALL	72
94204	BURN NOS BACK	72
94205	BURN NOS GENITALIA	72
94209	BURN NOS TRUNK NEC	72
94210	1ST DEG BURN TRUNK NOS	72
94211	1ST DEG BURN BREAST	72
94212	1ST DEG BURN CHEST WALL	72
94213	1ST DEG BURN ABDOMN WALL	72
94214	1ST DEG BURN BACK	72
94215	1ST DEG BURN GENITALIA	72
94219	1ST DEG BURN TRUNK NEC	72
94220	2ND DEG BURN TRUNK NOS	72
94221	2ND DEG BURN BREAST	72
94222	2ND DEG BURN CHEST WALL	72
94223	2ND DEG BURN ABDOMN WALL	72
94224	2ND DEG BURN BACK	72
94225	2ND DEG BURN GENITALIA	72
94229	2ND DEG BURN TRUNK NEC	72
94230	3RD DEG BURN TRUNK NOS	72
94231	3RD DEG BURN BREAST	72
94232	3RD DEG BURN CHEST WALL	72
94233	3RD DEG BURN ABDOMN WALL	72
94234	3RD DEG BURN BACK	72
94235	3RD DEG BURN GENITALIA	72
94239	3RD DEG BURN TRUNK NEC	72
94240	DEEP 3RD BURN TRUNK NOS	72
94241	DEEP 3RD DEG BURN BREAST	72
94242	DEEP 3RD BURN CHEST WALL	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
94243	DEEP 3RD BURN ABDOM WALL	72
94244	DEEP 3RD DEG BURN BACK	72
94245	DEEP 3RD BURN GENITALIA	72
94249	DEEP 3RD BURN TRUNK NEC	72
94250	3RD BRN W LOSS-TRUNK NOS	72
94251	3RD BURN W LOSS-BREAST	72
94252	3RD BRN W LOSS-CHEST WLL	72
94253	3RD BRN W LOSS-ABDOM WLL	72
94254	3RD DEG BURN W LOSS-BACK	72
94255	3RD BRN W LOSS-GENITALIA	72
94259	3RD BRN W LOSS-TRUNK NEC	72
94300	BURN NOS ARM-UNSPEC	72
94301	BURN NOS FOREARM	72
94302	BURN NOS ELBOW	72
94303	BURN NOS UPPER ARM	72
94304	BURN NOS AXILLA	72
94305	BURN NOS SHOULDER	72
94306	BURN NOS SCAPULA	72
94309	BURN NOS ARM-MULTIPLE	72
94310	1ST DEG BURN ARM NOS	72
94311	1ST DEG BURN FOREARM	72
94312	1ST DEG BURN ELBOW	72
94313	1ST DEG BURN UPPER ARM	72
94314	1ST DEG BURN AXILLA	72
94315	1ST DEG BURN SHOULDER	72
94316	1ST DEG BURN SCAPULA	72
94319	1ST DEG BURN ARM-MULT	72
94320	2ND DEG BURN ARM NOS	72
94321	2ND DEG BURN FOREARM	72
94322	2ND DEG BURN ELBOW	72
94323	2ND DEG BURN UPPER ARM	72
94324	2ND DEG BURN AXILLA	72
94325	2ND DEG BURN SHOULDER	72
94326	2ND DEG BURN SCAPULA	72
94329	2ND DEG BURN ARM-MULT	72
94330	3RD DEG BURN ARM NOS	72
94331	3RD DEG BURN FOREARM	72
94332	3RD DEG BURN ELBOW	72
94333	3RD DEG BURN UPPER ARM	72
94334	3RD DEG BURN AXILLA	72
94335	3RD DEG BURN SHOULDER	72
94336	3RD DEG BURN SCAPULA	72
94339	3RD DEG BURN ARM-MULT	72
94340	DEEP 3 DEG BURN ARM NOS	72
94341	DEEP 3 DEG BURN FOREARM	72
94342	DEEP 3 DEG BURN ELBOW	72
94343	DEEP 3 DEG BRN UPPER ARM	72
94344	DEEP 3 DEG BURN AXILLA	72
94345	DEEP 3 DEG BURN SHOULDER	72
94346	DEEP 3 DEG BURN SCAPULA	72
94349	DEEP 3 DEG BURN ARM-MULT	72
94350	3RD BURN W LOSS-ARM NOS	72
94351	3RD BURN W LOSS-FOREARM	72
94352	3RD BURN W LOSS-ELBOW	72
94353	3RD BRN W LOSS-UPPER ARM	72
94354	3RD BURN W LOSS-AXILLA	72
94355	3RD BURN W LOSS-SHOULDER	72
94356	3RD BURN W LOSS-SCAPULA	72
94359	3RD BURN W LOSS ARM-MULT	72
94400	BURN NOS HAND-UNSPEC	72
94401	BURN NOS FINGER	72
94402	BURN NOS THUMB	72
94403	BURN NOS MULT FINGERS	72
94404	BURN NOS FINGER W THUMB	72
94405	BURN NOS PALM	72
94406	BURN NOS BACK OF HAND	72
94407	BURN NOS WRIST	72
94408	BURN NOS HAND-MULTIPLE	72
94410	1ST DEG BURN HAND NOS	72
94411	1ST DEG BURN FINGER	72
94412	1ST DEG BURN THUMB	72
94413	1ST DEG BURN MULT FINGER	72
94414	1 DEG BURN FINGR W THUMB	72
94415	1ST DEG BURN PALM	72
94416	1 DEG BURN BACK OF HAND	72
94417	1ST DEG BURN WRIST	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
94418	1ST DEG BURN HAND-MULT	72
94420	2ND DEG BURN HAND NOS	72
94421	2ND DEG BURN FINGER	72
94422	2ND DEG BURN THUMB	72
94423	2ND DEG BURN MULT FINGER	72
94424	2 DEG BURN FINGR W THUMB	72
94425	2ND DEG BURN PALM	72
94426	2 DEG BURN BACK OF HAND	72
94427	2ND DEG BURN WRIST	72
94428	2ND DEG BURN HAND-MULT	72
94430	3RD DEG BURN HAND NOS	72
94431	3RD DEG BURN FINGER	72
94432	3RD DEG BURN THUMB	72
94433	3RD DEG BURN MULT FINGER	72
94434	3 DEG BURN FINGR W THUMB	72
94435	3RD DEG BURN PALM	72
94436	3 DEG BURN BACK OF HAND	72
94437	3RD DEG BURN WRIST	72
94438	3RD DEG BURN HAND-MULT	72
94440	DEEP 3 DEG BRN HAND NOS	72
94441	DEEP 3 DEG BURN FINGER	72
94442	DEEP 3 DEG BURN THUMB	72
94443	DEEP 3RD BRN MULT FINGER	72
94444	DEEP 3RD BRN FNGR W THMB	72
94445	DEEP 3 DEG BURN PALM	72
94446	DEEP 3RD BRN BACK OF HND	72
94447	DEEP 3 DEG BURN WRIST	72
94448	DEEP 3 DEG BRN HAND-MULT	72
94450	3RD BRN W LOSS-HAND NOS	72
94451	3RD BURN W LOSS-FINGER	72
94452	3RD BURN W LOSS-THUMB	72
94453	3RD BRN W LOSS-MULT FNGR	72
94454	3RD BRN W LOSS-FNGR/THMB	72
94455	3RD BURN W LOSS-PALM	72
94456	3RD BRN W LOSS-BK OF HND	72
94457	3RD BURN W LOSS-WRIST	72
94458	3RD BRN W LOSS HAND-MULT	72
94500	BURN NOS LEG-UNSPEC	72
94501	BURN NOS TOE	72
94502	BURN NOS FOOT	72
94503	BURN NOS ANKLE	72
94504	BURN NOS LOWER LEG	72
94505	BURN NOS KNEE	72
94506	BURN NOS THIGH	72
94509	BURN NOS LEG-MULTIPLE	72
94510	1ST DEG BURN LEG NOS	72
94511	1ST DEG BURN TOE	72
94512	1ST DEG BURN FOOT	72
94513	1ST DEG BURN ANKLE	72
94514	1ST DEG BURN LOWER LEG	72
94515	1ST DEG BURN KNEE	72
94516	1ST DEG BURN THIGH	72
94519	1ST DEG BURN LEG-MULT	72
94520	2ND DEG BURN LEG NOS	72
94521	2ND DEG BURN TOE	72
94522	2ND DEG BURN FOOT	72
94523	2ND DEG BURN ANKLE	72
94524	2ND DEG BURN LOWER LEG	72
94525	2ND DEG BURN KNEE	72
94526	2ND DEG BURN THIGH	72
94529	2ND DEG BURN LEG-MULT	72
94530	3RD DEG BURN LEG NOS	72
94531	3RD DEG BURN TOE	72
94532	3RD DEG BURN FOOT	72
94533	3RD DEG BURN ANKLE	72
94534	3RD DEG BURN LOW LEG	72
94535	3RD DEG BURN KNEE	72
94536	3RD DEG BURN THIGH	72
94539	3RD DEG BURN LEG-MULT	72
94540	DEEP 3RD DEG BRN LEG NOS	72
94541	DEEP 3RD DEG BURN TOE	72
94542	DEEP 3RD DEG BURN FOOT	72
94543	DEEP 3RD DEG BURN ANKLE	72
94544	DEEP 3RD DEG BRN LOW LEG	72
94545	DEEP 3RD DEG BURN KNEE	72
94546	DEEP 3RD DEG BURN THIGH	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
94549	DEEP 3 DEG BURN LEG-MULT	72
94550	3 DEG BRN W LOSS-LEG NOS	72
94551	3 DEG BURN W LOSS-TOE	72
94552	3 DEG BURN W LOSS-FOOT	72
94553	3 DEG BURN W LOSS-ANKLE	72
94554	3 DEG BRN W LOSS-LOW LEG	72
94555	3 DEG BURN W LOSS-KNEE	72
94556	3 DEG BURN W LOSS-THIGH	72
94559	3 DEG BRN W LOSS LEG-MLT	72
9460	BURN NOS MULTIPLE SITE	72
9461	1ST DEG BURN MULT SITE	72
9462	2ND DEG BURN MULT SITE	72
9463	3RD DEG BURN MULT SITE	72
9464	DEEP 3 DEG BRN MULT SITE	72
9465	3RD BRN W LOSS-MULT SITE	72
9470	BURN OF MOUTH & PHARYNX	72
9471	BURN LARYNX/TRACHEA/LUNG	72
9472	BURN OF ESOPHAGUS	72
9473	BURN OF GI TRACT	72
9474	BURN OF VAGINA & UTERUS	72
9478	BURN INTERNAL ORGAN NEC	72
9479	BURN INTERNAL ORGAN NOS	72
94800	BDY BRN < 10%/3D DEG NOS	72
94810	10-19% BDY BRN/3 DEG NOS	72
94811	10-19% BDY BRN/10-19% 3D	72
94820	20-29% BDY BRN/3 DEG NOS	72
94821	20-29% BDY BRN/10-19% 3D	72
94822	20-29% BDY BRN/20-29% 3D	72
94830	30-39% BDY BRN/3 DEG NOS	72
94831	30-39% BDY BRN/10-19% 3D	72
94832	30-39% BDY BRN/20-29% 3D	72
94833	30-39% BDY BRN/30-39% 3D	72
94840	40-49% BDY BRN/3 DEG NOS	72
94841	40-49% BDY BRN/10-19% 3D	72
94842	40-49% BDY BRN/20-29% 3D	72
94843	40-49% BDY BRN/30-39% 3D	72
94844	40-49% BDY BRN/40-49% 3D	72
94850	50-59% BDY BRN/3 DEG NOS	72
94851	50-59% BDY BRN/10-19% 3D	72
94852	50-59% BDY BRN/20-29% 3D	72
94853	50-59% BDY BRN/30-39% 3D	72
94854	50-59% BDY BRN/40-49% 3D	72
94855	50-59% BDY BRN/50-59% 3D	72
94860	60-69% BDY BRN/3 DEG NOS	72
94861	60-69% BDY BRN/10-19% 3D	72
94862	60-69% BDY BRN/20-29% 3D	72
94863	60-69% BDY BRN/30-39% 3D	72
94864	60-69% BDY BRN/40-49% 3D	72
94865	60-69% BDY BRN/50-59% 3D	72
94866	60-69% BDY BRN/60-69% 3D	72
94870	70-79% BDY BRN/3 DEG NOS	72
94871	70-79% BDY BRN/10-19% 3D	72
94872	70-79% BDY BRN/20-29% 3D	72
94873	70-79% BDY BRN/30-39% 3D	72
94874	70-79% BDY BRN/40-49% 3D	72
94875	70-79% BDY BRN/50-59% 3D	72
94876	70-79% BDY BRN/60-69% 3D	72
94877	70-79% BDY BRN/70-79% 3D	72
94880	80-89% BDY BRN/3 DEG NOS	72
94881	80-89% BDY BRN/10-19% 3D	72
94882	80-89% BDY BRN/20-29% 3D	72
94883	80-89% BDY BRN/30-39% 3D	72
94884	80-89% BDY BRN/40-49% 3D	72
94885	80-89% BDY BRN/50-59% 3D	72
94886	80-89% BDY BRN/60-69% 3D	72
94887	80-89% BDY BRN/70-79% 3D	72
94888	80-89% BDY BRN/80-89% 3D	72
94890	90% + BDY BRN/3D DEG NOS	72
94891	90% + BDY BRN/10-19% 3RD	72
94892	90% + BDY BRN/20-29% 3RD	72
94893	90% + BDY BRN/30-39% 3RD	72
94894	90% + BDY BRN/40-49% 3RD	72
94895	90% + BDY BRN/50-59% 3RD	72
94896	90% + BDY BRN/60-69% 3RD	72
94897	90% + BDY BRN/70-79% 3RD	72
94898	90% + BDY BRN/80-89% 3RD	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
94899	90% + BDY BRN/90% + 3RD	72
9490	BURN NOS	72
9491	1ST DEGREE BURN NOS	72
9492	2ND DEGREE BURN NOS	72
9493	3RD DEGREE BURN NOS	72
9494	DEEP 3RD DEG BURN NOS	72
9495	3RD BURN W LOSS-SITE NOS	72
9500	OPTIC NERVE INJURY	72
9501	INJURY TO OPTIC CHIASM	72
9502	INJURY TO OPTIC PATHWAYS	72
9503	INJURY TO VISUAL CORTEX	72
9509	INJ OPTIC NERV/PATH NOS	72
9510	INJURY OCULOMOTOR NERVE	72
9511	INJURY TROCHLEAR NERVE	72
9512	INJURY TRIGEMINAL NERVE	72
9513	INJURY ABDUCENS NERVE	72
9514	INJURY TO FACIAL NERVE	72
9515	INJURY TO ACOUSTIC NERVE	72
9516	INJURY ACCESSORY NERVE	72
9517	INJURY HYPOGLOSSAL NERVE	72
9518	INJURY CRANIAL NERVE NEC	72
9519	INJURY CRANIAL NERVE NOS	72
95200	C1-C4 SPIN CORD INJ NOS	72
95201	COMPLETE LES CORD/C1-C4	72
95202	ANTERIOR CORD SYND/C1-C4	72
95203	CENTRAL CORD SYND/C1-C4	72
95204	C1-C4 SPIN CORD INJ NEC	72
95205	C5-C7 SPIN CORD INJ NOS	72
95206	COMPLETE LES CORD/C5-C7	72
95207	ANTERIOR CORD SYND/C5-C7	72
95208	CENTRAL CORD SYND/C5-C7	72
95209	C5-C7 SPIN CORD INJ NEC	72
95210	T1-T6 SPIN CORD INJ NOS	72
95211	COMPLETE LES CORD/T1-T6	72
95212	ANTERIOR CORD SYND/T1-T6	72
95213	CENTRAL CORD SYND/T1-T6	72
95214	T1-T6 SPIN CORD INJ NEC	72
95215	T7-T12 SPIN CORD INJ NOS	72
95216	COMPLETE LES CORD/T7-T12	72
95217	ANTERIOR CORD SYN/T7-T12	72
95218	CENTRAL CORD SYN/T7-T12	72
95219	T7-T12 SPIN CORD INJ NEC	72
9522	LUMBAR SPINAL CORD INJUR	72
9523	SACRAL SPINAL CORD INJUR	72
9524	CAUDA EQUINA INJURY	72
9528	SPIN CORD INJ-MULT SITE	72
9529	SPINAL CORD INJURY NOS	72
9530	CERVICAL ROOT INJURY	72
9531	DORSAL ROOT INJURY	72
9532	LUMBAR ROOT INJURY	72
9533	SACRAL ROOT INJURY	72
9534	BRACHIAL PLEXUS INJURY	72
9535	LUMBOSACRAL PLEX INJURY	72
9538	MULT NERVE ROOT/PLEX INJ	72
9539	INJ NERVE ROOT/PLEX NOS	72
9540	INJ CERV SYMPATH NERVE	72
9541	INJ SYMPATH NERVE NEC	72
9548	INJURY TRUNK NERVE NEC	72
9549	INJURY TRUNK NERVE NOS	72
9550	INJURY AXILLARY NERVE	72
9551	INJURY MEDIAN NERVE	72
9552	INJURY ULNAR NERVE	72
9553	INJURY RADIAL NERVE	72
9554	INJ MUSCULOCUTAN NERVE	72
9555	INJ CUTAN SENSO NERV/ARM	72
9556	INJURY DIGITAL NERVE	72
9557	INJ NERVE SHLDR/ARM NEC	72
9558	INJ MULT NERVE SHLDR/ARM	72
9559	INJ NERVE SHLDR/ARM NOS	72
9560	INJURY SCIATIC NERVE	72
9561	INJURY FEMORAL NERVE	72
9562	INJ POSTERIOR TIB NERVE	72
9563	INJURY PERONEAL NERVE	72
9564	INJ CUTAN SENSO NERV/LEG	72
9565	INJ NERVE PELV/LEG NEC	72
9568	INJ MULT NERVE PELV/LEG	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
9569	INJ NERVE PELV/LEG NOS	72
9570	INJ SUPERF NERV HEAD/NCK	72
9571	INJURY TO NERVE NEC	72
9578	INJURY TO MULT NERVES	72
9579	INJURY TO NERVE NOS	72
9580	AIR EMBOLISM	72
9581	FAT EMBOLISM	72
9582	SECONDARY/RECUR HEMORR	72
9583	POSTTRAUM WND INFEC NEC	97
9584	TRAUMATIC SHOCK	72
9585	TRAUMATIC ANURIA	72
9586	VOLKMANN'S ISCH CONTRACT	72
9587	TRAUM SUBCUTAN EMPHYSEMA	11
9588	EARLY COMPLIC TRAUMA NEC	11
9591	TRUNK INJURY NOS	11
9592	SHLDR/UPPER ARM INJ NOS	11
9593	ELB/FOREARM/WRST INJ NOS	11
9594	HAND INJURY NOS	11
9595	FINGER INJURY NOS	11
9596	HIP & THIGH INJURY NOS	11
9597	LOWER LEG INJURY NOS	11
9598	INJURY MLT SITE/SITE NEC	11
9599	INJURY-SITE NOS	11
9600	POISONING-PENICILLINS	72
9601	POIS-ANTIFUNGAL ANTIBIOT	72
9602	POISON-CHLORAMPHENICOL	72
9603	POIS-ERYTHROMYC/MACROLID	72
9604	POISONING-TETRACYCLINE	72
9605	POIS-CEPHALOSPORIN GROUP	72
9606	POIS-ANTIMYCOCAC ANTIBIO	72
9607	POIS-ANTINEOP ANTIBIOTIC	72
9608	POISONING-ANTIBIOTIC NEC	72
9609	POISONING-ANTIBIOTIC NOS	72
9610	POISONING-SULFONAMIDES	72
9611	POIS-ARSENIC ANTI-INFEC	72
9612	POIS-HEAV MET ANTI-INFEC	72
9613	POIS-QUINOLINE/HYDROXYQU	72
9614	POISONING-ANTIMALARIALS	72
9615	POIS-ANTIPROTOZ DRUG NEC	72
9616	POISONING-ANTHELMINTICS	72
9617	POISONING-ANTIVIRAL DRUG	72
9618	POIS-ANTIMYCOCAC DRG NEC	72
9619	POIS-ANTI-INFECT NEC/NOS	72
9620	POIS-CORTICOSTEROIDS	72
9621	POISONING-ANDROGENS	72
9622	POISONING-OVARIAN HORMON	72
9623	POISON-INSULIN/ANTIDIAB	72
9624	POIS-ANT PITUITARY HORM	72
9625	POIS-POST PITUITARY HORM	72
9626	POISONING-PARATHYROIDS	72
9627	POISONING-THYROID/DERIV	72
9628	POISON-ANTITHYROID AGENT	72
9629	POISONING HORMON NEC/NOS	72
9630	POIS-ANTIALLRG/ANTIEMET	72
9631	POIS-ANTINEOPL/IMMUNOSUP	72
9632	POISONING-ACIDIFYING AGT	72
9633	POISONING-ALKALIZING AGT	72
9634	POISONING-ENZYMES NEC	72
9635	POISONING-VITAMINS NEC	72
9638	POISONING-SYSTEM AGT NEC	72
9639	POISONING-SYSTEM AGT NOS	72
9640	POISONING-IRON/COMPOUNDS	72
9641	POISON-LIVER/ANTIANEMICS	72
9642	POISONING-ANTICOAGULANTS	72
9643	POISONING-VITAMIN K	72
9644	POISON-FIBRINOLYSIS AGNT	72
9645	POISONING-COAGULANTS	72
9646	POISONING-GAMMA GLOBULIN	72
9647	POISONING-BLOOD PRODUCT	72
9648	POISONING-BLOOD AGT NEC	72
9649	POISONING-BLOOD AGT NOS	72
96500	POISONING-OPIMUM NOS	72
96501	POISONING-HEROIN	72
96502	POISONING-METHADONE	72
96509	POISONING-OPIATES NEC	72
9651	POISONING-SALICYLATES	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9654	POIS-AROM ANALGESICS NEC	72
9655	POISONING-PYRAZOLE DERIV	72
9656	POISONING-ANTIRHEUMATICS	72
9657	POIS-NO-NARC ANALGES NEC	72
9658	POIS-ANALGES/ANTIPYR NEC	72
9659	POIS-ANALGES/ANTIPYR NOS	72
9660	POISON-OXAZOLIDINE DERIV	72
9661	POISON-HYDANTOIN DERIVAT	72
9662	POISONING-SUCCINIMIDES	72
9663	POIS-ANTICNVUL NEC/NOS	72
9664	POIS-ANTI-PARKINSON DRUG	72
9670	POISONING-BARBITURATES	72
9671	POISONING-CHLORAL HYDRAT	72
9672	POISONING-PARALDEHYDE	72
9673	POISONING-BROMINE COMPN D	72
9674	POISONING-METHAQUALONE	72
9675	POISONING-GLUTETHIMIDE	72
9676	POISON-MIX SEDATIVE NEC	72
9678	POIS-SEDATIVE/HYPNOT NEC	72
9679	POIS-SEDATIVE/HYPNOT NOS	72
9680	POIS-CNS MUSCLE DEPRESS	72
9681	POISONING-HALOTHANE	72
9682	POISON-GAS ANESTHET NEC	72
9683	POISON-INTRAVEN ANESTHET	72
9684	POIS-GEN ANESTH NEC/NOS	72
9685	POIS-TOPIC/INFILT ANESTH	72
9686	POIS-NERVE/PLEX-BLK ANES	72
9687	POISON-SPINAL ANESTHETIC	72
9689	POIS-LOCAL ANEST NEC/NOS	72
9690	POISONING-ANTIDEPRESSANT	72
9691	POIS-PHENOTHIAZINE TRANQ	72
9692	POIS-BUTYROPHENONE TRANQ	72
9693	POISON-ANTIPSYCHOTIC NEC	72
9694	POIS-BENZODIAZEPINE TRAN	72
9695	POISON-TRANQUILIZER NEC	72
9696	POISONING-HALLUCINOGENS	72
9697	POISON-PSYCHOSTIMULANTS	72
9698	POISON-PSYCHOTROPIC NEC	72
9699	POISON-PSYCHOTROPIC NOS	72
9700	POISONING-ANALEPTICS	72
9701	POISON-OPIATE ANTAGONIST	72
9708	POIS-CNS STIMULANTS NEC	72
9709	POIS-CNS STIMULANT NOS	72
9710	POIS-PARASYMPATHOMIMETIC	72
9711	POIS-PARASYMPATHOLYTICS	72
9712	POISON-SYMPATHOMIMETICS	72
9713	POISONING-SYMPATHOLYTICS	72
9719	POIS-AUTONOMIC AGENT NOS	72
9720	POIS-CARD RHYTHM REGULAT	72
9721	POISONING-CARDIOTONICS	72
9722	POISONING-ANTILIPEMICS	72
9723	POIS-GANGLION BLOCK AGT	72
9724	POIS-CORONARY VASODILAT	72
9725	POISON-VASODILATOR NEC	72
9726	POIS-ANTIHYPERTEN AGENT	72
9727	POISON-ANTIVARICOSE DRUG	72
9728	POISON-CAPILLARY ACT AGT	72
9729	POIS-CARDIOVASC AGT NEC	72
9730	POIS-ANTACID/ANTIGASTRIC	72
9731	POIS-IRRITANT CATHARTICS	72
9732	POIS-EMOLLIENT CATHARTIC	72
9733	POISONING-CATHARTIC NEC	72
9734	POISONING-DIGESTANTS	72
9735	POISONING-ANTIDIARRH AGT	72
9736	POISONING-EMETICS	72
9738	POISONING-GI AGENTS NEC	72
9739	POISONING-GI AGENT NOS	72
9740	POIS-MERCURIAL DIURETICS	72
9741	POIS-PURINE DIURETICS	72
9742	POIS-H2CO3 ANHYDRA INHIB	72
9743	POISONING-SALURETICS	72
9744	POISONING-DIURETICS NEC	72
9745	POIS-ELECTRO/CAL/WAT AGT	72
9746	POISON-MINERAL SALTS NEC	72
9747	POIS-URIC ACID METABOL	72
9750	POISONING-OXYTOCIC AGENT	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
9751	POIS-SMOOTH MUSCLE RELAX	72
9752	POIS-SKELET MUSCLE RELAX	72
9753	POISON-MUSCLE AGENT NEC	72
9754	POISONING-ANTITUSSIVES	72
9755	POISONING-EXPECTORANTS	72
9756	POIS-ANTI-COLD DRUGS	72
9757	POISONING-ANTIASTHMATICS	72
9758	POIS-RESPIR DRUG NEC/NOS	72
9760	POIS-LOCAL ANTI-INFECT	72
9761	POISONING-ANTI-PRURITICS	72
9762	POIS-LOC ASTRING/DETERG	72
9763	POIS-EMOL/DEMUL/PROTECT	72
9764	POISON-HAIR/SCALP PREP	72
9765	POIS-EYE ANTI-INFEC/DRUG	72
9766	POISON-ENT PREPARATION	72
9767	POIS-TOPICAL DENTAL DRUG	72
9768	POIS-SKIN/MEMBR AGNT NEC	72
9769	POIS-SKIN/MEMBR AGNT NOS	72
9770	POISONING-DIETETICS	72
9771	POISON-LIPOTROPIC DRUGS	72
9772	POISONING-ANTIDOTES NEC	72
9773	POISON-ALCOHOL DETERRENT	72
9774	POIS-PHARMACEUT EXCIPIEN	72
9778	POISON-MEDICINAL AGT NEC	72
9779	POISON-MEDICINAL AGT NOS	72
9780	POISONING-BCG VACCINE	72
9781	POIS-TYPH/PARATYPH VACC	72
9782	POISONING-CHOLERA VACCIN	72
9783	POISONING-PLAGUE VACCINE	72
9784	POISONING-TETANUS VACCIN	72
9785	POIS-DIPHThERIA VACCINE	72
9786	POIS-PERTUSSIS VACCINE	72
9788	POIS-BACT VACCIN NEC/NOS	72
9789	POIS-MIX BACTER VACCINES	72
9790	POISON-SMALLPOX VACCINE	72
9791	POISON-RABIES VACCINE	72
9792	POISON-TYPHUS VACCINE	72
9793	POIS-YELLOW FEVER VACCIN	72
9794	POISONING-MEASLES VACCIN	72
9795	POIS-POLIOMYELIT VACCINE	72
9796	POIS-VIRAL/RICK VACC NEC	72
9797	POISONING-MIXED VACCINE	72
9799	POIS-VACCINE/BIOLOG NEC	72
9800	TOXIC EFF ETHYL ALCOHOL	72
9801	TOXIC EFF METHYL ALCOHOL	72
9802	TOXIC EFF ISOPROPYL ALC	72
9803	TOXIC EFFECT FUSEL OIL	72
9808	TOXIC EFFECT ALCOHOL NEC	72
9809	TOXIC EFFECT ALCOHOL NOS	72
981	TOXIC EFF PETROLEUM PROD	72
9820	TOXIC EFFECT BENZENE	72
9821	TOXIC EFF CARBON TETRACH	72
9822	TOXIC EFF CARBON DISULFI	72
9823	TX EF CL-HYDCARB SLV NEC	72
9824	TOXIC EFFECT NITROGLYCOL	72
9828	TOXIC EFF NONPETROL SOLV	72
9830	TOX EFF CORROSIVE AROMAT	72
9831	TOXIC EFFECT ACIDS	72
9832	TOXIC EFF CAUSTIC ALKALI	72
9839	TOXIC EFFECT CAUSTIC NOS	72
9840	TX EFF INORG LEAD COMPND	72
9841	TOX EFF ORG LEAD COMPND	72
9848	TOX EFF LEAD COMPND NEC	72
9849	TOX EFF LEAD COMPND NOS	72
9850	TOXIC EFFECT MERCURY	72
9851	TOXIC EFFECT ARSENIC	72
9852	TOXIC EFFECT MANGANESE	72
9853	TOXIC EFFECT BERYLLIUM	72
9854	TOXIC EFFECT ANTIMONY	72
9855	TOXIC EFFECT CADMIUM	72
9856	TOXIC EFFECT CHROMIUM	72
9858	TOXIC EFFECT METALS NEC	72
9859	TOXIC EFFECT METAL NOS	72
986	TOX EFF CARBON MONOXIDE	72
9870	TOXIC EFF LIQ PETROL GAS	72
9871	TOX EF HYDROCARB GAS NEC	72

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
9872	TOXIC EFF NITROGEN OXIDE	72
9873	TOXIC EFF SULFUR DIOXIDE	72
9874	TOXIC EFFECT FREON	72
9875	TOX EFF LACRIMOGENIC GAS	72
9876	TOXIC EFF CHLORINE GAS	72
9877	TOX EFF HYDROCYAN ACD GS	72
9878	TOXIC EFF GAS/VAPOR NEC	72
9879	TOXIC EFF GAS/VAPOR NOS	72
9880	TOXIC EFF FISH/SHELLFISH	72
9881	TOXIC EFFECT MUSHROOMS	72
9882	TOX EFF BERRY/PLANT NEC	72
9888	TOX EFF NOXIOUS FOOD NEC	72
9889	TOX EFF NOXIOUS FOOD NOS	72
9890	TOXIC EFFECT CYANIDES	72
9891	TOXIC EFFECT STRYCHNINE	72
9892	TOX EFF CHLOR HYDROCARB	72
9893	TOX EFF ORGANPHOS/CARBAM	72
9894	TOXIC EFF PESTICIDES NEC	72
9895	TOXIC EFFECT VENOM	72
9896	TOXIC EFF SOAP/DETERGENT	72
9897	TOX EFF AFLATOX/MYCOTOX	72
98981	TOXIC EFFECT OF ASBESTOS	72
98982	TOXIC EFFECT OF LATEX	72
98983	TOXIC EFFECT OF SILICONE	72
98984	TOXIC EFFECT OF TOBACCO	72
98989	TOX EFF NONMED SUBST NEC	72
9899	TOX EFF NONMED SUBST NOS	72
990	EFFECTS RADIATION NOS	72
9910	FROSTBITE OF FACE	72
9911	FROSTBITE OF HAND	72
9912	FROSTBITE OF FOOT	72
9913	FROSTBITE NEC/NOS	72
9914	IMMERSION FOOT	72
9915	CHILBLAINS	72
9916	HYPOTHERMIA	72
9918	EFFECT REDUCED TEMP NEC	72
9919	EFFECT REDUCED TEMP NOS	72
9920	HEAT STROKE & SUNSTROKE	72
9921	HEAT SYNCOPE	72
9922	HEAT CRAMPS	72
9923	HEAT EXHAUST-ANHYDROTIC	72
9924	HEAT EXHAUST-SALT DEPLE	72
9925	HEAT EXHAUSTION NOS	72
9926	HEAT FATIGUE, TRANSIENT	72
9927	HEAT EDEMA	72
9928	HEAT EFFECT NEC	72
9929	HEAT EFFECT NOS	72
9930	BAROTRAUMA, OTITIC	31
9931	BAROTRAUMA, SINUS	31
9932	EFF HIGH ALTITUD NEC/NOS	72
9933	CAISSON DISEASE	72
9934	EFF AIR PRESS BY EXPLOS	72
9938	EFFECT AIR PRESSURE NEC	72
9939	EFFECT AIR PRESSURE NOS	72
9940	EFFECTS OF LIGHTNING	72
9941	DROWNING/NONFATAL SUBMER	72
9942	EFFECTS OF HUNGER	72
9943	EFFECTS OF THIRST	72
9944	EXHAUSTION-EXPOSURE	72
9945	EXHAUSTION-EXCESS EXERT	72
9946	MOTION SICKNESS	11
9947	ASPHYXIATION/STRANGULAT	72
9948	EFFECTS ELECTRIC CURRENT	72
9949	EFFECT EXTERNAL CAUS NEC	72
9950	ANAPHYLACTIC SHOCK	78
9951	ANGIONEUROTIC EDEMA	72
9952	ADV EFF MED/BIOL SUB NOS	72
9953	ALLERGY, UNSPECIFIED	18
9954	SHOCK DUE TO ANESTHESIA	72
99560	ANPHYLCT SHK FOOD NOS	78
99561	ANPHYLCT SHK PEANUTS	78
99562	ANPHYLCT SHK CRSTACNS	78
99563	ANPHYLCT SHK FRTS VEG	78
99564	ANPHYLCT SHK TR NTS SEED	78
99565	ANPHYLCT SHK FISH	78
99566	ANPHYLCT SHK FOOD ADDTV	78

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
99567	ANPHYLCT SHK MILK PROD	78
99568	ANPHYLCT SHK EGGS	78
99569	ANPHYLCT SHK OT SPF FOOD	78
99581	ADULT PHYSICAL ABUSE	91
99589	ADVERSE EFFECT NEC	63
99600	MALFUNC CARD DEV/GRF NOS	36
99601	MALFUNC CARDIAC PACEMAKE	36
99602	MALFUNC PROSTH HRT VALVE	36
99603	MALFUNC CORON BYPASS GRF	36
99604	MCH CMP AUTM MPLNT DFBRL	36
99609	MALFUNC CARD DEV/GRF NEC	36
9961	MALFUNC VASC DEVICE/GRAF	36
9962	MALFUN NEURO DEVICE/GRAF	63
99630	MALFUNC GU DEV/GRAFT NOS	53
99631	MALFUNC URETHRAL CATH	53
99632	MALFUNCTION IUD	56
99639	MALFUNC GU DEV/GRAFT NEC	53
9964	MALF INT ORTHPED DEV/GRF	24
99651	CORNEAL GRFT MALFUNCTION	68
99652	OTH TISSUE GRAFT MALFUNC	72
99653	LENS PROSTHESIS MALFUNC	68
99654	BREAST PROSTH MALFUNC	18
99659	MALFUNC OTH DEVICE/GRAFT	72
99660	REACTION-UNSP DEVIC/GRFT	72
99661	REACT-CARDIAC DEV/GRAFT	36
99662	REACT-OTH VASC DEV/GRAFT	36
99663	REACT-NERV SYS DEV/GRAFT	63
99664	REACT-INDWELL URIN CATH	53
99665	REACT-OTH GENITOURIN DEV	53
99666	REACT-INTER JOINT PROST	24
99667	REACT-OTH INT ORTHO DEV	24
99669	REACT-INT PROS DEVIC NEC	72
99670	COMP-UNSP DEVICE/GRAFT	72
99671	COMP-HEART VALVE PROSTH	36
99672	COMP-OTH CARDIAC DEVICE	36
99673	COMP-REN DIALYS DEV/GRFT	36
99674	COMP-OTH VASC DEV/GRAFT	36
99675	COMP-NERV SYS DEV/GRAFT	63
99676	COMP-GENITOURIN DEV/GRFT	53
99677	COMP-INTERNAL JOINT PROS	24
99678	COMP-OTH INT ORTHO DEVIC	24
99679	COMP-INT PROST DEVIC NEC	72
99680	COMP ORGAN TRANSPLNT NOS	72
99681	COMPL KIDNEY TRANSPLANT	53
99682	COMPL LIVER TRANSPLANT	41
99683	COMPL HEART TRANSPLANT	36
99684	COMPL LUNG TRANSPLANT	33
99685	COMPL MARROW TRANSPLANT	86
99686	COMPL PANCREAS TRANSPLNT	41
99689	COMP OTH ORGAN TRANSPLNT	72
99690	COMP REATTACH EXTREM NOS	24
99691	COMPL REATTACHED FOREARM	24
99692	COMPL REATTACHED HAND	24
99693	COMPL REATTACHED FINGER	24
99694	COMPL REATTACHED ARM NEC	24
99695	COMPL REATTACHED FOOT	24
99696	COMPL REATTACHED LEG NEC	24
99699	COMPL REATTACH PART NEC	24
99700	NERVOUS SYST COMPLC NOS	63
99701	SURG COMPLICATION - CNS	63
99702	IATROGEN CV INFARC/HMRHG	63
99709	SURG COMP NERV SYSTM NEC	63
9971	SURG COMPL-HEART	36
9972	SURG COMP-PERI VASC SYST	36
9973	SURG COMPLIC-RESPIR SYST	33
9974	SURG COMP-DIGESTV SYSTEM	41
9975	SURG COMPL-URINARY TRACT	53
99760	AMPUTAT STUMP COMPL NOS	24
99761	NEUROMA AMPUTATION STUMP	24
99762	INFECTION AMPUTAT STUMP	24
99769	AMPUTAT STUMP COMPL NEC	24
99791	SURG COMP - HYPERTENSION	36
99799	SURG COMPL-BODY SYST NEC	11
9980	POSTOPERATIVE SHOCK	72
9982	ACCIDENTAL OP LACERATION	72
9983	POSTOP WOUND DISRUPTION	11

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
9984	FB LEFT DURING PROCEDURE	72
9985	POSTOPERATIVE INFECTION*	97
9986	PERSIST POSTOP FISTULA	72
9987	POSTOP FORGN SUBST REACT	72
99881	EMPHYSEMA RESULT FRM PROC	33
99882	CTRCT FRGMT FRM CTR SURG	68
99889	OTH SPCF CMPLC PROCD NEC	11
9989	SURGICAL COMPLICAT NOS	11
9990	GENERALIZED VACCINIA	97
9991	AIR EMBOL COMP MED CARE	33
9992	VASC COMP MED CARE NEC	36
9993	INFEC COMPL MED CARE NEC	97
9994	ANAPHYLACTIC SHOCK-SERUM	78
9995	SERUM REACTION NEC	86
9996	ABO INCOMPATIBILITY REAC	86
9997	RH INCOMPATIBILITY REACT	86
9998	TRANSFUSION REACTION NEC	86
9999	COMPLIC MED CARE NEC/NOS	11
*E8000	RR COLLISION NOS-EMPLOY	
*E8001	RR COLL NOS-PASSENGER	
*E8002	RR COLL NOS-PEDESTRIAN	
*E8003	RR COLL NOS-PED CYCLIST	
*E8008	RR COLL NOS-PERSON NEC	
*E8009	RR COLL NOS-PERSON NOS	
*E8010	RR COLL W OTH OBJ-EMPLOY	
*E8011	RR COLL W OTH OBJ-PASNGR	
*E8012	RR COLL W OTH OBJ-PEDEST	
*E8013	RR COLL W OTH OBJ-CYCL	
*E8018	RR COL W OTH OBJ-PER NEC	
*E8019	RR COL W OTH OBJ-PER NOS	
*E8020	RR ACC W DERAILED-EMPLOYEE	
*E8021	RR ACC W DERAILED-PASSENGER	
*E8022	RR ACC W DERAILED-PEDEST	
*E8023	RR ACC W DERAILED-PED CYCL	
*E8028	RR ACC W DERAILED-PERS NEC	
*E8029	RR ACC W DERAILED-PERS NOS	
*E8030	RR ACC W EXPLOSION-EMPL	
*E8031	RR ACC W EXPLOS-PASNGR	
*E8032	RR ACC W EXPLOS-PEDEST	
*E8033	RR ACC W EXPLOS-PED CYCL	
*E8038	RR ACC W EXPLOS-PERS NEC	
*E8039	RR ACC W EXPLOS-PERS NOS	
*E8040	FALL ON/FROM TRAIN-EMPL	
*E8041	FALL FROM TRAIN-PASSENGER	
*E8042	FALL FROM TRAIN-PEDEST	
*E8043	FALL FROM TRAIN-PED CYCL	
*E8048	FALL FROM TRAIN-PERS NEC	
*E8049	FALL FROM TRAIN-PERS NOS	
*E8050	HIT BY TRAIN-EMPLOYEE	
*E8051	HIT BY TRAIN-PASSENGER	
*E8052	HIT BY TRAIN-PEDESTRIAN	
*E8053	HIT BY TRAIN-PED CYCLIST	
*E8058	HIT BY TRAIN-PERSON NEC	
*E8059	HIT BY TRAIN-PERSON NOS	
*E8060	RR ACC NEC-EMPLOYEE	
*E8061	RR ACC NEC-PASSENGER	
*E8062	RR ACC NEC-PEDESTRIAN	
*E8063	RR ACC NEC-PED CYCLIST	
*E8068	RR ACC NEC-PERSON NEC	
*E8069	RR ACC NEC-PERSON NOS	
*E8070	RR ACCIDENT NOS-EMPLOYEE	
*E8071	RR ACC NOS-PASSENGER	
*E8072	RR ACC NOS-PEDESTRIAN	
*E8073	RR ACC NOS-PED CYCLIST	
*E8078	RR ACC NOS-PERSON NEC	
*E8079	RR ACC NOS-PERSON NOS	
*E8100	MV-TRAIN COLL-DRIVER	
*E8101	MV-TRAIN COLL-PASNGR	
*E8102	MV-TRAIN COLL-MOTORCYCL	
*E8103	MV-TRAIN COLL-MCYCL PSGR	
*E8104	MV-TRAIN COLL-ST CAR	
*E8105	MV-TRAIN COLL-ANIM RID	
*E8106	MV-TRAIN COLL-PED CYCL	
*E8107	MV-TRAIN COLL-PEDEST	
*E8108	MV-TRAIN COLL-PERS NEC	
*E8109	MV-TRAIN COLL-PERS NOS	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E8110	REENTRANT MV COLL-DRIVER .....	.....
*E8111	REENTRANT MV COLL-PASNGR .....	.....
*E8112	REENTRANT COLL-MOTCYCL .....	.....
*E8113	REENTRANT COLL-MCYC PSGR .....	.....
*E8114	REENTRANT COLL-ST CAR .....	.....
*E8115	REENTRANT COLL-ANIM RID .....	.....
*E8116	REENTRANT COLL-PED CYCL .....	.....
*E8117	REENTRANT COLL-PEDEST .....	.....
*E8118	REENTRANT COLL-PERS NEC .....	.....
*E8119	REENTRANT COLL-PERS NOS .....	.....
*E8120	MV COLLISION NOS-DRIVER .....	.....
*E8121	MV COLLISION NOS-PASNGR .....	.....
*E8122	MV COLLIS NOS-MOTORCYCL .....	.....
*E8123	MV COLL NOS-MCYCL PSNGR .....	.....
*E8124	MV COLLISION NOS-ST CAR .....	.....
*E8125	MV COLL NOS-ANIM RID .....	.....
*E8126	MV COLL NOS-PED CYCL .....	.....
*E8127	MV COLLISION NOS-PEDEST .....	.....
*E8128	MV COLLIS NOS-PERS NEC .....	.....
*E8129	MV COLLIS NOS-PERS NOS .....	.....
*E8130	MV-OTH VEH COLL-DRIVER .....	.....
*E8131	MV-OTH VEH COLL-PASNGR .....	.....
*E8132	MV-OTH VEH COLL-MOTCYCL .....	.....
*E8133	MV-OTH VEH COLL-MCYC PSG .....	.....
*E8134	MV-OTH VEH COLL-ST CAR .....	.....
*E8135	MV-OTH VEH COLL-ANIM RID .....	.....
*E8136	MV-OTH VEH COLL-PED CYCL .....	.....
*E8137	MV-OTH VEH COLL-PEDEST .....	.....
*E8138	MV-OTH VEH COLL-PERS NEC .....	.....
*E8139	MV-OTH VEH COLL-PERS NOS .....	.....
*E8140	MV COLL W PEDEST-DRIVER .....	.....
*E8141	MV COLL W PEDEST-PASNGR .....	.....
*E8142	MV COLL W PEDEST-MOTCYCL .....	.....
*E8143	MV COLL W PED-MCYCL PSGR .....	.....
*E8144	MV COLL W PEDEST-ST CAR .....	.....
*E8145	MV COLL W PED-ANIM RID .....	.....
*E8146	MV COLL W PED-PED CYCL .....	.....
*E8147	MV COLL W PEDEST-PEDEST .....	.....
*E8148	MV COLL W PEDES-PERS NEC .....	.....
*E8149	MV COLL W PEDES-PERS NOS .....	.....
*E8150	MV COLL W OTH OBJ-DRIVER .....	.....
*E8151	MV COLL W OTH OBJ-PASNGR .....	.....
*E8152	MV COLL W OTH OBJ-MOCYCL .....	.....
*E8153	MV COLL W OBJ-MCYCL PSGR .....	.....
*E8154	MV COLL W OBJ-ST CAR .....	.....
*E8155	MV COLL W OBJ-ANIM RIDER .....	.....
*E8156	MV COLL W OBJ-PED CYCL .....	.....
*E8157	MV COLL W OBJ-PEDEST .....	.....
*E8158	MV COLL W OBJ-PERS NEC .....	.....
*E8159	MV COLL W OBJ-PERS NOS .....	.....
*E8160	LOSS CONTROL MV ACC-DRIV .....	.....
*E8161	LOSS CONTROL MV ACC-PSGR .....	.....
*E8162	LOSS CONTROL MV-MOCYCL .....	.....
*E8163	LOSS CONTROL MV-MCYC PSG .....	.....
*E8164	LOSS CONT MV ACC-ST CAR .....	.....
*E8165	LOSS CONT MV-ANIM RIDER .....	.....
*E8166	LOSS CONTROL MV-PED CYCL .....	.....
*E8167	LOSS CONTROL MV-PEDEST .....	.....
*E8168	LOSS CONTROL MV-PERS NEC .....	.....
*E8169	LOSS CONTROL MV-PERS NOS .....	.....
*E8170	MV ACC BOARD/ALIGHT-DRIV .....	.....
*E8171	MV ACC BOARD/ALIGHT-PSGR .....	.....
*E8172	MV BOARD/ALIGHT-MOTCYCL .....	.....
*E8173	MV BRD/ALIGHT-MCYCL PSGR .....	.....
*E8174	MV ACC BRD/ALIGHT-ST CAR .....	.....
*E8175	MV BRD/ALIGHT-ANIM RIDER .....	.....
*E8176	MV BRD/ALIGHT-PED CYCL .....	.....
*E8177	MV BRD/ALIGHT-PEDESTRIAN .....	.....
*E8178	MV BOARD/ALIGHT-PERS NEC .....	.....
*E8179	MV BOARD/ALIGHT-PERS NOS .....	.....
*E8180	MV TRAFF ACC NEC-DRIVER .....	.....
*E8181	MV TRAFF ACC NEC-PASNGR .....	.....
*E8182	MV TRAFF ACC NEC-MOCYCL .....	.....
*E8183	MV TRAFF ACC-MCYCL PSGR	
*E8184	MV TRAFF ACC NEC-ST CAR	
*E8185	MV TRAFF ACC-ANIM RIDER	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E8186	MV TRAFF ACC-PED CYC .....	.....
*E8187	MV TRAFF ACC NEC-PEDEST .....	.....
*E8188	MV TRAFF ACC-PERS NEC .....	.....
*E8189	MV TRAFF ACC-PERS NOS .....	.....
*E8190	TRAFFIC ACC NOS-DRIVER .....	.....
*E8191	TRAFFIC ACC NOS-PASNGR .....	.....
*E8192	TRAFFIC ACC NOS-MOTCYCL .....	.....
*E8193	TRAFF ACC NOS-MCYCL PSGR .....	.....
*E8194	TRAFFIC ACC NOS-ST CAR .....	.....
*E8195	TRAFF ACC NOS-ANIM RIDER .....	.....
*E8196	TRAFFIC ACC NOS-PED CYCL .....	.....
*E8197	TRAFFIC ACC NOS-PEDEST .....	.....
*E8198	TRAFFIC ACC NOS-PERS NEC .....	.....
*E8199	TRAFFIC ACC NOS-PERS NOS .....	.....
*E8200	SNOW VEH ACC-DRIVER .....	.....
*E8201	SNOW VEH ACC-PASNGR .....	.....
*E8202	SNOW VEH ACC-MOTORCYCL .....	.....
*E8203	SNOW VEH ACC-MCYCL PSGR .....	.....
*E8204	SNOW VEH ACC-ST CAR .....	.....
*E8205	SNOW VEH ACC-ANIM RIDER .....	.....
*E8206	SNOW VEH ACC-PED CYCL .....	.....
*E8207	SNOW VEH ACC-PEDEST .....	.....
*E8208	SNOW VEH ACC-PERS NEC .....	.....
*E8209	SNOW VEH ACC-PERS NOS .....	.....
*E8210	OTH OFF-ROAD MV ACC-DRIV .....	.....
*E8211	OTH OFF-ROAD MV ACC-PSGR .....	.....
*E8212	OTH OFF-ROAD MV-MOCYCL .....	.....
*E8213	OTH OFF-ROAD MV-MCYC PSG .....	.....
*E8214	OTH OFF-ROAD MV-ST CAR .....	.....
*E8215	OTH OFF-ROAD MV-ANIM RID .....	.....
*E8216	OTH OFF-ROAD MV-PED CYCL .....	.....
*E8217	OTH OFF-ROAD MV-PEDEST .....	.....
*E8218	OTH OFF-ROAD MV-PERS NEC .....	.....
*E8219	OTH OFF-ROAD MV-PERS NOS .....	.....
*E8220	OTH COLL W MOV OBJ-DRIV .....	.....
*E8221	OTH COLL W MOV OBJ-PSGR .....	.....
*E8222	OTH COLL MOV OBJ-MOCYCL .....	.....
*E8223	OTH COLL MOV OBJ-CYC PSG .....	.....
*E8224	OTH COLL MOV OBJ-ST CAR .....	.....
*E8225	OTH COLL MOV OBJ-RIDER .....	.....
*E8226	OTH COLL MOV OBJ-PED CYC .....	.....
*E8227	OTH COLL MOV OBJ-PEDEST .....	.....
*E8228	OTH COLL MOV OBJ-PER NEC .....	.....
*E8229	OTH COLL MOV OBJ-PER NOS .....	.....
*E8230	OTH COLL STNDNG OBJ-DRIV .....	.....
*E8231	OTH COLL STNDNG OBJ-PSGR .....	.....
*E8232	OTH COLL STND OBJ-MOCYCL .....	.....
*E8233	OTH COLL STN OBJ-CYC PSG .....	.....
*E8234	OTH COLL STND OBJ-ST CAR .....	.....
*E8235	OTH COLL STND OBJ-RIDER .....	.....
*E8236	OTH COLL STN OBJ-PED CYC .....	.....
*E8237	OTH COLL STND OBJ-PEDEST .....	.....
*E8238	OTH COLL STN OBJ-PER NEC .....	.....
*E8239	OTH COL-STND-OBJ-PER NOS .....	.....
*E8240	N-TRAF BOARD/ALIGHT-DRIV .....	.....
*E8241	N-TRAF BOARD/ALIGHT-PSGR .....	.....
*E8242	N-TRAF BRD/ALIGHT-MOCYCL .....	.....
*E8243	N-TRAF BRD/ALIT-MCYC PSG .....	.....
*E8244	N-TRAF BRD/ALIT-ST CAR .....	.....
*E8245	N-TRAF BRD/ALIT-ANIM RID .....	.....
*E8246	N-TRAF BRD/ALIT-PED CYCL .....	.....
*E8247	N-TRAF BRD/ALIT-PEDEST .....	.....
*E8248	N-TRAF BRD/ALIT-PERS NEC .....	.....
*E8249	N-TRAF BRD/ALIT-PERS NOS .....	.....
*E8250	MV N-TRAFF ACC NEC-DRIV .....	.....
*E8251	MV N-TRAFF NEC/NOS-PSGR .....	.....
*E8252	MV N-TRAF ACC NEC-MOCYCL .....	.....
*E8253	MV N-TRAFF NEC-MCYC PSGR .....	.....
*E8254	MV N-TRAFF NEC-ST CAR .....	.....
*E8255	MV N-TRAF NEC-ANIM RIDER .....	.....
*E8256	MV N-TRAFF NEC-PED CYCL .....	.....
*E8257	MV N-TRAFF NEC-PEDEST .....	.....
*E8258	MV N-TRAFF NEC-PERS NEC .....	.....
*E8259	MV N-TRAFF NEC-PERS NOS	
*E8260	PEDAL CYCLE ACC-PEDEST	
*E8261	PED CYCL ACC-PED CYCLIST	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8262	PED CYCLE ACC-ANIM RIDER .....	.....
*E8263	PED CYC ACC-OCC ANIM VEH .....	.....
*E8264	PED CYCLE ACC-OCC ST CAR .....	.....
*E8268	PED CYCLE ACC-PERS NEC .....	.....
*E8269	PED CYCLE ACC-PERS NOS .....	.....
*E8270	ANIMAL DRAWN VEH-PEDEST .....	.....
*E8272	ANIM DRAWN VEH-ANIM RID .....	.....
*E8273	ANIMAL DRAWN VEH-OCCUPAN .....	.....
*E8274	ANIM DRAWN-OCC ST CAR .....	.....
*E8278	ANIM DRAWN VEH-PERS NEC .....	.....
*E8279	ANIM DRAWN VEH-PERS NOS .....	.....
*E8280	RIDDEN ANIMAL ACC-PEDEST .....	.....
*E8282	RIDDEN ANIMAL ACC-RIDER .....	.....
*E8284	RIDDEN ANIMAL ACC-ST CAR .....	.....
*E8288	RIDDEN ANIM ACC-PERS NEC .....	.....
*E8289	RIDDEN ANIM ACC-PERS NOS .....	.....
*E8290	OTH ROAD VEH ACC-PEDEST .....	.....
*E8294	OTH RD VEH ACC-ST CAR .....	.....
*E8298	OTH RD VEH ACC-PERS NEC .....	.....
*E8299	OTH RD VEH ACC-PERS NOS .....	.....
*E8300	BOAT ACC W SUBMERS-UNPOW .....	.....
*E8301	BOAT ACC W SUBMERS-POWER .....	.....
*E8302	BOAT ACC W SUBMERS-CREW .....	.....
*E8303	BOAT ACC W SUBMERS-PSGR .....	.....
*E8304	BOAT SUBMERS-WATER SKIER .....	.....
*E8305	BOAT SUBMERS-SWIMMER .....	.....
*E8306	BOAT SUBMERS-DOCKERS .....	.....
*E8308	BOAT SUBMERS-PERS NEC .....	.....
*E8309	BOAT SUBMERS-PERS NOS .....	.....
*E8310	BOAT ACC INJ NEC-UNPOWER .....	.....
*E8311	BOAT ACC INJ NEC-POWER .....	.....
*E8312	BOAT ACC INJ NEC-CREW .....	.....
*E8313	BOAT ACC INJ NEC-PASSENG .....	.....
*E8314	BOAT ACC INJ NEC-SKIER .....	.....
*E8315	BOAT ACC INJ NEC-SWIM .....	.....
*E8316	BOAT ACC INJ NEC-DOCKER .....	.....
*E8318	BOAT INJ NEC-PERSON NEC .....	.....
*E8319	BOAT INJ NEC-PERSON NOS .....	.....
*E8320	SUBMERS NEC-UNPOW BOAT .....	.....
*E8321	SUBMERS NEC-POWER BOAT .....	.....
*E8322	SUBMERS NEC-CREW .....	.....
*E8323	SUBMERS NEC-PASSENGER .....	.....
*E8324	SUBMERS NEC-WATER SKIER .....	.....
*E8325	SUBMERS NEC-SWIMMER .....	.....
*E8326	SUBMERS NEC-DOCKER .....	.....
*E8328	SUBMERS NEC-PERSON NEC .....	.....
*E8329	SUBMERS NEC-PERSON NOS .....	.....
*E8330	W/CRAFT STAIR FALL-UNPOW .....	.....
*E8331	W/CRAFT STAIR FALL-POWER .....	.....
*E8332	WTRCRAFT STAIR FALL-CREW .....	.....
*E8333	WTRCRAFT STAIR FALL-PSGR .....	.....
*E8334	W/CRAFT STAIR FALL-SKIER .....	.....
*E8335	W/CRAFT STAIR FALL-SWIM .....	.....
*E8336	W/CRF STAIR FALL-DOCKER .....	.....
*E8338	W/CRF STAIR FALL-PER NEC .....	.....
*E8339	W/CRF STAIR FALL-PER NOS .....	.....
*E8340	W/CRAFT FALL NEC-UNPOW .....	.....
*E8341	W/CRAFT FALL NEC-POWER .....	.....
*E8342	WATERCRAFT FALL NEC-CREW .....	.....
*E8343	WTRCRAFT FALL NEC-PASNGR .....	.....
*E8344	W/CRAFT FALL NEC-SKIER .....	.....
*E8345	W/CRAFT FALL NEC-SWIM .....	.....
*E8346	WTRCRAFT FALL NEC-DOCKER .....	.....
*E8348	W/CRFT FALL NEC-PERS NEC .....	.....
*E8349	W/CRFT FALL NEC-PERS NOS .....	.....
*E8350	W/CRAFT FALL NOS-UNPOW .....	.....
*E8351	W/CRAFT FALL NOS-POWER .....	.....
*E8352	WTRCRAFT FALL NOS-CREW .....	.....
*E8353	WTRCRAFT FALL NOS-PASNGR .....	.....
*E8354	W/CRAFT FALL NOS-SKIER .....	.....
*E8355	W/CRAFT FALL NOS-SWIM .....	.....
*E8356	WTRCRAFT FALL NOS-DOCKER .....	.....
*E8358	W/CRFT FALL NOS-PERS NEC .....	.....
*E8359	W/CRFT FALL NOS-PERS NOS	
*E8360	MACHINE ACC-UNPOW BOAT	
*E8361	MACH ACC-OCC POWER BOAT	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E8362	MACHINERY ACCIDENT-CREW .....	.....
*E8363	MACHINERY ACC-PASNGR .....	.....
*E8364	MACHINE ACCIDENT-SKIER .....	.....
*E8365	MACHINE ACCIDENT-SWIM .....	.....
*E8366	MACHINERY ACC-DOCKER .....	.....
*E8368	MACHINERY ACC-PERS NEC .....	.....
*E8369	MACHINERY ACC-PERS NOS .....	.....
*E8370	EXPLOSION-OCC UNPOW BOAT .....	.....
*E8371	EXPLOSION-OCC POWER BOAT .....	.....
*E8372	WATERCRAFT EXPLOS-CREW .....	.....
*E8373	WATERCRAFT EXPLOS-PASNGR .....	.....
*E8374	WATERCRAFT EXPLOS-SKIER .....	.....
*E8375	WATERCRAFT EXPLOS-SWIM .....	.....
*E8376	WATERCRAFT EXPLOS-DOCKER .....	.....
*E8378	WATERCRAFT EXPL-PERS NEC .....	.....
*E8379	WATERCRAFT EXPL-PERS NOS .....	.....
*E8380	WATERCRAFT ACC NEC-UNPOW .....	.....
*E8381	WATERCRAFT ACC NEC-POWER .....	.....
*E8382	WATERCRAFT ACC NEC-CREW .....	.....
*E8383	WATERCRFT ACC NEC-PASNGR .....	.....
*E8384	WATERCRAFT ACC NEC-SKIER .....	.....
*E8385	WATRCRFT ACC NEC-SWIMMER .....	.....
*E8386	WATERCRFT ACC NEC-DOCKER .....	.....
*E8388	WTRCRFT ACC NEC-PERS NEC .....	.....
*E8389	WTRCRFT ACC NEC-PERS NOS .....	.....
*E8400	TK OFF/LAND-SPCRFT .....	.....
*E8401	TK OFF/LAND-MILIT CRAFT .....	.....
*E8402	TK OFF/LAND-CREW AIRCRFT .....	.....
*E8403	TK OFF/LAND-PSNG AIRCRFT .....	.....
*E8404	TK OFF/LAND-COMM CRF NEC .....	.....
*E8405	TK OFF/LAND-AIRCRAFT NEC .....	.....
*E8406	TK OFF/LAND-UNP AIRCRFT .....	.....
*E8407	TK OFF/LAND-PARACHUTIST .....	.....
*E8408	TK OFF/LAND-GROUND CREW .....	.....
*E8409	TK OFF/LAND-PERS NEC .....	.....
*E8410	POW AIRCRAFT ACC-SPCRFT .....	.....
*E8411	POWER AIRCRAFT ACC-MILIT .....	.....
*E8412	POWER AIRCRAFT ACC-CREW .....	.....
*E8413	POWER AIRCRAFT ACC-PSNGR .....	.....
*E8414	AIRCRAF ACC-OCC COMM NEC .....	.....
*E8415	OTH POWERED AIRCRAFT ACC .....	.....
*E8416	POW AIRC ACC-UNP AIRCR .....	.....
*E8417	AIRCRAFT ACC-PARACHUTIST .....	.....
*E8418	AIRCRAFT ACC-GROUND CREW .....	.....
*E8419	AIRCRAFT ACC NOS-PERS NEC .....	.....
*E8426	UNPOWER AIRCRAFT ACC-OCC .....	.....
*E8427	UNPOW AIRCRF ACC-CHUTIST .....	.....
*E8428	UNPOW AIRCRF ACC-GR CREW .....	.....
*E8429	UNPOW AIRCRF ACC-PER NEC .....	.....
*E8430	FALL-OCC SPACECRAFT .....	.....
*E8431	FALL-MILIT AIRCRAFT OCCP .....	.....
*E8432	FALL-CREW COMM AIRCRAFT .....	.....
*E8433	FALL-PSNG COMM AIRCRAFT .....	.....
*E8434	FALL-OCC COMM AIRCRF NEC .....	.....
*E8435	FALL-OCCUP OTH AIRCRAFT .....	.....
*E8436	FALL-OCC UNPOWER AIRCRAF .....	.....
*E8437	FALL-PARACHUTIST .....	.....
*E8438	AIRCRAFT FALL-GROUND CREW .....	.....
*E8439	AIRCRAFT FALL-PERSON NEC .....	.....
*E8440	AIRCRAFT ACC NEC-SPCRFT .....	.....
*E8441	AIRCRAFT ACC NEC-MILITARY .....	.....
*E8442	AIRCRAFT ACC NEC-CREW .....	.....
*E8443	AIRCRAFT ACC NEC-PASNGR .....	.....
*E8444	AIRCRAFT ACC NEC-COMM NEC .....	.....
*E8445	AIRCRAFT ACC NEC-OCCP NEC .....	.....
*E8446	AIRCRAFT ACC NEC-UNP AIRCR .....	.....
*E8447	AIRCRAFT ACC-PARACHUTIST .....	.....
*E8448	AIRCRAFT ACC NEC-GRD CREW .....	.....
*E8449	AIRCRAFT ACC NEC-PERS NEC .....	.....
*E8450	SPACECRAFT ACC-OCCUPANT .....	.....
*E8458	SPACECRAFT ACC-GRND CREW .....	.....
*E8459	SPACECRAFT ACC-PERS NEC .....	.....
*E846	INDUS VEH ACC ON PREMISE .....	.....
*E847	CABL CAR ACC NOT ON RAIL	
*E848	OTH VEHICLE ACC NEC	
*E8490	ACCIDENT IN HOME	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E8491	ACCIDENT ON FARM .....	.....
*E8492	ACCIDENT IN MINE/QUARRY .....	.....
*E8493	ACC ON INDUSTR PREMISES .....	.....
*E8494	ACCID IN RECREATION AREA .....	.....
*E8495	ACCID ON STREET/HIGHWAY .....	.....
*E8496	ACCIDENT IN PUBLIC BLDG .....	.....
*E8497	ACCID IN RESIDENT INSTIT .....	.....
*E8498	ACCIDENT IN PLACE NEC .....	.....
*E8499	ACCIDENT IN PLACE NOS .....	.....
*E8500	ACC POISON-HEROIN .....	.....
*E8501	ACC POISON-METHADONE .....	.....
*E8502	ACC POISON-OPiates NEC .....	.....
*E8503	ACC POISON-SALICYLATES .....	.....
*E8504	ACC POISON-AROM ANALGESC .....	.....
*E8505	ACC POISON-PYRAZOLE DERV .....	.....
*E8506	ACC POISON-ANTIRHEUMATIC .....	.....
*E8507	ACC POISON-NONNARC ANALG .....	.....
*E8508	ACC POISON-ANALGESIC NEC .....	.....
*E8509	ACC POISON-ANALGESIC NOS .....	.....
*E851	ACC POISON-BARBITURATES .....	.....
*E8520	ACC POISN-CHLORL HYDRATE .....	.....
*E8521	ACC POISON-PARALDEHYDE .....	.....
*E8522	ACC POISON-BROMINE CMPND .....	.....
*E8523	ACC POISON-METHAQUALONE .....	.....
*E8524	ACC POISON-GLUTETHIMIDE .....	.....
*E8525	ACC POISON-MIX SEDTV NEC .....	.....
*E8528	ACC POISON-SEDATIVES NEC .....	.....
*E8529	ACC POISON-SEDATIVES NOS .....	.....
*E8530	ACC POIS-PHENTHAZ TRANQ .....	.....
*E8531	ACC POIS-BUTYRPHEN TRANQ .....	.....
*E8532	ACC POISN-BENZDIAZ TRANQ .....	.....
*E8538	ACC POISN-TRANQUILZR NEC .....	.....
*E8539	ACC POISN-TRANQUILZR NOS .....	.....
*E8540	ACC POISON-ANTIDEPRESSNT .....	.....
*E8541	ACC POISON-HALLUCINOGENS .....	.....
*E8542	ACC POISN-PSYCHSTIMULANT .....	.....
*E8543	ACC POISON-CNS STIMULANT .....	.....
*E8548	ACC POISN PSYCHOTROP NEC .....	.....
*E8550	ACC POISN-ANTICONVULSANT .....	.....
*E8551	ACC POISN-CNS DEPRES NEC .....	.....
*E8552	ACC POISN-LOCAL ANESTHET .....	.....
*E8553	ACC POISON-CHOLINERGICS .....	.....
*E8554	ACC POISN-ANTICHOLINERG .....	.....
*E8555	ACC POISON-ADRENERGICS .....	.....
*E8556	ACC POISN-SYMPATHOLYTICS .....	.....
*E8558	ACC POISON-CNS DRUG NEC .....	.....
*E8559	ACC POISON-CNS DRUG NOS .....	.....
*E856	ACC POISON-ANTIBIOTICS .....	.....
*E857	ACC POIS-OTH ANTI-INFECT .....	.....
*E8580	ACC POISON-HORMONES .....	.....
*E8581	ACC POISN-SYSTEMIC AGENT .....	.....
*E8582	ACC POISON-BLOOD AGENT .....	.....
*E8583	ACC POISN-CARDIOVASC AGT .....	.....
*E8584	ACC POISON-GI AGENT .....	.....
*E8585	ACC POISN-METABOL AGNT .....	.....
*E8586	ACC POISN-MUSCL/RESP AGT .....	.....
*E8587	ACC POISN-SKIN/EENT AGNT .....	.....
*E8588	ACC POISONING-DRUG NEC .....	.....
*E8589	ACC POISONING-DRUG NOS .....	.....
*E8600	ACC POISN-ALCOHOL BEVRAG .....	.....
*E8601	ACC POISON-ETHYL ALCOHOL .....	.....
*E8602	ACC POISN-METHYL ALCOHOL .....	.....
*E8603	ACC POISN-ISOPROPYL ALC .....	.....
*E8604	ACC POISON-FUSEL OIL .....	.....
*E8608	ACC POISON-ALCOHOL NEC .....	.....
*E8609	ACC POISON-ALCOHOL NOS .....	.....
*E8610	ACC POIS-SYNTH DETERGENT .....	.....
*E8611	ACC POISON-SOAP PRODUCTS .....	.....
*E8612	ACC POISON-POLISHES .....	.....
*E8613	ACC POISON-CLEANSER NEC .....	.....
*E8614	ACC POISON-DISINFECTANTS .....	.....
*E8615	ACC POISON-LEAD PAINTS .....	.....
*E8616	ACC POISON-PAINTS NEC .....	.....
*E8619	ACC POISON-CLEANSER NOS	
*E8620	ACC POISN-PETROL SOLVENT	
*E8621	ACC POISN-PETROLEUM FUEL	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8622	ACC POIS-LUBRICATING OIL .....	.....
*E8623	ACC POIS-PETROLEUM SOLID .....	.....
*E8624	ACC POISN-SOLVENTS NEC .....	.....
*E8629	ACC POISN-SOLVENT NOS .....	.....
*E8630	ACC POIS-CHLORINE PESTIC .....	.....
*E8631	ACC POIS-PHOSPH PESTICID .....	.....
*E8632	ACC POISON-CARBAMATES .....	.....
*E8633	ACC POISN-MIXED PESTICID .....	.....
*E8634	ACC POISON-PESTICIDE NEC .....	.....
*E8635	ACC POISON-HERBICIDES .....	.....
*E8636	ACC POISON-FUNGICIDES .....	.....
*E8637	ACC POISON-RODENTICIDES .....	.....
*E8638	ACC POISON-FUMIGANTS .....	.....
*E8639	ACC POIS-AGRCULT NEC/NOS .....	.....
*E8640	ACC POIS-CORROSIV AROMAT .....	.....
*E8641	ACC POISON-ACIDS .....	.....
*E8642	ACC POISN-CAUSTIC ALKALI .....	.....
*E8643	ACC POISON-CAUSTIC NEC .....	.....
*E8644	ACC POISON-CAUSTIC NOS .....	.....
*E8650	ACC POISON-MEAT .....	.....
*E8651	ACC POISON-SHELLFISH .....	.....
*E8652	ACC POISON-FISH NEC .....	.....
*E8653	ACC POISON-BERRIES/SEEDS .....	.....
*E8654	ACC POISON-PLANTS NEC .....	.....
*E8655	ACC POISON-MUSHROOMS .....	.....
*E8658	ACC POISON-FOOD NEC .....	.....
*E8659	ACC POISN-FOOD/PLANT NOS .....	.....
*E8660	ACC POISONING-LEAD .....	.....
*E8661	ACC POISONING-MERCURY .....	.....
*E8662	ACC POISONING-ANTIMONY .....	.....
*E8663	ACC POISONING-ARSENIC .....	.....
*E8664	ACC POISON-METALS NEC .....	.....
*E8665	ACC POISON-PLANT FOOD .....	.....
*E8666	ACC POISON-GLUES .....	.....
*E8667	ACC POISON-COSMETICS .....	.....
*E8668	ACC POIS-SOLID/LIQ NEC .....	.....
*E8669	ACC POIS-SOLID/LIQ NOS .....	.....
*E867	ACC POISON-PIPED GAS .....	.....
*E8680	ACC POIS-LIQ PETROL GAS .....	.....
*E8681	ACC POIS-UTL GAS NEC/NOS .....	.....
*E8682	ACC POISON-EXHAUST GAS .....	.....
*E8683	ACC POIS-CO/DOMESTIC FUEL .....	.....
*E8688	ACC POIS-CARBN MONOX NEC .....	.....
*E8689	ACC POIS-CARBN MONOX NOS .....	.....
*E8690	ACC POISN-NITROGEN OXIDE .....	.....
*E8691	ACC POISN-SULFUR DIOXIDE .....	.....
*E8692	ACC POISON-FREON .....	.....
*E8693	ACC POISON-TEAR GAS .....	.....
*E8694	SCNDHND TBCCO SMOKE .....	.....
*E8698	ACC POISON-GAS/VAPOR NEC .....	.....
*E8699	ACC POISON-GAS/VAPOR NOS .....	.....
*E8700	ACC CUT/HEM IN SURGERY .....	.....
*E8701	ACC CUT/HEM IN INFUSION .....	.....
*E8702	ACC CUT/HEM-PERFUSN NEC .....	.....
*E8703	ACC CUT/HEM IN INJECTION .....	.....
*E8704	ACC CUT/HEM W SCOPE EXAM .....	.....
*E8705	ACC CUT/HEM W CATHETERIZ .....	.....
*E8706	ACC CUT/HEM W HEART CATH .....	.....
*E8707	ACC CUT/HEM W ENEMA .....	.....
*E8708	ACC CUT IN MED CARE NEC .....	.....
*E8709	ACC CUT IN MED CARE NOS .....	.....
*E8710	POST-SURGICAL FORGN BODY .....	.....
*E8711	POSTINFUSION FOREIGN BDY .....	.....
*E8712	POSTPERFUSION FORGN BODY .....	.....
*E8713	POSTINJECTION FORGN BODY .....	.....
*E8714	POSTENDOSCOPY FORGN BODY .....	.....
*E8715	POSTCATHETER FORGN BODY .....	.....
*E8716	FB POST HEART CATHETER .....	.....
*E8717	FB POST-CATHETER REMOVAL .....	.....
*E8718	POST-OP FOREIGN BODY NEC .....	.....
*E8719	POST-OP FOREIGN BODY NOS .....	.....
*E8720	FAILURE STERILE SURGERY .....	.....
*E8721	FAILURE STERILE INFUSION .....	.....
*E8722	FAIL STERILE PERFUSN NEC	
*E8723	FAIL STERILE INJECTION	
*E8724	FAIL STERILE ENDOSCOPY	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E8725	FAIL STERILE CATHETER .....	.....
*E8726	FAIL STERILE HEART CATH .....	.....
*E8728	FAIL STERILE PROCED NEC .....	.....
*E8729	FAIL STERILE PROCED NOS .....	.....
*E8730	EXCESS FLUID IN INFUSION .....	.....
*E8731	INCOR DILUT INFUSN FLUID .....	.....
*E8732	THERAP RADIATION OVERDOS .....	.....
*E8733	INADV RADIAT EXP-MEDICAL .....	.....
*E8734	DOSAG FAIL-SHOCK THERAPY .....	.....
*E8735	WRNG TEMP IN APPLIC/PACK .....	.....
*E8736	NONADMIN NECESS MEDICINE .....	.....
*E8738	FAILURE IN DOSAGE NEC .....	.....
*E8739	FAILURE IN DOSAGE NOS .....	.....
*E8740	INSTRMNT FAIL IN SURGERY .....	.....
*E8741	INSTRUMNT FAIL-INFUSION .....	.....
*E8742	INSTRMNT FAIL-PERFUS NEC .....	.....
*E8743	INSTRUMNT FAIL-ENDOSCOPY .....	.....
*E8744	INSTRMNT FAIL-CATHETERIZ .....	.....
*E8745	INSTRMNT FAIL-HEART CATH .....	.....
*E8748	INSTRMNT FAIL-PROCED NEC .....	.....
*E8749	INSTRMNT FAIL-PROCED NOS .....	.....
*E8750	CONTAMINATED TRANSFUSION .....	.....
*E8751	CONTAMINATED INJECTION .....	.....
*E8752	CONTAMINATED DRUG NEC .....	.....
*E8758	CONTAMINATION NEC .....	.....
*E8759	CONTAMINATION NOS .....	.....
*E8760	MISMATCH BLOOD-TRANSFUSN .....	.....
*E8761	WRONG FLUID IN INFUSION .....	.....
*E8762	FAILURE IN SUTURE .....	.....
*E8763	MISPLACED ENDOTRACH TUBE .....	.....
*E8764	FAIL INTROD/REMOVE TUBE .....	.....
*E8765	PERFORMANCE-INAPPROP OP .....	.....
*E8768	MEDICAL MISADVENTURE NEC .....	.....
*E8769	MEDICAL MISADVENTURE NOS .....	.....
*E8780	ABN REACT-ORG TRANSPLANT .....	.....
*E8781	ABN REACT-ARTIF IMPLANT .....	.....
*E8782	ABN REACT-ANASTOM/GRAFT .....	.....
*E8783	ABN REACT-EXTERNAL STOMA .....	.....
*E8784	ABN REACT-PLAST SURG NEC .....	.....
*E8785	ABN REACT-LIMB AMPUTAT .....	.....
*E8786	ABN REAC-ORGAN REM NEC .....	.....
*E8788	ABN REACT-SURG PROC NEC .....	.....
*E8789	ABN REACT-SURG PROC NOS .....	.....
*E8790	ABN REACT-CARDIAC CATH .....	.....
*E8791	ABN REACT-RENAL DIALYSIS .....	.....
*E8792	ABN REACT-RADIOTHERAPY .....	.....
*E8793	ABN REACT-SHOCK THERAPY .....	.....
*E8794	ABN REACT-FLUID ASPIRAT .....	.....
*E8795	ABN REACT-GASTRIC SOUND .....	.....
*E8796	ABN REACT-URINARY CATH .....	.....
*E8797	ABN REACT-BLOOD SAMPLING .....	.....
*E8798	ABN REACT-PROCEDURE NEC .....	.....
*E8799	ABN REACT-PROCEDURE NOS .....	.....
*E8800	FALL ON ESCALATOR .....	.....
*E8801	FALL ON SIDEWALK CURB .....	.....
*E8809	FALL ON STAIR/STEP NEC .....	.....
*E8810	FALL FROM LADDER .....	.....
*E8811	FALL FROM SCAFFOLDING .....	.....
*E882	FALL FROM BUILDING .....	.....
*E8830	DIVING ACCIDENT .....	.....
*E8831	FALL INTO WELL .....	.....
*E8832	FALL INTO STORM DRAIN .....	.....
*E8839	FALL INTO OTHER HOLE .....	.....
*E8840	FALL FROM PLAYGRND EQUIP .....	.....
*E8841	FALL FROM CLIFF .....	.....
*E8842	FALL FROM CHAIR .....	.....
*E8843	FALL FROM WHEELCHAIR .....	.....
*E8844	FALL FROM BED .....	.....
*E8845	FALL FROM FURNITURE NEC .....	.....
*E8846	FALL FROM COMMODE .....	.....
*E8849	FALL-1 LEVEL TO OTH NEC .....	.....
*E885	FALL ON LEVEL-TRIPPING .....	.....
*E8860	FALL IN SPORTS	
*E8869	FALL ON LEVEL NEC/NOS	
*E887	FRACTURE, CAUSE NOS	
*E888	FALL NEC & NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8900	PRIVAT DWELL FIRE-EXPLOS .....	.....
*E8901	PRIV DWEL FIRE-PVC FUMES .....	.....
*E8902	PRIV DWEL FIRE-FUMES NOS .....	.....
*E8903	PRIV DWEL FIRE-BURNING .....	.....
*E8908	PRIV DWEL FIRE-ACCID NEC .....	.....
*E8909	PRIV DWEL FIRE-ACCID NOS .....	.....
*E8910	FIRE IN BLDG-EXPLOSION .....	.....
*E8911	FIRE IN BLDG-PVC FUMES .....	.....
*E8912	FIRE IN BLDG-FUMES NOS .....	.....
*E8913	FIRE IN BLDG-BURNING .....	.....
*E8918	FIRE IN BLDG-ACCID NEC .....	.....
*E8919	FIRE IN BLDG-ACCID NOS .....	.....
*E892	FIRE NOT IN BUILDING .....	.....
*E8930	CLOTHING FIRE-PRIV DWELL .....	.....
*E8931	CLOTHING FIRE-BLDG NEC .....	.....
*E8932	CLOTHING FIRE NOT IN BLD .....	.....
*E8938	CLOTHING FIRE NEC .....	.....
*E8939	CLOTHING FIRE NOS .....	.....
*E894	FIRE-HIGHLY INFLAM MATER .....	.....
*E895	BURN ACC IN PRIVAT DWELL .....	.....
*E896	BURN ACC IN BLDG NEC .....	.....
*E897	BURN ACC NOT IN BLDG .....	.....
*E8980	BURNING BEDCLOTHES .....	.....
*E8981	FIRE ACCIDENT NEC .....	.....
*E899	FIRE ACCIDENT NOS .....	.....
*E9000	EXCESSIVE HEAT: WEATHER .....	.....
*E9001	EXCESSIVE HEAT, MAN-MADE .....	.....
*E9009	EXCESSIVE HEAT NOS .....	.....
*E9010	EXCESSIVE COLD: WEATHER .....	.....
*E9011	EXCESSIVE COLD, MAN-MADE .....	.....
*E9018	EXCESSIVE COLD NEC .....	.....
*E9019	EXCESSIVE COLD NOS .....	.....
*E9020	HIGH ALTITUDE RESIDENCE .....	.....
*E9021	AIR PRESS CHNGE: AIRCRFT .....	.....
*E9022	AIR PRESS CHANGE: DIVING .....	.....
*E9028	AIR PRESSURE CHANGE NEC .....	.....
*E9029	AIR PRESSURE CHANGE NOS .....	.....
*E903	TRAVEL AND MOTION .....	.....
*E9040	ABANDONMENT/LACK OF CARE .....	.....
*E9041	LACK OF FOOD .....	.....
*E9042	LACK OF WATER .....	.....
*E9043	EXPOSURE NEC .....	.....
*E9049	PRIVATION NOS .....	.....
*E9050	VENOMOUS SNAKE BITE .....	.....
*E9051	VENOMOUS SPIDER BITE .....	.....
*E9052	SCORPION STING .....	.....
*E9053	HORNET/WASP/BEE STING .....	.....
*E9054	CENTIPEDE BITE .....	.....
*E9055	VENOMOUS ARTHROPODS NEC .....	.....
*E9056	VENOM SEA ANIMALS/PLANTS .....	.....
*E9057	POISONING BY OTHER PLANT .....	.....
*E9058	VENOMOUS BITE/STING NEC .....	.....
*E9059	VENOMOUS BITE/STING NOS .....	.....
*E9060	DOG BITE .....	.....
*E9061	RAT BITE .....	.....
*E9062	NONVENOMOUS SNAKE BITE .....	.....
*E9063	ANIMAL BITE NEC .....	.....
*E9064	NONVENOM ARTHROPOD BITE .....	.....
*E9065	ANIMAL BITE NOS .....	.....
*E9068	INJ NEC CAUSED BY ANIMAL .....	.....
*E9069	INJ NOS CAUSED BY ANIMAL .....	.....
*E907	ACC DUE TO LIGHTNING .....	.....
E908	CATAclysmic STORM/FLOOD* .....	.....
*E9080	ACCIDENT D/T HURRICANE .....	.....
*E9081	ACCIDENT D/T TORNADO .....	.....
*E9082	ACCIDENT D/T FLOODS .....	.....
*E9083	ACC D/T SNOW BLIZZARD .....	.....
*E9084	ACCIDENT D/T DUST STORM .....	.....
*E9088	ACCIDENT D/T STORM NEC .....	.....
*E9089	ACC D/T STORM/FLOOD NOS .....	.....
E909	ACC D/T AVALANCH/EARTHQU* .....	.....
*E9090	ACC D/T EARTHQUAKES .....	.....
*E9091	ACC D/T VOLCANIC ERUPT .....	.....
*E9092	ACC D/T AVALANCHE	
*E9093	ACC D/T DAM COLLAPSE	
*E9094	ACC D/T TIDALWAVE NOS	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E9098	ACC D/T ERUPTIONS NEC .....	.....
*E9099	ACC D/T ERUPTIONS NOS .....	.....
*E9100	WATER-SKIING ACCIDENT .....	.....
*E9101	SKIN/SCUBA DIVING ACC .....	.....
*E9102	SWIMMING ACCIDENT NOS .....	.....
*E9103	SWIMMING/DIVING ACC NEC .....	.....
*E9104	DROWNING IN BATHTUB .....	.....
*E9108	ACCIDENTAL DROWNING NEC .....	.....
*E9109	ACCIDENTAL DROWNING NOS .....	.....
*E911	RESP OBSTR-FOOD INHAL .....	.....
*E912	RESP OBSTR-INHAL OBJ NEC .....	.....
*E9130	SUFFOCAT IN BED/CRADLE .....	.....
*E9131	SUFFOCATION-PLASTIC BAG .....	.....
*E9132	SUFFOCATION-LACK OF AIR .....	.....
*E9133	CAVE-IN NOS .....	.....
*E9138	SUFFOCATION NEC .....	.....
*E9139	SUFFOCATION NOS .....	.....
*E914	FB ENTERING EYE .....	.....
*E915	FB ENTERING OTH ORIFICE .....	.....
*E916	STRUCK BY FALLING OBJECT .....	.....
*E9170	STRUCK IN SPORTS .....	.....
*E9171	CROWD ACCIDENT .....	.....
*E9172	STRUCK IN RUNNING WATER .....	.....
*E9179	STRUCK BY OBJ/PERSON NEC .....	.....
*E918	CAUGHT BETWEEN OBJECTS .....	.....
*E9190	MACHINE ACCID-AGRICULT .....	.....
*E9191	MACHINE ACCID-MINING .....	.....
*E9192	LIFTING MACHINE ACCIDENT .....	.....
*E9193	METALWORKING MACHINE ACC .....	.....
*E9194	WOODWORKING MACHINE ACC .....	.....
*E9195	PRIME MOVER MACHINE ACC .....	.....
*E9196	TRANSMISSION MACHINE ACC .....	.....
*E9197	EARTH MOVING MACHINE ACC .....	.....
*E9198	MACHINERY ACCIDENT NEC .....	.....
*E9199	MACHINERY ACCIDENT NOS .....	.....
*E9200	ACC-POWERED LAWN MOWER .....	.....
*E9201	ACC-POWER HAND TOOL NEC .....	.....
*E9202	ACC-POWER HOUSE APPLIANC .....	.....
*E9203	KNIFE/SWORD/DAGGER ACC .....	.....
*E9204	ACCID-OTHER HAND TOOLS .....	.....
*E9205	ACC-HYPODERMIC NEEDLE .....	.....
*E9208	ACC-CUTTING INSTRUM NEC .....	.....
*E9209	ACC-CUTTING INSTRUM NOS .....	.....
*E9210	BOILER EXPLOSION .....	.....
*E9211	GAS CYLINDER EXPLOSION .....	.....
*E9218	PRESS VESSEL EXPLOS NEC .....	.....
*E9219	PRESS VESSEL EXPLOS NOS .....	.....
*E9220	HANDGUN ACCIDENT .....	.....
*E9221	SHOTGUN ACCIDENT .....	.....
*E9222	HUNTING RIFLE ACCIDENT .....	.....
*E9223	MILITARY FIREARM ACCID .....	.....
*E9228	FIREARM ACCIDENT NEC .....	.....
*E9229	FIREARM ACCIDENT NOS .....	.....
*E9230	FIREWORKS ACCIDENT .....	.....
*E9231	BLASTING MATERIALS ACCID .....	.....
*E9232	EXPLOSIVE GASES ACCIDENT .....	.....
*E9238	EXPLOSIVES ACCIDENT NEC .....	.....
*E9239	EXPLOSIVES ACCIDENT NOS .....	.....
*E9240	ACC-HOT LIQUID & STEAM .....	.....
*E9241	ACCID-CAUSTIC SUBSTANCE .....	.....
*E9242	ACC-HOT TAP WATER .....	.....
*E9248	HOT SUBSTANCE ACCID NEC .....	.....
*E9249	HOT SUBSTANCE ACCID NOS .....	.....
*E9250	DOMESTIC WIRING ACCIDENT .....	.....
*E9251	ELECTR POWER GENERAT ACC .....	.....
*E9252	INDUST WIRING/MACHIN ACC .....	.....
*E9258	ELECTRIC CURRENT ACC NEC .....	.....
*E9259	ELECTRIC CURRENT ACC NOS .....	.....
*E9260	RADIOFREQ RADIAT EXPOSUR .....	.....
*E9261	INFRA-RED APPL RAD EXOS .....	.....
*E9262	VIS/ULTRAVIOL LGHT EXPOS .....	.....
*E9263	X-RAY/GAMMA RAY EXPOSURE .....	.....
*E9264	LASER EXPOSURE .....	.....
*E9265	RADIOACT ISOTOPE EXPOSUR	
*E9268	RADIATION EXPOSURE NEC	
*E9269	RADIATION EXPOSURE NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E927	ACCID FROM OVEREXERTION .....	.....
*E9280	ACC D/T WEIGHTLESS ENVIR .....	.....
*E9281	EXPOSURE TO NOISE .....	.....
*E9282	EXPOSURE TO VIBRATION .....	.....
*E9288	ACCIDENT NEC .....	.....
*E9289	ACCIDENT NOS .....	.....
*E9290	LATE EFF MOTOR VEHIC ACC .....	.....
*E9291	LATE EFF TRANSPORT ACC .....	.....
*E9292	LATE EFF ACC POISONING .....	.....
*E9293	LATE EFF ACCIDENTAL FALL .....	.....
*E9294	LATE EFF FIRE ACC .....	.....
*E9295	LATE EFF ENVIRONMENT ACC .....	.....
*E9298	LATE EFF ACCIDENT NEC .....	.....
*E9299	LATE EFF ACCIDENT NOS .....	.....
*E9300	ADV EFF PENICILLINS .....	.....
*E9301	ADV EFF ANTIFUNG ANTBOT .....	.....
*E9302	ADV EFF CHLORAMPHENICOL .....	.....
*E9303	ADV EFF ERYTHROMYCIN .....	.....
*E9304	ADV EFF TETRACYCLINE .....	.....
*E9305	ADV EFF CEPHALOSPORIN .....	.....
*E9306	ADV EFF ANTMYCOB ANTBOT .....	.....
*E9307	ADV EFF ANTINEOP ANTBOT .....	.....
*E9308	ADV EFF ANTIBIOTICS NEC .....	.....
*E9309	ADV EFF ANTIBIOTIC NOS .....	.....
*E9310	ADV EFF SULFONAMIDES .....	.....
*E9311	ADV EFF ARSENIC ANTI-INF .....	.....
*E9312	ADV EFF METAL ANTI-INF .....	.....
*E9313	ADV EFF QUINOLINE .....	.....
*E9314	ADV EFF ANTIMALARIALS .....	.....
*E9315	ADV EFF ANTPROTAZOAL NEC .....	.....
*E9316	ADV EFF ANTHELMINTICS .....	.....
*E9317	ADV EFF ANTIVIRAL DRUGS .....	.....
*E9318	ADV EFF ANTIMYCOBAC NEC .....	.....
*E9319	ADV EFF ANTINFCT NEC/NOS .....	.....
*E9320	ADV EFF CORTICOSTEROIDS .....	.....
*E9321	ADV EFF ANDROGENS .....	.....
*E9322	ADV EFF OVARIAN HORMONES .....	.....
*E9323	ADV EFF INSULIN/ANTIDIAB .....	.....
*E9324	ADV EFF ANT PITUITARY .....	.....
*E9325	ADV EFF POST PITUITARY .....	.....
*E9326	ADV EFF PARATHYROID .....	.....
*E9327	ADV EFF THYROID & DERIV .....	.....
*E9328	ADV EFF ANTITHYROID AGNT .....	.....
*E9329	ADV EFF HORMONES NEC/NOS .....	.....
*E9330	ADV EFF ANALLRG/ANTEMET .....	.....
*E9331	ADV EFF ANTINEOPLASTIC .....	.....
*E9332	ADV EFF ACIDIFYING AGENT .....	.....
*E9333	ADV EFF ALKALIZING AGENT .....	.....
*E9334	ADV EFF ENZYMES NEC .....	.....
*E9335	ADV EFF VITAMINS NEC .....	.....
*E9338	ADV EFF SYSTEMIC AGT NEC .....	.....
*E9339	ADV EFF SYSTEMIC AGT NOS .....	.....
*E9340	ADV EFF IRON & COMPOUNDS .....	.....
*E9341	ADV EFF LIVER/ANTIANEMIC .....	.....
*E9342	ADV EFF ANTICOAGULANTS .....	.....
*E9343	ADV EFF VITAMIN K .....	.....
*E9344	ADV EFF FIBRINOLYSIS AGT .....	.....
*E9345	ADV EFF COAGULANTS .....	.....
*E9346	ADV EFF GAMMA GLOBULIN .....	.....
*E9347	ADV EFF BLOOD PRODUCTS .....	.....
*E9348	ADV EFF BLOOD AGENT NEC .....	.....
*E9349	ADV EFF BLOOD AGENT NOS .....	.....
*E9350	ADV EFF HEROIN .....	.....
*E9351	ADV EFF METHADONE .....	.....
*E9352	ADV EFF OPIATES .....	.....
*E9353	ADV EFF SALICYLATES .....	.....
*E9354	ADV EFF AROM ANALGSC NEC .....	.....
*E9355	ADV EFF PYRAZOLE DERIV .....	.....
*E9356	ADV EFF ANTIRHEUMATICS .....	.....
*E9357	ADV EFF NON-NARC ANALGSC .....	.....
*E9358	ADV EFF ANALGESICS NEC .....	.....
*E9359	ADV EFF ANALGESIC NOS .....	.....
*E9360	ADV EFF OXAZOLIDIN DERIV .....	.....
*E9361	ADV EFF HYDANTOIN DERIV	
*E9362	ADV EFF SUCCINIMIDES	
*E9363	ADV EFF ANTCONVL NEC/NOS	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E9364	ADV EFF ANTI-PARKINSON .....	.....
*E9370	ADV EFF BARBITURATES .....	.....
*E9371	ADV EFF CHLORAL HYDRATE .....	.....
*E9372	ADV EFF PARALDEHYDE .....	.....
*E9373	ADV EFF BROMINE COMPNDS .....	.....
*E9374	ADV EFF METHAQUALONE .....	.....
*E9375	ADV EFF GLUTETHIMIDE .....	.....
*E9376	ADV EFF MIX SEDATIVE .....	.....
*E9378	ADV EFF SEDAT/HYPNOT NEC .....	.....
*E9379	ADV EFF SEDAT/HYPNOT NOS .....	.....
*E9380	ADV EFF CNS MUSCL DEPRES .....	.....
*E9381	ADV EFF HALOTHANE .....	.....
*E9382	ADV EFF GAS ANESTHET NEC .....	.....
*E9383	ADV EFF INTRAVEN ANESTH .....	.....
*E9384	ADV EFF GEN ANES NEC/NOS .....	.....
*E9385	ADV EFF TOPIC/INFIL ANES .....	.....
*E9386	ADV EFF NERVE-BLOCK ANES .....	.....
*E9387	ADV EFF SPINAL ANESTHET .....	.....
*E9389	ADV EFF LOC ANES NEC/NOS .....	.....
*E9390	ADV EFF ANTIDEPRESSANTS .....	.....
*E9391	ADV EFF PHENOTHIAZ TRANQ .....	.....
*E9392	ADV EFF BUTYROPHEN TRANQ .....	.....
*E9393	ADV EFF ANTIPSYCHOTC NEC .....	.....
*E9394	ADV EFF BENZODIAZ TRANQ .....	.....
*E9395	ADV EFF TRANQUILIZER NEC .....	.....
*E9396	ADV EFF HALLUCINOGENS .....	.....
*E9397	ADV EFF PSYCHOSTIMULANTS .....	.....
*E9398	ADV EFF PSYCHOTROPIC NEC .....	.....
*E9399	ADV EFF PSYCHOTROPIC NOS .....	.....
*E9400	ADV EFF ANALEPTICS .....	.....
*E9401	ADV EFF OPIAT ANTAGONIST .....	.....
*E9408	ADV EFF CNS STIMULNT NEC .....	.....
*E9409	ADV EFF CNS STIMULNT NOS .....	.....
*E9410	ADV EFF CHOLINERGICS .....	.....
*E9411	ADV EFF PARASYMPATHOLYTC .....	.....
*E9412	ADV EFF SYMPATHOMIMETICS .....	.....
*E9413	ADV EFF SYMPATHOLYTICS .....	.....
*E9419	ADV EFF AUTONOM AGNT NOS .....	.....
*E9420	ADV EFF CARD RHYTH REGUL .....	.....
*E9421	ADV EFF CARDIOTONICS .....	.....
*E9422	ADV EFF ANTILIPEMICS .....	.....
*E9423	ADV EFF GANGLION-BLOCK .....	.....
*E9424	ADV EFF CORONARY VASODIL .....	.....
*E9425	ADV EFF VASODILATORS NEC .....	.....
*E9426	ADV EFF ANTIHYPERTEN AGT .....	.....
*E9427	ADV EFF ANTIVARICOSE .....	.....
*E9428	ADV EFF CAPILLARY-ACT .....	.....
*E9429	ADV EFF CARDIOVASC NEC .....	.....
*E9430	ADV EFF ANTACIDS .....	.....
*E9431	ADV EFF IRRIT CATHARTIC .....	.....
*E9432	ADV EFF EMOLL CATHARTICS .....	.....
*E9433	ADV EFF CATHARTICS NEC .....	.....
*E9434	ADV EFF DIGESTANTS .....	.....
*E9435	ADV EFF ANTIDIARRHEA AGT .....	.....
*E9436	ADV EFF EMETICS .....	.....
*E9438	ADV EFF GI AGENT NEC .....	.....
*E9439	ADV EFF GI AGENT NOS .....	.....
*E9440	ADV EFF MERCURY DIURETIC .....	.....
*E9441	ADV EFF PURINE DIURETICS .....	.....
*E9442	ADV EFF ACETAZOLAMIDE .....	.....
*E9443	ADV EFF SALURETICS .....	.....
*E9444	ADV EFF DIURETICS NEC .....	.....
*E9445	ADV EFF ELECTROLYTE AGNT .....	.....
*E9446	ADV EFF MINERAL SALT NEC .....	.....
*E9447	ADV EFF URIC ACID METAB .....	.....
*E9450	ADV EFF OXYTOCIC AGENTS .....	.....
*E9451	ADV EFF SMOOTH MUSC RELX .....	.....
*E9452	ADV EFF SKELET MUSC RELX .....	.....
*E9453	ADV EFF MUSC AGT NEC/NOS .....	.....
*E9454	ADV EFF ANTITUSSIVES .....	.....
*E9455	ADV EFF EXPECTORANTS .....	.....
*E9456	ADV EFF ANTI-COMMON COLD .....	.....
*E9457	ADV EFF ANTI-ASTHMATICS .....	.....
*E9458	ADV EFF RESP DRG NEC/NOS	
*E9460	ADV EFF LOC ANTI-INFECTV	
*E9461	ADV EFF ANTIPRURITICS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E9462	ADV EFF LOCAL ASTRINGENT .....	.....
*E9463	ADV EFF EMOLLIENT/DEMULC .....	.....
*E9464	ADV EFF HAIR/SCALP PREP .....	.....
*E9465	ADV EFF EYE ANTI-INF/DRG .....	.....
*E9466	ADV EFF ENT ANTI-INF/DRG .....	.....
*E9467	ADV EFF TOPIC DENTAL DRG .....	.....
*E9468	ADV EFF SKIN AGENT NEC .....	.....
*E9469	ADV EFF SKIN AGENT NOS .....	.....
*E9470	ADV EFF DIETETICS .....	.....
*E9471	ADV EFF LIPOTROPIC DRUGS .....	.....
*E9472	ADV EFF ANTIDOTES NEC .....	.....
*E9473	ADV EFF ALCOHOL DETER .....	.....
*E9474	ADV EFF PHARMACEUT EXCIP .....	.....
*E9478	ADV EFF MEDICINAL NEC .....	.....
*E9479	ADV EFF MEDICINAL NOS .....	.....
*E9480	ADV EFF BCG VACCINE .....	.....
*E9481	ADV EFF TYPHOID VACCINE .....	.....
*E9482	ADV EFF CHOLERA VACCINE .....	.....
*E9483	ADV EFF PLAGUE VACCINE .....	.....
*E9484	ADV EFF TETANUS VACCINE .....	.....
*E9485	ADV EFF DIPHTHER VACCINE .....	.....
*E9486	ADV EFF PERTUSSIS VACCIN .....	.....
*E9488	ADV EFF BACT VAC NEC/NOS .....	.....
*E9489	ADV EFF MIX BACT VACCINE .....	.....
*E9490	ADV EFF SMALLPOX VACCINE .....	.....
*E9491	ADV EFF RABIES VACCINE .....	.....
*E9492	ADV EFF TYPHUS VACCINE .....	.....
*E9493	ADV EFF YELLOW FEVER VAC .....	.....
*E9494	ADV EFF MEASLES VACCINE .....	.....
*E9495	ADV EFF POLIO VACCINE .....	.....
*E9496	ADV EFF VIRAL VACC NEC .....	.....
*E9497	ADV EFF MIXED VIRAL-BACT .....	.....
*E9499	ADV EFF BIOLOGIC NEC/NOS .....	.....
*E9500	POISON-ANALGESICS .....	.....
*E9501	POISON-BARBITURATES .....	.....
*E9502	POISON-SEDAT/HYPNOTIC .....	.....
*E9503	POISON-PSYCHOTROPIC AGT .....	.....
*E9504	POISON-DRUG/MEDICIN NEC .....	.....
*E9505	POISON-DRUG/MEDICIN NOS .....	.....
*E9506	POISON-AGRICULT AGENT .....	.....
*E9507	POISON-CORROSIV/CAUSTIC .....	.....
*E9508	POISON-ARSENIC .....	.....
*E9509	POISON-SOLID/LIQUID NEC .....	.....
*E9510	POISON-PIPED GAS .....	.....
*E9511	POISON-GAS IN CONTAINER .....	.....
*E9518	POISON-UTILITY GAS NEC .....	.....
*E9520	POISON-EXHAUST GAS .....	.....
*E9521	POISON-CO NEC .....	.....
*E9528	POISON-GAS/VAPOR NEC .....	.....
*E9529	POISON-GAS/VAPOR NOS .....	.....
*E9530	INJURY-HANGING .....	.....
*E9531	INJURY-SUFF W PLAS BAG .....	.....
*E9538	INJURY-STRANG/SUFF NEC .....	.....
*E9539	INJURY-STRANG/SUFF NOS .....	.....
*E954	INJURY-SUBMERSION .....	.....
*E9550	INJURY-HANDGUN .....	.....
*E9551	INJURY-SHOTGUN .....	.....
*E9552	INJURY-HUNTING RIFLE .....	.....
*E9553	INJURY-MILITARY FIREARM .....	.....
*E9554	INJURY-FIREARM NEC .....	.....
*E9555	INJURY-EXPLOSIVES .....	.....
*E9559	INJURY-FIREARM/EXPL NOS .....	.....
*E956	INJURY-CUT INSTRUMENT .....	.....
*E9570	INJURY-JUMP FM RESIDENCE .....	.....
*E9571	INJURY-JUMP FM STRUC NEC .....	.....
*E9572	INJURY-JUMP FM NATUR SIT .....	.....
*E9579	INJURY-JUMP NEC .....	.....
*E9580	INJURY-MOVING OBJECT .....	.....
*E9581	INJURY-BURN, FIRE .....	.....
*E9582	INJURY-SCALD .....	.....
*E9583	INJURY-EXTREME COLD .....	.....
*E9584	INJURY-ELECTROCUTION .....	.....
*E9585	INJURY-MOTOR VEH CRASH .....	.....
*E9586	INJURY-AIRCRAFT CRASH	
*E9587	INJURY-CAUSTIC SUBSTANCE	
*E9588	INJURY-NEC	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E9589	INJURY-NOS .....	.....
*E959	LATE EFF OF SELF-INJURY .....	.....
*E9600	UNARMED FIGHT OR BRAWL .....	.....
*E9601	RAPE .....	.....
*E961	ASSAULT-CORROSIV/CAUST .....	.....
*E9620	ASSAULT-POIS W MEDIC AGT .....	.....
*E9621	ASSAULT-POIS W SOLID/LIQ .....	.....
*E9622	ASSAULT-POIS W GAS/VAPOR .....	.....
*E9629	ASSAULT-POISONING NOS .....	.....
*E963	ASSAULT-HANGING/STRANGUL .....	.....
*E964	ASSAULT-SUBMERSION .....	.....
*E9650	ASSAULT-HANDGUN .....	.....
*E9651	ASSAULT-SHOTGUN .....	.....
*E9652	ASSAULT-HUNTING RIFLE .....	.....
*E9653	ASSAULT-MILITARY WEAPON .....	.....
*E9654	ASSAULT-FIREARM NEC .....	.....
*E9655	ASSAULT-ANTIPERSON BOMB .....	.....
*E9656	ASSAULT-GASOLINE BOMB .....	.....
*E9657	ASSAULT-LETTER BOMB .....	.....
*E9658	ASSAULT-EXPLOSIVE NEC .....	.....
*E9659	ASSAULT-EXPLOSIVE NOS .....	.....
*E966	ASSAULT-CUTTING INSTR .....	.....
*E9670	BATTER BY FATHER/STEPFTH .....	.....
*E9671	CHILD ABUSE BY PERS NEC .....	.....
*E9679	CHILD ABUSE NOS .....	.....
*E9680	ASSAULT-FIRE .....	.....
*E9681	ASSLT-PUSH FROM HI PLACE .....	.....
*E9682	ASSAULT-STRIKING W OBJ .....	.....
*E9683	ASSAULT-HOT LIQUID .....	.....
*E9684	ASSAULT-CRIMINAL NEGLECT .....	.....
*E9685	ASSLT-TRANSPORT VEHICLE .....	.....
*E9688	ASSAULT NEC .....	.....
*E9689	ASSAULT NOS .....	.....
*E969	LATE EFFECT ASSAULT .....	.....
*E970	LEGAL INTERVENT-FIREARM .....	.....
*E971	LEGAL INTERVENT-EXPLOSIV .....	.....
*E972	LEGAL INTERVENT-GAS .....	.....
*E973	LEGAL INTERVEN-BLUNT OBJ .....	.....
*E974	LEGAL INTERVEN-CUT INSTR .....	.....
*E975	LEGAL INTERVENTION NEC .....	.....
*E976	LEGAL INTERVENTION NOS .....	.....
*E977	LATE EFF-LEGAL INTERVENT .....	.....
*E978	LEGAL EXECUTION .....	.....
*E9800	UNDETERM POIS-ANALGESICS .....	.....
*E9801	UNDETERM POIS-BARBITURAT .....	.....
*E9802	UNDET POIS-SED/HYPN NEC .....	.....
*E9803	UNDETERM POIS-PSYCHOTROP .....	.....
*E9804	UNDET POIS-MED AGNT NEC .....	.....
*E9805	UNDET POIS-MED AGNT NOS .....	.....
*E9806	UNDET POIS-CORROS/CAUST .....	.....
*E9807	UNDET POIS-AGRICULT AGNT .....	.....
*E9808	UNDETER POIS-ARSENIC .....	.....
*E9809	UNDETER POIS-SOL/LIQ NEC .....	.....
*E9810	UNDETER POIS-PIPED GAS .....	.....
*E9811	UNDET POIS-CONTAINER GAS .....	.....
*E9818	UNDET POIS-UTIL GAS NEC .....	.....
*E9820	UNDETER POIS-EXHAUST GAS .....	.....
*E9821	UNDETERMIN POISON-CO NEC .....	.....
*E9828	UNDET POIS-GAS/VAPOR NEC .....	.....
*E9829	UNDET POIS-GAS/VAPOR NOS .....	.....
*E9830	UNDETERMIN CIRC-HANGING .....	.....
*E9831	UNDET CIRC-SUF PLAST BAG .....	.....
*E9838	UNDET CIRC-SUFFOCATE NEC .....	.....
*E9839	UNDET CIRC-SUFFOCATE NOS .....	.....
*E984	UNDETERM CIRC-SUBMERSION .....	.....
*E9850	UNDETERMIN CIRC-HANDGUN .....	.....
*E9851	UNDETERMIN CIRC-SHOTGUN .....	.....
*E9852	UNDET CIRC-HUNTING RIFLE .....	.....
*E9853	UNDET CIRC-MILITARY ARMS .....	.....
*E9854	UNDETER CIRC-FIREARM NEC .....	.....
*E9855	UNDETERM CIRC-EXPLOSIVE .....	.....
*E986	UNDET CIRC-CUT INSTRUMNT .....	.....
*E9870	UNDET CIRC-FALL RESIDENC .....	.....
*E9871	UNDET FALL STRUCTURE NEC	
*E9872	UNDET FALL NATURAL SITE	
*E9879	UNDET CIRC-FALL SITE NOS	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*E9880	UNDETERM CIRC-MOVING OBJ	
*E9881	UNDETERM CIRC-BURN, FIRE	
*E9882	UNDETERM CIRC-SCALD	
*E9883	UNDETERM CIRC-EXTRM COLD	
*E9884	UNDETERM CIRC-ELECTROCUT	
*E9885	UNDET CIRC-MOT VEH CRASH	
*E9886	UNDET CIRC-AIRCRAFT CRASH	
*E9887	UNDET CIRC-CAUSTIC SUBST	
*E9888	UNDETERM CIRCUMST NEC	
*E9889	UNDETERM CIRCUMST NOS	
*E989	LATE EFF INJ-UNDET CIRC	
*E9900	WAR INJ:GASOLINE BOMB	
*E9909	WAR INJURY:FIRE NEC	
*E9910	WAR INJ:RUBBER BULLET	
*E9911	WAR INJURY:PELLETS	
*E9912	WAR INJURY:BULLET NEC	
*E9913	WAR INJ:ANTIPERSON BOMB	
*E9919	WAR INJ:FRAGMENTS NEC	
*E992	WAR INJ:MARINE EXPLOS	
*E993	WAR INJURY:EXPLOS NEC	
*E994	WAR INJ:AIRCRAFT DESTRUC	
*E995	WAR INJUR-CONVEN WAR NEC	
*E996	WAR INJ:NUCLEAR WEAPONS	
*E9970	WAR INJURY:LASERS	
*E9971	WAR INJURY:BIOL WARFARE	
*E9972	WAR INJURY:GAS/FUM/CHEM	
*E9978	WAR INJ-UNCONVEN WAR NEC	
*E9979	WAR INJ-UNCONVEN WAR NOS	
*E998	WAR INJ:POST WAR OPERAT	
*E999	LATE EFF OF WAR INJURY	
V010	CHOLERA CONTACT	11
V011	TUBERCULOSIS CONTACT	11
V012	POLIOMYELITIS CONTACT	11
V013	SMALLPOX CONTACT	11
V014	RUBELLA CONTACT	11
V015	RABIES CONTACT	11
V016	VENEREAL DIS CONTACT	11
V017	VIRAL DIS CONTACT NEC	11
V018	COMMUNIC DIS CONTACT NEC	11
V019	COMMUNIC DIS CONTACT NOS	11
V020	CHOLERA CARRIER	11
V021	TYPHOID CARRIER	11
V022	AMEBIASIS CARRIER	11
V023	GI PATHOGEN CARRIER NEC	11
V024	DIPHTHERIA CARRIER	11
V025	BACTERIA DIS CARRIER NEC	11
V026	VIRAL HEPATITIS CARRIER*	11
V027	GONORRHEA CARRIER	11
V028	VENEREAL DIS CARRIER NEC	11
V029	CARRIER NEC	11
V030	VACCIN FOR CHOLERA	11
V031	VACC-TYPHOID-PARATYPHOID	11
V032	VACCIN FOR TUBERCULOSIS	11
V033	VACCIN FOR PLAGUE	11
V034	VACCIN FOR TULAREMIA	11
V035	VACCIN FOR DIPHTHERIA	11
V036	VACCIN FOR PERTUSSIS	11
V037	TETANUS TOXOID INOCULAT	11
V0381	ND VAC HMOPHUS INFLNZ B	11
V0382	ND VAC STRPTCS PNEUMNI B	11
V0389	ND OTHER SPECIF VACINATION	11
V039	VACCIN FOR BACT DIS NOS	11
V040	VACCIN FOR POLIOMYELITIS	11
V041	VACCIN FOR SMALLPOX	11
V042	VACCIN FOR MEASLES	11
V043	VACCIN FOR RUBELLA	11
V044	VACCIN FOR YELLOW FEVER	11
V045	VACCIN FOR RABIES	11
V046	VACCIN FOR MUMPS	11
V047	VACCIN FOR COMMON COLD	11
V048	VACCIN FOR INFLUENZA	11
V050	ARBOVIRUS ENCEPH VACCIN	11
V051	VACC ARBOVIRAL DIS NEC	11
V052	VACCIN FOR LEISHMANIASIS	11
V053	NEED PRPHYL VC VRL HEPAT	11
V054	NEED PRPHYL VC VARICELLA	11

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
V058	VACCIN FOR DISEASE NEC	11
V059	VACCIN FOR SINGL DIS NOS	11
V060	VACCIN FOR CHOLERA + TAB	11
V061	VACCIN FOR DTP	11
V062	VACCIN FOR DTP + TAB	11
V063	VACCIN FOR DTP + POLIO	11
V064	VAC-MEASLE-MUMPS-RUBELLA	11
V065	ND VAC TETANUS-DIPHTHRIA	11
V066	ND VAC STRP PNUMN/INFLNZ	11
V068	VAC-DIS COMBINATIONS NEC	11
V069	VAC-DIS COMBINATIONS NOS	11
V070	PROPHYLACTIC ISOLATION	11
V071	DESENSITIZA TO ALLERGENS	11
V072	PROPHYLACT IMMUNOTHERAPY	11
V0731	PROPHYLAC FLUORIDE ADMIN	11
V0739	OTHER PROPHYLAC CHEMOTHR	11
V074	NEED PSTMNPASL HRMN RPLC	11
V078	PROPHYLACTIC MEASURE NEC	11
V079	PROPHYLACTIC MEASURE NOS	11
V08	ASYMP HIV INFECTN STATUS	86
V090	INF MCRG RSTN PNCLLINS	97
V091	INF MCRG RSTN B-LACTAM	97
V092	INF MCRG RSTN MACROLIDES	97
V093	INF MCRG RSTN TTRCYCLN	97
V094	INF MCRG RSTN AMNGLCSDS	97
V0950	INF MCR RST QN FLR NT ML	97
V0951	INF MCRG RSTN QN FLRQ ML	97
V096	INF MCRG RSTN SULFNMIDES	97
V0970	INF MCR RST OTH AG NT ML	97
V0971	INF MCRG RSTN OTH AG MLT	97
V0980	INF MCR RST OT DRG NT ML	97
V0981	INF MCRG RSTN OTH DRG ML	97
V0990	INFC MCRG DRGRST NT MULT	97
V0991	INFC MCRG DRGRST MULT	97
V1000	HX OF GI MALIGNANCY NOS	11
V1001	HX OF TONGUE MALIGNANCY	11
V1002	HX-ORAL/PHARYNX MALG NEC	11
V1003	HX-ESOPHAGEAL MALIGNANCY	11
V1004	HX OF GASTRIC MALIGNANCY	11
V1005	HX OF COLONIC MALIGNANCY	11
V1006	HX-RECTAL & ANAL MALIG	11
V1007	HX OF LIVER MALIGNANCY	11
V1009	HX OF GI MALIGNANCY NEC	11
V1011	HX-BRONCHOGENIC MALIGNAN	11
V1012	HX-TRACHEAL MALIGNANCY	11
V1020	HX-RESP ORG MALIGNAN NOS	11
V1021	HX-LARYNGEAL MALIGNANCY	11
V1022	HX-NOSE/EAR/SINUS MALIG	11
V1029	HX-INTRATHORACIC MAL NEC	11
V103	HX OF BREAST MALIGNANCY	11
V1040	HX-FEMALE GENIT MALG NOS	11
V1041	HX-CERVICAL MALIGNANCY	11
V1042	HX-UTERUS MALIGNANCY NEC	11
V1043	HX OF OVARIAN MALIGNANCY	11
V1044	HX-FEMALE GENIT MALG NEC	11
V1045	HX-MALE GENIT MALIG NOS	11
V1046	HX-PROSTATIC MALIGNANCY	11
V1047	HX-TESTICULAR MALIGNANCY	11
V1049	HX-MALE GENIT MALIG NEC	11
V1050	HX-URINARY MALIGNAN NOS	11
V1051	HX OF BLADDER MALIGNANCY	11
V1052	HX OF KIDNEY MALIGNANCY	11
V1059	HX-URINARY MALIGNAN NEC	11
V1060	HX OF LEUKEMIA NOS	11
V1061	HX OF LYMPHOID LEUKEMIA	11
V1062	HX OF MYELOID LEUKEMIA	11
V1063	HX OF MONOCYTIC LEUKEMIA	11
V1069	HX OF LEUKEMIA NEC	11
V1071	HX-LYMPHOSARCOMA	11
V1072	HX-HODGKIN'S DISEASE	11
V1079	HX-LYMPHATIC MALIGN NEC	11
V1081	HX OF BONE MALIGNANCY	11
V1082	HX-MALIG SKIN MELANOMA	11
V1083	HX-SKIN MALIGNANCY NEC	11
V1084	HX OF EYE MALIGNANCY	11
V1085	HX OF BRAIN MALIGNANCY	11

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
V1086	HX-MALIGN NERVE SYST NEC	11
V1087	HX OF THYROID MALIGNANCY	11
V1088	HX-ENDOCRINE MALIGN NEC	11
V1089	HX OF MALIGNANCY NEC	11
V109	HX OF MALIGNANCY NOS	11
V110	HX OF SCHIZOPHRENIA	11
V111	HX OF AFFECTIVE DISORDER	11
V112	HX OF NEUROSIS	11
V113	HX OF ALCOHOLISM	11
V118	HX-MENTAL DISORDER NEC	11
V119	HX-MENTAL DISORDER NOS	11
V1200	PRSNL HST UNSP NFCT PRST	11
V1201	PRSNL HST TUBERCULOSIS	11
V1202	PRSNL HST POLIOMYELITIS	11
V1203	PERSONAL HISTRY MALARIA	11
V1209	PRSNL HST OTH NFCT PARST	11
V121	HX-NUTRITION DEFICIENCY	11
V122	HX-ENDOCR/META/IMMUN DIS	11
V123	HX-BLOOD DISEASES	11
V1250	HX-CIRCULATORY DIS NOS	11
V1251	HX-VEN THROMBOSIS/EMBOLS	11
V1252	HX-THROMBOPHLEBITIS	11
V1259	HX-CIRCULATORY DIS NEC	11
V126	HX-RESPIRATORY SYS DIS	11
V1270	PRSNL HST UNSPC DGSTV DS	11
V1271	PRSNL HST PEPTIC ULCR DS	11
V1272	PRSNL HST COLONIC POLYPS	11
V1279	PRSNL HST OT SPF DGST DS	11
V1300	PRSNL HST URNR DSRD UNSP	11
V1301	PRSNL HST URNR DSRD CALC	11
V1309	PRSN HST OT SPF URN DSRD	11
V131	HX-TROPHOBLASTIC DISEASE	11
V132	HX-GENITAL/OBSTETRIC DIS	11
V133	HX-SKIN/SUBCUTAN TIS DIS	11
V134	HX OF ARTHRITIS	11
V135	HX-MUSCULOSKELET DIS NEC	11
V136	HX-CONGENITAL MALFORM	11
V137	HX-PERINATAL PROBLEMS	11
V138	HX OF DISEASES NEC	11
V139	HX OF DISEASE NOS	11
V140	HX-PENICILLIN ALLERGY	11
V141	HX-ANTIBIOT ALLERGY NEC	11
V142	HX-SULFONAMIDES ALLERGY	11
V143	HX-ANTI-INFECT ALLERGY	11
V144	HX-ANESTHETIC ALLERGY	11
V145	HX-NARCOTIC ALLERGY	11
V146	HX-ANALGESIC ALLERGY	11
V147	HX-VACCINE ALLERGY	11
V148	HX-DRUG ALLERGY NEC	11
V149	HX-DRUG ALLERGY NOS	11
V150	HX OF ALLERGY NEC	11
V151	HX-MAJOR CARDIOVASC SURG	11
V152	HX-MAJOR ORGAN SURG NEC	11
V153	HX OF IRRADIATION	11
V155	HX OF INJURY	11
V156	HX OF POISONING	11
V157	HX OF CONTRACEPTION	11
V1581	HX OF PAST NONCOMPLIANCE	11
V1582	HISTORY OF TOBACCO USE	11
V1584	HX-EXPOSURE ASBESTOS	11
V1585	HX-EXPS HAZRD BODY FLUID	11
V1586	HX-EXPOSURE TO LEAD	11
V1589	HX-HEALTH HAZARDS NEC	11
V159	HX-HEALTH HAZARD NOS	11
V160	FAMILY HX-GI MALIGNANCY	11
V161	FM HX-TRACH/BRONCHOG MAL	11
V162	FAM HX-INTRATHORACIC MAL	11
V163	FAMILY HX-BREAST MALIG	11
V165	FAMILY HX-URINARY MALIG	11
V166	FAMILY HX-LEUKEMIA	11
V167	FAM HX-LYMPH NEOPLAS NEC	11
V168	FAMILY HX-MALIGNANCY NEC	11
V169	FAMILY HX-MALIGNANCY NOS	11
V170	FAM HX-PSYCHIATRIC COND	11
V171	FAMILY HX-STROKE	11
V172	FAM HX-NEUROLOG DIS NEC	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V173	FAM HX-ISCHEM HEART DIS	11
V174	FAM HX-CARDIOVAS DIS NEC	11
V175	FAMILY HX-ASTHMA	11
V176	FAM HX-CHR RESP COND NEC	11
V177	FAMILY HX-ARTHRITIS	11
V178	FAM HX-MUSCLOSCL DIS NEC	11
V180	FAM HX-DIABETES MELLITUS	11
V181	FM HX-ENDO/METAB DIS NEC	11
V182	FAMILY HX-ANEMIA	11
V183	FAM HX-BLOOD DISORD NEC	11
V184	FAM HX-MENTAL RETARDAT	11
V185	FAMILY HX-GI DISORDERS	11
V186	FAMILY HX-KIDNEY DISEASE	11
V187	FAMILY HX-GU DISEASE NEC	11
V188	FM HX-INFECT/PARASIT DIS	11
V190	FAMILY HX-BLINDNESS	11
V191	FAMILY HX-EYE DISORD NEC	11
V192	FAMILY HX-DEAFNESS	11
V193	FAMILY HX-EAR DISORD NEC	11
V194	FAMILY HX-SKIN CONDITION	11
V195	FAM HX-CONGEN ANOMALIES	11
V196	FAMILY HX-ALLERGIC DIS	11
V197	CONSANGUINITY	11
V198	FAMILY HX-CONDITION NEC	11
V200	FOUNDLING HEALTH CARE	11
V201	CARE OF HEALTHY CHLD NEC	11
V202	ROUTIN CHILD HEALTH EXAM	11
V210	RAPID CHILDHOOD GROWTH	11
V211	PUBERTY	11
V212	ADOLESCENCE GROWTH NEC	11
V218	CONSTIT STATE IN DEV NEC	11
V219	CONSTIT STATE IN DEV NOS	11
V220	SUPERVIS NORMAL 1ST PREG	57
V221	SUPERVIS OTH NORMAL PREG	57
*V222	PREG STATE, INCIDENTAL .....	.....
V230	PREG W HX OF INFERTILITY	57
V231	PREG W HX-TROPHOBLAS DIS	57
V232	PREG W HX OF ABORTION	57
V233	GRAND MULTIPARITY	57
V234	PREG W POOR OBSTETRIC HX	57
V235	PREG W POOR REPRODUCT HX	57
V237	INSUFFICNT PRENATAL CARE	57
V238	SUPRV HIGH-RISK PREG NEC	57
V239	SUPRV HIGH-RISK PREG NOS	57
V240	POSTPART CARE AFTER DEL	57
V241	POSTPART CARE-LACTATION	57
V242	ROUT POSTPART FOLLOW-UP	57
V2501	PRESCRIP-ORAL CONTRACEPT	11
V2502	INITIATE CONTRACEPT NEC	11
V2509	CONTRACEPTIVE MANGMT NEC	11
V251	INSERTION OF IUD	11
V252	STERILIZATION	11
V253	MENSTRUAL EXTRACTION	56
V2540	CONTRACEPT SURVEILL NOS	11
V2541	CONTRACEPT PILL SURVEILL	11
V2542	IUD SURVEILLANCE	11
V2543	SRVL MPLNT SBD RM CNTRCEP	11
V2549	CONTRACEPT SURVEILL NEC	11
V255	NSRT MPLNT SBD RM CNTRCEP	11
V258	CONTRACEPTIVE MANGMT NEC	11
V259	CONTRACEPTIVE MANGMT NOS	11
V260	TUBOPLASTY OR VASOPLASTY	11
V261	ARTIFICIAL INSEMINATION	11
V262	PROCREATIVE MGMT-INVEST	11
V263	GENETIC COUNSELING	11
V264	PROCREATIVE MGMT-COUNSEL	11
V268	PROCREATIVE MANGMT NEC	11
V269	PROCREATIVE MANGMT NOS	11
*V270	DELIVER-SINGLE LIVEBORN .....	.....
*V271	DELIVER-SINGLE STILLBORN .....	.....
*V272	DELIVER-TWINS, BOTH LIVE .....	.....
*V273	DEL-TWINS, 1 NB, 1 SB .....	.....
*V274	DELIVER-TWINS, BOTH SB .....	.....
*V275	DEL-MULT BIRTH, ALL LIVE	
*V276	DEL-MULT BRTH, SOME LIVE	
*V277	DEL-MULT BIRTH, ALL SB	

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ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
*V279	OUTCOME OF DELIVERY NOS	57
V280	SCREENING-CHROMOSOM ANOM	57
V281	SCREEN-ALPHAFETOPROTEIN	57
V282	SCREEN BY AMNIOCENT NEC	57
V283	SCREEN-FETAL MALFORM	57
V284	SCREEN-FETAL RETARDATION	57
V285	SCREEN-ISOIMMUNIZATION	57
V288	ANTENATAL SCREENING NEC	57
V289	ANTENATAL SCREENING NOS	57
V290	NB OBSRV SUSPCT INFECT	11
V291	NB OBSRV SUSPCT NEURLGCL	11
V292	OBSRV NB SUSPC RESP COND	11
V298	NB OBSRV OTH SUSPCT COND	11
V299	NB OBSRV UNSP SUSPCT CND	11
V3000	SINGLE LB IN-HOSP W/O CS	57
V3001	SINGLE LB IN-HOSP W CS	57
V301	SINGL LIVEBRN-BEFORE ADM	57
V302	SINGLE LIVEBORN-NONHOSP	57
V3100	TWIN-MATE LB-HOSP W/O CS	57
V3101	TWIN-MATE LB-IN HOS W CS	57
V311	TWIN, MATE LB-BEFORE ADM	57
V312	TWIN, MATE LB-NONHOSP	57
V3200	TWIN-MATE SB-HOSP W/O CS	57
V3201	TWIN-MATE SB-HOSP W CS	57
V321	TWIN, MATE SB-BEFORE ADM	57
V322	TWIN, MATE SB-NONHOSP	57
V3300	TWIN-NOS-IN HOSP W/O CS	57
V3301	TWIN-NOS-IN HOSP W CS	57
V331	TWIN NOS-BEFORE ADMISSN	57
V332	TWIN NOS-NONHOSP	57
V3400	OTH MULT LB-HOSP W/O CS	57
V3401	OTH MULT LB-IN HOSP W CS	57
V341	OTH MULT NB-BEFORE ADM	57
V342	OTH MULTIPLE NB-NONHOSP	57
V3500	OTH MULT SB-HOSP W/O CS	57
V3501	OTH MULT SB-IN HOSP W CS	57
V351	OTH MULT SB-BEFORE ADM	57
V352	OTH MULTIPLE SB-NONHOSP	57
V3600	MULT LB/SB-IN HOS W/O CS	57
V3601	MULT LB/SB-IN HOSP W CS	57
V361	MULT NB/SB-BEFORE ADM	57
V362	MULTIPLE NB/SB-NONHOSP	57
V3700	MULT BRTH NOS-HOS W/O CS	57
V3701	MULT BIRTH NOS-HOSP W CS	57
V371	MULT BRTH NOS-BEFORE ADM	57
V372	MULT BIRTH NOS-NONHOSP	57
V3900	LIVEBORN NOS-HOSP W/O CS	57
V3901	LIVEBORN NOS-HOSP W CS	57
V391	LIVEBORN NOS-BEFORE ADM	57
V392	LIVEBORN NOS-NONHOSP	57
V400	PROBLEMS WITH LEARNING	91
V401	PROB WITH COMMUNICATION	91
V402	MENTAL PROBLEMS NEC	91
V403	BEHAVIORAL PROBLEMS NEC	91
V409	MENTAL/BEHAVIOR PROB NOS	91
V410	PROBLEMS WITH SIGHT	11
V411	EYE PROBLEMS NEC	11
V412	PROBLEMS WITH HEARING	11
V413	EAR PROBLEMS NEC	11
V414	VOICE PRODUCTION PROBLEM	11
V415	SMELL AND TASTE PROBLEM	11
V416	PROBLEM W SWALLOWING	11
V417	SEXUAL FUNCTION PROBLEM	91
V418	PROBL W SPECIAL FUNC NEC	91
V419	PROBL W SPECIAL FUNC NOS	91
V420	KIDNEY TRANSPLANT STATUS	53
V421	HEART TRANSPLANT STATUS	36
V422	HEART VALVE TRANSPLANT	36
V423	SKIN TRANSPLANT STATUS	18
V424	BONE TRANSPLANT STATUS	24
V425	CORNEA TRANSPLANT STATUS	68
V426	LUNG TRANSPLANT STATUS	33
V427	LIVER TRANSPLANT STATUS	41
V429	TRANSPLANT STATUS NOS	11
V430	EYE REPLACEMENT NEC	68
V431	LENS REPLACEMENT NEC	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V432	HEART REPLACEMENT NEC	36
V433	HEART VALVE REPLAC NEC	36
V434	BLOOD VESSEL REPLAC NEC	36
V435	BLADDER REPLACEMENT NEC	53
V4360	JOINT REPLACED UNSPCF	11
V4361	JOINT REPLACED SHOULDER	11
V4362	JOINT REPLACED ELBOW	11
V4363	JOINT REPLACED WRIST	11
V4364	JOINT REPLACED HIP	11
V4365	JOINT REPLACED KNEE	11
V4366	JOINT REPLACED ANKLE	11
V4369	OTH SPCF JOINT REPLACED	11
V437	LIMB REPLACEMENT NEC	24
V4381	LARYNX REPLACEMENT	11
V4382	BREAST REPLACEMENT	11
V4389	ORGAN/TISS REPLACMNT NEC	11
V440	TRACHEOSTOMY STATUS	11
V441	GASTROSTOMY STATUS	11
V442	ILEOSTOMY STATUS	11
V443	COLOSTOMY STATUS	11
V444	ENTEROSTOMY STATUS NEC	11
V445	CYSTOSTOMY STATUS	11
V446	URINOSTOMY STATUS NEC	11
V447	ARTIFICIAL VAGINA STATUS	11
V448	ARTIF OPEN STATUS NEC	11
V449	ARTIF OPEN STATUS NOS	11
V4500	STATUS CARDIAC DVCE UNSPCF	11
V4501	STATUS CARDIAC PACEMAKER	11
V4502	STATUS AUTM CRD DFBRLTR	11
V4509	STATUS OTH SPCF CRDC DVC	11
V451	RENAL DIALYSIS STATUS	11
V452	VENTRICULAR SHUNT STATUS	11
V453	INTESTINAL BYPASS STATUS	11
V454	ARTHRODESIS STATUS	11
V4551	PRSC NTRUTR CNTRCPTV DVC	11
V4552	PRSC SBDRLM CNTRCP MPLNT	11
V4559	PRSC OTHER CNTRCPTV DVC	11
V4581	AORTOCORONARY BYPASS	11
V4582	STATUS-POST PTCA	11
V4583	BREAST IMPL REMOV STATUS	11
V4589	POSTSURGICAL STATES NEC	11
V460	DEPENDENCE ON ASPIRATOR	33
V461	DEPENDENCE ON RESPIRATOR	33
V468	MACHINE DEPENDENCE NEC	11
V469	MACHINE DEPENDENCE NOS	11
V470	INTERN ORGAN DEFICIENCY	11
V471	MECH PROB W INTERNAL ORG	11
V472	CARDIORESPIRAT PROBL NEC	11
V473	DIGESTIVE PROBLEMS NEC	11
V474	URINARY PROBLEMS NEC	11
V475	GENITAL PROBLEMS NEC	11
V479	PROBL W INTERNAL ORG NOS	11
V480	DEFICIENCIES OF HEAD	11
V481	DEFICIENCIES NECK/TRUNK	11
V482	MECHANICAL PROB W HEAD	11
V483	MECH PROB W NECK & TRUNK	11
V484	SENSORY PROBLEM W HEAD	11
V485	SENSOR PROB W NECK/TRUNK	11
V486	DISFIGUREMENTS OF HEAD	11
V487	DISFIGUREMENT NECK/TRUNK	11
V488	PROB-HEAD/NECK/TRUNK NEC	11
V489	PROB-HEAD/NECK/TRUNK NOS	11
V490	DEFICIENCIES OF LIMBS	11
V491	MECHANICAL PROB W LIMBS	11
V492	MOTOR PROBLEMS W LIMBS	11
V493	SENSORY PROBLEMS W LIMBS	11
V494	DISFIGUREMENTS OF LIMBS	11
V495	LIMB PROBLEMS NEC	11
V4960	STATUS AMPUT UP LMB NOS	11
V4961	STATUS AMPUT THUMB	11
V4962	STATUS AMPUT OTH FINGERS	11
V4963	STATUS AMPUT HAND	11
V4964	STATUS AMPUT WRIST	11
V4965	STATUS AMPUT BELOW ELBOW	11
V4966	STATUS AMPUT ABOVE ELBOW	11
V4967	STATUS AMPUT SHOULDER	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V4970	STATUS AMPUT LWR LMB NOS	11
V4971	STATUS AMPUT GREAT TOE	11
V4972	STATUS AMPUT OTHR TOE(S)	11
V4973	STATUS AMPUT FOOT	11
V4974	STATUS AMPUT ANKLE	11
V4975	STATUS AMPUT BELOW KNEE	11
V4976	STATUS AMPUT ABOVE KNEE	11
V4977	STATUS AMPUT HIP	11
V498	PROBL INFLU HEALTH NEC	11
V499	PROBL INFLU HEALTH NOS	11
V500	HAIR TRANSPLANT	11
V501	PLASTIC SURGERY NEC	11
V502	ROUTINE CIRCUMCISION	11
V503	EAR PIERCING	11
V5041	PRPHYLCT ORGN RMVL BRST	11
V5042	PRPHYLCT ORGN RMVL OVARY	11
V5049	PRPHYLCT ORGN RMVL OTHER	11
V508	ELECTIVE SURGERY NEC	11
V509	ELECTIVE SURGERY NOS	11
V51	AFTERCARE W PLASTIC SURG	18
V520	FITTING ARTIFICIAL ARM	24
V521	FITTING ARTIFICIAL LEG	24
V522	FITTING ARTIFICIAL EYE	11
V523	FITTING DENTAL PROSTHES	31
V524	FIT/ADJ BREAST PROS/IMPL	18
V528	FITTING PROSTHESIS NEC	24
V529	FITTING PROSTHESIS NOS	24
V531	FIT CONTACT LENS/GLASSES	68
V532	ADJUSTMENT HEARING AID	31
V533	ADJUST CARDIAC PACEMAKER*	36
V5331	FTNG CARDIAC PACEMAKER	11
V5332	FTNG AUTMTC DFIBRILLATOR	11
V5339	FTNG OTH CARDIAC DEVICE	11
V534	FIT ORTHODONTIC DEVICE	31
V535	FIT/ADJ INTES APPL NEC	41
V536	FITTING URINARY DEVICES	53
V537	FIT ORTHOPEDIC DEVICES	24
V538	ADJUSTMENT OF WHEELCHAIR	24
V539	ADJUSTMNT DEVICE NEC/NOS	24
V540	REMOVAL INT FIXATION DEV	11
V548	ORTHOPEDIC AFTERCARE NEC	24
V549	ORTHOPEDIC AFTERCARE NOS	24
V550	ATTEN TO TRACHEOSTOMY	31
V551	ATTEN TO GASTROSTOMY	41
V552	ATTEN TO ILEOSTOMY	41
V553	ATTEN TO COLOSTOMY	41
V554	ATTEN TO ENTEROSTOMY NEC	41
V555	ATTEN TO CYSTOSTOMY	53
V556	ATTEN TO URINOSTOMY NEC	53
V557	ATTEN ARTIFICIAL VAGINA	56
V558	ATTN TO ARTIF OPEN NEC	11
V559	ATTN TO ARTIF OPEN NOS	11
V560	RENAL DIALYSIS ENCOUNTER	11
V561	FIT/ADJ DIALYSIS CATHETR	53
V568	DIALYSIS ENCOUNTER, NEC	11
V570	BREATHING EXERCISES	11
V571	PHYSICAL THERAPY NEC	11
V5721	ENCNTR OCCUPATNAL THRPY	11
V5722	ENCNTR VOCATIONAL THRPY	11
V573	SPEECH THERAPY	11
V574	ORTHOPTIC TRAINING	11
V5781	ORTHOTIC TRAINING	24
V5789	REHABILITATION PROC NEC	11
V579	REHABILITATION PROC NOS	11
V580	RADIOTHERAPY ENCOUNTER	11
V581	CHEMOTHERAPY ENCOUNTER	11
V582	BLOOD TRANSFUSION, NO DX	11
V583	ATTEN-SURG DRESSNG/SUTUR	11
V584	POSTSURG AFTERCARE NEC*	11
V5841	ENCNTR PLND PO WND CLSR	11
V5849	POSTOP OTH SPECFD AFTRCR	11
V585	ORTHODONTICS AFTERCARE	31
V5861	LONG-TERM USE ANTICOAGUL	36
V5869	LONG-TERM USE MEDS NEC	11
V5881	FIT/ADJ VASCULAR CATHETR	11
*V5882	FIT/ADJ NON-VSC CATH NEC	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V5889	OTHER SPECIFIED AFTERCARE	11
V589	AFTERCARE NOS	11
V5901	BLOOD DONOR-WHOLE BLOOD	11
V5902	BLOOD DONOR-STEM CELLS	11
V5909	BLOOD DONOR NEC	11
V591	SKIN DONOR	11
V592	BONE DONOR	11
V593	BONE MARROW DONOR	11
V594	KIDNEY DONOR	11
V595	CORNEA DONOR	11
V596	LIVER DONOR	11
V598	ORG OR TISSUE DONOR NEC	11
V599	ORG OR TISSUE DONOR NOS	11
V600	LACK OF HOUSING	91
V601	INADEQUATE HOUSING	91
V602	ECONOMIC PROBLEM	91
V603	PERSON LIVING ALONE	91
V604	NO FAMILY ABLE TO CARE	91
V605	HOLIDAY RELIEF CARE	91
V606	PERSON IN RESIDENT INST	91
V608	HOUSING/ECONO CIRCUM NEC	91
V609	HOUSING/ECONO CIRCUM NOS	91
V610	FAMILY DISRUPTION	91
V6120	CNSL PRNT-CHLD PROB NOS	91
V6121	CNSL VICTIM CHILD ABUSE	91
V6129	PARENT-CHILD PROBLEM NEC	91
V613	PROBLEM W AGED PARENT	91
V6141	ALCOHOLISM IN FAMILY	91
V6149	FAMILY HEALTH PROBL NEC	91
V615	MULTIPARITY	56
V616	ILLEGITIMATE PREGNANCY	91
V617	UNWANTED PREGNANCY NEC	91
V618	FAMILY CIRCUMSTANCES NEC	91
V619	FAMILY CIRCUMSTANCE NOS	91
V620	UNEMPLOYMENT	91
V621	ADVERSE EFF-WORK ENVIRON	91
V622	OCCUP CIRCUMSTANCES NEC	91
V623	EDUCATIONAL CIRCUMSTANCE	91
V624	SOCIAL MALADJUSTMENT	91
V625	LEGAL CIRCUMSTANCES	91
V626	REFUSAL OF TREATMENT	91
V6281	INTERPERSONAL PROBL NEC	91
V6282	BEREAVEMENT, UNCOMPLICAT	91
V6289	PSYCHOLOGICAL STRESS NEC	91
V629	PSYCHOSOCIAL CIRCUM NOS	91
V630	HOME REMOTE FROM HOSPITL	91
V631	NO MEDICAL SERV IN HOME	91
V632	WAIT ADM TO OTH FACILITY	91
V638	NO MED FACILITIES NEC	91
V639	NO MED FACILITIES NOS	91
V640	NO VACCIN/CONTRAINDICAT	11
V641	NO PROC/CONTRAINDICATION	11
V642	NO PROC/PATIENT DECISION	11
V643	NO PROC FOR REASONS NEC	11
V650	HEALTHY PERSON W SICK	11
V651	PERSON CONSULT FOR ANOTH	91
V652	PERSON FEIGNING ILLNESS	91
V653	DIETARY SURVEIL/COUNSEL	82
V6540	COUNSELING NOS	91
V6541	EXERCISE COUNSELING	11
V6542	COUNSLNG SBSTN USE ABUSE	91
V6543	COUNSELING INJRY PREVENT	11
V6544	HIV COUNSELING	86
V6545	CONSLN OT SEX TRNSMT DIS	97
V6549	OTHER SPECIFD COUNSELING	11
V655	PERSN W FEARED COMPLAINT	91
V658	REASON FOR CONSULT NEC	91
V659	REASON FOR CONSULT NOS	91
V660	SURGICAL CONVALESCENCE	11
V661	RADIOTHERAPY CONVALESCEN	11
V662	CHEMOTHERAPY CONVALESCEN	11
V663	MENTAL DIS CONVALESCENCE	11
V664	FRACTURE TREATMNT CONVAL	11
V665	CONVALESCENCE NEC	11
V666	COMB TREATMENT CONVALES	11
V669	CONVALESCENCE NOS	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V670	SURGERY FOLLOW-UP	11
V671	RADIOTHERAPY FOLLOW-UP	11
V672	CHEMOTHERAPY FOLLOW-UP	11
V673	PSYCHIATRIC FOLLOW-UP	91
V674	FU EXAM TREATD HEALED FX	11
V6751	HIGH-RISK RX NEC EXAM	11
V6759	FOLLOW-UP EXAM NEC	11
V676	COMB TREATMENT FOLLOW-UP	11
V679	FOLLOW-UP EXAM NOS	11
V680	ISSUE MEDICAL CERTIFICAT	91
V681	ISSUE REPEAT PRESCRIPT	11
V682	REQUEST EXPERT EVIDENCE	11
V6881	REFERRAL-NO EXAM/TREAT	11
V6889	ADMINISTRTRVE ENCOUNTEC NEC	11
V689	ADMINISTRTRVE ENCOUNTEC NOS	11
V690	LACK OF PHYSICAL EXERCISE	11
V691	INAPPRT DIET EAT HABITS	11
V692	HIGH-RISK SEXUAL BEHAVR	97
V693	GAMBLING AND BETTING	91
V698	OTH PRBLMS RLTD LFSTYLE	91
V699	PRBLM RLTD LFSTYLE NOS	91
V700	ROUTINE MEDICAL EXAM	11
V701	PSYCH EXAM-AUTHORITY REQ	91
V702	GEN PSYCHIATRIC EXAM NEC	91
V703	MED EXAM NEC-ADMIN PURP	11
V704	EXAM-MEDICOLEGAL REASONS	11
V705	HEALTH EXAM-GROUP SURVEY	11
V706	HEALTH EXAM-POP SURVEY	11
V707	EXAM-CLINICAL RESEARCH	11
V708	GENERAL MEDICAL EXAM NEC	11
V709	GENERAL MEDICAL EXAM NOS	11
V7101	OBSV-ADULT ANTISOC BEHAV	91
V7102	OBSV-ADOLESC ANTISOC BEH	91
V7109	OBSERV-MENTAL COND NEC	91
V711	OBSV-SUSPCT MAL NEOPLASM	88
V712	OBSERV-SUSPECT TB	11
V713	OBSERV-WORK ACCIDENT	11
V714	OBSERV-ACCIDENT NEC	11
V715	OBSERV FOLLOWING RAPE	91
V716	OBSERV-INFLECTED INJ NEC	11
V717	OBS-SUSP CARDIOVASC DIS	11
V718	OBSERV-SUSPECT COND NEC	11
V719	OBSERV-SUSPECT COND NOS	11
V720	EYE & VISION EXAMINATION	68
V721	EAR & HEARING EXAM	31
V722	DENTAL EXAMINATION	31
V723	GYNECOLOGIC EXAMINATION	56
V724	PREG EXAM-PREG UNCONFIRM	56
V725	RADIOLOGICAL EXAM NEC	11
V726	LABORATORY EXAMINATION	11
V727	SKIN/SENSITIZATION TESTS	11
V7281	PREOP CARDIOVASCULAR EXAM	11
V7282	PREOP RESPIRATORY EXAM	11
V7283	OTH SPCF PREOP EXAM	11
V7284	PREOP EXAM UNSPCF	11
V7285	OTH SPECIFIED EXAM	11
V729	EXAMINATION NOS	11
V730	SCREENING-POLIOMYELITIS	11
V731	SCREENING FOR SMALLPOX	11
V732	SCREENING FOR MEASLES	11
V733	SCREENING FOR RUBELLA	11
V734	SCREENING-YELLOW FEVER	11
V735	SCREENING-ARBOVIRUS DIS	11
V736	SCREENING FOR TRACHOMA	11
V7388	SCRN OTH SPCF CHLMYD DIS	11
V7389	SCRN OTH SPCF VIRAL DIS	11
V7398	SCRN UNSPCF CHLMYD DIS	11
V7399	SCRN UNSPCF VIRAL DIS	11
V740	SCREENING FOR CHOLERA	11
V741	SCREENING-PULMONARY TB	11
V742	SCREENING FOR LEPROSY	11
V743	SCREENING FOR DIPHTHERIA	11
V744	SCREEN-BACT CONJUNCTIVIT	11
V745	SCREEN FOR VENERAL DIS	11
V746	SCREENING FOR YAWS	11
V748	SCREEN-BACTERIAL DIS NEC	11

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD-9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD-9	ICD-9 Description	MDC
V749	SCREEN-BACTERIAL DIS NOS	11
V750	SCREEN-RICKETTSIAL DIS	11
V751	SCREENING FOR MALARIA	11
V752	SCREEN FOR LEISHMANIASIS	11
V753	SCREEN-TRYPANOSOMIASIS	11
V754	SCREEN-MYCOTIC INFECT	11
V755	SCREEN-SCHISTOSOMIASIS	11
V756	SCREEN FOR FILARIASIS	11
V757	SCREEN FOR HELMINTHIASIS	11
V758	SCREEN-PARASITIC DIS NEC	11
V759	SCREEN FOR INFEC DIS NOS	11
V760	SCREEN MAL NEOP-RESP ORG	11
V762	SCREEN MAL NEOP-CERVIX	11
V763	SCREEN MAL NEOP-BLADDER	11
V7641	SCREEN MAL NEOP-RECTUM	11
V7642	SCREEN MAL NEOP-ORAL CAV	11
V7643	SCREEN MAL NEOP-SKIN	11
V7649	SCREEN MAL NEOP-SITE NEC	11
V768	SCREEN-NEOPLASM NEC	11
V769	SCREEN-NEOPLASM NOS	11
V770	SCREEN-THYROID DISORDER	11
V771	SCREEN-DIABETES MELLITUS	11
V772	SCREEN FOR MALNUTRITION	11
V773	SCREEN-PHENYLKETONURIA	11
V774	SCREEN FOR GALACTOSEMIA	11
V775	SCREENING FOR GOUT	11
V776	SCREEN-CYSTIC FIBROSIS	11
V777	SCREEN-INBORN ERR METAB	11
V778	SCREENING FOR OBESITY	11
V779	SCREEN-ENDOC/NUT/MET NEC	11
V780	SCREEN-IRON DEFIC ANEMIA	11
V781	SCREEN-DEFIC ANEMIA NEC	11
V782	SCREEN-SICKLE CELL DIS	11
V783	SCRN-HEMOGLOBINOPATH NEC	11
V788	SCREEN-BLOOD DIS NEC	11
V789	SCREEN-BLOOD DIS NOS	11
V790	SCREENING FOR DEPRESSION	11
V791	SCREENING FOR ALCOHOLISM	11
V792	SCREEN-MENTAL RETARDAT	11
V793	SCREEN-DEVELOPMENT PROB	11
V798	SCREEN-MENTAL DIS NEC	11
V799	SCREEN-MENTAL DIS NOS	11
V800	SCREEN-NEUROLOGICAL COND	11
V801	SCREENING FOR GLAUCOMA	11
V802	SCREENING-EYE COND NEC	11
V803	SCREENING FOR EAR DIS	11
V810	SCRN-ISCHEMIC HEART DIS	11
V811	SCREEN FOR HYPERTENSION	11
V812	SCREEN-CARDIOVASC NEC	11
V813	SCREEN-BRONCH/EMPHYSEMA	11
V814	SCREEN-RESPIR COND NEC	11
V815	SCREEN FOR NEPHROPATHY	11
V816	SCREEN FOR GU COND NEC	11
V820	SCREEN FOR SKIN COND	11
V821	SCREEN-RHEUMATOID ARTHR	11
V822	SCREEN-RHEUMAT DIS NEC	11
V823	SCREEN-CONG HIP DISLOCAT	11
V824	POSTNAT SCREEN-CHROM ABN	11
V825	SCREEN-CONTAMINATION NEC	11
V826	MULTIPHASIC SCREENING	11
V828	SCREEN FOR CONDITION NEC	11
V829	SCREEN FOR CONDITION NOS	11

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

CPT 1/ HCPCS ²	HOPD status indicator	Description
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
19200	C	Removal of breast

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT 1/ HCPCS ²	HOPD status indicator	Description
19220	C	Removal of breast
19240	C	Removal of breast
19260	C	Removal of chest wall lesion
19271	C	Revision of chest wall

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT 1/ HCPCS ²	HOPD status indicator	Description
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20100	C	Explore wound, neck
20101	C	Explore wound, chest
20102	C	Explore wound, abdomen
20103	C	Explore wound, extremity
20150	C	Excise epiphyseal bar
20660	C	Apply,remove fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant forearm, complete
20808	C	Replantation, hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation, foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
20972	C	Bone-skin graft, metatarsal
20973	C	Bone-skin graft, great toe
21045	C	Extensive jaw surgery
21137	C	Reduction of forehead
21138	C	Reduction of forehead
21139	C	Reduction of forehead
21141	C	Reconstruct midface, lefort
21142	C	Reconstruct midface, lefort
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconstruct lower jaw bone
21194	C	Reconstruct lower jaw bone
21195	C	Reconstruct lower jaw bone
21196	C	Reconstruct lower jaw bone
21198	C	Reconstruct lower jaw bone
21247	C	Reconstruct lower jaw bone
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21261	C	Revise eye sockets
21263	C	Revise eye sockets
21268	C	Revise eye sockets
21344	C	Repair of sinus fracture
21346	C	Repair of nose/jaw fracture
21347	C	Repair of nose/jaw fracture
21348	C	Repair of nose/jaw fracture
21356	C	Repair cheek bone fracture

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
21360	C	Repair cheek bone fracture
21365	C	Repair cheek bone fracture
21366	C	Repair cheek bone fracture
21385	C	Repair eye socket fracture
21386	C	Repair eye socket fracture
21387	C	Repair eye socket fracture
21390	C	Repair eye socket fracture
21395	C	Repair eye socket fracture
21406	C	Repair eye socket fracture
21407	C	Repair eye socket fracture
21408	C	Repair eye socket fracture
21422	C	Repair mouth roof fracture
21423	C	Repair mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Repair craniofacial fracture
21433	C	Repair craniofacial fracture
21435	C	Repair craniofacial fracture
21436	C	Repair craniofacial fracture
21470	C	Repair lower jaw fracture
21495	C	Repair hyoid bone fracture
21510	C	Drainage of bone lesion
21557	C	Remove tumor, neck or chest
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Repair sternum fracture
22100	C	Remove part of neck vertebra
22101	C	Remove part, thorax vertebra
22102	C	Remove part, lumbar vertebra
22103	C	Remove extra spine segment
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22222	C	Revision of thorax spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22325	C	Repair of spine fracture
22326	C	Repair neck spine fracture
22327	C	Repair thorax spine fracture
22328	C	Repair each add spine fx
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion
22612	C	Lumbar spine fusion
22614	C	Spine fusion, extra segment
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1–2 segments

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
22819	C	Kyphectomy, 3 & more segments
22830	C	Exploration of spinal fusion
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelvic fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23035	C	Drain shoulder bone lesion
23125	C	Removal of collarbone
23195	C	Removal of head of humerus
23200	C	Removal of collar bone
23210	C	Removal of shoulderblade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23395	C	Muscle transfer, shoulder/arm
23397	C	Muscle transfers
23400	C	Fixation of shoulder blade
23440	C	Removal/transplant tendon
23470	C	Reconstruct shoulder joint
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24150	C	Extensive humerus surgery
24151	C	Extensive humerus surgery
24152	C	Extensive radius surgery
24153	C	Extensive radius surgery
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24935	C	Revision of amputation
24940	C	Revision of upper arm
25170	C	Extensive forearm surgery
25390	C	Shorten radius/ulna
25391	C	Lengthen radius/ulna
25392	C	Shorten radius & ulna
25393	C	Lengthen radius & ulna
25405	C	Repair/graft radius or ulna
25420	C	Repair/graft radius & ulna
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single toe-hand transfer
26554	C	Double toe-hand transfer
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27035	C	Denervation of hip joint
27036	C	Excision of hip joint/muscle

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery
27078	C	Extensive hip surgery
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement
27130	C	Total hip replacement
27132	C	Total hip replacement
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant of femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Repair slipped epiphysis
27178	C	Repair slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Repair slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Pelvic fracture(s) treatment
27216	C	Treat pelvic ring fracture
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat fracture of thigh
27235	C	Repair of thigh fracture
27236	C	Repair of thigh fracture
27240	C	Treatment of thigh fracture
27244	C	Repair of thigh fracture
27245	C	Repair of thigh fracture
27248	C	Repair of thigh fracture
27253	C	Repair of hip dislocation
27254	C	Repair of hip dislocation
27258	C	Repair of hip dislocation
27259	C	Repair of hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27446	C	Revision of knee joint
27447	C	Total knee replacement
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
27470	C	Repair of thigh
27472	C	Repair/graft of thigh
27475	C	Surgery to stop leg growth
27477	C	Surgery to stop leg growth
27479	C	Surgery to stop leg growth
27485	C	Surgery to stop leg growth
27486	C	Revise knee joint replace
27487	C	Revise knee joint replace
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Repair of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Repair of thigh fracture
27519	C	Repair of thigh growth plate
27524	C	Repair of kneecap fracture
27535	C	Treatment of knee fracture
27536	C	Repair of knee fracture
27540	C	Repair of knee fracture
27557	C	Repair of knee dislocation
27558	C	Repair of knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31292	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31580	C	Revision of larynx
31582	C	Revision of larynx
31584	C	Repair of larynx fracture
31587	C	Revision of larynx
31600	C	Incision of windpipe
31601	C	Incision of windpipe
31610	C	Incision of windpipe
31725	C	Clearance of airways
31760	C	Repair of windpipe
31766	C	Reconstruction of windpipe

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
31770	C	Repair/graft of bronchus
31775	C	Reconstruct bronchus
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31785	C	Remove windpipe lesion
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32005	C	Treat lung lining chemically
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest, free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Open drainage, lung lesion
32201	C	Percut drainage, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus (add-on)
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32601	C	Thoracoscopy, diagnostic
32602	C	Thoracoscopy, diagnostic
32603	C	Thoracoscopy, diagnostic
32604	C	Thoracoscopy, diagnostic
32605	C	Thoracoscopy, diagnostic
32606	C	Thoracoscopy, diagnostic
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant w/bypass

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
32853	C	Lung transplant, double
32854	C	Lung transplant w/bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33206	C	Insertion of heart pacemaker
33207	C	Insertion of heart pacemaker
33208	C	Insertion of heart pacemaker
33210	C	Insertion of heart electrode
33211	C	Insertion of heart electrode
33212	C	Insertion of pulse generator
33213	C	Insertion of pulse generator
33214	C	Upgrade of pacemaker system
33216	C	Revision implanted electrode
33217	C	Insert/revise electrode
33218	C	Repair pacemaker electrodes
33220	C	Repair pacemaker electrode
33233	C	Removal of pacemaker system
33234	C	Removal of pacemaker system
33235	C	Remove pacemaker electrode
33236	C	Remove electrode/ thoracotomy
33237	C	Remove electrode/ thoracotomy
33238	C	Remove electrode/ thoracotomy
33240	C	Insert/replace pulse gener
33241	C	Remove pulse generator only
33242	C	Repair pulse generator/leads
33243	C	Remove generator/ thoracotomy
33244	C	Remove generator
33245	C	Implant heart defibrillator
33246	C	Implant heart defibrillator
33247	C	Insert/replace leads
33249	C	Insert/replace leads/gener
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement, aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement, aortic valve

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
33414	C	Repair, aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	CABG, vein, six+
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	CABG, artery-vein, six+
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	CABG, arterial, four+
33542	C	Removal of heart lesion
33545	C	Repair of heart damage
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair (simple fontan)
33617	C	Repair by modified fontan
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
33694	C	Repair of heart defects
33697	C	Repair of heart defects
33702	C	Repair of heart defects
33710	C	Repair of heart defects
33720	C	Repair of heart defect
33722	C	Repair of heart defect
33730	C	Repair heart-vein defect(s)
33732	C	Repair heart-vein defect
33735	C	Revision of heart chamber
33736	C	Revision of heart chamber
33737	C	Revision of heart chamber
33750	C	Major vessel shunt
33755	C	Major vessel shunt
33762	C	Major vessel shunt
33764	C	Major vessel shunt & graft
33766	C	Major vessel shunt
33767	C	Atrial septectomy/septostomy
33770	C	Repair great vessels defect
33771	C	Repair great vessels defect
33774	C	Repair great vessels defect
33775	C	Repair great vessels defect
33776	C	Repair great vessels defect
33777	C	Repair great vessels defect
33778	C	Repair great vessels defect
33779	C	Repair great vessels defect
33780	C	Repair great vessels defect
33781	C	Repair great vessels defect
33786	C	Repair arterial trunk
33788	C	Revision of pulmonary artery
33800	C	Aortic suspension
33802	C	Repair vessel defect
33803	C	Repair vessel defect
33813	C	Repair septal defect
33814	C	Repair septal defect
33820	C	Revise major vessel
33822	C	Revise major vessel
33824	C	Revise major vessel
33840	C	Remove aorta constriction
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aorta graft
33861	C	Ascending aorta graft
33863	C	Ascending aorta graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aorta graft
33877	C	Thoracoabdominal graft
33910	C	Remove lung artery emboli
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33918	C	Repair pulmonary atresia
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33930	C	Removal of donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
33973	C	Insert balloon device
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
34001	C	Removal of artery clot
34051	C	Removal of artery clot

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
34101	C	Removal of artery clot
34111	C	Removal of arm artery clot
34151	C	Removal of artery clot
34201	C	Removal of artery clot
34203	C	Removal of leg artery clot
34401	C	Removal of vein clot
34421	C	Removal of vein clot
34451	C	Removal of vein clot
34471	C	Removal of vein clot
34490	C	Removal of vein clot
34501	C	Repair valve, femoral vein
34502	C	Reconstruct, vena cava
34510	C	Transposition of vein valve
34520	C	Cross-over vein graft
34530	C	Leg vein fusion
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35011	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture, spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35180	C	Repair blood vessel lesion
35182	C	Repair blood vessel lesion
35184	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35190	C	Repair blood vessel lesion
35201	C	Repair blood vessel lesion
35206	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35226	C	Repair blood vessel lesion
35231	C	Repair blood vessel lesion
35236	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35256	C	Repair blood vessel lesion
35261	C	Repair blood vessel lesion
35266	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35286	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35321	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35458	C	Repair arterial blockage
35459	C	Repair arterial blockage
35460	C	Repair venous blockage
35470	C	Repair arterial blockage
35471	C	Repair arterial blockage
35472	C	Repair arterial blockage
35473	C	Repair arterial blockage
35474	C	Repair arterial blockage
35475	C	Repair arterial blockage
35476	C	Repair venous blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35484	C	Atherectomy, open
35485	C	Atherectomy, open
35490	C	Atherectomy, percutaneous
35491	C	Atherectomy, percutaneous
35492	C	Atherectomy, percutaneous
35493	C	Atherectomy, percutaneous
35494	C	Atherectomy, percutaneous
35495	C	Atherectomy, percutaneous
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35511	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
35582	C	Vein bypass graft
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
35646	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Artery bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35761	C	Exploration of artery/vein
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35860	C	Explore limb vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35903	C	Excision, graft, extremity
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36834	C	Repair A-V aneurysm
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
37195	C	Thrombolytic therapy, stroke
37200	C	Transcatheter biopsy
37201	C	Transcatheter therapy infuse
37202	C	Transcatheter therapy infuse
37204	C	Transcatheter occlusion
37205	C	Transcatheter stent
37206	C	Transcatheter stent
37207	C	Transcatheter stent
37208	C	Transcatheter stent
37209	C	Exchange arterial catheter
37250	C	Intravascular us
37251	C	Intravascular us
37565	C	Ligation of neck vein
37600	C	Ligation of neck artery
37605	C	Ligation of neck artery
37606	C	Ligation of neck artery
37615	C	Ligation of neck artery
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37620	C	Revision of major vein
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38240	C	Bone marrow/stem transplant
38241	C	Bone marrow/stem transplant
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38700	C	Removal of lymph nodes, neck

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
38720	C	Removal of lymph nodes, neck
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39400	C	Visualization of chest
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal; neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42145	C	Repair, palate, pharynx/uvula
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Partial removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43130	C	Removal of esophagus pouch
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43510	C	Surgical opening of stomach
43520	C	Incision of pyloric muscle
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal stomach, partial
43633	C	Removal stomach, partial
43634	C	Removal stomach, partial
43635	C	Partial removal of stomach
43638	C	Partial removal of stomach
43639	C	Removal stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43830	C	Place gastrostomy tube
43831	C	Place gastrostomy tube
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle catheter, bowel
44020	C	Exploration of small bowel
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excision of bowel lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44130	C	Bowel to bowel fusion
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44500	C	Intro, gastrointestinal tube
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain, app abscess, open
44901	C	Drain, app abscess, perc
44950	C	Appendectomy
44955	C	Appendectomy
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove, rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum; remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rectumbladder fistula
45805	C	Repair fistula; colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula; colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair, imperforated anus
46744	C	Repair, cloacal anomaly
46746	C	Repair, cloacal anomaly
46748	C	Repair, cloacal anomaly
46751	C	Repair of anal sphincter
47001	C	Needle biopsy, liver
47010	C	Open drainage, liver lesion
47011	C	Percut drain, liver lesion

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
47134	C	Partial removal, donor liver
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
47490	C	Incision of gallbladder
47550	C	Bile duct endoscopy
47600	C	Removal of gallbladder
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraoperative
48500	C	Surgery of pancreas cyst
48510	C	Drain pancreatic pseudocyst
48511	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Open drainage abdom ab-
		sscess
49041	C	Percut drain abdom abscess
49060	C	Open drain retroper abscess
49061	C	Percutdrain retroper abscess
49062	C	Drain to peritoneal cavity
49200	C	Removal of abdominal lesion
49201	C	Removal of abdominal lesion
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50020	C	Open drain renal abscess
50021	C	Percut drain renal abscess
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50080	C	Removal of kidney stone
50081	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Removal of kidney
50225	C	Removal of kidney
50230	C	Removal of kidney
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50340	C	Removal of kidney
50360	C	Transplantation of kidney
50365	C	Transplantation of kidney
50370	C	Remove transplanted kidney
50380	C	Reimplantation of kidney
50400	C	Revision of kidney/ureter
50405	C	Revision of kidney/ureter
50500	C	Repair of kidney wound
50520	C	Close kidney-skin fistula
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50570	C	Kidney endoscopy
50572	C	Kidney endoscopy
50574	C	Kidney endoscopy & biopsy
50575	C	Kidney endoscopy
50576	C	Kidney endoscopy & treat-
		ment
50578	C	Renal endoscopy; radiotracer
50580	C	Kidney endoscopy & treat-
		ment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to bowel
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
50970	C	Ureter endoscopy
50972	C	Ureter endoscopy & catheter
50974	C	Ureter endoscopy & biopsy
50976	C	Ureter endoscopy & treatment
50978	C	Ureter endoscopy & tracer
50980	C	Ureter endoscopy & treatment
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes
51580	C	Remove bladder; revise tract
51585	C	Removal of bladder & nodes
51590	C	Remove bladder; revise tract
51595	C	Remove bladder; revise tract
51596	C	Remove bladder, create
		pouch
51597	C	Removal of pelvic structures
51800	C	Revision of bladder/urethra
51820	C	Revision of urinary tract
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53085	C	Drainage of urinary leakage
53415	C	Reconstruction of urethra
53443	C	Reconstruction of urethra
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis, urethra

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
54336	C	Revise penis, urethra
54390	C	Repair penis and bladder
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55860	C	Surgical exposure, prostate
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
56308	C	Laparoscopy; hysterectomy
56310	C	Laparoscopic enterolysis
56314	C	Lapar; drain lymphocele
56315	C	Laparoscopic appendectomy
56322	C	Laparoscopy, vagus nerves
56323	C	Laparoscopy, vagus nerves
56324	C	Laparoscopy, cholecystoenter
56340	C	Laparoscopic cholecystectomy
56341	C	Laparoscopic cholecystectomy
56342	C	Laparoscopic cholecystectomy
56345	C	Laparoscopic splenectomy
56347	C	Laparoscopic jejunostomy
56348	C	Lapar; resect intestine
56349	C	Laparoscopy; fundoplasty
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
56805	C	Repair clitoris
57108	C	Partial removal of vagina
57110	C	Removal of vagina
57120	C	Closure of vagina
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy
57308	C	Fistula repair, transperine
57310	C	Repair urethrovaginal lesion
57311	C	Repair urethrovaginal lesion
57320	C	Repair bladder-vagina lesion
57330	C	Repair bladder-vagina lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix, repair pelvis
58140	C	Removal of uterus lesion
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	Vaginal hysterectomy
58263	C	Vaginal hysterectomy
58267	C	Hysterectomy & vagina repair
58270	C	Hysterectomy & vagina repair

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
58275	C	Hysterectomy, revise vagina
58280	C	Hysterectomy, revise vagina
58285	C	Extensive hysterectomy
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58600	C	Division of fallopian tube
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s)
58615	C	Occlude fallopian tube(s)
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Percut drain ovary abscess
58823	C	Percut drain pelvic abscess
58825	C	Transposition, ovary(s)
58900	C	Biopsy of ovary(s)
58920	C	Partial removal of ovary(s)
58925	C	Removal of ovarian cyst(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59150	C	Treat ectopic pregnancy
59151	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
59866	C	Abortion
60212	C	Parital thyroid excision
60252	C	Removal of thyroid
60254	C	Extensive thyroid surgery
60260	C	Repeat thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60500	C	Explore parathyroid glands
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60512	C	Autotransplant, parathyroid
60520	C	Removal of thymus gland
60521	C	Removal thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
61105	C	Drill skull for examination
61106	C	Drill skull for exam/surgery
61107	C	Drill skull for implantation

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
61108	C	Drill skull for drainage
61120	C	Pierce skull for examination
61130	C	Pierce skull, exam/surgery
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull, remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull; implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61330	C	Decompress eye socket
61332	C	Explore/biopsy eye socket
61333	C	Explore orbit; remove lesion
61334	C	Explore orbit; remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull, pressure relief
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61570	C	Remove brain foreign body
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect, artery, sinus
61610	C	Transect, artery, sinus
61611	C	Transect, artery, sinus
61612	C	Transect, artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61626	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61700	C	Inner skull vessel surgery
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61712	C	Skull or spine microsurgery
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull; brain biopsy
61751	C	Brain biopsy with cat scan
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61791	C	Treat trigeminal tract
61795	C	Brain surgery using computer
61850	C	Implant neuroelectrodes
61855	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61865	C	Implant neuroelectrodes
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
61880	C	Revise/remove neuroelectrode
61888	C	Revise/remove neuroreceiver
62000	C	Repair of skull fracture
62005	C	Repair of skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
62351	C	Implant spinal catheter
63001	C	Removal of spinal lamina
63003	C	Removal of spinal lamina
63005	C	Removal of spinal lamina
63011	C	Removal of spinal lamina
63012	C	Removal of spinal lamina
63015	C	Removal of spinal lamina
63016	C	Removal of spinal lamina
63017	C	Removal of spinal lamina
63020	C	Neck spine disk surgery
63030	C	Low back disk surgery
63035	C	Added spinal disk surgery
63040	C	Neck spine disk surgery
63042	C	Low back disk surgery
63045	C	Removal of spinal lamina
63046	C	Removal of spinal lamina
63047	C	Removal of spinal lamina
63048	C	Removal of spinal lamina
63055	C	Decompress spinal cord
63056	C	Decompress spinal cord
63057	C	Decompress spinal cord
63064	C	Decompress spinal cord
63066	C	Decompress spinal cord
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Removal of vertebral body
63085	C	Removal of vertebral body
63086	C	Removal of vertebral body
63087	C	Removal of vertebral body
63088	C	Removal of vertebral body
63090	C	Removal of vertebral body
63091	C	Removal of vertebral body
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord
63197	C	Incise spinal column & cord
63198	C	Incise spinal column & cord
63199	C	Incise spinal column & cord
63200	C	Release of spinal cord
63250	C	Revise spinal cord vessels
63251	C	Revise spinal cord vessels
63252	C	Revise spinal cord vessels
63265	C	Excise intraspinal lesion
63266	C	Excise intraspinal lesion
63267	C	Excise intraspinal lesion
63268	C	Excise intraspinal lesion
63270	C	Excise intraspinal lesion
63271	C	Excise intraspinal lesion
63272	C	Excise intraspinal lesion

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Removal of vertebral body
63655	C	Implant neuroelectrodes
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
63741	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64802	C	Remove sympathetic nerves
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64820	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65110	C	Removal of eye
65112	C	Remove eye, revise socket
65114	C	Remove eye, revise socket
65273	C	Repair of eye wound
67414	C	Explore/decompress eye socket
67445	C	Explore/decompress eye socket
67570	C	Decompress optic nerve
69155	C	Extensive ear/neck surgery
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69955	C	Release facial nerve
69960	C	Release inner ear canal
69970	C	Remove inner ear lesion
69979	C	Temporal bone surgery
74300	C	X-ray bile ducts, pancreas
74301	C	Additional x-rays at surgery
75894	C	X-rays, transcatheter therapy
75896	C	X-rays, transcatheter therapy
75900	C	Arterial catheter exchange
75940	C	X-ray placement, vein filter
75945	C	Intravascular us
75946	C	Intravascular us
75960	C	Transcatheter intro, stent
75961	C	Retrieval, broken catheter
75962	C	Repair arterial blockage
75964	C	Repair artery blockage, each

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
75966	C	Repair arterial blockage
75968	C	Repair artery blockage, each
75970	C	Vascular biopsy
75978	C	Repair venous blockage
75992	C	Atherectomy, x-ray exam
75993	C	Atherectomy, x-ray exam
75994	C	Atherectomy, x-ray exam
75995	C	Atherectomy, x-ray exam
75996	C	Atherectomy, x-ray exam
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92977	C	Dissolve clot, heart vessel
92978	C	Intravas us, heart (add-on)
92979	C	Intravas us, heart (add-on)
92980	C	Insert intracoronary stent
92981	C	Insert intracoronary stent
92982	C	Coronary artery dilation

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
92984	C	Coronary artery dilation
92986	C	Revision of aortic valve
92987	C	Revision of mitral valve
92990	C	Revision of pulmonary valve
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
92995	C	Coronary atherectomy
92996	C	Coronary atherectomy
92997	C	Pul art balloon repair, perc
92998	C	Pul art balloon repair, perc
94652	C	Pressure breathing (IPPB)
94656	C	Initial ventilator mgmt
95920	C	Intraoperative nerve testing
95961	C	Electrode stimulation, brain
95962	C	Electrode stimulation, brain
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services

ADDENDUM G.—CPT CODES WHICH
WOULD BE PAID ONLY AS INPATIENT
PROCEDURES—Continued

CPT 1/ HCPCS 2	HOPD status indicator	Description
99234	C	Observ/hosp same date
99235	C	Observ/hosp same date
99236	C	Observ/hosp same date
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult
99262	C	Follow-up inpatient consult
99263	C	Follow-up inpatient consult
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99297	C	Neonatal critical care
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care, hospital

ADDENDUM H.—STATUS INDICATORS; HOW VARIOUS SERVICES ARE TREATED UNDER OUTPATIENT PPS

Indicator	Service	Status
A	Pulmonary Rehabilitation Clinical Trial	Not paid under PPS
C	Inpatient Procedures	Admit Patient; Bill as Inpatient
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS Fee Schedule
E	Non-covered Items and Services	Non-paid
A	Physical, Occupational and Speech Therapy	Rehabilitation Fee Schedule
A	Ambulance	Ambulance Fee Schedule
A	EPO for ESRD patients	National Rate
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule
A	Physician Services for ESRD patients	Not paid under PPS
A	Screening Mammography	National Rate
N	Incidental Services, packaged into APC Rate	Packaged
P	Partial Hospitalization	Paid per diem APC
S	Significant Procedure, not discounted when multiple	Paid
T	Procedure, multiple discount applies	Paid
V	Visit to Clinic or Emergency Department	Paid
X	Ancillary Service	Paid

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL

Hospital	SMI
010001	2.17
010004	1.18
010005	1.37
010006	1.95
010007	1.07
010008	1.16
010009	1.18
010010	1.40
010011	1.64
010012	1.32
010015	1.40
010016	2.19
010018	4.13
010019	1.91
010021	1.24
010022	1.30
010023	2.49
010024	1.95
010025	1.38
010027	0.76
010029	1.97
010031	1.32
010032	0.83
010033	1.17
010034	1.48
010035	2.18
010036	1.16

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
010038	2.60
010039	1.40
010040	2.15
010043	1.31
010044	1.38
010045	1.25
010046	1.43
010047	0.97
010049	1.93
010050	1.14
010051	1.06
010052	0.89
010053	1.37
010054	1.30
010055	2.14
010056	1.66
010058	0.57
010059	1.22
010061	1.66
010062	1.14
010064	1.95
010065	1.52
010066	0.77
010068	0.97
010069	1.56
010072	1.49
010073	1.32

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
010078	1.65
010079	1.59
010080	0.75
010081	1.86
010083	1.37
010084	3.64
010087	1.89
010089	1.67
010090	1.80
010091	1.02
010092	1.67
010094	1.23
010095	0.91
010097	1.23
010098	1.05
010099	1.32
010100	1.67
010101	1.42
010102	0.85
010103	1.63
010104	1.75
010108	1.18
010109	1.33
010110	0.82
010112	1.15
010113	1.97
010114	1.52

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
010115	0.94	030030	2.01	040041	2.17
010117	0.80	030033	1.38	040042	1.31
010118	1.77	030034	0.77	040044	0.90
010119	1.56	030035	2.11	040045	1.17
010120	1.24	030036	1.65	040047	1.14
010123	1.62	030037	2.92	040048	1.69
010124	2.29	030038	2.39	040050	1.28
010125	0.91	030040	1.22	040051	1.14
010126	1.80	030041	0.85	040053	1.01
010127	1.88	030043	1.66	040054	1.68
010128	0.91	030044	1.34	040055	1.97
010129	1.10	030047	1.01	040058	1.26
010130	1.13	030049	0.50	040060	0.80
010131	1.88	030054	0.57	040062	1.75
010134	1.02	030055	1.65	040064	0.75
010137	0.97	030059	1.77	040066	2.43
010138	0.86	030060	1.43	040067	0.73
010139	2.05	030061	1.44	040069	1.84
010143	1.42	030062	1.32	040070	1.19
010144	2.30	030064	1.67	040071	1.30
010145	1.16	030065	2.01	040072	1.26
010146	1.76	030067	1.01	040074	1.65
010148	1.30	030068	1.71	040075	1.08
010149	1.70	030069	2.11	040076	1.13
010150	1.60	030080	1.67	040077	1.05
010152	1.49	030083	1.52	040078	2.58
010155	1.00	030085	1.78	040080	1.19
012005	1.01	030086	1.52	040081	0.62
013025	1.08	030087	3.31	040082	1.05
013027	0.80	030088	1.58	040084	1.68
013028	0.66	030089	1.83	040085	1.19
013029	1.07	030092	1.84	040088	1.98
013030	0.40	030093	1.16	040090	0.75
013300	0.87	030094	1.42	040091	1.19
014000	0.86	030095	1.99	040093	0.79
014002	0.85	033025	1.10	040100	1.19
014003	0.83	033026	1.27	040105	0.79
020001	2.09	033028	1.06	040106	1.28
020002	1.79	034004	0.89	040107	1.23
020004	1.27	034008	0.92	040109	1.10
020005	0.69	034009	0.87	040114	4.13
020006	1.37	034010	0.87	040116	2.11
020007	0.58	034013	0.92	040118	2.05
020008	1.36	034015	0.87	040119	1.78
020009	0.71	034019	0.87	040124	1.44
020010	0.38	040001	1.28	040126	1.58
020011	0.68	040002	1.32	040132	0.55
020012	2.31	040003	1.12	043026	1.00
020013	1.41	040004	2.28	043027	0.59
020014	1.05	040005	1.32	043028	0.84
020017	2.01	040007	3.03	043029	1.09
020024	1.21	040008	0.82	043031	0.57
020025	0.68	040010	2.01	043032	2.32
024001	0.97	040011	0.98	043300	1.25
030001	1.79	040014	1.96	044004	0.86
030002	1.72	040015	1.00	044005	0.88
030003	1.36	040016	1.43	044006	0.99
030004	0.58	040017	1.71	044010	1.02
030006	1.90	040018	1.55	044011	1.22
030007	1.72	040019	1.59	044012	0.87
030008	2.23	040020	1.88	050002	1.32
030009	0.94	040021	2.05	050006	1.90
030010	1.69	040022	1.39	050007	1.51
030011	2.18	040024	1.10	050008	1.66
030012	1.24	040025	1.03	050009	2.00
030013	1.74	040026	1.75	050013	1.37
030014	1.81	040027	2.26	050014	1.64
030016	1.26	040028	1.09	050015	1.65
030017	2.04	040029	2.25	050016	1.33
030018	2.22	040030	0.89	050017	3.14
030019	1.67	040032	0.63	050018	1.71
030022	1.17	040035	0.75	050021	1.89
030023	1.69	040036	2.40	050022	1.82
030024	2.35	040037	1.04	050024	1.27
030025	1.07	040039	1.54	050025	1.51
030027	0.94	040040	0.87	050026	1.47

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
050028	1.74	050139	5.33	050272	1.00
050029	1.52	050140	2.13	050274	0.97
050030	1.19	050144	1.48	050276	0.82
050032	1.83	050145	1.65	050277	0.95
050033	1.48	050147	0.87	050278	1.65
050036	1.87	050148	1.44	050279	1.47
050038	0.97	050149	1.31	050280	1.77
050039	1.59	050150	1.63	050281	2.70
050042	1.90	050152	1.47	050282	1.50
050043	1.96	050153	1.61	050283	0.80
050045	2.02	050155	1.55	050286	0.66
050046	1.29	050158	2.29	050289	1.71
050047	2.10	050159	0.92	050290	1.53
050051	1.00	050167	0.91	050291	1.11
050054	1.05	050168	2.16	050292	0.96
050055	1.00	050169	1.74	050293	1.01
050056	2.22	050170	1.58	050295	1.82
050057	1.79	050172	1.15	050296	1.42
050058	1.75	050173	1.94	050298	1.38
050060	1.35	050174	2.40	050299	2.41
050061	3.66	050175	2.19	050300	1.97
050063	1.75	050177	1.24	050301	1.85
050065	1.82	050179	1.57	050302	2.08
050066	1.58	050180	1.38	050305	1.24
050067	1.28	050183	0.85	050307	1.90
050068	1.58	050186	1.01	050308	1.59
050069	1.74	050188	2.43	050309	1.86
050077	1.69	050189	1.39	050310	2.15
050078	1.44	050191	1.67	050312	1.61
050079	1.44	050192	1.03	050313	1.91
050080	1.28	050193	1.02	050315	0.79
050081	0.76	050194	1.62	050317	1.14
050082	1.83	050195	1.64	050320	0.82
050084	1.62	050196	1.47	050324	2.00
050088	0.88	050197	1.72	050325	1.13
050089	1.28	050204	2.12	050327	1.41
050090	1.74	050205	1.23	050328	2.07
050091	2.15	050207	2.14	050329	0.95
050092	1.12	050208	1.82	050331	1.37
050093	2.09	050211	1.70	050333	0.66
050095	2.30	050213	0.87	050334	2.40
050096	1.07	050214	1.49	050335	0.87
050097	2.60	050215	1.99	050336	1.52
050099	1.51	050217	1.50	050337	1.14
050100	1.55	050219	1.30	050342	1.35
050101	1.84	050222	1.71	050343	2.06
050102	1.20	050224	1.77	050348	1.07
050103	1.80	050225	1.36	050349	0.79
050104	1.28	050226	1.82	050350	1.29
050107	1.81	050228	0.83	050351	2.19
050108	1.89	050230	1.83	050352	1.43
050109	1.63	050231	3.90	050353	1.85
050110	2.15	050232	1.83	050355	0.70
050111	4.65	050233	1.56	050357	1.43
050112	1.70	050234	1.11	050359	1.99
050113	0.86	050235	1.81	050360	1.91
050114	1.16	050236	1.43	050366	1.30
050115	1.17	050238	1.29	050367	1.24
050116	1.84	050239	1.61	050369	1.65
050117	1.85	050240	1.79	050377	0.63
050118	1.57	050241	1.47	050378	1.36
050121	2.17	050242	1.55	050379	1.01
050122	1.88	050243	1.35	050380	2.26
050124	1.35	050245	0.80	050382	1.93
050125	2.05	050248	0.94	050385	1.50
050126	1.96	050251	1.29	050388	0.70
050127	1.21	050253	0.87	050390	1.65
050128	1.51	050254	2.05	050391	1.74
050129	1.99	050256	1.00	050392	1.11
050131	1.59	050257	0.99	050393	2.05
050132	1.46	050260	0.73	050394	2.34
050133	1.50	050261	1.33	050396	2.78
050135	1.02	050262	1.51	050397	0.89
050136	1.65	050264	1.57	050401	1.47
050137	1.40	050267	1.76	050404	0.97
050138	6.45	050270	1.79	050406	0.85

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
050407	1.88	050550	2.12	050701	1.31
050410	0.67	050551	1.73	050702	0.67
050411	3.99	050552	0.84	050704	0.90
050414	1.85	050557	1.41	050707	14.19
050417	1.81	050559	1.43	050708	10.17
050418	0.88	050560	2.06	050709	2.00
050419	1.63	050561	2.70	052031	0.57
050420	1.18	050564	1.37	053026	1.10
050421	1.64	050565	1.22	053027	0.70
050423	1.31	050566	1.01	053028	0.78
050424	2.03	050567	1.57	053029	0.96
050426	2.03	050568	1.73	053030	0.71
050427	0.54	050569	1.58	053031	0.90
050430	0.92	050570	1.70	053032	0.60
050431	2.44	050571	1.96	053033	0.93
050432	1.91	050573	1.69	053034	1.10
050433	0.99	050577	2.79	053035	1.06
050434	0.87	050578	0.73	053036	0.83
050435	1.52	050579	1.68	053037	1.02
050436	1.04	050580	1.49	053300	0.98
050438	1.44	050581	1.60	053301	1.27
050440	0.94	050583	2.12	053302	1.00
050441	1.43	050584	1.30	053304	0.81
050443	0.92	050585	1.59	053305	0.65
050444	1.74	050586	1.91	054001	0.87
050446	0.93	050588	1.69	054003	0.87
050447	1.14	050589	1.89	054009	0.88
050448	2.02	050590	2.07	054012	0.73
050449	2.24	050591	2.43	054028	0.91
050454	1.18	050592	1.91	054032	0.64
050455	2.27	050593	1.34	054050	1.09
050456	3.32	050594	1.76	054052	0.81
050457	1.34	050597	1.82	054053	0.99
050459	1.62	050598	2.19	054055	0.83
050464	2.06	050599	1.07	054060	0.87
050468	1.25	050601	2.01	054064	0.83
050469	1.07	050603	1.16	054065	0.70
050470	1.37	050607	0.80	054069	0.67
050471	2.08	050608	1.17	054074	0.87
050476	1.66	050609	1.29	054075	0.87
050477	2.95	050613	0.56	054077	0.87
050478	1.03	050615	2.57	054078	0.89
050481	2.09	050616	1.75	054085	0.87
050482	0.68	050618	0.63	054087	0.78
050483	1.07	050624	1.63	054091	0.83
050485	2.20	050625	1.96	054093	0.88
050486	1.97	050630	1.57	054094	0.88
050488	1.39	050633	1.63	054095	0.87
050491	1.64	050636	1.58	054096	0.88
050492	1.50	050638	0.95	054097	0.77
050494	2.02	050641	1.75	054098	0.87
050496	1.71	050644	1.85	054099	0.87
050497	0.69	050661	0.87	054104	0.88
050498	1.60	050662	0.77	054105	0.87
050502	2.55	050663	1.40	054106	0.87
050503	2.26	050666	0.75	054108	0.88
050506	1.59	050667	0.76	054110	0.87
050515	9.08	050668	0.73	054111	0.76
050516	2.17	050675	1.66	054113	0.87
050517	1.62	050676	0.62	054115	0.87
050522	1.91	050677	1.36	054116	0.88
050523	1.38	050678	1.54	054117	0.87
050526	0.94	050680	1.00	054119	0.87
050528	1.34	050682	0.77	054122	0.84
050531	3.15	050684	1.39	054123	0.90
050534	1.59	050685	1.72	054125	0.99
050535	1.82	050686	1.98	054126	0.84
050537	1.75	050688	1.10	054130	0.71
050539	1.29	050689	1.57	054131	0.96
050542	1.40	050693	1.61	054133	0.85
050543	1.13	050694	1.42	054139	0.74
050545	0.69	050695	1.12	060001	1.99
050546	0.66	050696	2.25	060003	1.61
050547	0.76	050697	2.81	060004	1.07
050548	0.74	050699	0.94	060006	1.40
050549	1.90	050700	1.65	060007	1.23

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
060008	1.36
060009	1.52
060010	1.62
060011	0.87
060012	1.19
060013	1.25
060014	1.69
060015	1.18
060016	1.38
060018	1.61
060020	1.40
060022	1.18
060023	1.77
060024	1.08
060027	1.45
060028	1.69
060029	0.76
060030	1.94
060031	1.60
060032	1.84
060033	1.07
060034	1.44
060036	1.30
060037	0.93
060038	0.89
060041	0.71
060042	1.10
060043	0.85
060044	1.42
060046	1.98
060047	0.61
060049	1.82
060050	1.25
060052	1.09
060053	1.12
060054	1.94
060056	0.86
060057	1.36
060058	0.90
060060	1.12
060062	0.97
060063	0.59
060064	2.03
060065	1.79
060068	0.85
060070	1.04
060071	1.40
060073	1.14
060075	2.15
060076	1.29
060085	0.67
060087	1.53
060088	1.00
060090	0.98
060096	1.69
060100	1.39
060103	2.74
060104	1.65
062009	0.56
062011	1.54
063026	0.66
063027	1.04
063029	1.68
063030	1.60
063301	0.93
063302	0.84
064007	0.87
064009	0.84
064010	1.03
064012	0.87
064016	0.90
070001	1.94
070002	1.78
070003	1.57
070004	1.60
070005	1.17

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
070006	1.53
070007	1.85
070008	1.32
070009	1.98
070010	1.61
070011	1.43
070012	1.47
070015	1.40
070016	1.40
070017	1.81
070018	1.58
070019	2.00
070020	1.45
070021	1.68
070022	1.67
070024	1.59
070025	1.83
070026	1.49
070027	1.35
070028	1.48
070029	1.55
070030	1.74
070031	1.25
070033	1.27
070034	1.72
070035	1.57
070036	1.39
070039	0.71
072003	3.24
072004	0.59
074000	0.88
074007	0.87
074008	1.05
074012	0.85
080001	2.01
080002	1.54
080003	1.89
080004	1.72
080005	2.03
080006	2.09
080007	1.48
083300	3.49
084002	0.85
090001	2.44
090002	1.64
090003	1.28
090004	1.64
090005	3.11
090006	1.65
090007	0.98
090008	1.67
090010	3.66
090011	2.05
090015	0.45
093025	0.72
093300	1.30
094004	0.83
100001	1.06
100002	1.64
100004	1.02
100006	1.46
100007	2.13
100008	2.17
100009	1.70
100010	1.72
100012	1.78
100014	1.50
100015	1.87
100017	1.69
100018	1.33
100019	2.56
100020	2.02
100022	0.97
100023	1.98
100024	2.03
100025	1.48

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
100026	1.75
100027	1.01
100028	2.09
100029	1.41
100030	1.98
100032	1.36
100034	1.52
100035	1.72
100038	1.35
100039	2.01
100040	2.03
100043	1.52
100044	1.71
100045	1.54
100046	1.49
100047	1.26
100048	1.07
100049	1.78
100050	1.69
100051	1.51
100052	2.11
100053	1.82
100054	1.38
100055	1.74
100056	2.29
100057	2.09
100060	1.86
100061	1.71
100062	1.99
100063	1.72
100067	1.72
100068	1.44
100069	1.78
100070	1.59
100071	1.31
100072	1.32
100073	1.26
100075	1.48
100076	1.70
100077	2.49
100078	0.75
100080	1.72
100081	1.10
100082	1.63
100084	1.49
100085	1.16
100086	1.65
100087	2.28
100088	2.12
100090	1.93
100092	1.75
100093	1.85
100098	0.79
100099	1.92
100102	1.22
100103	0.73
100105	1.68
100106	1.55
100107	1.38
100108	1.16
100109	1.78
100110	1.45
100112	0.66
100113	1.90
100114	1.70
100117	2.13
100118	1.37
100121	1.75
100122	1.98
100124	1.45
100125	1.53
100126	1.53
100127	2.01
100128	1.83
100129	2.14
100130	1.43

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
100131	1.86	100246	2.06	110005	1.63
100132	1.62	100248	1.63	110006	2.18
100134	0.90	100249	1.80	110007	1.70
100135	2.75	100252	1.73	110008	1.51
100137	1.45	100253	1.80	110009	0.79
100138	0.74	100254	1.34	110010	2.18
100139	0.94	100255	2.19	110011	1.69
100140	1.56	100256	1.73	110013	1.06
100142	1.47	100258	1.84	110014	1.34
100144	2.03	100259	1.87	110015	1.16
100145	1.58	100260	2.23	110016	2.15
100146	0.98	100262	2.19	110017	0.87
100147	0.82	100263	1.74	110018	1.44
100150	1.46	100264	1.44	110020	2.09
100151	2.14	100265	1.46	110023	1.74
100154	2.20	100266	1.68	110024	2.23
100156	1.32	100267	1.86	110025	2.03
100157	2.28	100268	1.68	110026	1.20
100159	0.92	100269	2.11	110027	0.96
100160	1.32	100270	0.71	110028	1.98
100161	1.33	100271	1.26	110029	1.30
100162	1.50	100275	1.48	110030	1.69
100165	1.51	100276	2.14	110031	2.13
100166	1.31	100277	0.65	110032	1.80
100167	3.04	100279	1.38	110033	2.46
100168	1.86	100280	1.22	110034	0.96
100169	1.82	100281	1.39	110035	1.85
100170	1.83	100282	1.05	110037	1.10
100172	0.97	102006	0.68	110038	1.50
100173	2.15	102007	0.68	110039	1.99
100174	1.46	102008	0.70	110040	1.68
100175	1.00	102009	0.69	110041	1.64
100176	1.67	102013	2.55	110042	1.39
100177	2.17	103026	1.00	110043	2.40
100179	2.60	103027	1.16	110044	1.77
100180	1.43	103028	1.00	110045	1.93
100181	2.56	103030	0.65	110046	1.89
100183	1.79	103031	0.83	110048	0.97
100187	1.84	103032	1.25	110049	0.82
100189	1.64	103033	0.98	110050	1.04
100191	1.77	103034	0.97	110051	1.23
100199	1.74	103036	2.58	110052	0.70
100200	2.55	103037	1.10	110054	1.63
100203	1.35	103039	1.00	110056	0.86
100204	1.76	103300	7.82	110059	1.69
100206	2.07	103301	1.80	110061	0.77
100208	1.27	104001	0.46	110062	0.63
100209	1.49	104002	0.39	110063	1.28
100210	1.37	104005	0.90	110064	1.33
100211	1.37	104007	0.48	110065	0.73
100212	1.65	104008	0.92	110066	1.77
100213	1.07	104015	0.79	110069	2.30
100217	2.28	104016	0.85	110070	1.18
100220	1.93	104017	0.87	110071	0.78
100221	1.55	104018	0.84	110072	0.99
100222	0.88	104024	0.94	110073	1.47
100223	1.50	104026	0.78	110074	1.92
100224	1.67	104029	0.87	110075	1.43
100225	1.63	104034	0.87	110076	1.93
100226	1.36	104036	0.83	110078	1.94
100228	2.07	104037	0.87	110079	0.80
100229	1.31	104038	0.87	110080	1.62
100230	1.16	104040	0.84	110082	2.52
100231	1.51	104041	0.84	110083	2.25
100232	1.33	104045	0.74	110086	1.24
100234	1.48	104046	0.88	110087	1.83
100235	1.49	104047	0.84	110088	0.61
100236	1.45	104052	0.86	110089	1.66
100237	1.83	104054	0.87	110091	2.11
100238	1.91	104056	0.87	110092	1.14
100239	1.86	104057	0.87	110093	0.54
100240	3.25	104060	0.88	110094	0.65
100241	1.33	110001	1.79	110095	1.69
100242	1.47	110002	1.20	110096	1.12
100243	1.28	110003	1.68	110097	0.86
100244	1.72	110004	1.67	110098	0.90

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
110100	0.81	112003	1.11	130036	2.54
110101	0.94	112004	0.55	130037	1.41
110103	0.80	113026	0.88	130043	1.22
110104	1.47	113027	1.00	130044	0.97
110105	2.14	113300	1.92	130045	1.41
110107	1.34	114000	0.87	130048	0.73
110108	0.53	114002	0.90	130049	2.21
110109	0.97	114003	0.87	130054	0.41
110111	1.25	114008	0.87	130056	0.52
110112	0.89	114010	0.95	130060	2.39
110113	0.94	114012	0.87	130061	1.14
110114	1.18	114015	0.73	133025	0.98
110115	1.85	114016	0.87	134002	0.86
110118	0.49	114017	0.87	134003	0.87
110120	0.76	114020	0.87	134009	0.89
110121	2.61	114022	0.87	140001	1.59
110122	1.77	114023	1.07	140002	1.55
110124	1.47	114024	0.89	140003	0.97
110125	2.34	114025	0.88	140004	1.72
110127	0.94	114030	0.99	140005	0.91
110128	1.67	114031	0.87	140007	1.70
110129	1.88	114032	0.93	140008	1.74
110130	1.03	114033	0.86	140010	1.53
110132	1.22	114034	0.87	140011	1.20
110134	0.76	120001	1.96	140012	1.37
110135	2.17	120002	1.75	140013	1.73
110136	0.73	120003	1.36	140014	1.60
110140	1.50	120004	1.42	140015	1.51
110141	0.74	120005	2.13	140016	1.22
110142	0.98	120006	1.51	140018	1.27
110143	1.96	120007	2.14	140019	1.03
110144	1.16	120009	0.77	140024	1.12
110146	1.38	120010	1.83	140025	1.03
110149	1.01	120012	0.86	140026	1.38
110150	1.84	120014	1.93	140027	1.23
110152	1.07	120018	0.50	140029	1.37
110153	1.97	120019	1.67	140030	1.91
110155	0.97	120022	0.91	140031	1.01
110156	1.40	120024	0.55	140032	1.49
110161	2.31	120025	0.54	140033	1.74
110163	2.66	120026	1.90	140034	1.41
110164	2.06	120027	1.30	140035	1.12
110165	1.75	122001	0.55	140036	1.63
110166	1.76	123025	0.98	140037	1.11
110168	2.11	123300	1.31	140038	0.93
110169	4.16	124001	0.87	140040	1.53
110171	1.46	130001	1.01	140041	1.22
110172	2.42	130002	1.74	140042	1.03
110174	1.22	130003	1.89	140043	1.96
110176	1.81	130005	3.16	140045	0.98
110177	2.02	130006	1.41	140046	1.49
110178	5.17	130007	2.35	140047	0.81
110179	1.57	130008	1.14	140048	1.32
110181	0.88	130009	1.62	140049	1.34
110183	1.25	130010	0.61	140051	1.65
110184	1.38	130011	2.22	140052	1.64
110185	1.00	130012	1.01	140053	2.10
110186	2.20	130013	1.74	140054	1.49
110187	1.44	130014	3.11	140055	0.97
110188	1.69	130015	0.83	140058	1.43
110189	1.46	130016	1.29	140059	1.52
110190	1.07	130017	1.35	140061	1.13
110191	2.22	130018	1.34	140062	1.49
110192	1.58	130019	1.49	140063	1.34
110193	1.86	130021	0.71	140064	1.88
110194	0.88	130022	2.96	140065	1.59
110195	0.93	130024	1.71	140066	1.06
110198	2.26	130025	1.44	140067	1.69
110200	2.96	130026	4.85	140068	1.16
110201	1.64	130027	1.11	140069	1.02
110203	0.92	130028	2.66	140070	1.20
110205	1.12	130029	1.22	140074	0.80
110207	0.90	130030	0.59	140075	1.74
110208	1.02	130031	1.59	140077	1.09
110209	0.87	130034	1.10	140079	1.60
112000	0.74	130035	1.22	140080	1.47

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
140081	1.09	140182	1.07	144034	0.87
140082	1.27	140184	1.18	144035	0.70
140083	0.97	140185	1.69	144036	0.87
140084	2.00	140186	1.38	150001	1.61
140086	1.36	140187	1.32	150002	1.43
140087	1.46	140188	0.88	150003	1.66
140088	1.07	140189	1.08	150004	1.39
140089	1.85	140190	1.09	150005	1.71
140090	1.74	140191	1.21	150006	1.92
140091	3.74	140193	1.54	150007	1.45
140093	1.60	140197	1.13	150008	1.65
140094	1.49	140199	1.24	150009	1.94
140095	1.23	140200	1.17	150010	1.77
140097	0.94	140202	1.75	150011	1.22
140100	1.86	140203	1.71	150012	2.09
140101	1.27	140205	2.25	150013	1.33
140102	1.24	140206	1.54	150014	1.49
140103	1.02	140207	1.64	150015	1.86
140105	1.69	140208	1.45	150018	1.79
140107	0.93	140209	1.75	150019	1.31
140108	1.87	140210	1.30	150020	1.63
140109	1.07	140211	1.62	150022	1.83
140110	1.37	140212	0.83	150023	1.53
140112	1.18	140213	1.41	150024	0.87
140113	1.41	140215	0.83	150026	1.68
140114	1.63	140217	1.36	150027	1.05
140115	1.42	140218	1.20	150029	2.35
140116	1.76	140220	1.26	150030	1.66
140117	1.85	140223	2.05	150031	1.09
140118	1.95	140224	1.55	150033	1.60
140119	1.80	140228	1.54	150034	1.72
140120	1.33	140230	0.69	150036	1.17
140121	1.50	140231	1.57	150037	1.71
140122	1.64	140233	1.68	150038	1.11
140125	1.34	140234	1.61	150039	1.50
140127	2.76	140236	0.85	150042	1.94
140128	1.05	140239	1.86	150043	1.21
140129	1.30	140240	1.33	150044	1.60
140130	1.67	140242	1.87	150045	1.05
140132	1.97	140245	1.16	150046	1.76
140133	1.22	140246	1.08	150047	1.24
140135	1.66	140250	1.10	150049	1.19
140137	0.82	140251	2.01	150050	1.33
140138	1.23	140252	1.48	150051	1.48
140139	1.07	140253	1.85	150052	1.40
140140	1.33	140258	1.56	150053	1.45
140141	1.17	140271	0.88	150054	1.11
140143	1.51	140275	1.61	150056	1.94
140144	1.01	140276	1.63	150057	2.23
140145	1.27	140280	1.52	150058	1.77
140146	1.33	140281	1.81	150059	1.45
140147	1.34	140285	1.32	150060	0.96
140148	1.95	140286	1.49	150061	1.55
140150	1.06	140288	1.39	150062	1.22
140151	0.92	140289	1.52	150063	1.01
140152	1.13	140290	2.00	150064	1.23
140155	1.65	140291	1.60	150065	1.50
140158	1.12	140292	1.54	150066	1.04
140160	2.20	140294	1.55	150067	1.34
140161	1.64	140297	1.05	150069	1.92
140162	1.50	140300	0.85	150070	1.15
140164	1.96	142006	0.45	150071	1.01
140165	1.45	142009	3.19	150072	1.32
140166	1.23	143025	0.86	150073	1.14
140167	1.62	143026	0.82	150074	1.67
140168	1.32	143027	0.97	150075	1.54
140170	1.01	143300	1.06	150076	1.45
140171	0.94	144005	0.95	150078	1.20
140172	1.02	144009	0.83	150079	1.08
140173	0.82	144019	0.63	150084	2.25
140174	1.54	144025	0.87	150089	1.72
140176	1.84	144026	0.87	150090	1.23
140177	1.32	144029	0.83	150091	1.20
140179	1.69	144030	0.88	150092	1.20
140180	1.34	144031	0.92	150094	1.41
140181	1.31	144033	0.67	150095	1.42

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
150096	1.49
150097	1.54
150098	1.19
150099	1.55
150101	1.40
150102	1.08
150103	0.99
150104	1.30
150105	1.19
150106	1.13
150109	2.13
150110	1.04
150111	1.06
150112	2.02
150113	1.59
150114	1.11
150115	2.08
150122	1.50
150123	0.82
150124	1.12
150125	1.62
150126	1.68
150127	0.82
150128	1.69
150129	1.59
150130	0.69
150132	1.73
150133	1.56
150134	1.14
150136	1.54
152007	0.40
152009	0.65
153025	1.30
153027	1.28
153029	0.87
153030	1.06
154009	1.02
154011	1.10
154013	0.93
154014	0.89
154026	0.93
154027	1.01
154028	0.89
154031	0.92
154032	1.07
154035	0.99
154036	0.78
154037	0.93
154038	0.92
154042	0.99
160001	1.86
160002	2.59
160003	1.15
160005	1.83
160007	0.76
160008	1.41
160009	1.01
160012	0.99
160013	1.50
160014	1.94
160016	1.77
160018	1.11
160020	1.14
160021	1.75
160023	1.50
160024	2.22
160026	1.26
160027	1.30
160028	1.42
160029	2.17
160030	2.48
160031	1.04
160032	1.53
160033	2.49
160034	1.58
160035	0.68

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
160036	1.83
160037	1.48
160039	1.55
160040	1.93
160041	0.99
160043	1.21
160044	1.78
160045	1.77
160046	1.83
160047	1.49
160048	1.01
160049	0.74
160050	1.60
160051	2.00
160052	1.25
160054	1.08
160055	1.26
160056	1.13
160057	1.88
160058	1.21
160060	1.24
160061	1.23
160062	1.09
160063	1.20
160064	3.23
160065	1.09
160066	1.68
160067	1.71
160068	1.47
160069	1.99
160070	1.20
160072	1.42
160073	0.85
160074	0.98
160075	1.08
160076	1.45
160077	1.08
160079	4.24
160080	1.87
160081	1.81
160082	2.11
160083	2.02
160085	1.01
160086	0.88
160088	1.24
160089	1.76
160090	1.12
160091	1.11
160092	1.24
160093	0.88
160094	1.41
160095	1.21
160097	1.19
160098	1.01
160099	1.09
160101	0.81
160102	2.26
160103	0.84
160104	1.48
160106	1.80
160107	1.18
160108	1.50
160109	1.04
160110	1.40
160111	1.08
160112	1.94
160113	0.87
160114	1.70
160115	1.35
160116	1.29
160117	1.96
160118	1.15
160120	0.60
160122	1.26
160124	1.42
160126	1.34

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
160129	1.50
160130	1.11
160131	1.01
160134	0.78
160135	2.27
160138	1.07
160140	1.12
160142	0.86
160143	1.18
160145	1.07
160146	2.30
160147	1.32
160151	1.13
160152	1.09
160153	1.92
164002	1.50
164003	0.55
170001	3.46
170004	1.09
170006	1.76
170008	4.11
170009	1.24
170010	1.50
170012	2.13
170013	2.22
170014	1.45
170015	1.20
170016	1.74
170017	1.87
170018	0.91
170019	1.59
170020	2.78
170022	1.64
170023	4.37
170024	1.11
170025	1.09
170026	1.87
170027	1.94
170030	0.97
170031	1.18
170032	0.91
170033	2.77
170034	1.32
170035	0.94
170036	0.68
170037	2.66
170038	0.68
170039	0.88
170040	1.73
170041	1.10
170043	0.67
170044	1.02
170045	2.01
170049	2.05
170051	0.69
170052	0.96
170053	0.68
170054	0.95
170055	0.89
170056	0.66
170057	1.15
170058	2.03
170060	1.24
170061	1.30
170063	0.91
170064	1.04
170066	0.70
170067	1.30
170068	3.21
170070	1.46
170072	0.79
170073	0.79
170074	1.39
170075	0.68
170076	1.36
170077	1.25

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
170079	0.97	180001	1.55	180117	1.65
170080	1.00	180004	1.47	180118	1.01
170081	0.97	180005	1.38	180120	1.03
170082	1.22	180006	0.81	180121	1.56
170084	0.96	180007	2.08	180122	1.08
170085	1.09	180009	1.91	180123	1.82
170086	3.87	180010	2.00	180124	2.10
170088	0.80	180011	1.61	180126	1.02
170089	0.78	180012	2.05	180127	1.79
170090	0.75	180013	1.84	180128	1.58
170092	0.90	180014	2.28	180129	1.05
170093	0.96	180015	1.36	180130	2.45
170094	0.95	180016	1.56	180132	1.90
170095	1.45	180017	1.73	180133	1.57
170097	1.17	180018	1.84	180134	1.10
170098	2.04	180019	2.09	180136	3.09
170099	1.52	180021	1.44	180137	1.26
170100	0.48	180023	1.17	180138	1.56
170101	0.93	180024	1.41	180139	1.29
170102	1.64	180025	1.90	180140	0.76
170103	2.21	180026	1.32	183026	0.71
170104	2.49	180027	1.97	183027	0.94
170105	1.25	180030	1.02	183028	0.94
170106	0.69	180031	0.96	183029	0.37
170109	1.09	180032	0.86	184000	0.97
170110	1.13	180033	1.17	184002	0.54
170112	0.78	180034	1.28	184007	0.87
170113	1.24	180035	1.57	184008	1.77
170114	1.55	180036	1.89	184009	0.89
170115	1.16	180037	1.79	184011	0.90
170116	1.58	180038	1.35	184015	0.58
170117	0.61	180040	2.44	184016	0.87
170119	0.91	180041	1.25	190002	1.76
170120	1.91	180042	1.35	190003	1.31
170122	1.84	180043	1.04	190004	1.85
170123	2.08	180044	1.58	190007	1.13
170124	1.58	180045	1.77	190008	1.93
170126	0.71	180046	1.53	190013	1.52
170128	1.27	180047	1.06	190014	1.54
170131	1.23	180048	1.79	190015	1.47
170133	8.93	180049	1.54	190017	1.17
170134	0.95	180051	1.93	190018	1.33
170137	1.88	180053	1.34	190019	1.55
170139	0.54	180054	1.58	190020	1.59
170142	2.10	180055	2.20	190025	1.27
170143	1.98	180056	1.65	190026	1.50
170144	2.15	180058	0.89	190027	1.39
170145	3.14	180059	1.06	190029	1.12
170146	1.47	180060	0.55	190033	0.71
170147	0.99	180063	0.89	190034	1.07
170148	1.87	180064	1.83	190035	1.77
170150	1.96	180065	0.81	190036	2.07
170151	1.23	180066	1.80	190037	0.69
170152	0.84	180067	1.70	190039	1.30
170160	0.91	180070	1.31	190040	1.94
170164	1.11	180072	1.54	190041	1.62
170166	0.85	180075	1.14	190043	0.48
170168	0.81	180078	1.33	190044	1.38
170171	0.92	180079	1.13	190045	1.44
170175	2.07	180080	2.64	190046	1.19
170176	2.23	180087	2.13	190048	0.84
170182	2.39	180088	2.47	190049	1.65
171304	0.55	180092	1.45	190050	1.41
171305	0.25	180093	1.89	190053	1.19
172004	0.52	180094	1.01	190054	1.46
173025	0.92	180095	1.17	190059	1.10
173026	1.13	180099	1.18	190060	1.70
173027	1.39	180101	1.10	190064	2.05
173028	1.31	180102	2.26	190065	1.40
174003	1.04	180103	1.89	190071	0.99
174006	0.58	180104	2.18	190077	0.58
174012	0.87	180105	1.08	190078	1.81
174014	1.08	180106	0.94	190079	1.14
174015	0.86	180108	0.85	190081	0.70
174016	0.98	180115	1.05	190083	0.87
174018	0.88	180116	1.57	190086	1.98

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
190088	1.12
190089	0.98
190090	1.16
190092	1.37
190095	1.18
190098	1.05
190099	0.91
190102	2.37
190103	0.64
190106	1.16
190109	1.03
190110	1.03
190111	1.93
190112	2.34
190113	1.92
190114	0.99
190115	3.87
190116	1.61
190118	1.14
190120	0.90
190124	1.74
190125	1.51
190128	1.55
190130	0.96
190131	1.04
190133	0.92
190134	0.76
190135	1.81
190136	0.66
190138	5.44
190140	1.22
190142	0.67
190144	1.96
190145	0.95
190146	1.30
190147	1.09
190148	0.73
190149	1.02
190151	1.27
190152	1.81
190155	0.92
190156	0.64
190158	1.34
190160	1.79
190162	1.18
190164	2.12
190167	1.08
190170	0.74
190173	1.39
190175	1.34
190176	1.15
190177	2.05
190178	0.74
190182	2.60
190184	0.76
190185	1.59
190186	0.70
190189	0.62
190190	1.14
190191	1.41
190196	1.97
190197	1.71
190200	1.62
190201	1.49
190202	1.66
190203	1.94
190204	1.60
190205	1.77
190206	1.40
190207	2.12
190208	0.72
190218	1.79
190231	3.50
192004	0.83
192005	0.84
192006	1.19

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
192008	0.69
192016	3.00
193027	1.10
193028	1.15
193034	0.80
193038	1.02
193041	0.54
193044	1.63
193300	0.94
194000	1.52
194004	0.83
194014	0.88
194018	0.87
194019	0.73
194020	0.25
194021	0.77
194022	0.72
194023	0.77
194024	1.12
194027	0.82
194029	0.87
194031	0.91
194044	0.86
194058	0.87
200001	1.86
200002	1.40
200003	1.19
200006	0.83
200007	1.15
200008	1.81
200009	1.54
200012	1.32
200013	1.34
200015	1.44
200016	1.20
200017	2.09
200018	1.43
200019	1.47
200020	1.45
200021	1.86
200023	0.74
200024	1.69
200025	1.55
200026	1.22
200027	1.72
200028	1.17
200031	1.22
200032	1.35
200033	1.44
200034	1.84
200037	1.30
200038	1.53
200039	1.59
200040	1.69
200041	1.47
200043	0.84
200050	1.86
200051	1.71
200052	1.16
200055	0.96
200062	0.94
200063	2.11
200066	1.38
203025	0.94
204005	0.97
204006	0.87
204007	0.49
213027	1.00
213028	3.29
214000	0.87
214003	0.90
214013	0.87
214015	0.83
214017	0.92
220001	1.47
220003	1.33

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
220004	1.42
220006	1.58
220008	1.28
220010	2.11
220011	1.11
220015	1.44
220016	1.36
220017	1.49
220019	1.54
220020	1.20
220021	1.39
220023	1.35
220024	1.57
220025	1.72
220028	1.32
220029	1.37
220030	1.00
220031	1.23
220033	1.41
220035	1.51
220036	1.34
220038	1.34
220041	1.44
220042	1.41
220046	1.76
220049	1.91
220050	1.43
220051	1.80
220052	1.45
220053	1.41
220055	1.70
220057	1.47
220058	1.25
220060	1.45
220062	0.92
220063	1.65
220064	1.49
220065	1.24
220066	1.70
220067	1.44
220068	0.85
220070	1.21
220071	1.29
220073	1.37
220074	1.34
220075	1.85
220076	1.30
220077	1.46
220079	1.18
220080	1.35
220081	2.37
220082	1.52
220083	1.63
220084	1.85
220086	1.38
220088	1.44
220089	1.39
220090	1.30
220092	1.36
220094	1.34
220095	1.31
220098	1.49
220100	1.35
220101	1.46
220104	1.01
220105	1.39
220106	1.45
220107	1.50
220108	1.76
220111	1.69
220116	1.19
220119	1.29
220123	1.94
220126	1.54
220128	1.33
220135	1.30

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
220153	0.58	230070	2.18	230184	3.32
220154	1.12	230071	7.65	230186	1.14
220163	1.16	230072	1.47	230188	1.49
220171	1.19	230075	1.75	230189	0.87
222000	0.87	230076	3.06	230190	0.81
222002	0.71	230077	2.07	230191	1.28
222006	1.00	230078	1.39	230193	1.40
222008	0.64	230080	1.87	230194	0.77
222023	0.86	230081	1.68	230195	1.92
222024	1.89	230082	1.20	230197	2.26
222026	0.79	230085	2.54	230199	1.41
222027	0.64	230086	1.11	230201	1.62
222029	0.75	230087	1.49	230204	1.54
222035	0.82	230089	1.65	230205	1.56
222043	0.55	230092	1.51	230207	1.33
222044	1.06	230093	1.78	230208	1.41
222045	3.55	230095	1.72	230211	0.63
223026	0.79	230096	1.52	230212	1.34
223027	0.90	230097	2.13	230213	0.90
223028	1.40	230099	1.46	230216	1.34
223029	0.74	230100	1.27	230217	1.43
223030	0.98	230101	1.47	230219	1.22
223302	1.52	230103	1.38	230221	1.32
224007	0.92	230104	1.52	230222	1.85
224013	0.97	230105	2.40	230223	1.88
224018	0.89	230106	1.26	230227	1.86
224021	0.89	230107	0.91	230230	1.90
224022	0.96	230108	1.60	230232	0.74
224023	0.46	230110	1.73	230235	1.34
224029	0.86	230111	1.17	230236	1.93
224034	0.95	230113	0.81	230239	1.53
224035	1.00	230114	5.22	230241	1.51
230001	1.47	230115	1.11	230244	1.80
230002	2.51	230116	1.29	230253	1.49
230003	1.26	230117	1.67	230254	1.85
230004	1.78	230118	1.55	230257	3.48
230005	1.49	230119	1.44	230259	1.76
230006	1.28	230120	1.61	230264	2.51
230007	1.78	230121	1.75	230269	1.97
230012	0.78	230122	2.20	230270	2.14
230013	1.37	230124	1.31	230273	1.30
230015	1.42	230125	1.19	230275	1.19
230017	1.83	230128	1.62	230276	0.72
230019	1.92	230129	1.63	230277	1.59
230020	2.00	230130	2.06	230278	1.19
230021	1.92	230132	1.49	230279	0.90
230022	1.70	230133	1.48	230280	1.39
230024	1.81	230134	1.63	233025	0.89
230027	1.15	230135	1.52	233026	0.79
230029	1.78	230137	1.52	233027	0.92
230030	1.90	230141	1.56	233028	1.02
230031	1.49	230142	1.31	233300	2.34
230032	2.24	230143	1.63	234006	1.00
230034	1.35	230144	1.68	234011	0.92
230035	1.44	230145	1.55	234021	0.71
230036	1.67	230146	1.30	234023	0.96
230037	1.56	230147	1.26	234029	0.88
230038	2.19	230149	1.06	234030	1.86
230040	1.53	230151	1.31	240001	2.47
230041	1.71	230153	1.37	240002	1.93
230042	1.24	230154	0.97	240004	0.93
230046	1.34	230155	1.08	240005	0.74
230047	1.99	230156	1.52	240006	1.80
230053	0.96	230157	1.89	240007	1.63
230054	1.81	230159	1.95	240008	1.94
230055	1.38	230162	0.76	240009	0.99
230056	1.15	230165	2.29	240010	2.46
230058	1.64	230167	1.77	240011	2.02
230059	2.18	230169	1.80	240013	1.40
230060	1.51	230171	1.00	240014	1.40
230062	1.07	230172	1.21	240016	1.95
230063	1.54	230174	1.44	240017	2.36
230065	1.90	230175	0.83	240018	2.14
230066	1.70	230176	1.98	240019	1.84
230068	1.71	230178	1.16	240020	1.25
230069	1.27	230180	1.27	240021	1.27

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
240022	1.34
240023	1.35
240025	1.23
240027	1.94
240028	1.28
240029	1.86
240030	2.15
240031	1.28
240036	1.67
240037	1.16
240038	1.95
240040	1.51
240041	1.38
240043	2.18
240044	1.64
240045	1.77
240047	2.26
240048	2.67
240049	1.24
240050	1.79
240051	1.75
240052	1.46
240053	2.00
240056	2.27
240057	1.55
240058	1.01
240059	2.57
240061	4.46
240063	1.85
240064	2.03
240065	1.13
240066	2.49
240069	2.04
240071	1.73
240072	1.77
240073	1.05
240075	1.69
240076	1.69
240077	1.50
240078	2.33
240079	0.99
240080	1.36
240082	1.19
240083	1.40
240084	1.54
240085	0.88
240086	1.32
240087	1.24
240088	1.28
240089	0.91
240090	2.46
240093	1.69
240094	1.12
240096	0.90
240097	3.54
240098	1.21
240099	1.17
240100	1.99
240101	1.25
240102	0.96
240103	1.07
240104	1.64
240105	0.74
240106	0.98
240107	1.22
240108	1.58
240109	1.21
240110	1.50
240111	1.44
240112	1.29
240114	1.11
240115	1.86
240116	1.25
240117	0.88
240119	0.75
240121	1.42

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
240122	1.00
240123	1.29
240124	1.40
240125	1.17
240127	1.02
240128	2.03
240129	1.41
240130	1.68
240132	1.77
240133	2.16
240135	0.55
240137	2.27
240138	0.98
240139	1.39
240141	1.52
240142	1.16
240143	1.24
240144	1.74
240145	0.93
240146	1.44
240148	0.93
240150	0.78
240152	1.65
240153	1.16
240154	1.13
240155	1.48
240157	1.80
240160	1.39
240161	0.99
240162	1.47
240163	1.20
240166	2.19
240169	1.46
240170	1.11
240171	1.72
240172	1.14
240173	1.58
240179	0.98
240184	1.24
240187	2.12
240193	1.36
240196	9.90
240200	0.61
240207	1.76
240210	1.90
240211	0.68
242004	0.77
243300	0.93
243302	6.10
244009	2.18
250001	1.60
250002	1.01
250003	0.68
250004	1.91
250005	0.71
250006	1.39
250007	1.33
250008	0.68
250009	2.02
250010	0.91
250012	0.85
250015	1.43
250017	0.84
250018	0.44
250019	1.59
250020	0.87
250021	0.53
250023	0.47
250024	0.59
250025	1.29
250027	1.13
250029	0.99
250030	0.74
250031	2.64
250032	1.28
250033	1.04

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
250034	2.16
250035	1.09
250036	1.21
250037	0.98
250038	0.83
250039	0.68
250040	1.66
250042	1.50
250043	1.13
250044	1.23
250045	1.10
250047	0.61
250048	2.62
250049	0.80
250050	1.38
250051	0.75
250057	1.64
250058	1.91
250059	1.35
250060	0.68
250061	0.93
250063	0.88
250065	0.92
250066	0.75
250067	0.92
250068	1.01
250069	2.29
250071	0.78
250072	1.58
250076	0.46
250077	0.91
250078	1.77
250079	0.81
250081	2.72
250082	1.70
250083	0.86
250084	1.93
250085	0.96
250088	1.12
250089	1.05
250093	1.16
250094	2.41
250095	1.56
250096	1.33
250097	1.88
250098	0.73
250099	2.48
250100	1.57
250101	0.73
250102	1.84
250104	2.12
250105	0.86
250107	0.79
250109	0.75
250112	0.85
250117	0.86
250119	1.04
250120	1.42
250122	1.74
250123	1.90
250124	0.83
250125	1.53
250126	0.83
250128	1.14
250131	0.93
250134	0.63
250136	2.86
250138	2.95
250141	1.97
250144	0.55
250145	0.85
250146	0.81
250148	1.26
250149	0.80
252003	0.32
253025	1.39

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
254001	0.81	260107	2.14	270012	2.09
254002	0.80	260108	1.39	270013	1.84
254006	0.94	260109	1.20	270014	2.23
260001	1.38	260110	1.85	270016	0.77
260002	1.40	260113	1.47	270017	1.27
260003	1.05	260115	1.07	270019	0.73
260004	0.88	260116	1.68	270021	1.21
260005	1.66	260119	1.64	270023	2.07
260006	1.88	260120	1.62	270024	0.63
260007	1.83	260122	1.18	270026	1.43
260008	0.82	260123	0.90	270027	0.93
260009	1.81	260127	0.99	270028	1.70
260011	1.67	260128	0.88	270029	1.26
260012	1.14	260129	1.28	270032	2.60
260013	1.37	260131	1.27	270033	0.61
260014	1.86	260134	1.52	270035	1.00
260015	1.41	260137	2.07	270036	0.85
260017	1.84	260138	1.71	270039	1.20
260018	0.69	260141	1.25	270040	1.45
260019	1.11	260142	1.96	270041	0.89
260020	2.06	260143	0.82	270044	1.42
260021	1.44	260147	0.96	270046	0.77
260022	1.43	260148	0.92	270048	1.75
260023	1.77	260158	1.11	270049	1.27
260024	1.06	260159	1.50	270050	1.18
260025	2.36	260160	0.95	270051	1.78
260027	1.54	260162	1.90	270052	0.67
260029	1.33	260163	1.08	270053	0.60
260030	0.75	260164	1.19	270057	1.54
260031	1.66	260166	1.39	270058	0.85
260032	1.73	260172	1.20	270059	0.49
260034	1.13	260173	0.79	270060	0.61
260035	0.87	260175	1.79	270063	0.77
260036	1.26	260176	1.68	270068	1.19
260039	0.91	260177	1.92	270072	0.43
260040	1.50	260178	2.47	270073	0.72
260042	1.10	260179	1.50	270079	1.16
260044	1.10	260180	1.46	270080	1.30
260047	1.37	260183	2.01	270081	0.65
260048	1.43	260186	1.55	270082	0.70
260050	1.51	260188	1.53	270083	0.89
260052	1.62	260189	0.57	270084	1.09
260053	1.26	260190	1.81	271225	0.49
260054	1.57	260191	1.68	271226	0.69
260055	0.95	260193	1.97	271227	0.50
260057	1.30	260195	1.26	271228	0.57
260059	1.16	260197	1.77	271229	0.67
260061	1.57	260198	1.52	271230	0.56
260062	1.52	260200	1.27	271231	0.67
260063	1.31	262001	0.66	271232	0.60
260064	1.66	262011	0.58	271233	0.61
260065	1.34	263025	1.28	280001	1.33
260066	1.25	263026	1.15	280003	2.35
260067	0.80	263300	2.18	280005	1.63
260068	1.63	263301	1.21	280009	2.17
260070	0.94	263302	1.23	280010	0.77
260073	0.97	264005	0.83	280011	1.58
260074	1.16	264007	0.82	280012	1.24
260077	2.07	264008	0.82	280013	1.41
260078	1.49	264010	0.65	280014	1.15
260079	0.91	264011	1.18	280015	1.48
260080	1.18	264013	0.87	280017	1.18
260081	1.66	264015	0.91	280018	1.13
260082	1.00	264016	2.03	280020	1.31
260085	1.73	264017	1.17	280021	1.75
260086	1.17	264021	0.69	280022	0.95
260091	2.45	264024	0.87	280023	1.19
260094	1.63	264025	0.78	280024	0.92
260095	1.42	264026	0.87	280025	0.75
260096	1.53	270002	1.64	280026	0.97
260097	2.58	270003	1.63	280028	2.02
260100	1.09	270004	1.74	280029	0.84
260102	0.79	270006	0.43	280030	1.72
260103	1.20	270007	0.70	280031	1.45
260104	1.54	270009	0.97	280032	1.81
260105	1.75	270011	1.46	280033	0.98

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
280034	1.65
280035	1.17
280037	1.01
280038	1.28
280039	1.56
280040	2.07
280041	0.95
280042	0.79
280043	2.09
280045	1.15
280046	1.06
280047	1.68
280048	1.22
280049	0.89
280050	1.16
280051	1.45
280052	1.44
280054	1.15
280055	0.84
280056	0.96
280057	1.45
280058	2.18
280060	1.30
280061	2.55
280062	2.96
280064	1.28
280065	1.88
280066	1.26
280068	0.87
280070	1.30
280073	1.10
280074	1.85
280075	2.00
280076	1.60
280077	2.48
280079	0.82
280080	1.19
280081	1.58
280082	0.87
280083	1.34
280084	1.01
280085	1.66
280088	2.74
280089	1.45
280090	0.72
280091	3.55
280092	0.98
280094	1.36
280097	1.08
280098	0.71
280101	0.73
280102	1.00
280104	1.38
280105	1.67
280106	1.22
280107	1.16
280108	5.55
280109	0.77
280110	1.50
280111	1.21
280114	0.89
280115	2.12
280117	1.72
280118	1.01
283025	0.66
283301	1.10
284007	1.47
290001	1.46
290002	0.51
290003	1.81
290005	2.49
290006	1.10
290007	1.00
290008	1.34
290009	1.40
290010	1.10

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
290011	0.79
290012	1.49
290013	0.59
290014	1.16
290015	0.88
290016	1.11
290019	1.56
290020	0.59
290021	1.46
290022	1.97
290027	0.84
290032	1.28
290038	1.08
292002	0.76
293027	0.96
294003	0.73
294004	0.78
294005	0.89
300001	1.67
300003	1.26
300005	1.56
300006	1.26
300007	1.57
300008	1.76
300009	1.23
300010	1.01
300011	1.75
300012	1.39
300013	1.07
300014	1.51
300015	1.57
300016	1.29
300017	1.43
300018	1.63
300019	1.64
300021	1.18
300022	1.75
300023	1.29
300024	1.46
300028	1.23
300029	2.12
300033	0.98
300034	1.66
303026	1.26
303027	1.00
304000	0.55
304001	7.13
304003	0.87
310001	1.58
310002	1.44
310005	1.62
310006	1.84
310008	2.66
310009	1.69
310010	1.36
310011	2.11
310012	2.19
310013	1.53
310014	1.69
310015	1.58
310016	1.81
310017	2.03
310018	1.76
310019	1.84
310020	1.87
310021	1.60
310022	1.72
310024	2.26
310025	1.84
310026	1.64
310027	1.62
310028	1.67
310029	2.82
310031	1.35
310032	1.65
310034	2.02

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
310036	1.44
310037	1.64
310039	2.07
310041	1.66
310042	1.68
310043	1.86
310044	1.53
310045	1.87
310047	2.07
310048	1.87
310050	1.25
310051	1.99
310052	1.53
310054	1.63
310056	1.12
310057	1.66
310058	0.83
310060	2.12
310061	1.95
310062	1.24
310063	1.90
310064	1.78
310067	1.73
310069	1.69
310070	1.96
310072	2.01
310073	1.63
310074	0.97
310076	1.38
310077	1.79
310078	1.45
310081	1.90
310083	1.00
310084	1.44
310086	1.58
310087	1.49
310088	1.28
310090	2.02
310091	2.12
310092	1.63
310093	1.61
310096	1.97
310105	1.06
310108	1.74
310111	1.49
310112	1.91
310113	1.77
310115	1.30
310116	1.65
310118	1.48
310120	1.25
312014	0.70
313025	0.95
313026	0.91
313027	0.99
313029	1.05
313030	0.78
313300	0.90
314001	1.00
314010	0.88
314011	0.89
314012	1.07
314021	0.91
314022	0.87
320001	0.97
320002	1.15
320003	1.52
320004	1.64
320005	1.85
320006	1.73
320009	1.59
320011	1.16
320012	1.48
320013	1.35
320014	1.02
320016	1.91

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
320017	1.31	330061	2.02	330193	1.70
320018	2.01	330062	0.92	330194	1.31
320019	0.80	330064	1.55	330195	1.49
320021	1.21	330065	1.65	330197	1.45
320022	1.76	330066	1.43	330198	1.68
320023	0.81	330067	1.75	330203	2.34
320030	1.17	330072	1.25	330205	1.39
320031	0.74	330073	1.30	330208	1.62
320032	0.91	330074	1.88	330209	1.54
320033	1.53	330075	1.32	330211	1.34
320035	0.72	330078	1.32	330212	1.64
320037	1.40	330079	1.38	330213	1.09
320038	1.46	330084	1.35	330214	1.82
320046	1.20	330085	1.19	330215	1.69
320048	0.91	330086	1.28	330218	1.16
320063	1.46	330088	1.15	330219	1.23
320065	1.32	330090	1.59	330221	1.36
320067	0.77	330091	1.53	330222	1.76
320068	0.91	330092	0.88	330223	1.29
320069	1.25	330094	1.27	330224	1.68
320074	1.31	330095	1.62	330225	1.51
320079	1.47	330096	1.49	330226	1.50
322002	1.31	330097	1.15	330229	1.40
322003	0.52	330100	3.05	330230	1.59
323025	0.92	330101	1.52	330232	1.38
323026	0.74	330102	1.90	330233	1.27
323027	0.92	330103	1.90	330235	1.96
323028	1.09	330104	1.44	330236	1.37
323029	0.87	330106	1.88	330238	1.53
324003	0.88	330107	1.75	330239	1.45
324004	0.87	330108	1.49	330241	1.63
324007	0.97	330111	1.34	330242	1.70
324008	0.98	330114	0.59	330245	1.49
324010	1.10	330115	1.59	330246	1.67
330001	1.68	330116	1.23	330247	3.47
330002	1.49	330118	1.68	330249	1.30
330003	1.56	330119	1.86	330250	1.51
330004	1.59	330121	0.87	330252	0.76
330005	1.62	330122	1.79	330254	1.34
330006	1.50	330125	1.31	330258	0.96
330007	1.54	330126	1.64	330259	1.52
330008	1.46	330132	0.98	330261	1.46
330010	1.38	330133	1.96	330263	1.76
330011	1.13	330135	1.56	330264	1.62
330012	1.47	330136	0.84	330265	1.10
330013	1.91	330140	1.72	330267	1.43
330014	1.26	330141	1.59	330268	0.96
330016	1.28	330144	1.48	330270	1.34
330020	0.84	330148	1.09	330273	1.63
330023	1.68	330151	1.30	330275	1.29
330024	1.55	330152	1.71	330276	1.21
330025	1.25	330153	1.51	330277	1.72
330027	0.61	330157	1.28	330279	1.84
330028	1.15	330158	1.69	330285	1.38
330029	1.05	330159	1.59	330286	1.62
330030	1.58	330160	1.40	330288	0.67
330033	1.02	330161	0.87	330290	1.25
330034	0.71	330162	2.57	330293	1.10
330036	1.57	330163	1.68	330304	1.79
330037	1.58	330164	1.28	330306	1.18
330038	1.23	330166	1.34	330307	1.80
330039	0.72	330167	2.53	330308	1.98
330041	2.14	330169	1.43	330314	1.81
330043	1.30	330171	1.48	330316	2.02
330044	1.61	330175	1.33	330327	1.13
330045	2.04	330177	1.24	330331	1.65
330046	1.31	330179	0.84	330332	2.55
330047	1.51	330180	1.26	330333	1.80
330048	1.78	330181	1.54	330336	1.40
330049	1.62	330182	2.51	330338	1.79
330053	1.20	330183	1.28	330339	2.41
330055	1.71	330184	1.53	330340	1.65
330056	1.29	330185	1.11	330350	1.42
330057	1.64	330188	1.66	330353	1.89
330058	1.40	330189	5.26	330357	1.29
330059	1.44	330191	1.48	330359	0.65

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
330372	1.88
330381	1.26
330386	1.30
330389	1.37
330390	0.94
330393	1.81
330394	1.59
330395	1.55
330397	0.96
330398	2.02
330399	0.88
332012	0.83
332021	0.53
332022	0.77
333025	0.77
333027	0.80
333028	0.72
333300	1.34
334002	0.87
334022	0.89
334023	1.10
334027	0.75
334048	1.30
334049	0.86
334055	0.83
340001	1.24
340002	2.20
340003	1.37
340004	1.79
340005	1.28
340006	0.92
340007	1.18
340008	1.44
340009	11.22
340010	1.92
340011	1.10
340012	1.45
340013	1.29
340014	0.99
340015	1.80
340016	1.99
340017	1.77
340018	1.40
340019	1.06
340020	1.31
340021	1.63
340022	1.20
340023	1.19
340024	1.41
340025	1.78
340027	1.94
340028	1.49
340030	1.51
340031	1.22
340032	1.67
340035	1.51
340036	1.05
340037	1.16
340038	2.00
340039	1.70
340040	1.99
340041	1.27
340042	1.29
340044	1.03
340045	0.69
340047	1.56
340049	4.05
340050	2.52
340051	1.76
340052	1.21
340053	2.01
340054	1.46
340055	1.23
340060	1.43
340061	1.19
340063	0.85

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
340064	1.88
340065	1.21
340067	1.46
340068	1.62
340069	1.54
340070	1.62
340071	1.21
340072	1.47
340073	1.93
340075	1.27
340080	1.07
340084	0.91
340085	1.49
340087	1.16
340088	1.73
340089	0.95
340090	1.30
340091	1.97
340093	1.10
340094	2.16
340096	1.65
340097	1.61
340098	1.74
340099	1.19
340100	0.55
340101	1.49
340104	1.12
340105	2.59
340106	1.25
340107	1.87
340109	2.34
340111	1.41
340112	1.15
340113	1.55
340114	1.32
340115	1.50
340116	1.75
340119	1.39
340120	1.17
340121	1.35
340123	1.38
340124	1.22
340125	2.53
340126	1.71
340127	1.20
340129	1.60
340130	1.69
340131	1.74
340132	1.29
340133	0.94
340141	1.78
340142	1.33
340143	1.72
340144	1.88
340145	1.56
340146	0.80
340147	1.96
340148	2.81
340151	1.53
340153	2.63
340155	1.59
340158	1.75
340159	0.93
340160	1.50
340162	1.08
340164	1.23
340166	1.28
340171	1.65
342003	1.01
342012	0.55
343025	1.00
344005	0.87
344006	0.87
344010	0.68
344011	1.01
344014	1.08

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
344015	0.87
344016	0.72
344019	0.87
350001	0.71
350002	2.20
350003	1.45
350004	2.27
350005	1.22
350006	1.32
350007	1.37
350008	1.11
350009	1.85
350010	1.32
350011	1.84
350012	1.09
350013	1.12
350014	1.20
350015	2.07
350016	0.69
350017	1.48
350018	1.45
350019	2.12
350020	0.83
350021	1.08
350023	1.43
350024	1.19
350025	0.90
350027	0.68
350029	0.88
350030	1.44
350033	1.32
350034	1.21
350035	0.56
350038	1.80
350039	1.23
350041	0.93
350042	1.75
350043	1.74
350044	1.10
350047	1.11
350049	1.43
350050	0.91
350051	1.04
350053	0.86
350055	0.81
350056	1.24
350058	1.02
350060	0.54
350061	1.54
360001	1.79
360002	1.50
360003	1.29
360006	2.02
360007	1.28
360008	1.36
360009	1.56
360010	1.64
360011	1.33
360012	1.89
360013	1.36
360014	1.63
360016	1.27
360017	2.64
360018	1.57
360019	1.38
360020	1.41
360021	3.45
360024	1.47
360025	1.10
360026	1.38
360027	1.68
360028	2.30
360029	1.62
360030	1.48
360031	1.34
360032	1.62

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
360034	0.96	360125	1.13	362015	0.99
360035	1.31	360126	1.25	363300	1.21
360036	1.55	360127	1.49	363303	1.31
360037	1.35	360128	1.04	363305	1.22
360038	1.43	360129	1.04	363306	0.86
360039	1.36	360130	1.36	364003	0.92
360040	1.24	360131	1.46	364017	0.85
360041	1.46	360132	1.67	364026	0.88
360042	1.24	360133	1.66	364029	0.93
360044	1.56	360134	1.63	364032	1.09
360045	1.24	360136	1.06	364038	1.10
360046	1.51	360137	1.52	370001	1.82
360047	0.97	360140	1.02	370002	1.98
360048	1.57	360141	1.82	370004	1.78
360049	1.60	360142	1.23	370005	0.92
360050	1.00	360143	1.50	370006	1.53
360051	1.96	360144	1.68	370007	1.43
360052	1.45	360145	1.63	370008	1.77
360054	1.69	360147	1.54	370011	1.12
360055	1.66	360148	1.36	370012	0.86
360056	1.67	360149	1.73	370013	1.89
360057	1.10	360150	1.77	370014	1.59
360058	1.19	360151	1.71	370015	1.18
360059	1.11	360152	1.71	370016	1.85
360062	1.69	360153	1.10	370017	1.20
360063	1.09	360154	1.00	370018	2.00
360064	2.07	360155	1.65	370019	1.45
360065	1.42	360156	1.42	370020	1.40
360066	1.64	360159	1.46	370021	0.86
360067	1.06	360161	1.53	370022	2.88
360068	1.53	360162	1.42	370023	1.43
360069	1.18	360163	1.85	370025	1.63
360070	1.23	360164	1.06	370026	1.88
360071	1.40	360165	1.00	370028	2.09
360072	1.47	360166	1.13	370029	1.59
360074	1.46	360170	1.30	370030	1.20
360075	1.50	360172	1.72	370032	2.50
360076	1.68	360174	1.67	370033	1.71
360077	1.61	360175	1.68	370034	1.60
360078	1.46	360176	1.14	370035	1.26
360079	1.80	360177	0.96	370036	0.53
360080	1.36	360178	1.37	370037	2.76
360081	1.53	360179	1.51	370038	0.96
360082	1.83	360180	1.80	370039	1.29
360083	1.53	360184	0.88	370040	2.17
360084	1.70	360185	1.41	370041	1.09
360085	1.93	360186	0.97	370042	0.91
360086	1.45	360187	1.64	370043	0.81
360087	1.48	360188	1.03	370045	0.98
360088	1.21	360189	1.44	370046	1.48
360089	1.34	360192	1.44	370047	1.81
360090	2.29	360193	1.52	370048	1.13
360091	1.47	360194	1.34	370049	2.04
360092	1.15	360195	1.77	370051	0.77
360093	1.93	360197	1.19	370054	1.70
360094	1.29	360200	1.00	370056	1.81
360095	1.59	360203	1.50	370057	1.23
360096	1.41	360204	1.26	370059	0.65
360098	1.88	360210	1.58	370060	1.04
360099	1.23	360211	1.46	370063	0.91
360100	1.62	360212	1.50	370064	1.03
360101	1.92	360213	1.32	370065	1.63
360102	1.87	360218	1.42	370071	0.89
360103	1.39	360230	1.87	370072	0.88
360106	1.05	360231	0.87	370076	1.46
360107	1.21	360234	1.31	370077	1.37
360108	1.11	360236	1.58	370078	2.17
360109	1.32	360239	1.64	370079	1.24
360112	1.66	360241	0.81	370080	1.02
360113	1.58	360243	0.87	370082	0.89
360114	1.30	360244	0.87	370083	1.54
360115	1.47	360245	0.89	370084	1.13
360116	1.07	362004	1.18	370085	1.07
360118	1.40	362007	0.33	370086	1.54
360121	1.94	362009	0.94	370089	1.35
360123	1.42	362014	3.41	370091	2.03

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
370092	1.63
370093	2.42
370094	1.99
370095	0.91
370097	1.46
370099	1.35
370100	0.88
370103	1.08
370105	2.87
370106	2.52
370108	1.02
370112	0.99
370113	1.21
370114	1.91
370121	1.82
370122	0.63
370123	1.81
370125	1.27
370126	0.84
370131	0.85
370133	1.16
370138	1.50
370139	1.03
370140	1.13
370141	1.14
370146	0.87
370148	1.40
370149	1.84
370153	1.69
370154	1.56
370156	1.46
370158	1.38
370159	1.35
370163	0.80
370165	0.99
370166	1.31
370169	1.50
370176	1.65
370177	1.07
370178	1.33
370179	0.90
370183	1.38
370186	1.45
370190	1.66
370192	2.00
372004	0.51
373025	0.97
373026	0.84
374003	0.71
374006	0.79
374008	1.09
374010	0.98
374012	0.88
374013	0.85
374017	0.90
374018	0.68
374019	0.95
374020	0.85
380001	2.38
380002	2.39
380003	2.52
380004	3.35
380005	2.55
380006	1.64
380007	2.26
380008	1.37
380009	1.48
380010	1.45
380011	1.95
380013	1.08
380014	2.43
380017	3.10
380018	1.40
380019	1.26
380020	3.28
380021	2.64

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
380022	2.06
380023	1.47
380025	2.38
380026	1.62
380027	1.58
380029	1.88
380031	1.02
380033	1.81
380035	2.25
380036	1.39
380037	1.74
380038	2.14
380039	1.64
380040	1.76
380042	1.52
380047	2.34
380048	0.72
380050	1.43
380051	1.77
380052	2.78
380056	1.24
380060	1.75
380061	2.66
380062	0.62
380063	1.77
380064	1.51
380065	0.96
380066	2.44
380068	1.03
380069	0.88
380070	1.04
380071	2.13
380072	1.31
380075	1.51
380078	1.14
380081	0.77
380082	2.32
380083	1.63
380084	1.58
380087	0.95
380088	1.55
380089	2.58
380090	1.93
384006	0.90
390001	1.79
390002	1.62
390003	1.11
390004	1.68
390005	1.48
390006	1.17
390007	2.39
390008	1.36
390009	1.68
390010	1.63
390011	1.57
390012	1.81
390013	1.93
390015	1.15
390016	1.43
390017	1.44
390018	1.86
390019	1.37
390022	1.85
390023	1.12
390024	1.99
390025	0.72
390026	1.36
390028	1.98
390029	1.72
390030	1.45
390031	1.55
390032	1.45
390035	1.67
390036	1.75
390037	1.76
390039	1.53

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
390040	1.13
390041	1.81
390042	1.62
390043	1.89
390044	1.76
390045	1.51
390046	1.31
390047	1.65
390048	1.55
390049	1.82
390050	2.01
390051	1.78
390052	1.65
390054	1.35
390055	1.76
390056	1.41
390057	1.67
390058	2.05
390060	1.16
390061	1.56
390062	1.87
390063	2.32
390065	1.63
390066	1.44
390067	1.84
390068	1.27
390069	1.51
390070	2.11
390071	1.61
390072	1.42
390073	1.70
390074	1.74
390075	1.53
390076	1.51
390078	1.74
390079	2.09
390080	1.57
390081	2.02
390083	1.19
390084	1.26
390086	1.57
390088	1.27
390090	1.91
390091	1.44
390093	1.31
390095	1.52
390096	1.46
390097	1.57
390100	1.70
390101	1.24
390102	1.81
390103	1.39
390104	1.26
390106	1.31
390107	1.66
390108	1.54
390109	1.15
390110	1.43
390111	1.36
390112	1.54
390113	1.55
390114	1.64
390115	1.44
390116	1.39
390118	1.85
390119	1.71
390121	1.59
390122	1.47
390123	2.69
390125	1.55
390126	1.77
390127	1.63
390128	1.87
390130	1.35
390131	1.69
390132	1.30

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
390133	1.71	390246	1.66	400114	0.95
390135	1.45	390247	0.66	400115	0.77
390136	2.33	390249	0.72	400117	1.34
390137	1.75	390256	1.26	400118	1.14
390138	1.45	390258	1.64	400120	1.44
390139	1.64	390260	2.34	400121	0.50
390142	1.16	390262	1.79	400122	0.65
390145	1.59	390263	1.87	400123	2.61
390146	1.37	390265	1.06	400124	6.42
390147	1.48	390266	1.65	404002	1.66
390150	1.32	390267	1.78	410001	1.45
390151	1.58	390268	1.70	410004	1.61
390152	1.65	390270	1.69	410005	2.08
390153	1.26	390277	0.67	410006	1.53
390154	1.82	390279	1.54	410007	1.72
390155	0.92	392024	1.04	410008	2.13
390156	2.28	392025	1.08	410009	2.11
390157	1.60	392026	0.75	410010	1.54
390158	1.49	393025	0.75	410011	1.94
390160	1.74	393026	1.05	410012	1.59
390161	1.69	393027	1.41	410013	1.81
390162	1.71	393031	1.11	413025	0.74
390163	1.58	393032	0.85	414000	1.33
390164	1.52	393035	0.67	420002	3.24
390166	1.19	393037	0.87	420004	2.85
390167	1.49	393038	1.12	420005	2.33
390168	1.50	393039	0.93	420006	0.86
390169	2.09	393040	2.28	420007	1.69
390170	1.87	393041	1.47	420009	1.66
390173	1.63	393042	0.92	420010	1.55
390174	1.70	393043	0.62	420011	1.18
390176	1.38	393046	0.83	420014	0.97
390178	1.69	393301	1.27	420015	1.61
390179	1.61	393302	1.02	420016	1.37
390180	1.30	394006	0.79	420018	1.37
390181	1.56	394007	0.48	420019	1.88
390183	1.60	394008	1.88	420020	2.01
390184	1.13	394020	0.83	420023	2.55
390185	1.87	394023	0.77	420026	2.05
390189	1.38	394027	0.81	420027	1.82
390191	1.91	394034	0.85	420030	1.60
390192	1.44	394040	0.78	420031	0.91
390193	1.86	394041	0.83	420033	1.52
390194	1.45	394045	0.90	420036	2.26
390195	1.85	400001	1.10	420037	1.41
390197	2.04	400002	3.18	420038	1.37
390198	1.58	400003	0.97	420039	1.18
390199	1.12	400004	1.33	420042	1.17
390200	1.05	400005	1.12	420043	1.29
390201	1.53	400006	1.58	420048	1.97
390203	1.75	400007	0.76	420049	1.93
390204	1.64	400009	1.26	420051	1.67
390205	1.61	400010	0.76	420053	1.66
390206	1.43	400011	1.43	420054	1.21
390209	1.34	400012	0.74	420055	1.18
390211	1.73	400013	0.89	420056	1.52
390213	0.70	400014	3.08	420057	1.16
390215	1.74	400016	1.70	420059	1.07
390217	1.41	400017	1.31	420061	1.12
390219	1.21	400018	0.90	420062	1.73
390220	2.63	400019	2.15	420064	1.02
390222	1.86	400021	1.36	420065	1.82
390223	0.85	400022	1.25	420066	1.27
390224	1.13	400026	0.61	420067	3.32
390225	1.43	400027	0.58	420068	1.63
390226	1.54	400028	1.08	420069	1.19
390228	1.53	400029	0.73	420070	2.73
390231	1.35	400032	0.75	420071	1.64
390233	1.41	400094	0.74	420072	0.83
390235	1.09	400098	0.89	420073	1.92
390236	1.42	400102	1.52	420074	0.95
390237	1.45	400106	0.99	420075	1.39
390238	3.25	400109	1.29	420078	1.85
390242	1.66	400111	0.92	420079	1.17
390244	0.64	400112	0.70	420080	2.72
390245	1.34	400113	1.34	420081	0.61

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
420082	1.81	440018	1.04	440151	1.31
420083	3.22	440019	1.54	440152	1.04
420085	2.37	440020	1.26	440153	1.27
420086	2.02	440022	1.03	440156	2.55
420087	1.99	440023	1.05	440157	1.10
420088	1.80	440024	1.75	440159	1.24
420089	2.68	440025	1.42	440161	2.26
420091	2.25	440026	0.88	440162	0.74
423025	1.90	440029	1.98	440166	1.81
423026	1.11	440030	1.74	440168	1.27
424006	0.87	440031	1.44	440173	2.57
424007	0.72	440032	0.99	440174	1.25
424008	0.88	440033	1.22	440175	1.48
424009	0.71	440034	1.61	440176	1.74
424010	0.88	440035	1.63	440178	1.26
430004	1.41	440039	1.45	440180	1.16
430005	1.88	440040	1.04	440181	1.25
430007	2.02	440041	0.76	440182	1.24
430008	1.54	440046	1.52	440183	2.93
430010	1.68	440047	1.09	440184	2.01
430011	2.90	440048	2.09	440185	1.39
430012	2.09	440049	1.66	440186	1.27
430013	1.87	440050	1.22	440187	1.25
430014	1.96	440051	1.04	440189	2.18
430015	3.56	440052	1.02	440192	1.07
430016	1.73	440053	1.89	440193	1.93
430018	0.99	440054	1.29	440194	1.39
430022	0.75	440056	1.12	440197	1.71
430023	1.01	440057	1.21	440200	1.34
430024	0.87	440058	1.97	440203	1.26
430026	0.95	440059	1.63	440205	0.92
430027	2.50	440060	1.01	440206	1.19
430028	1.47	440061	1.36	442007	0.68
430029	1.47	440063	1.59	443025	1.05
430031	1.06	440064	1.02	443026	1.03
430033	1.06	440065	1.53	443028	1.05
430034	0.94	440067	1.46	443029	2.01
430036	1.17	440068	1.45	444003	0.74
430037	2.29	440070	1.08	444004	0.88
430038	1.49	440071	1.63	444006	0.89
430040	2.17	440072	1.78	444010	0.82
430041	0.95	440073	1.68	444011	0.98
430043	1.53	440078	1.04	444012	0.94
430044	1.02	440081	1.32	444017	0.79
430047	1.12	440082	1.87	444018	0.83
430048	1.57	440083	0.79	450002	1.37
430049	0.75	440084	0.96	450004	1.02
430051	0.68	440090	0.99	450005	1.31
430054	1.45	440091	1.79	450007	1.80
430056	1.29	440100	1.07	450008	1.18
430057	1.28	440102	1.17	450010	1.39
430060	0.62	440103	1.50	450011	1.44
430062	1.23	440104	1.60	450014	0.96
430064	0.96	440105	3.75	450015	0.84
430065	0.83	440109	1.05	450016	1.80
430066	0.93	440110	1.24	450018	0.99
430073	1.13	440111	0.87	450020	1.20
430076	0.74	440114	1.25	450021	1.24
430077	1.90	440115	1.26	450023	1.72
430079	0.68	440120	2.21	450024	1.04
430087	0.73	440125	1.87	450025	1.49
434004	0.95	440130	1.95	450028	1.69
440001	1.36	440131	1.80	450029	1.15
440002	2.61	440132	1.41	450031	1.27
440003	1.62	440133	2.08	450032	1.07
440006	1.93	440135	1.28	450033	1.14
440007	0.72	440137	1.29	450034	1.59
440008	1.35	440141	0.73	450035	1.90
440009	2.00	440142	0.95	450037	1.47
440010	1.16	440143	1.07	450039	0.74
440011	1.53	440144	2.32	450040	1.37
440012	1.26	440145	0.84	450042	1.49
440014	1.03	440147	4.16	450044	1.46
440015	2.17	440148	1.30	450046	1.63
440016	1.29	440149	0.98	450047	1.22
440017	1.59	440150	2.08	450050	0.80

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
450051	1.46	450176	1.50	450352	1.18
450052	0.80	450177	1.22	450353	1.02
450053	0.92	450178	0.79	450355	0.77
450054	1.36	450181	0.82	450358	1.60
450055	1.00	450184	1.43	450362	1.27
450056	2.46	450185	0.86	450369	0.89
450058	1.43	450187	1.27	450370	1.74
450059	1.65	450188	0.97	450371	0.93
450063	0.64	450190	2.27	450372	1.36
450064	1.51	450191	1.41	450373	0.83
450065	0.74	450192	1.17	450374	0.67
450068	1.32	450193	2.81	450376	1.64
450072	1.43	450194	1.26	450378	1.08
450073	0.88	450196	1.57	450379	1.35
450078	0.73	450200	1.34	450381	0.79
450079	1.57	450201	1.38	450388	2.25
450080	1.86	450203	1.10	450389	1.49
450081	0.94	450209	1.12	450393	1.11
450082	0.99	450210	0.93	450395	0.97
450083	1.67	450211	1.61	450399	0.66
450085	0.93	450214	1.87	450400	1.05
450087	1.32	450217	0.67	450403	1.52
450090	1.47	450219	1.28	450411	0.91
450092	1.03	450221	0.75	450417	1.01
450094	2.09	450222	1.63	450418	1.39
450096	1.59	450224	1.28	450419	1.01
450097	2.23	450229	1.67	450422	9.97
450098	0.77	450231	1.43	450423	1.94
450099	1.43	450234	0.82	450424	1.76
450101	1.39	450235	1.09	450429	0.65
450102	1.75	450236	1.59	450431	1.41
450104	1.30	450237	1.07	450438	1.10
450107	1.79	450239	0.83	450446	0.89
450108	0.78	450241	0.81	450447	1.93
450109	0.94	450243	0.74	450451	0.79
450110	1.07	450246	0.87	450457	1.67
450111	1.51	450249	0.87	450460	1.05
450112	1.74	450250	0.83	450462	1.17
450113	1.67	450253	1.21	450464	0.81
450118	2.42	450258	0.70	450465	1.61
450119	1.55	450259	1.80	450467	0.95
450121	1.59	450264	0.59	450469	1.31
450123	0.96	450269	0.79	450473	0.77
450124	1.26	450270	0.77	450475	1.24
450126	1.30	450271	0.83	450484	1.77
450128	1.33	450272	1.57	450488	1.04
450130	1.72	450276	0.75	450489	0.64
450131	1.14	450278	0.84	450497	0.90
450132	1.38	450280	1.16	450498	1.18
450133	1.41	450283	0.87	450508	1.26
450135	1.30	450286	0.68	450514	1.83
450137	1.19	450288	0.91	450517	0.83
450140	0.82	450289	0.73	450518	2.02
450142	1.40	450292	0.98	450523	2.60
450143	0.90	450293	1.03	450530	1.42
450144	0.80	450296	1.38	450534	0.71
450145	0.70	450299	1.91	450535	1.55
450146	0.70	450303	0.67	450537	1.30
450147	1.34	450306	1.14	450538	1.15
450148	1.22	450307	0.68	450539	1.38
450149	1.22	450309	0.86	450544	1.25
450150	0.74	450315	1.51	450545	2.33
450151	0.90	450320	1.41	450547	0.87
450152	1.36	450321	0.73	450550	1.42
450153	1.40	450322	0.73	450551	1.40
450154	1.10	450324	1.27	450558	1.52
450155	0.94	450327	0.63	450559	0.85
450157	0.75	450330	1.08	450561	1.38
450160	1.08	450334	0.66	450563	1.29
450162	1.32	450337	0.82	450565	1.09
450163	1.06	450340	1.59	450570	0.93
450164	0.75	450341	1.25	450571	1.65
450165	1.04	450346	1.33	450573	0.89
450166	0.60	450347	1.24	450574	0.57
450169	0.66	450348	0.76	450575	0.68
450170	0.77	450351	1.70	450578	0.65

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
450580	1.13	450717	1.71	453052	0.98
450583	0.69	450718	1.60	453053	0.98
450584	1.00	450723	1.31	453054	1.08
450586	0.89	450724	1.95	453055	0.70
450587	1.45	450725	1.36	453056	1.05
450591	1.31	450727	1.06	453057	0.90
450596	1.39	450728	0.68	453059	0.98
450597	0.97	450730	1.45	453065	2.22
450603	0.70	450733	1.59	453072	0.61
450604	1.32	450735	0.44	453300	0.77
450605	1.09	450742	1.55	453302	0.98
450609	0.74	450743	1.60	453304	0.93
450610	1.48	450746	0.75	453305	0.71
450614	0.83	450747	1.74	454000	0.67
450615	0.77	450749	0.74	454006	0.59
450617	1.33	450750	0.91	454008	0.47
450620	0.91	450751	1.65	454009	0.60
450623	1.31	450754	1.07	454011	0.54
450626	0.89	450755	1.16	454012	0.77
450628	0.70	450757	0.67	454014	0.81
450630	1.39	450758	0.90	454018	0.89
450631	1.59	450760	1.75	454026	0.94
450632	0.54	450761	0.73	454028	0.87
450633	1.56	450763	1.30	454029	1.31
450634	1.96	450766	1.75	454030	0.86
450638	2.14	450769	0.74	454031	0.91
450639	1.42	450770	0.90	454032	0.88
450641	0.95	450771	1.37	454037	0.87
450643	1.42	450774	3.69	454038	0.87
450644	1.81	450775	1.81	454040	0.83
450646	1.79	450776	0.81	454042	0.81
450647	1.60	450777	0.85	454043	0.86
450648	0.94	450779	1.20	454045	0.88
450649	0.82	450780	3.40	454046	0.87
450651	1.42	450785	10.47	454050	0.87
450652	0.68	450788	1.26	454051	0.87
450653	1.78	450795	0.62	454056	1.08
450654	0.79	450796	10.29	454057	0.89
450656	1.58	450797	5.76	454058	0.87
450658	1.00	450798	0.35	454060	0.88
450659	2.15	450801	1.84	454063	0.85
450661	2.36	450802	1.60	454064	0.87
450662	1.22	450803	0.85	454065	0.89
450665	0.86	450804	3.50	454066	0.87
450666	1.39	450809	1.95	454069	0.96
450668	1.93	452013	0.64	454072	0.87
450669	1.42	452015	0.55	454073	0.99
450670	1.64	452016	0.55	454078	0.79
450672	1.81	452019	1.11	454083	0.89
450673	0.73	452022	1.00	454084	0.59
450674	3.52	452028	0.32	454086	0.96
450675	1.48	452033	0.65	454089	0.88
450677	1.30	452036	0.52	460001	1.97
450678	1.51	452037	1.39	460003	2.18
450683	1.16	452038	0.87	460004	1.73
450684	1.38	452039	0.69	460005	1.82
450686	1.46	452042	0.31	460006	2.28
450688	1.41	452043	0.71	460007	1.93
450690	0.99	452045	1.03	460008	1.45
450691	1.19	453025	0.88	460009	1.82
450694	1.27	453028	0.54	460010	1.64
450696	6.04	453029	1.25	460011	1.42
450697	1.28	453031	1.04	460013	2.16
450698	0.67	453032	0.52	460014	1.00
450700	0.84	453033	0.75	460015	1.88
450702	1.53	453034	0.67	460016	0.97
450703	1.10	453035	1.50	460017	2.21
450704	1.33	453036	1.40	460018	1.11
450705	1.17	453037	0.81	460019	1.13
450706	1.42	453038	0.83	460020	1.22
450709	2.71	453040	0.83	460021	1.65
450711	1.87	453041	0.59	460022	0.82
450712	0.88	453042	0.79	460023	1.97
450713	1.67	453044	0.90	460024	0.70
450715	0.98	453047	0.78	460025	0.49
450716	1.76	453048	0.82	460026	1.21

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
460027	0.97	490048	1.75	500008	1.18
460029	1.22	490050	1.86	500011	1.59
460030	1.62	490052	1.97	500012	2.00
460032	0.90	490053	2.23	500014	1.85
460033	1.28	490054	1.41	500015	1.31
460035	0.85	490057	1.82	500016	1.41
460036	1.20	490059	2.24	500019	2.04
460037	1.41	490060	1.62	500021	1.42
460039	0.93	490063	2.18	500023	1.39
460041	1.69	490066	1.89	500024	2.58
460042	1.59	490067	1.90	500025	1.31
460044	1.37	490069	1.11	500026	1.53
460046	7.81	490071	2.06	500027	1.87
460047	1.46	490073	2.81	500028	0.85
460049	7.48	490074	2.72	500029	0.72
460050	2.50	490075	1.83	500030	1.75
463025	1.08	490077	1.67	500031	1.29
463301	1.56	490079	1.49	500033	1.59
464003	0.87	490083	9.68	500036	1.80
464007	7.13	490084	1.84	500037	1.07
464009	0.85	490085	1.48	500039	1.93
464010	0.87	490088	1.64	500041	1.53
470001	1.35	490089	1.04	500042	2.22
470003	1.86	490090	1.74	500043	1.06
470004	1.06	490091	1.84	500044	1.72
470005	1.47	490092	1.45	500045	1.73
470006	1.59	490093	1.76	500048	1.17
470008	1.34	490094	1.43	500049	2.08
470010	1.23	490095	1.31	500050	1.84
470011	1.51	490097	1.24	500051	1.97
470012	1.99	490098	1.45	500053	1.48
470015	1.18	490099	0.74	500054	1.86
470018	1.39	490100	2.66	500055	1.33
470020	0.78	490101	2.21	500057	1.81
470023	1.49	490107	2.28	500058	1.96
470024	1.33	490110	2.29	500059	1.66
474001	0.72	490111	1.53	500060	1.30
480001	1.19	490112	1.76	500061	0.75
480002	1.30	490113	1.76	500062	0.59
490001	1.29	490114	1.12	500064	0.87
490002	1.14	490115	1.51	500065	1.76
490003	10.75	490116	1.57	500068	0.76
490004	1.69	490117	0.88	500069	0.92
490005	1.77	490118	2.01	500071	1.47
490006	1.28	490119	1.95	500072	1.74
490007	1.74	490120	1.62	500073	0.98
490009	1.36	490122	2.03	500074	1.51
490011	1.92	490123	1.41	500077	1.51
490012	1.02	490124	1.50	500079	1.17
490013	1.87	490126	1.64	500080	0.82
490014	2.11	490127	0.93	500084	1.43
490015	1.98	490130	1.61	500085	1.12
490017	2.14	490131	1.39	500086	1.34
490018	1.81	492001	0.21	500088	1.94
490019	1.46	493025	0.87	500089	1.19
490020	2.42	493026	0.71	500090	0.49
490021	2.69	493027	1.21	500092	1.10
490022	1.61	493028	0.71	500094	0.59
490023	1.59	493301	1.21	500096	1.26
490024	1.61	494001	0.87	500097	0.83
490027	1.31	494002	1.04	500098	0.98
490030	1.73	494011	0.82	500101	0.85
490031	1.54	494012	0.83	500102	1.00
490032	1.29	494016	0.73	500104	1.34
490033	1.15	494018	0.88	500106	0.79
490035	1.53	494020	0.87	500107	1.21
490037	1.63	494022	0.69	500108	1.72
490038	1.58	494023	0.78	500110	1.77
490040	2.07	494025	0.82	500118	1.62
490041	2.03	494026	0.78	500119	1.22
490042	1.75	494028	0.87	500122	1.43
490043	1.34	500001	1.86	500123	0.61
490044	1.62	500002	1.31	500124	1.52
490045	1.58	500003	1.61	500125	0.99
490046	2.03	500005	1.95	500129	1.44
490047	0.96	500007	2.03	500132	1.05

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued		ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued	
Hospital	SMI	Hospital	SMI	Hospital	SMI
500138	0.90	520013	1.76	520116	1.69
500139	1.62	520014	1.82	520117	1.51
500141	1.81	520015	2.06	520118	0.72
500146	1.69	520016	3.42	520120	0.77
502002	2.34	520017	1.46	520121	1.32
503025	0.99	520018	1.52	520122	0.97
503300	4.72	520019	1.65	520123	1.07
504002	0.75	520021	2.27	520124	1.31
504008	0.83	520024	1.40	520130	2.21
510001	1.62	520025	1.38	520131	1.43
510002	1.70	520026	1.75	520132	1.65
510004	0.77	520028	2.46	520134	1.16
510005	1.11	520029	0.89	520135	1.31
510006	1.86	520030	3.47	520136	1.37
510007	1.31	520031	2.68	520138	1.74
510008	1.52	520032	1.67	520139	3.15
510012	1.28	520033	2.40	520140	1.64
510013	1.17	520034	1.80	520141	1.42
510015	0.76	520035	3.33	520142	0.90
510016	0.73	520037	2.04	520144	3.38
510018	1.18	520038	2.45	520145	1.01
510020	0.88	520039	2.16	520146	1.97
510022	1.68	520040	1.31	520148	1.52
510023	1.56	520041	2.16	520149	0.80
510024	1.97	520042	1.28	520151	2.91
510026	1.12	520044	2.12	520152	1.99
510027	0.99	520045	1.37	520153	1.23
510028	1.04	520047	1.63	520154	1.95
510029	1.57	520048	1.62	520156	1.55
510030	1.50	520049	2.96	520157	1.12
510031	2.16	520051	1.85	520159	0.99
510033	1.48	520053	1.23	520160	1.73
510038	1.13	520054	1.19	520161	1.60
510039	1.54	520057	5.86	520170	2.11
510043	0.64	520058	1.96	520171	1.19
510046	1.05	520059	1.92	520173	2.77
510047	2.11	520060	1.19	520177	2.17
510048	0.95	520062	2.43	520178	1.73
510050	1.57	520063	3.44	523025	0.95
510053	1.03	520064	1.32	523300	2.03
510055	1.49	520066	2.82	524000	0.94
510058	1.66	520068	1.13	524001	0.79
510059	5.37	520069	1.39	524003	0.85
510060	1.13	520070	1.81	524017	0.35
510063	0.74	520071	1.66	524018	0.79
510065	0.80	520074	1.21	524034	0.87
510066	1.43	520075	1.68	524035	0.87
510067	1.52	520076	2.23	524038	0.98
510068	1.26	520077	0.97	524040	1.03
510070	2.03	520078	2.01	530002	1.40
510071	1.73	520082	2.49	530003	0.88
510072	1.04	520083	1.40	530004	1.06
510077	1.03	520084	2.38	530005	1.23
510081	0.71	520087	1.74	530006	1.40
510082	1.13	520088	1.61	530007	1.24
510084	1.27	520089	4.31	530008	1.34
510085	1.37	520090	1.38	530009	1.45
510086	0.91	520091	3.18	530010	1.95
511300	1.04	520092	1.51	530011	1.41
511301	0.58	520094	1.25	530012	1.58
513026	0.62	520095	4.22	530014	1.54
513027	0.98	520096	1.92	530015	1.59
513028	1.10	520097	1.73	530016	1.27
513030	1.04	520098	1.16	530017	1.64
514001	0.96	520100	1.94	530018	1.18
514007	1.22	520101	1.13	530019	1.15
514008	1.29	520102	1.82	530022	1.15
520002	2.63	520103	1.73	530023	1.07
520003	1.59	520107	1.51	530025	1.41
520004	2.63	520109	1.73	530026	1.00
520006	4.45	520110	1.36	530027	1.03
520007	1.27	520111	2.22	530029	0.75
520008	1.79	520112	2.23	530031	0.67
520009	1.27	520113	2.82	530032	1.52
520010	1.51	520114	1.27	532002	0.05
520011	2.38	520115	1.25	534003	0.87

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY
HOSPITAL—Continued

Hospital	SMI
650001	1.28

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS

Urban area (Constituent counties)	Wage index
0040 Abilene, TX	0.8081
Taylor, TX	
0060 Aguadilla, PR	0.4772
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	1.0011
Portage, OH	
Summit, OH	
0120 Albany, GA	0.8098
Dougherty, GA	
Lee, GA	
0160 ² Albany-Schenectady-Troy, NY	0.8640
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.8813
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8598
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0219
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9398
Blair, PA	
0320 Amarillo, TX	0.8483
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.3088
Anchorage, AK	
0440 Ann Arbor, MI	1.11271
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8731
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.8899
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4915
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9016
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.8746
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 ¹ Atlanta, GA	1.0024
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS

Urban area (Constituent counties)	Wage index
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.0442
Atlantic, NJ	
Cape May, NJ	
0600 Augusta-Aiken, GA-SC	0.9309
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 ¹ Austin-San Marcos, TX	0.8158
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 ² Bakersfield, CA	0.9976
Kern, CA	
0720 ¹ Baltimore, MD	0.9760
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 ² Bangor, ME	0.8538
Penobscot, ME	0.8538
0743 Barnstable-Yarmouth, MA	1.5644
Barnstable, MA	
0760 Baton Rouge, LA	0.8940
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8660
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1475
Whatcom, WA	
0870 ² Benton Harbor, MI	0.8988
Berrien, MI	
0875 ¹ Bergen-Passaic, NJ	1.1845
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9220
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8291
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.9103
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9150
Blount, AL	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.8015
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.9041
Monroe, IN	
1040 Bloomington-Normal, IL	0.8926
McLean, IL	
1080 Boise City, ID	0.9267
Ada, ID	
Canyon, ID	
1123 ^{1 2} Boston-Worcester-Lawrence- Lowell-Brockton, MA-NH (Massachusetts Hospitals)	1.0917
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1123 ¹ Boston-Worcester-Lawrence-Low- ell-Brockton, MA-NH (New Hampshire Hospitals)	1.0885
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0122
Boulder, CO	
1145 Brazoria, TX	0.8895
Brazoria, TX	
1150 Bremerton, WA	1.1148
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8291
Cameron, TX	
1260 Bryan-College Station, TX	0.7962
Brazos, TX	
1280 ¹ Buffalo-Niagara Falls, NY	0.9592
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9612
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4445
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8895
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9227
Natrona, WY	
1360 Cedar Rapids, IA	0.8888
Linn, IA	
1400 Champaign-Urbana, IL	0.8844
Champaign, IL	
1440 Charleston-North Charleston, SC	0.8931

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9042
Kanawha, WV	
Putnam, WV	
1520 ¹ Charlotte-Gastonia-Rock Hill, NC- SC	0.9568
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0359
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9123
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.9354
Laramie, WY	
1600 ¹ Chicago, IL	1.0507
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0231
Butte, CA	
1640 ¹ Cincinnati, OH-KY-IN	0.9465
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8204
Christian, KY	
Montgomery, TN	
1680 ¹ Cleveland-Lorain-Elyria, OH	0.9970
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9469
El Paso, CO	
1740 Columbia, MO	0.9678
Boone, MO	
1760 Columbia, SC	0.9368
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8573
Russell, AL	
Chattahoochee, GA	
Harris, GA	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
Muscogee, GA	
1840 ¹ Columbus, OH	0.9929
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8112
Nueces, TX	
San Patricio, TX	
1900 ² Cumberland, MD-WV (Maryland Hospitals)	0.8627
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (West Virginia Hospital)	0.8407
Allegany, MD	
Mineral, WV	
1920 ¹ Dallas, TX	0.9149
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.9121
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8496
Scott, IL	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9670
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9211
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8302
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8140
Macon, IL	
2080 ¹ Denver, CO	1.0532
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8576
Dallas, IA	
Polk, IA	
Warren, IA	
2160 ¹ Detroit, MI	1.0601
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7827
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9441
Kent, DE	
2200 Dubuque, IA	0.8292
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0133
St. Louis, MN	
Douglas, WI	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
2281 Dutchess County, NY	0.9860
Dutchess, NY	
2290 Eau Claire, WI	0.8755
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.8978
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9168
Elkhart, IN	
2335 ² Elmira, NY	0.8640
Chemung, NY	
2340 Enid, OK	0.8050
Garfield, OK	
2360 Erie, PA	0.9343
Erie, PA	
2400 Eugene-Springfield, OR	1.1288
Lane, OR	
2440 Evansville-Henderson, IN-KY	0.8505
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN (North Dakota Hospitals)	0.7905
Clay, MN	
Cass, ND	
2520 ² Fargo-Moorhead, ND-MN (Min- nesota Hospitals)	0.8665
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8460
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8686
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	0.9602
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1106
Genesee, MI	
2650 Florence, AL	0.7740
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8368
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0383
Larimer, CO	
2680 ¹ Ft. Lauderdale, FL	1.0534
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9017
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9847
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7687
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 ² Fort Walton Beach, FL	0.8947
Okaloosa, FL	
2760 Fort Wayne, IN	0.8896
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 ¹ Forth Worth-Arlington, TX	0.9192
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0491
Fresno, CA	
Madera, CA	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued		ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued		ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued	
Urban area (Constituent counties)	Wage index	Urban area (Constituent counties)	Wage index	Urban area (Constituent counties)	Wage index
2880 Gadsden, AL	0.8854	Lafourche, LA		3740 Kankakee, IL	0.9175
Etowah, AL		Terrebonne, LA		Kankakee, IL	
2900 Gainesville, FL	0.9542	3360 ¹ Houston, TX	1.0017	3760 ¹ Kansas City, KS-MO	0.9672
Alachua, FL		Chambers, TX		Johnson, KS	
2920 Galveston-Texas City, TX	0.9549	Fort Bend, TX		Leavenworth, KS	
Galveston, TX		Harris, TX		Miami, KS	
2960 Gary, IN	0.9542	Liberty, TX		Wyandotte, KS	
Lake, IN		Montgomery, TX		Cass, MO	
Porter, IN		Waller, TX		Clay, MO	
2975 ² Glens Falls, NY	0.8640	3400 Huntington-Ashland, WV-KY-OH	0.9728	Clinton, MO	
Warren, NY		Boyd, KY		Jackson, MO	
Washington, NY		Carter, KY		Lafayette, MO	
2980 Goldsboro, NC	0.8523	Greenup, KY		Platte, MO	
Wayne, NC		Lawrence, OH		Ray, MO	
2985 Grand Forks, ND-MN	0.8996	Cabell, WV		3800 Kenosha, WI	0.9206
Polk, MN		Wayne, WV		Kenosha, WI	
Grand Forks, ND		3440 Huntsville, AL	0.8428	3810 Killeen-Temple, TX	1.0180
2995 Grand Junction, CO	0.9110	Limestone, AL		Bell, TX	
Mesa, CO		Madison, AL		Coryell, TX	
3000 ¹ Grand Rapids-Muskegon-Holland, MI	1.0018	3480 ¹ Indianapolis, IN	0.9901	3840 Knoxville, TN	0.8569
Allegan, MI		Boone, IN		Anderson, TN	
Kent, MI		Hamilton, IN		Blount, TN	
Muskegon, MI		Hancock, IN		Knox, TN	
Ottawa, MI		Hendricks, IN		Loudon, TN	
3040 Great Falls, MT	0.9362	Johnson, IN		Sevier, TN	
Cascade, MT		Madison, IN		Union, TN	
3060 Greeley, CO	0.9856	Marion, IN		3850 Kokomo, IN	0.9350
Weld, CO		Morgan, IN		Howard, IN	
3080 Green Bay, WI	0.9323	Shelby, IN		Tipton, IN	
Brown, WI		3500 Iowa City, IA	0.9561	3870 La Crosse, WI-MN	0.8989
3120 ¹ Greensboro-Winston-Salem-High Point, NC	0.9418	Johnson, IA		Houston, MN	
Alamance, NC		3520 Jackson, MI	0.9302	La Crosse, WI	
Davidson, NC		Jackson, MI		3880 Lafayette, LA	0.8363
Davie, NC		3560 Jackson, MS	0.8279	Acadia, LA	
Forsyth, NC		Hinds, MS		Lafayette, LA	
Guliford, NC		Madison, MS		St. Landry, LA	
Randolph, NC		Rankin, MS		St. Martin, LA	
Stokes, NC		3580 Jackson, TN	0.8632	3920 Lafayette, IN	0.8984
Yadkin, NC		Madison, TN		Clinton, IN	
3150 Greenville, NC	0.9034	Chester, TN		Tippecanoe, IN	
Pitt, NC		3600 ^{1,2} Jacksonville, FL	0.8947	3960 Lake Charles, LA	0.7738
3160 Greenville-Spartanburg-Anderson, SC	0.9318	Clay, FL		Calcasieu, LA	
Anderson, SC		Duval, FL		3980 Lakeland-Winter Haven, FL	0.8947
Cherokee, SC		Nassau, FL		Polk, FL	
Greenville, SC		St. Johns, FL		4000 Lancaster, PA	0.9646
Pickens, SC		3605 ² Jacksonville, NC	0.8162	Lancaster, PA	
Spartanburg, SC		Onslow, NC		4040 Lansing-East Lansing, MI	1.0130
3180 Hagerstown, MD	1.0268	3610 ² Jamestown, NY	0.8640	Clinton, MI	
Washington, MD		Chautauqua, NY		Eaton, MI	
3200 Hamilton-Middletown, OH	0.9292	3620 Janesville-Beloit, WI	0.9128	Ingham, MI	
Butler, OH		Rock, WI		4080 ² Laredo, TX	0.7404
3240 Harrisburg-Lebanon-Carlisle, PA	0.9572	3640 Jersey City, NJ	1.1372	Webb, TX	
Cumberland, PA		Hudson, NJ		4100 Las Cruces, NM	0.9045
Dauphin, PA		3660 Johnson City-Kingsport-Bristol, TN- VA	0.8847	Dona Ana, NM	
Lebanon, PA		Carter, TN		4120 ¹ Las Vegas, NV-AZ	1.1349
Perry, PA		Hawkins, TN		Mohave, AZ	
3283 ^{1,2} Hartford, CT	1.2175	Sullivan, TN		Clark, NV	
Hartford, CT		Unicoi, TN		Nye, NV	
Litchfield, CT		Washington, TN		4150 Lawrence, KS	0.8728
Middlesex, CT		Bristol City, VA		Douglas, KS	
Tolland, CT		Scott, VA		4200 Lawton, OK	0.8770
3285 ² Hattiesburg, MS	0.7359	Washington, VA		Comanche, OK	
Forrest, MS		3680 Johnstown, PA	0.8671	4243 Lewiston-Auburn, ME	0.9226
Lamar, MS		Cambria, PA		Androscoggin, ME	
3290 Hickory-Morganton-Lenoir, NC	0.8687	Somerset, PA		4280 Lexington, KY	0.8579
Alexander, NC		3700 Jonesboro, AR	0.7643	Bourbon, KY	
Burke, NC		Craighead, AR		Clark, KY	
Caldwell, NC		3710 Joplin, MO	0.7933	Fayette, KY	
Catawba, NC		Jasper, MO		Jessamine, KY	
3320 Honolulu, HI	1.1628	Newton, MO		Madison, KY	
Honolulu, HI		3720 Kalamazoo-Battlecreek, MI	1.2009	Scott, KY	
3350 Houma, LA	0.8266	Calhoun, MI		Woodford, KY	
		Kalamazoo, MI		4320 Lima, OH	0.8885
		Van Buren, MI		Allen, OH	
				Auglaize, OH	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
4360 Lincoln, NE	0.9082
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8598
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8583
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.2124
Los Angeles, CA	
4520 Louisville, KY-IN	0.9212
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8460
Lubbock, TX	
4640 Lynchburg, VA	0.8680
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9109
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0103
Dane, WI	
4800 Mansfield, OH	0.8606
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4360
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8541
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0109
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL ..	0.9289
Brevard, FL	
4920 Memphis, TN-AR-MS	0.8423
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	1.0304
Merced, CA	
5000 Miami, FL	0.9427
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.0871
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9470
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI	1.0956
Anoka, MN	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5160 Mobile, AL	0.7942
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0406
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.1285
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8288
Ouachita, LA	
5240 Montgomery, AL	0.7919
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9493
Delaware, IN	
5330 Myrtle Beach, SC	0.8110
Horry, SC	
5345 Naples, FL	1.0205
Collier, FL	
5360 Nashville, TN	0.9336
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3123
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2175
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2175
New London, CT	
5560 New Orleans, LA	0.9397
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY	1.4537
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.0899
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1226

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8235
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5309
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9229
Marion, FL	
5800 Odessa-Midland, TX	0.7773
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8764
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1605
Thurston, WA	
5920 Omaha, NE-IA	0.9938
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1153
Orange, CA	
5960 Orlando, FL	0.9933
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.7902
Daviess, KY	
6015 Panama City, FL	0.8947
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (West Virginia Hospitals)	0.8118
Washington, OH	
Wood, WV	
6020 Parkersburg-Marietta, WV-OH (Ohio Hospitals)	0.8576
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8947
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8157
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.1427
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued		ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued		ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued	
Urban area (Constituent counties)	Wage index	Urban area (Constituent counties)	Wage index	Urban area (Constituent counties)	Wage index
Delaware, PA		Hanover, VA		7320 ¹ San Diego, CA	1.2388
Montgomery, PA		Henrico, VA		San Diego, CA	
Philadelphia, PA		Hopewell City, VA		7360 ¹ San Francisco, CA	1.362
6200 ¹ Phoenix-Mesa, AZ	0.9759	New Kent, VA		Marin, CA	
Maricopa, AZ		Petersburg City, VA		San Francisco, CA	
Pinal, AZ		Powhatan, VA		San Mateo, CA	
6240 Pine Bluff, AR	0.8003	Prince George, VA		7400 ¹ San Jose, CA	1.3783
Jefferson, AR		Richmond City, VA		Santa Clara, CA	
6280 ¹ Pittsburgh, PA	0.9896	6780 ¹ Riverside-San Bernardino, CA	1.0151	7440 ¹ San Juan-Bayamon, PR	0.4521
Allegheny, PA		Riverside, CA		Aguas Buenas, PR	
Beaver, PA		San Bernardino, CA		Barceloneta, PR	
Butler, PA		6800 Roanoke, VA	0.8581	Bayamon, PR	
Fayette, PA		Botetourt, VA		Canovanas, PR	
Washington, PA		Roanoke, VA		Carolina, PR	
Westmoreland, PA		Roanoke City, VA		Catano, PR	
6323 ² Pittsfield, MA	1.0917	Salem City, VA		Ceiba, PR	
Berkshire, MA		6820 Rochester, MN	1.1797	Comerio, PR	
6340 Pocatello, ID	0.8760	Olmsted, MN		Corozal, PR	
Bannock, ID		6840 ¹ Rochester, NY	0.9678	Dorado, PR	
6360 Ponce, PR	0.4740	Genesee, NY		Fajardo, PR	
Guayanilla, PR		Livingston, NY		Florida, PR	
Juana Diaz, PR		Monroe, NY		Guaynabo, PR	
Penuelas, PR		Ontario, NY		Humacao, PR	
Ponce, PR		Orleans, NY		Juncos, PR	
Villalba, PR		Wayne, NY		Los Piedras, PR	
Yauco, PR		6880 Rockford, IL	0.8703	Loiza, PR	
6403 Portland, ME	0.9537	Boone, IL		Luguillo, PR	
Cumberland, ME		Ogle, IL		Manati, PR	
Sagadahoc, ME		Winnebago, IL		Morovis, PR	
York, ME		6895 Rocky Mount, NC	0.8214	Naguabo, PR	
6440 ¹ Portland-Vancouver, OR-WA	1.1274	Edgecombe, NC		Naranjito, PR	
Clackamas, OR		Nash, NC		Rio Grande, PR	
Columbia, OR		6920 ¹ Sacramento, CA	1.1952	San Juan, PR	
Multnomah, OR		El Dorado, CA		Toa Alta, PR	
Washington, OR		Placer, CA		Toa Baja, PR	
Yamhill, OR		Sacramento, CA		Trujillo Alto, PR	
Clark, WA		6960 Saginaw-Bay City-Midland, MI	0.9567	Vega Alta, PR	
6483 ¹ Providence-Warwick-Pawtucket, RI	1.0888	Bay, MI		Vega Baja, PR	
Bristol, RI		Midland, MI		Yabucoa, PR	
Kent, RI		Saginaw, MI		7460 San Luis Obispo-Atascadero-Paso	
Newport, RI		6980 St. Cloud, MN	0.9667	Robles, CA	1.0825
Providence, RI		Benton, MN		San Luis Obispo, CA	
Washington, RI		Stearns, MN		7480 Santa Barbara-Santa Maria-	
6520 Provo-Orem, UT	0.9910	7000 St. Joseph, MO	0.9972	Lompoc, CA	1.1233
Utah, UT		Andrew, MO		Santa Barbara, CA	
6560 Pueblo, CO	0.8785	Buchanan, MO		7485 Santa Cruz-Watsonville, CA	1.4099
Pueblo, CO		7040 ¹ St. Louis, MO-IL	0.9063	Santa Cruz, CA	
6580 Punta Gorda, FL	0.8994	Clinton, IL		7490 Santa Fe, NM	0.9525
Charlotte, FL		Jersey, IL		Los Alamos, NM	
6600 Racine, WI	0.9207	Madison, IL		Santa Fe, NM	
Racine, WI		Monroe, IL		7500 Santa Rosa, CA	1.3167
6640 ¹ Raleigh-Durham-Chapel Hill, NC ...	0.9909	St. Clair, IL		Sonoma, CA	
Chatham, NC		Franklin, MO		7510 Sarasota-Bradenton, FL	0.9567
Durham, NC		Jefferson, MO		Manatee, FL	
Franklin, NC		Lincoln, MO		Sarasota, FL	
Johnston, NC		St. Charles, MO		7520 Savannah, GA	0.8776
Orange, NC		St. Louis, MO		Bryan, GA	
Wake, NC		St. Louis City, MO		Chatham, GA	
6660 Rapid City, SD	0.8277	Warren, MO		Effingham, GA	
Pennington, SD		7080 Salem, OR	0.9987	7560 ² Scranton-Wilkes-Barre-Hazle-	
6680 Reading, PA	0.9282	Marion, OR		ton, PA	.8615
Berks, PA		Polk, OR		Columbia, PA	
6690 Redding, CA	1.2017	7120 Salinas, CA	1.5270	Lackawanna, PA	
Shasta, CA		Monterey, CA		Luzerne, PA	
6720 Reno, NV	1.0169	7160 ¹ Salt Lake City-Ogden, UT	0.9458	Wyoming, PA	
Washoe, NV		Davis, UT		7600 ¹ Seattle-Bellevue-Everett, WA	1.1634
6740 ² Richland-Kennewick-Pasco, WA ...	1.0577	Salt Lake, UT		Island, WA	
Benton, WA		Weber, UT		King, WA	
Franklin, WA		7200 San Angelo, TX	0.7512	Snohomish, WA	
6760 Richmond-Petersburg, VA	0.9257	Tom Green, TX		7610 Sharon, PA	0.8948
Charles City County, VA		7240 ¹ San Antonio, TX	0.7744	Mercer, PA	
Chesterfield, VA		Bexar, TX		7620 ² Sheboygan, WI	0.8557
Colonial Heights City, VA		Comal, TX		Sheboygan, WI	
Dinwiddie, VA		Guadalupe, TX		7640 Sherman-Denison, TX	0.8229
Goochland, VA		Wilson, TX		Grayson, TX	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
7680 Shreveport-Bossier City, LA	0.9436
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8530
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.8988
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9939
St. Joseph, IN	
7840 Spokane, WA	1.1020
Spokane, WA	
7880 Springfield, IL	0.8793
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8151
Christian, MO	
Greene, MO	
Webster, MO	
g1 Springfield, MA	1.0917
8003 Hampden, MA.	
Hampshire, MA	
8050 State College, PA	0.9528
Centre, PA	
8080 ² Steubenville-Weirton, OH-WV	
(Ohio Hospitals)	0.8576
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8080 Steubenville-Weirton, OH-WV (West	
Virginia Hospitals)	0.8476
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.1157
San Joaquin, CA	
8140 Sumter, SC	0.8195
Sumter, SC	
8160 Syracuse, NY	0.9410
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 ² Tacoma, WA	1.0577
Pierce, WA	
8240 ² Tallahassee, FL	0.8947
Gadsden, FL	
Leon, FL	
8280 ¹ Tampa-St. Petersburg-Clearwater,	
FL	0.9179
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.9063
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.7538
Miller, AR	
Bowie, TX	
8400 Toledo, OH	1.0132
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9894
Shawnee, KS	
8480 Trenton, NJ	1.0399
Mercer, NJ	
8520 Tucson, AZ	0.9104
Pima, AZ	
8560 Tulsa, OK	0.8520
Creek, OK	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.7706
Tuscaloosa, AL	
8640 Tyler, TX	0.8792
Smith, TX	
8680 ² Utica-Rome, NY	0.8640
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3458
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0764
Ventura, CA	
8750 Victoria, TX	0.8451
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0460
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	1.0168
Tulare, CA	
8800 Waco, TX	0.8027
McLennan, TX	
8840 ¹ Washington, DC-MD-VA-WV	1.0863
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8402
Black Hawk, IA	
8940 Wausau, WI	0.9814
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL ..	1.0288
Palm Beach, FL	
9000 ² Wheeling, WV-OH (West Virginia	
Hospitals)	0.7938
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 ² Wheeling, WV-OH (Ohio Hos-	
pitals)	0.8576
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.8990
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7864
Archer, TX	
Wichita, TX	
9140 ² Williamsport, PA	0.8615
Lycoming, PA	

ADDENDUM J.—WAGE INDEX FOR URBAN
AREAS—Continued

Urban area (Constituent counties)	Wage index
9160 Wilmington-Newark, DE-MD	1.1968
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9427
New Hanover, NC	
Brunswick, NC	
9260 ² Yakima, WA	1.0577
Yakima, WA	
9270 Yolo, CA	1.0702
Yolo, CA	
9280 York, PA	0.9509
York, PA	
9320 Youngstown-Warren, OH	0.9897
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0957
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	1.0143
Yuma, AZ	

¹ Large Urban Area² Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1999.ADDENDUM K.—WAGE INDEX FOR RURAL
AREAS

Nonurban area	Wage index
Alabama	0.7385
Alaska	1.2534
Arizona	0.8082
Arkansas	0.7274
California	0.9976
Colorado	0.8454
Connecticut	1.2175
Delaware	0.8590
Florida	0.8947
Georgia	0.7933
Hawaii	1.1011
Idaho	0.8548
Illinois	0.7985
Indiana	0.8429
Iowa	0.7846
Kansas	0.7334
Kentucky	0.7902
Louisiana	0.7517
Maine	0.8538
Maryland	0.8627
Massachusetts	1.0917
Michigan	0.8988
Minnesota	0.8665
Mississippi	0.7359
Missouri	0.7510
Montana	0.8645
Nebraska	0.7683
Nevada	0.9267
New Hampshire	1.0324
New Jersey	(¹)
New Mexico	0.7927
New York	0.8640
North Carolina	0.8162
North Dakota	0.7471
Ohio	0.8576
Oklahoma	0.7207
Oregon	0.9957
Pennsylvania	0.8615
Puerto Rico	0.4083
Rhode Island	(¹)
South Carolina	0.8110
South Dakota	0.7564
Tennessee	0.7483
Texas	0.7404

ADDENDUM K.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Utah	0.8851
Vermont	0.9489
Virginia	0.7890
Washington	1.0577
West Virginia	0.7938
Wisconsin	0.8557
Wyoming	0.8763

¹All counties within the State are classified as urban.

ADDENDUM L.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Abilene, TX	0.8081
Albany, GA	0.7933
Albuquerque, NM	0.8813
Alexandria, LA	0.8598
Allentown-Bethlehem-Easton, PA	1.0219
Amarillo, TX	0.8483
Anchorage, AK	1.3088
Asheville, NC	0.9016
Atlanta, GA	1.0024
Augusta-Aiken, GA-SC	0.9309
Baltimore, MD	0.9760
Barnstable-Yarmouth, MA	1.4646
Baton Rouge, LA	0.8940
Benton Harbor, MI	0.8988
Bergen-Passaic, NJ	1.1845
Billings, MT	0.9220
Binghamton, NY	0.8989
Birmingham, AL	0.9150
Bismarck, ND	0.7838
Boise City, ID	0.9267
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.0885
Brazoria, TX	0.8895
Bryan-College Station, TX	0.7962
Buffalo-Niagara Falls, NY	0.9592
Burlington, VT	0.9612
Caguas, PR	0.4445
Canton-Massillon, OH	0.8895
Casper, WY	0.9227
Champaign-Urbana, IL	0.8844
Charleston-North Charleston, SC	0.8931
Charleston, WV	0.8819
Charlotte-Gastonia-Rock Hill, NC-SC	0.9568
Charlottesville, VA	0.9803
Chattanooga, TN-GA	0.8885
Chicago, IL	1.0507
Cincinnati, OH-KY-IN	0.9465
Clarksville-Hopkinsville, TN-KY	0.8204
Cleveland-Lorain-Elyria, OH	0.9970
Columbia, MO	0.9331
Columbus, GA-AL	0.8573
Columbus, OH	0.9929
Corpus Christi, TX	0.8112
Dallas, TX	0.9149
Danville, VA	0.8779
Davenport-Moline-Rock Island, IA-IL	0.8496
Dayton-Springfield, OH	0.9670
Denver, CO	1.0532
Des Moines, IA	0.8576
Duluth-Superior, MN-WI	1.0133
Dutchess County, NY	0.9860
Elkhart-Goshen, IN	0.9168
Eugene-Springfield, OR	1.1141
Evansville-Henderson, IN-KY	0.8505
Fargo-Moorhead, ND-MN (Minnesota Hospital)	0.8665

ADDENDUM L.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Fargo-Moorhead, ND-MN (South Dakota Hospital)	0.7905
Fayetteville, NC	0.8460
Flagstaff, AZ-UT	0.9602
Flint, MI	1.1106
Fort Collins-Loveland, CO	1.0383
Ft. Lauderdale, FL	1.0534
Fort Pierce-Port St. Lucie, FL	0.9847
Fort Smith, AR-OK	0.7582
Fort Walton Beach, FL	0.8694
Forth Worth-Arlington, TX	0.9192
Gadsden, AL	0.8854
Gainesville, FL	0.9542
Goldsboro, NC	0.8366
Grand Forks, ND-MN	0.8996
Grand Junction, CO	0.9110
Grand Rapids-Muskegon-Holland, MI	0.9908
Great Falls, MT	0.9362
Greeley, CO	0.9663
Green Bay, WI	0.9323
Greenville, NC	0.8844
Greenville-Spartanburg-Anderson, SC	0.9318
Harrisburg-Lebanon-Carlisle, PA	0.9572
Hartford, CT	1.1152
Hattiesburg, MS	0.7359
Hickory-Morganton-Lenoir, NC	0.8687
Honolulu, HI	1.1628
Houston, TX	1.0017
Huntington-Ashland, WV-KY-OH	0.9353
Huntsville, AL	0.8269
Indianapolis, IN	0.9901
Iowa City, IA	0.9441
Jackson, MS	0.8279
Jackson, TN	0.8632
Jacksonville, FL	0.8915
Johnson City-Kingsport-Bristol, TN-VA	0.8847
Jonesboro, AR	0.7643
Joplin, MO	0.7710
Kalamazoo-Battlecreek, MI	1.1713
Kansas City, KS-MO	0.9672
Knoxville, TN	0.8569
Lafayette, LA	0.8363
Lansing-East Lansing, MI	1.0025
Las Cruces, NM	0.9045
Las Vegas, NV-AZ	1.1349
Lexington, KY	0.8579
Lima, OH	0.8715
Lincoln, NE	0.8900
Little Rock-North Little Rock, AR	0.8598
Los Angeles-Long Beach, CA	1.2124
Louisville, KY-IN	0.9212
Macon, GA	0.8886
Madison, WI	1.0103
Mansfield, OH	0.8606
Memphis, TN-AR-MS	0.8423
Merced, CA	1.0304
Milwaukee-Waukesha, WI	0.9289
Minneapolis-St. Paul, MN-WI	1.0956
Modesto, CA	1.0406
Monroe, LA	0.8148
Montgomery, AL	0.7919
Myrtle Beach, SC	0.8162
Nashville, TN	0.9336
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2175
New London-Norwich, CT	1.1738
New Orleans, LA	0.9397
New York, NY	1.4537
Newark, NJ	1.0899
Newburgh, NY-PA	1.1356
Oakland, CA	1.5309

ADDENDUM L.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Odessa-Midland, TX	0.7773
Oklahoma City, OK	0.8764
Omaha, NE-IA	0.9938
Orange County, CA	1.1153
Orlando, FL	0.9933
Peoria-Pekin, IL	0.8157
Philadelphia, PA-NJ	1.1427
Pittsburgh, PA	0.9740
Pocatello, ID (Idaho Hospital)	0.8760
Pocatello, ID (Wyoming Hospitals)	0.8763
Portland, ME	0.9537
Portland-Vancouver, OR-WA	1.1274
Provo-Orem, UT	0.9910
Raleigh-Durham-Chapel Hill, NC	0.9909
Rapid City, SD	0.8277
Reno, NV	1.0169
Rochester, MN	1.1797
Rockford, IL	0.8703
Sacramento, CA	1.1952
Saginaw-Bay City-Midland, MI	0.9567
St. Cloud, MN	0.9667
St. Louis, MO-IL	0.9063
Salt Lake City-Ogden, UT	0.9458
San Diego, CA	1.2388
Santa Fe, NM	0.9414
Santa Rosa, CA	1.3003
Seattle-Bellevue-Everett, WA	1.1634
Sharon, PA	0.8835
Sherman-Denison, TX	0.8061
Sioux City, IA-NE	0.8530
Sioux Falls, SD	0.8885
South Bend, IN	0.9939
Spokane, WA	1.0819
Springfield, IL	0.8793
Springfield, MO	0.8151
State College, PA	0.8845
Syracuse, NY	0.9410
Tallahassee, FL	0.8566
Tampa-St. Petersburg-Clearwater, FL	0.9179
Texarkana, AR-Texarkana, TX	0.7538
Topeka, KS	0.9667
Tucson, AZ	0.9104
Tulsa, OK	0.8418
Tuscaloosa, AL	0.7706
Tyler, TX	0.8792
Vallejo-Fairfield-Napa, CA	1.3458
Victoria, TX	0.8451
Washington, DC-MD-VA-WV	1.0863
Waterloo-Cedar Falls, IA	0.8402
Wausau, WI	0.9501
Wichita, KS	0.8853
Wichita Falls, TX	0.7695
Rural Alabama	0.7385
Rural Illinois	0.7985
Rural Louisiana	0.7517
Rural Massachusetts	1.0481
Rural Michigan	0.8988
Rural Minnesota	0.8665
Rural Missouri	0.7510
Rural Nevada	0.8855
Rural New Mexico	0.7927
Rural Oregon	0.9957
Rural Washington	1.0577
Rural Wyoming	0.8763

[FR Doc. 98-23383 Filed 9-4-98; 8:45 am]

BILLING CODE 4120-01-P

Final Rule

Tuesday
September 8, 1998

Part III

**Department of
Energy**

**Office of Energy Efficiency and
Renewable Energy**

10 CFR Part 430

**Energy Conservation Program for
Consumer Products: Energy Conservation
Standards for Electric Cooking Products
(Electric Cooktops, Electric Self-Cleaning-
Ovens, and Microwave Ovens); Final Rule**

DEPARTMENT OF ENERGY**Office of Energy Efficiency and Renewable Energy****10 CFR Part 430**

[Docket Number EE-RM-S-97-700]

RIN 1904-AA84

Energy Conservation Program for Consumer Products; Energy Conservation Standards for Electric Cooking Products (Electric Cooktops, Electric Self-Cleaning-Ovens, and Microwave Ovens)

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy (DOE).

ACTION: Final rule.

SUMMARY: The Energy Policy and Conservation Act, as amended, prescribes energy conservation standards for certain major household appliances and requires the Department of Energy (DOE or Department) to administer an energy conservation program for these products. The National Appliance Energy Conservation Act amendments require DOE to consider amending the energy conservation standards for cooking products. DOE today promulgates this final rule to address the energy conservation standard for electric cooking products (including microwave products) and substitute the term "cooking products" for the current, obsolete term "kitchen ranges and ovens." DOE is not addressing at this time gas cooking products because it has not completed its analysis of the relevant issues.

DOE has determined that there would be no significant conservation of energy for electric cooktops, electric self-cleaning ovens and microwave ovens, and standards would not be economically justified. Therefore, the Department will not add new standards for these products. The Department, however, is amending its regulations to substitute the name "kitchen ranges and ovens" with "cooking products".

EFFECTIVE DATE: This rule is effective October 8, 1998.

ADDRESSES: A copy of the Technical Support Document (TSD) for these products may be read at the DOE Freedom of Information Reading Room, U.S. Department of Energy, Forrestal Building, room 1E-190, 1000 Independence Avenue, S.W., Washington, D.C. 20585, (202) 586-3142, between the hours of 9:00 a.m. and 4:00 p.m., Monday through Friday, except Federal holidays. Copies of the

TSD may be obtained from: U.S. Department of Energy, Office of Energy Efficiency and Renewable Energy, Forrestal Building, Mail Station EE-43, 1000 Independence Avenue, S.W., Washington, D.C. 20585. (202) 586-9127.

FOR FURTHER INFORMATION CONTACT:

Kathi Epping, U.S. Department of Energy, Office of Energy Efficiency and Renewable Energy, EE-43, 1000 Independence Avenue, S.W., Washington, D.C. 20585-0121, (202) 586-7425, or Eugene Margolis, Esq., U.S. Department of Energy, Office of General Counsel, GC-72, 1000 Independence Avenue, S.W., Washington, D.C. 20585, (202) 586-9507.

SUPPLEMENTARY INFORMATION:

- I. Introduction
 - a. Authority
 - b. Background
- II. Discussion of Electric Cooking Products Comments
 - a. Classes
 - b. Design Options
 - c. Other Comments
 - d. Other Comments Regarding the Draft Report and Supplemental Analysis
- III. Analysis of Electric Cooking Products Standards
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 - a. Review under the National Environmental Policy Act
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 - f. "Takings" Assessment Review
 - g. Federalism Review
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 - i. Review Under Small Business Regulatory Enforcement Fairness Act of 1996
- V. DOJ Views on the Proposed Rule

I. Introduction**a. Authority**

Part B of Title III of the Energy Policy and Conservation Act (EPCA), P.L. 94-163, as amended by the National Energy Conservation Policy Act (NECPA), P.L. 95-619, by the National Appliance Energy Conservation Act (NAECA), P.L. 100-12, by the National Appliance Energy Conservation Amendments of 1988 (NAECA 1988), P.L. 100-357, and the Energy Policy Act of 1992 (EPAct), P.L. 102-486¹ created the Energy

¹ The Energy Policy and Conservation Act, as amended by the National Energy Conservation

Conservation Program for Consumer Products other than Automobiles. The consumer products subject to this program are called "covered products." The covered products specified by statute include kitchen ranges and ovens. EPCA, § 322, 42 U.S.C. 6292.

For kitchen ranges and ovens, EPCA prescribed an initial Federal energy conservation standard effective in 1990 and specified that the Department shall publish a final rule no later than January 1, 1992, to determine if the 1990 standards should be amended. EPCA, § 325(h), 42 U.S.C. 6295(h). Any new or amended standard is required to be designed so as to achieve the maximum improvement in energy efficiency that is technologically feasible and economically justified. EPCA, § 325(o)(2)(A), 42 U.S.C. 6295(o)(2)(A). The Secretary may not prescribe any amended standard which increases the maximum allowable energy use or decreases the minimum required energy efficiency of a covered product. EPCA, § 325(o)(1), 42 U.S.C. 6295(o)(1).

Section 325(o)(2)(B)(i) provides that DOE, in determining whether a standard is economically justified, must determine whether the benefits of the standard exceed its burdens, based, to the greatest extent practicable, on a weighing of the following seven factors:

(1) The economic impact of the standard on the manufacturers and on the consumers of the products subject to such standard;

(2) The savings in operating costs throughout the estimated average life of the covered product in the type (or class) compared to any increase in the price of, in the initial charges for, or maintenance expenses of, the covered products which are likely to result from the imposition of the standard;

(3) The total projected amount of energy savings likely to result directly from the imposition of the standard;

(4) Any lessening of the utility or the performance of the covered products likely to result from the imposition of the standard;

(5) The impact of any lessening of competition, as determined in writing by the Attorney General, that is likely to result from the imposition of the standard;

(6) The need for national energy conservation; and

(7) Other factors the Secretary considers relevant.

Policy Act, the National Appliance Energy Conservation Act, the National Appliance Energy Conservation Amendments of 1988, and the Energy Policy Act of 1992, is referred to in this notice as the "EPCA." Part B of Title III is codified at 42 U.S.C. 6291 et seq.

In addition, section 325(o)(2)(B)(iii) establishes a rebuttable presumption of economic justification in instances where the Secretary determines that "the additional cost to the consumer of purchasing a product complying with an energy conservation standard level will be less than three times the value of the energy savings during the first year that the consumer will receive as a result of the standard, as calculated under the applicable test procedure."

The Department analyzes the merits of efficiency improvements for each class of product independently. The Department applies the same criteria to determine the technological feasibility and economic justification of each product class, regardless of fuel type.

b. Background

The current standard (effective January 1, 1990) states that kitchen ranges and ovens with an electrical supply cord shall not be equipped with a constant burning pilot light.

In 1990, DOE published an advance notice of proposed rulemaking with regard to standards for nine covered products, including electric kitchen ranges and ovens. 55 FR 39624 (September 28, 1990) (hereinafter referred to as the September 1990 advance notice). The September 1990 advance notice presented the product classes that DOE planned to analyze and provided a detailed discussion of the analytical methodology and analytical models that the Department expected to use.

On March 4, 1994, DOE published a notice of proposed rulemaking (NPR) concerning eight products, including the kitchen ranges and ovens. 59 FR 10464 (March 4, 1994) (hereinafter referred to as the Proposed Rule.) The Department proposed that the annual energy use of kitchen ranges and ovens shall be the sum of the annual energy use of any of the following components incorporated into the kitchen range and oven and shall not exceed the allowable sum of energy usages for those components listed in Table 1-1. These proposed standards were estimated to save 5.9 quads.

TABLE 1-1.—PROPOSED STANDARDS LEVELS FOR KITCHEN RANGES AND OVENS

Kitchen range and oven component	Annual energy use, effective as of September 10, 2001
1. Electric ovens, self-cleaning	267 kWh.
2. Electric ovens, non-self-cleaning.	218 kWh.

TABLE 1-1.—PROPOSED STANDARDS LEVELS FOR KITCHEN RANGES AND OVENS—Continued

Kitchen range and oven component	Annual energy use, effective as of September 10, 2001
3. Gas ovens, self-cleaning	1.64 MMBtu.
4. Gas ovens, non-self-cleaning.	1.14 MMBtu.
5. Microwave ovens	233 kWh.
6. Electric cooktop, coil element.	260 kWh.
7. Electric cooktop, smooth element.	294 kWh.
8. Gas cooktop	1.71 MMBtu.

DOE received over 8,000 comments during the comment period on the 1994 Proposed Rule and from participants at the public hearings held in Washington, DC on April 5-7, 1994 and June 7-8, 1994. 59 comments dealt specifically with kitchen ovens, cooktops, and microwave ovens.

After reviewing the comments on the proposed standards for kitchen cooktops, conventional ovens, and microwave ovens, the Department concluded that a number of significant issues were raised which required additional analysis. In 1995, the Department revised the analyses regarding kitchen cooktops, ovens, and microwave ovens to account for the comments and data received during the public comment period. (This revised analysis became the basis for the 1996 Draft Report.)

A moratorium was placed on publication of proposed or final rules for appliance efficiency standards as part of the FY 1996 appropriations legislation. Pub. L. 104-134. That moratorium expired on September 30, 1996.

In 1995 and 1996, the Department conducted a review of its process for developing appliance energy efficiency standards. This review resulted in the publication of a final rule, entitled "Procedures for Consideration of New or Revised Energy Conservation Standards for Consumer Products" (hereinafter referred to as the Process Rule). 61 FR 36973 (July 15, 1996). Although the new procedures in the Process Rule do not apply to this rulemaking (61 FR at 36980) DOE has employed an approach consistent with the new procedures in completing work on this rule. In keeping with the new process, and based on comments received in response to the Proposed Rule, DOE distributed for comment a Draft Report on the Potential Impact of Alternative Energy Efficiency Levels for

Residential Cooking Products (hereinafter referred to as Draft Report). The Draft Report contained DOE's revised analysis, begun in 1995, examining five alternative efficiency levels. The revised analysis drastically reduced the amount of energy which could be saved at each efficiency level. The Draft Report was distributed to a mailing list that included all of the commenters on the proposed rule on kitchen cooktops, ovens, and microwave ovens on May 5, 1996. (EE-RM-S-97-700 No. 1 and No. 2.) The letter invited comment on the Draft Report by no later than July 1, 1996. During June and July 1996, DOE received three comments on the Draft Report and related issues.

The analysis in the Draft Report indicates that establishing new or revised standards for microwave ovens is not economically justified because the payback period exceeds the life of the product and would produce increased life-cycle costs and a negative net present value. The analysis in the Draft Report and the comments received prompted further examination of gas cooktops, gas ovens, and electric non-self-cleaning ovens. DOE prepared an analysis to supplement the Draft Report that focuses exclusively on the possible elimination of standing pilot lights for gas products and improving non-self-cleaning conventional electric ovens by venting and insulating them like self-cleaning electric ovens. The supplemental analysis used the latest available data from AHAM regarding the trends over time of shares of sales of non-self-cleaning conventional ovens and gas products with pilot lights. It also used the latest utility price forecasts from the Annual Energy Outlook of the Energy Information Administration, AEO 97, and the Gas Research Institute, GRI 97.

In a **Federal Register** Notice of limited reopening of the record and opportunity for public comment (63 FR 9975) dated February 27, 1998, the Department reopened the comment period for cooking products for 30 days. This notice announced the availability of the supplemental analysis and gave indication of the prescriptive standard the Department was inclined to promulgate in the final rule. The notice also indicated the Department's intent to change the name of this rulemaking from "kitchen ranges and ovens" to "cooking products." This change was made because the term "kitchen ranges and ovens" does not accurately describe the products considered which include conventional ranges, cooktops and ovens and microwave ovens.

Due to a request by the American Gas Association (AGA) for additional time,

this notice was followed by another notice reopening the comment period through April 28, 1998. The Department received 31 comments in response to these notices. Based on the comments to the Reopening Notice that identified significant issues surrounding gas cooking products, DOE decided to sever the electric cooking products from the gas cooking products in this rulemaking.

II. Discussion of Electric Cooking Products Comments

This section addresses comments to the 1994 Proposed Rule, the 1996 Draft Report, the Supplemental Analysis, and the 1998 reopening notice.² This section only addresses comments relating to electric cooking products and does not discuss gas cooking products.

a. Classes

Microwave Ovens

D. Wilson (Frigidaire, Transcript, Apr. 7 at 268) commented that heating elements are a utility to Frigidaire's customers and therefore require an additional product class for microwave ovens. Les Harris (Sharp Electronics Corporation, Transcript, Apr. 7 at 285–288) commented that there should be separate product classes for the convection and browner type microwave ovens based on their specific utility, as well as additional product classes for different cavity sizes. Jack Weizeorick (AHAM, Transcript, Apr. 7 at 258–260) also argued for two product classes: conventional microwave ovens with and without browning elements. He based this argument on the test procedure which he says does not measure the energy that the browning element absorbs from the microwaves. Mr. Weizeorick also argued for a third product class to include combination microwave/convection ovens.

Amana Refrigeration, Inc. (No. 347 at 6) urged DOE to define a specific product class for convection/microwave ovens because of the browning utility which causes a loss of about four percentage points of efficiency. Frigidaire Company (No. 544 at 2) submitted that microwave ovens with browning elements need a separate product class because its data shows the browner versions are consistently lower in efficiency by 2.0 percent.

Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 5–7) argued that DOE's approach of a single class microwave oven is too simplistic because there are certain design constraints in the various type products that have a significant effect on their design and efficiency. They commented that the following design differences in microwave ovens justify additional product classes: (a) (structurally) fixed ovens, (b) portable ovens, (c) heating elements in the oven which absorb microwave energy, (d) convection ovens where the heating elements are not located in the cooking cavity, and (e) volume efficiency relationships for portable ovens only. Consequently, AHAM recommended the adoption of five classes of microwave ovens, as follows:

1. Portable Microwave Only—Less than 0.8 ft³ total cavity volume
2. Portable Microwave Only—0.8 to 1.19 ft³ total cavity volume
3. Portable Microwave Only—1.2 ft³ total cavity volume
4. Portable Microwave/Thermal
5. Built-in (Fixed)

Gregg Greulich (Whirlpool, No. 599 at 5) agreed with these classes, and Tim Brooks (Whirlpool, EE–RM–S–97–700 No. 6 at 2) reiterated in his 1996 comments the need for separate microwave oven classes in future rulemakings. O.P. Clay (Sharp, No. 521 at 2), relying on data supplied to DOE, supported at least three product classes: small cavity size, large cavity size, and convection/microwave ovens. C.M. Walsh (Thermador, No. 622 at 1) recommended that microwave ovens with a usable volume greater than 1.75 cubic feet be put into a separate category that is excluded from the standard.

Les Harris (Sharp Electronics Corporation, Transcript, Apr. 7 at 287–288) requested exclusion of the microwave standard for convection and browner type microwave ovens because of the small number that are sold and because they provide a specific utility different from the standard microwave oven.

The Department believes more efficiency/cost data is needed to separate the ovens into separate product classes. However, because DOE is not promulgating standards for microwave ovens in this rule (see section III. e.), the Department does not believe it is necessary to examine this issue at this time.

Commercial-type Products for Residential Use

L. Durden (Viking Range Corp, Transcript, Apr. 7 at 180, 189, 196, 197

and No. 866 at 1) requested a separate energy classification for commercial-type home cooking products. He argued that the replacement alternative for these products would be purely commercial products which consume large amounts of energy and are not safe for home use. A purely commercial range if placed next to cabinetry will not pass the heat requirements (will cause scorching and burning of the cabinetry). Mr. Durden stated that there is a precedent for separate product classes for through-the-door service refrigerators and larger-sized refrigerator freezers, and consequently, a similar consideration (separate energy class) should be considered for commercial-type home cooking products. G. Greulich (Whirlpool, Transcript, Apr. 7 at 219) suggested DOE have a more specific definition in regard to commercial-type versus standard products. AHAM (AHAM, No. 001 at 14–15) and R. Zipkin (Russell Range, Transcript, Jun. 7 at 323) recommended that DOE define a separate product class for high-capacity ranges.

C.B. Walsh (Thermador, No. 622 at 2–6) commented that the useful characteristics of the professional style range would have to be sacrificed in order for it to meet the best efficiency levels of a standard range. He commented that these appliances should be categorized as high capacity. He said the definition of a high capacity oven should be changed from a volume of 5 or more cubic feet to 4.5 or more cubic feet (to include a professional oven with the dimensions of 28 inches wide, 14 inches high, and 20 inches deep) and its bake burner energy minimum changed from 30,000 BTU/h to 22,500 BTU/h because efficiency improvements may make today's level of performance (at 30,000 BTU/h) possible with a burner rated at 25,000 BTU/h or less.

ACEEE (ACEEE, No. 557 at 23) commented that DOE should develop a separate product class for commercial products that are sold in limited quantities in the residential sector. Because the Department is not promulgating minimum energy efficiency standards for cooking products in today's rule, the Department believes this comment is not a concern at this time.

b. Design Options

Oven Door Window

The Department received several comments which argued there would be reduced utility and a decrease in efficiency with this design option. G. Greulich (Whirlpool, Transcript, Apr. 7

²Comments with unspecified docket numbers belong to docket number EE–RM–90–201. This docket contains the September 1990 advance notice and the 1994 Proposed Rule. Docket No. EE–RM–S–97–700 contains the 1996 Draft Report, comments to the 1996 Draft Report, comments to the 1998 reopening notice and the supplemental analysis. Comments from this docket are specified with Docket number EE–RM–S–97–700.

at 211–212) commented that more than half of its consumers prefer to purchase products with the window feature and those consumers say it is an important part of customer satisfaction from a utility standpoint. G. Greulich (Whirlpool, No. 391 at 7) and D. Karl Landstrom (Battelle, Transcript, Apr. 7 at 239–240 and Transcript, Jun. 7 at 292–294) commented that the 1994 proposed standard would adversely affect cooking utility and quality because of the number of times the consumer would open the door to check the food. H. Brooke Stauffer (AHAM, Transcript, Apr. 7 at 170–172, 177) argued that the elimination of the oven door window would not only reduce utility but also is probably prohibited by the NAECA Safe Harbor Provisions. AHAM (AHAM No. 001 at 6) said the Proposed Rule “violates NAECA’s ‘safe harbor’ prohibition against standards which result in significant adverse utility or feature impacts (Section 325 (o)(4)).”

Lyn Cook (Independent Home Economist, No. 749 at 1) conducted limited tests using 17 door openings with no window. She found the cooking results to be borderline to unacceptable in terms of cooking performance.

Arthur D. Little, Inc. (ADL, No. 001 at 22–24) commented that this option has a “positive energy savings” (from 12.49 to 14.35 percent for a standard oven) and a “good payback.” ADL also commented, however, this design option “does change the utility of the oven, that is, consumers currently perceive a major benefit in the window option, and are willing to pay a premium for this feature.” ADL reported 70 percent of all units shipped include a window.

W.W. Olson (Assoc Professor & Extension Housing Technology Specialist, No. 736 at 1) requested that the removal of the oven door window option be deleted from the proposed standard. She based her comment on the added burden this design would place on persons with limited strength or a painful grasp. In addition, the elimination of the oven window would burden people who use a wide range of wheeled assistive devices, frail people (early Alzheimers), and people with impaired sense of smell because the window would serve as an early visual warning of burning or a fire within the oven.

Margery Tippie (Redbook Magazine, No. 488 at 1) commented that all baked goods recipes state a range of baking times, e.g. “bake 15 to 20 minutes, or until golden brown”. She said the consumers should “begin checking for doneness at a minimum of 15 minutes

baking time, and to proceed until the desired degree of doneness is achieved. An oven window helps in the process.” She argued that without the window, there would be constant heat (energy) loss since the oven would be opened for frequent checking. Lydia Botham (Land O’Lakes, Inc., No. 623 at 1) commented that this design option (as well as reduced vent rate and improved door seals) may increase the energy efficiency of the oven, but more testing should be done to ensure consumers are not negatively impacted.

ACEEE (ACEEE, No. 557 at 23) commented that DOE should exclude this design option from the analysis, since it is just as likely to increase as decrease energy use.

P. Gordon (Marsco Manufacturing Co., No. 595 at 1) urged DOE to consider not eliminating the glass in oven doors as an option to gain energy efficiency. He commented that heat reflective glasses have been able to replace a very expensive borosilicate glass produced in Germany. Michael E. Hobbs (Marsco Manufacturing Co., No. 865 at 1) also urged DOE to reconsider this design option and to eliminate it. Senators Paul Simon, Carol Moseley-Braun and Barbara Boxer (U.S. Senate, No. 891 at 1, No. 892 at 1, and No. 907 at 1) also supported the argument to eliminate the oven door window design option.

DOE agrees with the various commenters that the removal of the oven door window may cause the users of the ovens to open the doors more frequently and therefore, has the potential to result in increased energy usage. The opportunity exists to improve the oven door window in the future. A newer, proven oven window material is needed that has higher thermal insulation properties, can withstand high oven temperatures, and has the mechanical strength compatible with the other oven parts. Until such a technology is proven, DOE will eliminate this design option.

Reduction of Thermal Mass

G. Greulich (Whirlpool, Transcript, Apr. 7 at 217) commented that Consumer Reports showed a customer preference for the larger oven cavity and not the 30 percent smaller oven cavity which was assumed in the TSD. Also, utility may potentially be lost because consumers may not be able to cook multiple dishes in a smaller oven. In addition, Whirlpool stated this design option affects product durability, manufacturing stability, product resistance, and susceptibility to being crushed during transit. Arthur D. Little, Inc. (AHAM, No. 001 at 21–22) commented that this design option will

improve the oven efficiency, but reductions in material thickness are very limited. These limitations are based on: the average porcelain thickness needed for adequate wall coverage and sheet metal thickness reduction limitations (due to the use of already thin materials.) The ADL analysis showed that a ½ to 1 lb reduction in oven cavity thermal mass will reduce oven energy consumption by 0.35 to 0.70 percent. ACEEE (ACEEE, No. 557 at 23) commented that DOE should exclude this design option in the analysis because the quality and life of the ovens may be harmed.

The Department agrees with all arguments against inclusion of this design option. Due to the issues of consumer product safety and structural integrity, DOE has eliminated reduced thermal mass as a design option. However, the opportunity exists to improve this technology in the future. Newer, less expensive materials or coatings may be developed in the future which maintain structural strength, reduce or maintain cost, but reduce thermal mass.

Forced Convection

For electric ovens, G. Greulich (Whirlpool, Transcript, Apr. 7 at 215–216) commented that this design option would result in considerable changes in consumer utility because many recipes are not easily converted (from natural convection). The timing is different and “generational recipes” which are handed down from one generation to the next would not cook the same way. M. Thompson (Whirlpool, No. 391 at 13) also submitted that industry aggregate efficiency for electric self-clean ovens is 2 percent. They reported the industry aggregate incremental costs of this design option are approximately 6 to 7 times higher than the DOE TSD cost with payback periods dramatically increased (from 6 to 302 years for electric standard ovens and from 8 to 363 years for electric self-clean ovens). Lyn Cook (Independent Home Economist, No. 749 at 2) commented that this option would require a revolution in consumer cooking methods because it would dramatically change the way oven cooking is done.

Arthur D. Little, Inc. (AHAM, No. 001 at 7–11) commented that based on its evaluation of available data, information provided by manufacturers, and oven thermal analysis, this option does not meet consumer payback requirements and changes the utility of the oven. ADL concluded that the overall energy savings is less than 8 kWh/y as compared to DOE’s estimates of 41 kWh/y and 33 kWh/y for self-cleaning

and standard ovens, respectively. The reported incremental price increase for this option is \$81.95 which would result in payback periods of 141 and 106 years, respectively, for these ovens.

ACEEE (ACEEE, No. 557 at 23) commented that this option looks promising. ACEEE argued against the comment concerning "old family recipes" and said such recipes may need modification, but this problem could be solved by allowing consumers to turn off this feature for a single use at a time.

The Department disagrees with arguments that consumer utility is decreased. The consumer is given the option to turn the forced convection feature on or off. The consumer is therefore given the choice to be more energy efficient. The Department realizes that certain recipes may have to be modified if the design option is used, but the consumer would learn how to use it if desired. Secondly, the technology is already in the marketplace. DOE recognizes that full credit for energy efficiency is not realized because the oven test procedure measures energy use over short periods of time. Certain foods would take less time (energy) to cook with convection, e.g. approximately 3 hours to cook an average turkey with convection, compared to 5–6 hours without it. The Department also believes this reduced cooking time increases utility to the consumer.

Improved Door Seals

M. Thompson (Whirlpool, Transcript, Apr. 7 at 223–224) argued that a little bit of leakage is absolutely critical especially when baking to allow enough moisture release. Gregg Greulich (Whirlpool, No. 391 at 9) commented that this design option needs to be considered in conjunction with the electric standard Reduced Vent Rate design option to minimize the overall impact on cooking performance. Lyn Cook (Independent Home Economist, No. 749 at 2) also recommended that DOE consider the Improved Door Seal and Reduced Vent Rate options together because both have an influence on the natural convective air flow through the oven cavity. Lydia Botham (Land O'Lakes, No. 623 at 1) commented that this design option may increase the energy efficiency of the oven, but more testing should be done.

For standard electric ovens, Arthur D. Little, Inc (AHAM, No. 001 at 17–18) analyzed this design option and concluded that it will have a very minor impact on oven efficiency (from 12.15 to 12.39 percent) and a price premium that creates a payback in excess of 10 years.

Additionally, the cooking performance of the oven may be affected. Tim Brooks (Whirlpool, EE–RM–S–97–700 No. 6 at 2) commented that improved door seals are not justified because of insignificant energy savings (0.2%) with excessive payback—less than \$1 saved per year.

DOE agrees with the comments that sufficient air flow through the oven cavity is required to allow for proper heating and moisture conditions while cooking. This design option does not call for elimination of the air flow by improved seals; it merely states they can be improved "without sealing the oven completely." Moreover, because this design option was not contained in any standard levels the Department found to be economically justified in today's rule, the Department does not consider it to be an issue in this rulemaking.

Bi-Radiant Oven

Tim Brooks (Whirlpool, EE–RM–S–97–700 No. 6 at 3) stated that the 50 percent improvement assumption is unsupported by facts. He also noted technical problems making this design option impractical. The Department finds in today's rule that this design option is not economically justified.

Reflective Surfaces

Gregg Greulich (Whirlpool, No. 391 at 10) said that this design option causes loss of consumer utility (oven cleaning) and is not financially justified. He also commented that industry aggregate incremental costs of this design option are approximately 12 to 13 times higher than the DOE TSD cost, resulting in a 152 year payback (Transcript, Jun. 7 at 339). Tim Brooks (Whirlpool, EE–RM–S–97–700 No. 6 at 3) stated that maintaining highly reflective oven walls is impractical.

C.B. Walsh (Thermador, No. 622 at 2) commented that he was not aware of a reflective material which will retain its reflectivity after repeated exposure to pyrolytic self-cleaning oven temperatures (850–950F). Lyn Cook (Independent Home Economist, No. 749 at 2) commented that such surfaces would quickly discolor, and their longevity would be restricted. She recommended DOE eliminate this design option. ACEEE (ACEEE, No. 557 at 23) commented that DOE should exclude this design option in the analysis because it would be impossible to keep the surfaces clean and shiny, particularly in self-cleaning ovens.

Arthur D. Little, Inc (AHAM, No. 001 at 11–17) analyzed this design option for electric ovens and concluded: (1) current oven utility is not maintainable using reflective surfaces (the characteristics of this reflected radiation

are different than the normal radiation emitted by the current cavity); (2) only modest energy savings are possible (from 12.15 baseline efficiency to 12.73 efficiency); and (3) consumer payback is long (8.62 to 11.33 years).

Marcia Copeland (Betty Crocker, EE–RM–S–97–700 No. 5 at 1) disagreed with the statement in the Draft Report that reflective pans are assumed to have no maintenance cost and could easily be maintained by the consumer. Copeland stated that Betty Crocker's experience with consumer testing indicates this assumption is incorrect but did not provide supporting data. Tim Brooks (Whirlpool, EE–RM–S–97–700 No. 6 at 3) concurred and stated that the pans would become non-reflective in about one year.

DOE agrees with the lack of sophistication in the technology to maintain a clean, reflective oven surface or reflective cooktop pans, and therefore achieve an energy efficiency improvement, over the life of the products. Therefore, DOE has eliminated the improved reflective surfaces in ovens and reflective pans for cooktops as design options in this rule.

Oven Separator

Marcia Copeland (Betty Crocker, EE–RM–S–97–700 No. 5 at 1) stated that an oven separator would have low consumer acceptance and only adds to the cost of the appliance. She also stated that the existence of a German model has no relevance for American consumers but did not provide any reasoning for this statement. However, because the Oven Separator design option only was used for max tech and was not found to be economically justified, the Department does not believe this issue is a concern.

Added Insulation

DOE received comments which said there would be loss of consumer utility with this design option and that it is not cost effective. D. Horstman (Maytag, No. 490 at 3) commented that manufacturers would be forced to reduce the oven cavity size drastically to comply with the proposed standards. He said there would be less utility to the consumer and insufficient fuel cost savings to justify the cost premium. Likewise, Gregg Greulich (Whirlpool, No. 391 at 11) submitted that this design option will reduce consumer utility (oven size), and result in an excessive payback (increase from 5 to 8 years for standard electric ovens and increase from 11 to 35 years for self-cleaning electric ovens). Whirlpool said this design option would not be justified.

Arthur D. Little, Inc (AHAM, No. 001 at 19–21) commented that its analysis shows that although a 2-inch increase in insulation will have a large impact (1.4 percentage points on a 12.15 percent efficiency baseline) on the oven energy usage, it will have a negative impact on the utility of the oven and range appliances. Either the size of the overall cabinet must increase, or the oven cavity volume must be reduced. In addition AHAM's comments agreed that thicker insulation (up to 4 inches) can achieve a 1.4 percentage point increase in oven efficiency, but the implementation of this design may affect the utility of the appliance for the reasons stated above.

The arguments against this design option involve reduction of consumer utility due to decreased oven cavity volume, if the same oven footprint is maintained. The Department has eliminated this design option because it reduces consumer utility and results in an increase in the life-cycle cost with a negligible decrease in energy use.

Improved Insulation

Tom Hoff (Microtherm Inc., No. 605 at 2–4) commented that his company has a micro porous thermal insulation which has significantly higher thermal insulation capability than existing technology and can be used in oven and range applications.

Maytag (Maytag, EE-RM-S-97-700 No. 9 at 4) stated that insulating the non-self-cleaning oven in a manner similar to the self-cleaning oven does not improve efficiency in a cost justifiable manner. Maytag stated that the higher efficiency of the self-cleaning models is not due solely to the difference in insulation but is also due to the several panes of heat reflective glass in the door and the inner baffles.

AHAM (AHAM, EE-RM-S-97-700 No. 26 at 3) commented that there is nothing in DOE's analysis which contradicts the significant evidence from manufacturers that further insulation will result in negligible savings in energy. AHAM commented that in order to attain any possible real increase in efficiency, non-self cleaning products would have to undergo total door reconstruction (including door seal, heat insulating glass) at great, cost-prohibitive expense.

The Department did consider higher performing insulation (See Draft Report Table 1–9) but did not consider the Microtherm product specifically due to a lack of data, particularly material costs and possible installation or fabrication cost. The Department only considered the increased performance and cost of higher density fiberglass insulation in

existing cavities and did not consider changes to any door glass or inner baffles, although improved door seals were considered separately.

Reduced Vent Size

Gregg Greulich (Whirlpool, No. 391 at 9) commented that this design option needs to be considered in conjunction with the design option for Improved Door Seal design to minimize the overall impact on cooking performance. Marcia K. Copeland (General Mills, Inc., No. 355 at 2) commented that reducing oven vent size will negatively impact high moisture foods such as pound cake, two-crust fruit pies, roasting, meat loaf, lasagna, and foods that need drying such as pastry, biscuits, and cookies. The reduced vent size may result in increased baking time, and consumers will be less satisfied with the results. Karen Johnson (Borden, No. 560 at 1) supported these comments. Lydia Botham (Land O'Lakes, No. 623 at 1) commented that this design option may increase the energy efficiency of the oven, but more testing should be done.

Maytag (Maytag, EE-RM-S-97-700 No. 9 at 4) stated that because vent size is designed to be at an optimum for cooking performance, any reduction in size will affect cooking performance. Gregg Greulich (Whirlpool, EE-RM-S-97-700 No. 33 at 2) stated that the venting Whirlpool uses in self-cleaning ovens is virtually identical to the venting in its non-self-cleaning models. Whirlpool's testing shows that reducing the venting will only serve to degrade cooking performance and will not save energy.

AHAM (AHAM, EE-RM-S-97-700 No. 26 at 3) commented that DOE erroneously assumed that a reduction in the vent opening of a non-self-cleaning oven to the same size as a self-clean oven would result in energy savings. AHAM commented that vent openings are not automatically larger in non-self-cleaning ovens. AHAM stated that the size of the vent opening is determined by several factors, only one of which is the cleaning type. AHAM commented that if a smaller vent opening were effectively required for all models, the product performance would be degraded on some models by reducing the moisture loss.

Oven venting is necessary for the cooking process, but reducing the vent rate inherently reduces the energy lost in the cooking process and therefore, increases the overall efficiency of the oven. The Department assumed that self-cleaning ovens have smaller vents than non-self-cleaning ovens due to safety concerns regarding air flow during the high temperature cleaning

cycle. Since the venting systems on self-cleaning ovens provide satisfactory cooking performance, it was assumed that these reduced vents could satisfactorily be applied to non-self-cleaning ovens and yield an efficiency improvement. However, this assumption is refuted by the Whirlpool comment that there is no difference in venting in its products and the AHAM comment that vent openings are not automatically larger in non-self-cleaning ovens. Thus, the Department has probably overstated any energy savings from this design option. In making today's determination DOE is not considering any energy savings from this design option.

Improved Contact Conductance

Arthur D. Little, Inc (AHAM, No. 001 at 24–27) reported the results of its analysis and testing on this design option for electric cooktops. Its results showed that the major mechanism for heat transfer was physical contact between the pot and coil, not contact pressure. The DOE test procedure uses an aluminum block which may be flatter than an actual cooking pot. ADL stated it found minimal real world efficiency improvements possible. The Department agrees that the heat transfer method is a function of physical contact and that this contact is influenced by the flatness of the object on the cooktop.

Improved Efficiency of the Magnetron Power Supply/Transformer

Charles Samuels (AHAM, Transcript, Apr. 7 at 51) argued that the transformer improvements were based on faulty communications between DOE's contractors and industry; consequently DOE has over-estimated the cost and energy improvement potential and not taken into account the problems with product size and weight that would be caused by more efficient transformers, even if technologically feasible.

D. Susak (Advance Transformer Company, Transcript, Apr. 7 at 272) commented that efficiency increases to 96 percent are not attainable at any price, much less at \$5 as stated in the TSD. Mr. Susak reported results from some testing that resulted in a transformer efficiency of 91.4 percent with an additional cost of \$6.45 per unit and a payback period greater than six years. This improvement was from only one of its current designs and should not be expected for all designs. Gregg Greulich (Whirlpool, No. 599 at 3) agreed with the Advance Transformer study and said that Whirlpool's own study corroborates it. He said this design option should be dropped. Jack Weizeorick, AHAM (April 7, rebuttal at

341–344) commented that the TSD reference “(56)” to C. Huene (TSD, Vol 2, App E, p 1–49) was incorrect. Mr. Huene was contacted, and he stated he never said that a 95 percent efficient transformer was available at a cost of \$5.

O.P. Clay (Sharp, No. 521 at 2) commented that DOE’s provided cost estimates of \$7.90 for the purpose of increasing the efficiency of microwave ovens from 54 to 62.5 percent cannot be achieved. Data was supplied that showed a 1 percent improvement would cost \$4.05, and achieving an additional 2.5 percent would cost \$9.00. Sharp estimated the three design options proposed by DOE would cost at least \$13.05 and only increase the efficiency 3.5 percent. Sharp urged that DOE not include microwave ovens in the rulemaking based on these estimates.

Robert Lagoussie, International Microwave Power Institute (April 7, at 309–310) commented that a technical paper by Dr. C. R. Buffler on an improved power supply was misinterpreted in the TSD. Mr. Lagoussie commented that the improvement was technically but not economically feasible in 1978, and it would be even less economically feasible today. D. Wilson (Frigidaire, Transcript, Apr. 7 at 262–263) commented that Dr. Buffler reported an efficiency number based on theory that was not meant to be a practical solution. The commenter reported that it will be difficult to improve the present efficiency levels of 45 to 50 percent dramatically unless there are technological breakthroughs.

Clayton Bond (Toshiba Corporation, Transcript, Apr. 7 at 317–318) commented that his company had met with the other three magnetron manufacturers in Japan (there are none in the U.S.), and their response to the proposed standard is that the efficiency of the magnetron can be increased marginally (1 percent, or from 71 to 72 percent), but the cost of even this marginal improvement would be cost prohibitive. This one percent increase in efficiency would result in a cost increase of more than double the current price of the tube in this country. Other concerns were that it would take three years to develop; it would require new tooling, jigs, and expensive materials, and this improved design would be sold only in the U.S. market which is one-third of the world market. Likewise, Gregg Greulich (Whirlpool, No. 599 at 3) commented that magnetrons produced today are 71% efficient with a maximum realistic efficiency of 72%. He argued that this design option should be dropped since the magnetrons are as efficient as possible already.

Dennis Wilson, Frigidaire (April 7, rebuttal at 345) commented that an increased efficiency microwave oven would require an increase in a transformer size and additional costs. Frigidaire’s written comments (No. 544 at 3) further argued that the company would be at an economic disadvantage in the European marketplace because this increased size would make the higher efficiency microwave oven incompatible with the common chassis used for both the domestic and export markets.

Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 10) commented that the high efficiency transformer would be larger and heavier than the transformer used today and would result in an increase in the overall size of microwave ovens which would result in increased shipping costs since fewer could be shipped in a standard sized truck or container.

E. Toomey (Goldstar, No. 503 at 1) commented that her company is currently using a 95% efficient magnetron which “leaves no room for improvement.” At present, she said her company’s ovens are already rated at close to 60% efficiency. ACEEE (ACEEE, No. 557 at 24) urged DOE to include the effects of the adoption of European power supply standards on U.S. microwave manufacturers.

DOE has analyzed the data which was submitted during the comment period and found the data to be contradictory in part. The comments summarized above indicate technological barriers to improving the efficiency of microwave ovens above the baseline value of 54 percent. However, AHAM data (AHAM, No. 001 at B–1) reports efficiency/cavity volume and efficiency/oven type which show many units above 54 percent efficiency and a significant number above 57 percent, thus indicating the technology exists to improve the efficiency of the ovens. Moreover, because this design option was not contained in any standard levels the Department found to be economically justified in today’s rule, the Department does not consider it to be an issue in this rulemaking.

Modified Waveguide

Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 11) commented that only a small efficiency improvement may be available on some microwave ovens by reducing the length or improving the finish on the waveguides. Many of the ovens produced in 1993 already have these new features. Gregg Greulich (Whirlpool, No. 599 at 3) agreed with this comment and said that this design option should be dropped.

He also said that it is possible to increase the coupling between the magnetron and the cavity for a specific load in such a way that the efficiency would improve for that specific load. However, there were several significant disadvantages to this tight coupling which he supplied in his written comments. D. Wilson (Frigidaire, No. 544 at 4) commented that this design option would require the redesign and retooling of the waveguide since the waveguide itself is an integral part of the cavity design, and a separate part would be necessary in order to reduce the material costs. Cost estimates were provided in the written comments. The Department believes these comments are well founded. Therefore, this design option was eliminated.

Microwave Oven Fan Efficiency

Les Harris (Sharp Electronics Corporation, Transcript, Apr. 7 at 282–284) commented that the efficiency increase and associated cost increase with the fan in the TSD are in error. Various options are listed and agreement with the TSD is possible (at 0.8 percent increase), but the cost increase is \$7 to \$8.22, not \$1.05 as stated in the TSD. This cost would significantly extend the payback period. Also, the improvement previously stated requires an electronically commuted DC motor, which has been theoretically proven, but not proven in practice.

Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 11) commented that manufacturers’ data indicates that most fans use between 15 and 32 watts of power, but some use a high of 75 watts. AHAM supplied data which shows an increased efficiency fan, which uses 15.2 watts over the “standard” fan which uses approximately 21 watts, at an additional cost of \$2.20. If an electronically commuted DC motor were used, the power would be reduced to 7.7 watts at an additional cost of \$8.25.

D. Wilson (Frigidaire, No. 544 at 4) commented that a more efficient fan motor could be manufactured without a capital investment but would require engineering and testing to qualify the component. The revised motor is assumed to be directly interchangeable with the current motor and not require a tooling investment. Cost estimates were provided in the written comments.

Gregg Greulich (Whirlpool, No. 599 at 3) commented that fans use about 25 watts and an efficiency improvement of 10% amounts to 2.5 watts. He stated this improvement could possibly double the cost of the fan which increases the payback period, while providing minimal energy savings. He

recommended deleting this design option.

The Department incorporated this data in the Draft Report analysis which showed a decreased efficiency improvement at increased cost.

c. Other Comments

Significance of Energy Savings

H. Brooke Stauffer (AHAM, Transcript, Apr. 7 at 169, 170) commented that AHAM does not believe a performance standard is justified because the amount of energy saved is insignificant. AHAM argued that the energy savings are exaggerated and the costs understated. AHAM said this position was based on tests conducted and data which suggests the costs reported in the TSD are one-third to one-fourth the actual manufacturer's cost to implement various design options. M. Thompson (Whirlpool, Transcript, Apr. 7 at 205, 206) gave annual cost savings for various design options and argued that their collective savings were small.

AHAM (AHAM, No. 001 at 6) further commented that because the energy used by ranges is minor, the proposed standards do not meet the threshold NAECA criterion that an amended standard must result in "significant conservation of energy" under Section 325 (o)(3)(B). AHAM argued that the total projected energy savings from proposed range performance standards are so low that the standard's benefits will not exceed its burdens as required under Section 325 (o)(2)(B)(i)(III).

While the term "significant" is not defined in EPCA, the U.S. Court of Appeals for the District of Columbia Circuit concluded that Congress intended the word "significant" to mean "non-trivial." *Natural Resources Defense Council v. Herrington*. 768 F.2d 1355, 1373 (D.C.Cir. 1985). Thus, for this rulemaking, DOE concludes that at each trial standard level the estimated energy savings is non-trivial and therefore significant.

Life Cycle Costs

D. Karl Landstrom (Battelle, Transcript, Apr. 7 at 233-234) commented that the life cycle cost data should be updated by DOE to use current DOE Energy Information Administration estimates of future cost projections rather than the 1991 estimated projections.

Gregg Greulich (Whirlpool, No. 391 at 5) commented that if all of DOE's first seven design options were to be incorporated into a new standard self-clean electric range, the total annual cost savings would be \$6.47. He pointed

out that in 1979 (when the FTC first considered labeling ranges), a total annual operating cost savings difference of \$7.00 would have been considered significant by consumers. The \$6.47 figure translates into \$3.33 in 1979 dollars, less than half of what the FTC deemed to be a significant cost savings to consumers.

Whirlpool (No. 391 at 6) also commented that DOE standards could affect eight different Whirlpool product categories. The cost of compliance in each product category will likely be millions to many tens of millions of dollars. Whirlpool argued that the cumulative impact of adding ranges, ovens, and cooktops, when coupled with the "diminutive energy savings," makes energy standards for this product category unjustifiable.

The Department has recalculated life-cycle costs using the latest Annual Energy Outlook (AEO) energy prices available at the time of the analysis. The Draft Report used AEO 95 energy prices, and the supplemental analysis used AEO 97 energy prices. In addition, the Gas Research Institute (GRI) 97 prices were used for a basis of comparison in the Supplemental Analysis.

Test Procedures

There were many comments on the test procedures, including annual energy consumption. These comments, however, were discussed and resolved in the Test Procedure Final Rule for Kitchen Ranges, Cooktops, Ovens, and Microwave Ovens. 62 FR 51976 (October 3, 1997).

Economic hardship

Joann Prater (MCD Corporation, Transcript, Apr. 7 at 276-277) commented that MCD Corporation would probably go out of business if the new microwave ruling is enacted for the following reasons: MCD Corporation is a small, single-line product company which recently invested \$5M in tooling for a new, more efficient oven which is scheduled to enter the market this year. This new oven, however, does not meet the new efficiency standard proposed in the NOPR. The company would not be able to capture its investment during the shorter period its new product would be on the market, and MCD could not retool for another new oven to be manufactured by the effective date of the new standards. She also commented that several assumptions in the TSD are incorrect. She maintained that the cost to retool is understated because the TSD did not include the additional costs to redesign features such as the power supply, the fan, the modified waveguide, an improved magnetron,

and new reflective surfaces. The TSD accounts for only the wave guide. The oral testimony was also supported by written comments (MCD Corporation, No. 742 at 1-20).

Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 1) commented that the proposed standards for microwave ovens would "eliminate the last remaining U.S. production and may concentrate U.S. sales in the hands of only one or two companies." J. Geary (Peerless-Premier Appliance Co., No. 352 at 1) commented about the adverse economic impact and the potential lessening of competition that the proposed standards would have on his company. He commented that DOE and the Attorney General had not adequately evaluated the impact of the standards on small manufacturers.

D. Horstman (Maytag, No. 490 at 3) commented that the proposed standards, if enacted, would force Maytag to spend millions of dollars at its plants with considerable competitive disadvantage compared to its primary competitors. He said Maytag may have to discontinue lower volume product lines and thus, further reduce competition in the marketplace.

D. Wilson (Frigidaire, No. 544 at 5) commented that the economic impact on the Dalton Microwave Operations would be significant if it needed to redesign its products to meet the proposed DOE requirements. He added that because only a few U.S. companies continue to manufacture this product, the addition of more economic burden will likely cause the remaining smaller manufacturers to close down, allowing the importers to completely take over the market.

Because the Department found in today's rule that standards for microwave ovens are not economically justified, today's rule will not result in any economic hardship.

Microwave Noise at Higher Efficiency

Robert Lagoussie, International Microwave Power Institute (April 7, at 310-313), R.D. Parlow (National Telecommunications and Information Administration, No. 689 at 1), Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 9-10) commented that a microwave oven produces electronic noise outside the normal frequency spectrum of 2,400 to 2,500 MHZ. There can be considerable electronic noise in the 2 to 3 GHz range which affects other devices (broadcast/cellular phone), and more noise is generated as the efficiency of the microwave increases. The International Special Committee on Electromagnetic Interference is considering a new noise

standard this year which would reduce the magnetron noise level requirement from 85 to 99 decibels currently to a new standard of 30 to 40 decibels. Amana Refrigeration, Inc. (No. 347 at 6) commented that the FCC has indicated that future requirements for noise interference will be tightened substantially. Amana said that design changes employed to achieve reduced noise will reduce the unit's efficiency.

The National Telecommunications and Information Administration, submitted comments on behalf of U.S. microwave manufacturers, expressing concern that the Department's interest in increasing microwave oven efficiency may be counterproductive to efforts being made to control radio noise. Increased microwave magnetron efficiency could raise radio noise levels, thereby, increasing the potential for interference (National Telecommunications and Information Administration, No. 689 at 1). The Department finds in today's rule that this design option is not economically justified; therefore, this rule will not cause increased noise.

Manufacturer Impact

In the Proposed Rule, DOE conducted a manufacturer impact analysis using the LBL Manufacturer Impact Model (LBL-MIM) as described in the TSD accompanying the 1994 Proposed Rule. Many comments were received regarding this analysis. In the revised analysis which supported the Draft Report, the Department used a computer model that simulates a hypothetical company to assess the likely impacts of standards on manufacturers and to determine the effects of standards on the industry at large. This model, the Manufacturer Analysis Model (MAM), is described in the TSD. Appendix C provides a broad array of outputs, including shipments, price, revenue, net income, and short- and long-run returns on equity. The "Output Table" in Appendix C lists values for all these outputs for the base case and for each of the five standard levels analyzed. It also gives a range for each of these estimates. The base case represents the forecasts of outputs with a range of energy efficiencies which are expected if there are no new or amended standards. A "Sensitivity Chart" (TSD, Appendix C) shows how returns on equity would be affected by a change in any one of the nine control variables of the model. The Manufacturer Analysis Model consists of 13 modules. The module which estimates the impact of standards on total industry net present value is version 1.2 of the Government Regulatory Impact Model (GRIM). The

GRIM was dated March 1, 1993 and was developed by the Arthur D. Little Consulting Company (ADL) under contract to AHAM, the Gas Appliance Manufacturers Association (GAMA), and the Air-Conditioning and Refrigeration Institute (ARI). (See TSD, Appendix C for more details.) The results of this analysis are reported in section III. c. of today's rule. However, these results were not utilized in coming to the conclusions reported in section III. e. All trial standard levels in today's rule were rejected based on consumer economics. Therefore, a revised manufacturer impact analysis was not necessary.

Rebound Effect

ACEEE (ACEEE, No. 557 at 3) commented that it did not understand DOE's estimate of 10% rebound effect for cooking, because this rebound effect implies that households purchasing efficient ranges and ovens would cook more.

A ten percent rebound effect was not used in the analysis. A rebound effect of less than one percent was used.

Microwave Ovens Not Covered Under NAECA

Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 2) argued that nothing in the statutory language of NAECA required or indicated that microwave ovens should fall within the definition of "kitchen ranges and ovens" in Section 322(a)(10) as opposed to other covered products.

The Department has previously determined that microwave ovens fall within the definition of "kitchen ranges and ovens." 43 FR 20108 (May 10, 1978).

Baseline Values Incorrect in TSD

Jack Weizeorick and Charles Samuels (AHAM, No. 001 at 7-9) commented that the microwave oven baseline value for shipment weighted average efficiency of 54.5 percent used in the TSD for the Proposed Rule is based on AHAM data of microwave ovens shipped in 1989. More recent shipment data shows a new, higher value of 55.8 percent. ACEEE (ACEEE, No. 557 at 23) commented that DOE should redo its analysis after it reduces the average baseline consumption of ovens and cooktops to be in line with recent data by utilities and GRI. The Department agreed and incorporated the 55.8 percent number into the Draft Report analysis.

Consumer Education Programs

AHAM (No. 001 at 16) stated that two reports indicated significant variations

in energy use among consumers preparing identical meals (50 and 60 percent differences respectively). AHAM recommend that DOE establish consumer education programs as a national priority for saving energy, in lieu of mandatory product performance standards. G. Greulich (Whirlpool, Transcript, Apr. 7 at 220) also commented that more emphasis should be placed on consumer education rather than engineering redesign of the ranges. R. Markum (Emerson Electric Co., No. 366 at 5) commented that much more potential energy savings exist through consumer education on the proper methods to achieve maximum cooking efficiency rather than through mandatory efficiency standards. Lyn Cook (Independent Home Economist, No. 749 at 2) commented that informing the consumer on how to make optimal use of energy efficient cooking methods is key to reducing the total amount of energy used. She quoted 18 points from ACEEE's Consumer Guide to Home Energy Savings which demonstrate how significant energy variances can be eliminated. Mark Krebs (Laclede Gas, EE-RM-S-97-700 No. 18 at 2) commented that the goals of energy efficiency and conservation are more likely to be achieved through facilitating consumer education rather than to simply dictate or restrict choices of technology.

The Department is required by statute to promulgate energy efficiency standards for cooking products if economically justified and technically feasible. EPCA, § 325, 42 U.S.C. § 6295. The Department's ENERGY STAR® program helps to educate consumers on the purchase of more energy efficient appliances. The program is increasing continually the list of products the program covers. One of the criteria the program uses to determine which products it should add to the program is an evaluation of whether there is a wide range of energy efficiencies among the products in the marketplace. Because there are not a wide range of efficiencies for cooking products, they have not been added to the Energy Star program thus far.

d. Other Comments Regarding the Draft Report and Supplemental Analysis

Marcia Copeland (Betty Crocker, EE-RM-S-97-700 No. 5 at 1-3) stated that the Draft Report did not address the implication of the changes to the proposed rule on consumers. She also requested DOE provide a glossary of terms.

DOE does analyze the effects of its rulemakings on consumers. For example, the Department abolished the

design option that eliminated the oven door window because of the adverse impact it would have on consumer utility. Because today's rule does not impose additional efficiency requirements on cooking products, the Department concludes that today's rule will not impact consumers.

The first time the Department uses an acronym, the Department spells it out, for example, "Technical Support Document (TSD)"; then the Department uses the acronym (e.g. TSD) throughout the rest of the document. The Department, however, agrees a glossary is a good suggestion, and the Department will provide a glossary in the TSD.

Electric Non-Self-Cleaning Ovens

In the reopening notice of February 27, 1998, DOE indicated a likelihood of not establishing standards for electric non-self-cleaning ovens. Many commenters supported no standards for electric non-self-cleaning ovens. Whirlpool (Whirlpool, EE-RM-S-97-700 No. 33 at 2) stated that no improved venting or insulation for electric non-self-cleaning ovens would meet all of DOE's minimum economic and utility requirements or its energy savings requirements under NAECA. Whirlpool supported the Department's decision not to establish performance standards for any electric cooking products. Whirlpool (Whirlpool, EE-RM-S-97-700 No. 6 at 1) stated that the cost of compliance testing would be greater than the potential energy savings of the design options. Maytag (Maytag, EE-RM-S-97-700 No. 9 at 4) supported DOE's conclusions regarding venting and insulating improvements on electric non-self-cleaning electric ranges.

AHAM (AHAM, EE-RM-S-97-700 No. 26 at 2) supported DOE's conclusion that no standards are appropriate for microwave ovens or other electric cooking products. AHAM (AHAM, EE-RM-S-97-700 No. 26 at 3) also cited cumulative regulatory burden placed on the manufacturers (due to the refrigerator, room air conditioner, and clothes washer rules) as another reason why standards for cooking products are inappropriate.

Steve Nadel (ACEEE, EE-RM-S-97-700 No. 32 at 2) supported no new standard for electric non-self-cleaning ovens. However, ACEEE disagreed with the rationale that the Department cannot be certain that all products if vented and insulated like self-cleaning counterparts will meet a specific performance standard because DOE can never be sure that a specific design option will always achieve a specific performance level. DOE could perform additional testing,

but given the modest savings of a standard, the burden of performance testing, and the fact that the rulemaking is already years behind, public interest is best served by finalizing a "no standard" standard for electric products.

Mark Krebs (Laclede Gas, EE-RM-S-97-700 No. 18 at 1) questioned how DOE could state that the record for electric cooking products is complete if performance data on electric ovens does not exist. In the reopening notice of February 27, 1998, however, the Department stated that DOE believed the record was complete for electric cooktops, electric self-cleaning ovens, and microwave ovens. The Department did not state the record was complete for electric non-self-cleaning ovens. The Department issued the February 1998 notice in order to complete the record.

The American Gas Association (AGA, EE-RM-S-97-700 No. 37 at 11-12) commented that the Department has not shown adequate justification for not issuing standards for electric cooking products. AGA commented that the analysis shows a performance standard for electric non-self-cleaning ovens is technologically feasible, economically justified, and will save significant energy. AGA stated that DOE's argument that no performance or usage data exists for these products (therefore it is unknown if they could meet a performance standard with improved insulation & venting) would imply that DOE would not pursue standards for any NAECA products where data did not already exist. The National Propane Gas Association (NPGA, EE-RM-S-97-700 No. 31 at 2) concurred with AGA's comments.

As discussed under "design options," the Department has received information from manufacturers indicating that their self-cleaning and non-self-cleaning ovens typically already use the same venting, and the Department has probably overstated the energy savings. The Department also believes that it has shown adequate justification (see Section "III. e. Conclusion") for rejecting standards for electric cooking products.

Separating the Rule

Many commenters requested the Department split off certain products from this rule and finalize the rule for those products immediately. AHAM (AHAM, EE-RM-S-97-700 No. 26 at 2) commented that the electric range and oven and microwave oven portion of this rulemaking should be finalized immediately. AHAM stated that failure to finalize this rule has created uncertainty among manufacturers, component suppliers, and other parties

and adversely affects investment and redesign decisions. Amana (Amana, EE-RM-S-97-700 No. 38 at 1) emphasized the importance of finalizing the electric range and microwave oven portions of the rule as soon as possible and separately, if necessary, from the gas cooking products rule. Amana cited the adverse effects the delay has caused on planning and investment. Whirlpool (Whirlpool, EE-RM-S-97-700 No. 33 at 4) stated that it has been waiting eight years for a final rule, which has not allowed them to be completely free to dedicate resources to innovative consumer features, without setting them forth. Consequently, Whirlpool urged DOE to issue a separate rule for electric cooking products immediately.

Sharp (Sharp, EE-RM-S-97-700 No. 35 at 1) fully supported DOE's conclusion that establishing new or revised energy conservation standards for microwave ovens are not technologically feasible or economically justified. Sharp requested that DOE separate microwave ovens from the other consumer products identified in the notice and issue, without delay, a final determination that DOE will not establish any energy conservation standards for microwave ovens. Sharp commented that such a final pronouncement by DOE will remove the lingering uncertainty that has hindered the microwave oven industry.

Due to requests that the rule be split in order to issue a final rule for electric cooking products without further delay, the Department has severed the electric cooking products from the gas cooking products in this rule.

Energy Rates

Commenters recommended that the Department should use the latest energy price forecasts and the Consumer Marginal Energy Rates (CMER) as recommended by the Advisory Committee on Appliance Energy Efficiency Standards (ACAES). Sharp (Sharp, EE-RM-S-97-700 No. 35 at 2) commented that if consumer marginal energy rates were used in the calculations for microwave ovens, it would greatly increase the payback period, which already extends beyond the economically acceptable timeframe. AGA (AGA, EE-RM-S-97-700 No. 37 at 9) also commented that DOE should use the latest AEO price projections and the energy cost recommendations of the ACAES. The National Propane Gas Association (NPGA, EE-RM-S-97-700 No. 31 at 2) concurred with AGA's comments. Edison Electric Institute (EEI, EE-RM-S-97-700 No. 21 at 1) commented that the analysis should be changed to show the results of

calculations over a range of marginal energy prices, which would lead to more accurate ranges of life-cycle-costs, rather than using "average" prices. EEI stated that the avoided energy cost rates using AEO 98 are lower than the rates used in the DOE analysis. EEI also commented that discount factors for this type of consumer appliance are probably too low. In addition, EEI commented that if the peak demand savings are assuming 100% coincidence with utility peak demands, 100% diversity, and 100% load factors, then the values are too high and should be adjusted downward to reflect actual coincidence, diversity, and load factors. AHAM (AHAM, EE-RM-S-97-700 No. 26 at 2) also commented that AEO 98 and CMER should be used. AHAM stated that these lower electricity rates would result in even longer paybacks for any possible standard level.

The Department is committed to certain procedures under the Process Rule. 61 FR 36973 (July 15, 1996). These procedures, however, do not apply entirely to certain rules already underway, 61 FR at 36980, including the cooking products rulemaking. The Supplemental Analysis, conducted in 1997, did use the most current energy price forecasts available at that time. In

addition, the Advisory Committee had not yet made its recommendations to the Department regarding CMER at the time the Supplemental Analysis was conducted. Furthermore, using these lower energy rates would not increase the likelihood that standards for electric cooking products would be economically justified because lower energy prices would only increase the payback period and decrease the life-cycle-cost savings. Consequently, the Department did not expend the resources to reanalyze the data using these new energy rates. Regarding peak demand savings, the Department agrees with EEI and did not assume 100 percent diversity, coincidence, or load factors. See Appendix E of the General Methodology in the TSD for a more complete explanation.

EEI questioned whether an energy efficiency standard should discuss emissions and environmental impacts. EEI commented that the Draft Report downplays the reductions in sulfur dioxide and nitrogen oxide emissions from power plants, on an overall and per kWh basis, and it does not appear that the report shows a decline in emissions for the years 2001–2030. EEI also stated that the impact of restructured electricity markets could

have a significant impact on emissions, as customers choose their preference of generation sources. The Department agrees that forecast emission rates for NO_x, SO₂, and CO₂ do fall over time. Emission rates may be affected by restructuring, but given the absence of clear indications of this effect, it was not incorporated into the analysis.

III. Analysis of Electric Cooking Products Standards

Revised standards for cooking products shall be designed to achieve the maximum improvement in energy efficiency that is technologically feasible and economically justified. These and related statutory criteria are addressed below.

a. Efficiency Levels Analyzed

The Department examined a range of standard levels for cooking products. Table 4–1 presents the five efficiency levels that had been selected for analysis for the five classes of electric cooking products. Level 5 corresponds to the highest efficiency level, max tech, considered in the engineering analysis. The final TSD contains the information analyzed in the Draft Report and the supplemental analysis.

TABLE 4–1.—ANNUAL ENERGY USE FOR STANDARD LEVELS ANALYZED IN THE PROPOSED RULE FOR KITCHEN RANGES, OVENS AND MICROWAVE OVENS

Product class	Standard level					
	Baseline	1	2	3	4	5
Electric ovens, self-cleaning (kWh)	303.7	303.7	303.7	303.7	220.0	213.7
Electric ovens, non-self-cleaning (kWh)	274.9	263.2	251.8	248.0	169.6	162.4
Microwave ovens (kWh)	143.2	143.2	143.2	143.2	143.2	132.4
Electric cooking top, coil element (kWh)	234.7	234.7	225.2	225.2	222.9	222.9
Electric cooking top, smooth element (kWh)	233.4	233.4	233.4	233.4	233.4	206.4

For analytical purposes the Department segmented the above classes into three groups: conventional ovens, conventional cooking tops, and microwave ovens. Rather than presenting the results for all classes of cooking products in today's notice, the Department selected a class of cooking products as being representative, or typical, of each group of the product, and DOE is presenting the results only for those representative classes. The results for the other classes can be found in the TSD in the same sections as those referenced for the representative class. The results and conclusions for each group are presented separately below.

1. Efficiency Levels Analyzed for Conventional Ovens

The Department selected non-self-cleaning electric ovens as being the representative class of conventional ovens. For non-self-cleaning electric ovens, trial standard level 1 accomplishes energy efficiency improvement from the baseline by reduced venting; level 2 includes improved insulation; level 3 includes improved seals; level 4 provides for a biradiant oven; level 5 includes reduced conduction losses, forced convection, and an oven separator.

For efficiency levels 1–3 of conventional ovens, the calculations are based on the supplemental analysis, using AEO 97 energy price forecasts. Efficiency levels 4–5 of conventional ovens are based on the Draft Report

analysis, which used AEO 95 energy price forecasts. They were not reanalyzed in the Supplemental analysis.

2. Efficiency Levels Analyzed for Conventional Cooking Tops

The Department selected electric-coil cooking tops as being representative of conventional cooking tops. For electric-coil cooking tops, trial standard level 1 remains at the baseline while levels 2 and 3 accomplish energy efficiency improvements from the baseline by incorporating improved heating element contact conductance; levels 4 and 5 add reflective surfaces.

Conventional electric cooktops were not addressed in the Supplemental Analysis. Values pertaining to cooktops referenced in today's rule are based on

the Draft Report, which used AEO 95 energy price forecasts.

3. Efficiency Levels Analyzed for Microwave Ovens

The Department considers all microwave ovens to comprise one class. For microwave ovens, trial standard levels 1 through 4 remain at the baseline, while level 5 incorporates an efficient power supply, an efficient fan, an efficient magnetron, and a reflective surface. All values referenced are from the Draft Report, which used AEO 95 energy price forecasts.

b. Significance of Energy Savings

Under section 325(o)(3)(B) of EPCA, the Department is prohibited from adopting a standard for a product if that standard would not result in "significant" energy savings. The Department forecasted energy consumption by the use of the Lawrence Berkeley Laboratory—Residential Energy Model (LBL-REM). See Appendix B of the TSD. To estimate the energy savings by the year 2030 due to revised standards, the energy consumption of new cooking products under the base case is compared to the energy consumption of those sold under the candidate standard levels. For the candidate energy conservation standards, the analysis projects that over the period 2001–2030, the following energy savings would result for all classes of the product. See Tables 3.3 and Supplemental Table 3.16b in the TSD.

1. Conventional Ovens

Level 1—0.05 Quad³
Level 2—0.10 Quad³
Level 3—0.03 Quad³
Level 4—1.68 Quad⁴
Level 5—1.68 Quad⁴

2. Conventional Cooking Tops

Level 1—0 Quad
Level 2—0.05 Quad
Level 3—0.05 Quad
Level 4—0.10 Quad
Level 5—0.45 Quad

3. Microwave Ovens.

Level 1—0 Quad
Level 2—0 Quad
Level 3—0 Quad
Level 4—0 Quad
Level 5—0.33 Quad

While the term "significant" is not defined in EPCA, the U.S. Court of Appeals for the District of Columbia

Circuit concluded that Congress intended the word "significant" to mean "non-trivial." *Natural Resources Defense Council v. Herrington*. 768 F.2d 1355, 1373 (D.C.Cir. 1985). Thus, for this rulemaking, DOE concludes that each standard level results in significant energy savings.

c. Economic Justification

Section 325(o)(2)(A) of EPCA provides seven factors to be evaluated, to the greatest extent practicable, in determining whether a conservation standard is economically justified.

1. Economic Impact on Manufacturers and Consumers

The engineering analysis identified improvements in efficiency along with the associated costs to manufacturers for each efficiency level for each class of product. For each design option, these associated costs constitute the increased per-unit cost to manufacturers to achieve the indicated energy efficiency levels. Manufacturer, wholesaler, and retailer markups will result in a consumer purchase price higher than the manufacturer cost.

To assess the likely impacts of standards on manufacturers and to determine the effects of standards on different-sized firms, the Department used a computer model that simulates hypothetical firms in the industry under consideration. This model, the Manufacturer Analysis Model (MAM), is explained in the TSD. (See TSD, Appendix C.) The cost of a compliance testing and certification program is an additional impact on the manufacturer. The Department's analysis, however, did not assess the impact of this program on the manufacturers.

For consumers, measures of economic impact are the changes in purchase price, annual energy expense, and installation costs. The purchase price, installation cost, and cumulative annual energy expense, i.e., life-cycle cost, of each standard level are presented in Chapter 3 of the TSD. Under section 325 of the EPCA, the life-cycle cost analysis is a separate factor to be considered in determining economic justification.

Conventional Ovens. The per-unit increased cost to manufacturers to meet efficiency level 1 for electric non-self-cleaning ovens is \$1.63; to meet level 2, the manufacturers' cost increase is \$4.84; level 3 is \$8.53; level 4 is \$71.03, and level 5 is \$125.94. See Technical Support Document, Table 1.11.

At those levels of efficiency, the consumer price increase, for electric non-self-cleaning ovens at level 1 is \$3.5; to meet level 2, the cost increase is \$11; level 3 is \$29; level 4 is \$179,

and level 5 is \$314. For electric non-self-cleaning ovens, the per-unit reduction in annual cost of operation, including energy expenses and any additional maintenance costs, at level 1 is \$1³; standard level 2 is \$2³; level 3 is \$2³; level 4 is \$8⁴, and level 5 is \$8⁴. See Technical Support Document, Table 4.4 and Supplemental Table 4.4.

The Lawrence Berkeley Laboratory—Manufacturer Impact Model analyzes the effects of the trial standard levels on both the long run and short run returns on equity. Short run return on equity refer to the effect during approximately the first three years, and long run return on equity refers to the effects beyond three years. The results (analyzed in the Draft Report) for all classes of conventional ovens⁵ show that revised standards would have some effect on a prototypical manufacturer's short-run return on equity with some decrease at the higher standard levels from the 10.53 percent in the base case. Standard levels 1 through 5 are projected to produce short-run returns on equity of 10.64 percent, 10.63 percent, 10.21 percent, 8.85 percent, and 5.14 percent, respectively. These standard levels have slight impacts on long-run return on equity. Standard levels 1 through 5 are projected to produce long-run return on equities of 10.51 percent, 10.51 percent, 10.35 percent, 10.33 percent, and 9.75 percent, respectively. See Technical Support Document, Tables 5.2 and 5.8.

Conventional Cooking Tops. The per-unit increased cost to manufacturers to meet the level 1 efficiency for electric-coil cooking tops is zero, since this class is at the baseline; to meet levels 2 and 3 the manufacturers' cost increase is \$2.28, and to meet levels 4 and 5 the cost is \$5.31. See Technical Support Document, Table 1.6.

At those levels of efficiency, the consumer price increase, for electric-coil cooking tops at level 1 is unchanged, since it is at the baseline; to meet levels 2 and 3 the cost increase is \$5, and at levels 4 and 5 it is \$12. See Technical Support Document, Table 4.1.

The per-unit reduction in annual cost of operation, including energy expenses and any increase in maintenance cost, for electric-coil cooking tops at level 1 is unchanged since it is at the baseline; standard levels 2 and 3 would reduce operational expenses by \$1, and levels 4 and 5 would reduce operational expenses by \$1. See Technical Support Document, Table 4.1.

The Lawrence Berkeley Laboratory—Manufacturer Impact Model results for

³Calculations are based on the supplemental analysis, using AEO 97 energy prices.

⁴Calculations are based Draft Report analysis, which used AEO 95 energy prices. They were not reanalyzed in the Supplemental analysis.

⁵These values, calculated in the Draft Report, were based on all classes of conventional ovens, including gas ovens.

all classes of conventional cooking tops show that revised standards would have slight impacts on a prototypical manufacturer's short-run return on equity⁶ with some decrease at the higher standard levels from the 10.84 percent in the base case. Standard levels 1 through 5 are projected to produce short-run return on equities of 11.07 percent, 11.04 percent, 11.08 percent, 11.02 percent, and 9.24 percent, respectively. These standard levels have slight impacts on long-run return on equity, with some decreases at the higher standard levels. Standard levels 1 through 5 are projected to produce long-run returns on equity of 10.77 percent, 10.78 percent, 10.78 percent, 10.42 percent and 9.71 percent, respectively. See Technical Support Document, Tables 5.1 and 5.7.

Microwave Ovens. The per-unit increased cost to manufacturers to meet efficiency levels 1 through 4 for microwave ovens is zero since these levels are at the baseline; to meet level 5, the manufacturers' cost increase is \$51.11. See Technical Support Document, Table 1.17.

At those levels of efficiency, the consumer price increase for microwave ovens at levels 1 through 4 is unchanged since they are at the baseline; to meet level 5, the cost increase is \$66. See Technical Support Document, Table 4.8.

The per-unit reduction in annual cost of operation at levels 1 through 4 would not reduce annual operational expense since it is at the baseline. Standard level 5 would reduce operational expenses by \$1. See Technical Support Document, Table 4.8.

The Lawrence Berkeley Laboratory-Manufacturer Impact Model results for microwave ovens show that revised standards would not affect a prototypical manufacturer's long nor short-run return on equity of 3.65 percent in the base case, except for max tech. Standard levels 1 through 5 are projected to produce short-run return on equities of 3.65 percent, 3.65 percent, 3.65 percent, 3.65 percent and 2.30 percent, respectively. Standard levels 1 through 5 are projected to produce long-run return on equities of 3.65 percent, 3.65 percent, 3.65 percent, 3.65 percent and 4.81 percent, respectively. See Technical Support Document, Tables 5.3 and 5.9.

2. Life-Cycle Cost and Net Present Value

One measure of the effect of proposed standards on consumers is the change in life-cycle costs, including recurring

operating expenses, purchase price, and installation costs resulting from the new standards. The change in life-cycle cost is quantified by the difference in the life-cycle costs between the base case and candidate standard case for each of the product classes analyzed. The life-cycle cost is the sum of the purchase price and the cumulative operating expense, including installation and maintenance expenditures, discounted over the lifetime of the appliance. The life-cycle cost was calculated for the range of efficiencies analyzed in the "Engineering Analysis" section of the TSD, for each class, in the year standards are imposed, using real consumer discount rate of six percent.

Conventional Ovens. A life-cycle cost is calculated for a unit meeting each of the candidate standard levels. For the representative class, life-cycle costs for non-self-cleaning ovens at standard levels 1 and 2 are at or less than the baseline unit. Of the five candidate standard levels, units meeting level 2 have the lowest consumer life-cycle cost for electric non-self-cleaning ovens. See Technical Support Document, Table 4.4 and Supplemental Table 4.4.

For the representative class of electric ovens, standard level 1 would cause reductions in life-cycle costs for the average consumer of \$6.1;³ standard level 2 would reduce average life-cycle costs by \$8.0;³ standard level 3 would result in an increase of \$6.6;³ level 4 would result in an increase of \$88.2;⁴ while standard level 5 would result in an increase of \$217.1.⁴ See Technical Support Document, Table 4.18 and Supplemental Table 4.39.

The Department examined the effect of different discount rates (2, 6, and 15 percent) on the life-cycle cost curves. See Figure 4.4, Table 4.4 and Supplemental Table 4.4 in the TSD. Life-cycle cost sensitivity to changes in energy price and equipment price were analyzed. See Figure 4.12, Table 4.12, and Supplemental Table 4.35 in the TSD. This analysis shows that the life-cycle cost minimum using the lowest State energy price occurs at standard level 1 for electric non-self-cleaning ovens but remains at standard level 2 for all other energy prices analyzed.

The Department also calculated paybacks using the energy prices calculated by the Gas Research Institute (GRI). The life-cycle cost minimums resulting from the GRI projections remain unchanged from the analysis using the AEO price forecasts. The payback periods increase slightly for electric non-self-cleaning ovens using the GRI forecasts, but these paybacks remain well within the expected life of the product. Therefore, the GRI prices

have no substantial impact on the outcome of the standard levels analyzed.

The net present value analysis, a measure of the net savings to society, indicates that for all classes of conventional electric ovens, standard levels 1–3 would produce a net present value of \$0.03 billion³ to consumers. The corresponding values for levels 4 and 5 result in a negative \$2.53 billion and negative \$6.23 billion, respectively.⁴ See Technical Support Document, Table 3.6e and Supplemental Table 3.28b.

Conventional Cooking Tops. A life-cycle cost is calculated for a unit meeting each of the candidate standard levels. For the representative class, life-cycle costs at all standard levels, except at max tech, are less than the baseline unit for electric coil cooktops. Of the five candidate standard levels, units meeting levels 2 and 3 have the lowest consumer life-cycle cost for electric coil cooktops. It should be noted that for another class, electric smooth element cooking tops, units meeting the baseline have the lowest consumer life-cycle costs. See Technical Support Document, Tables 4.1 and 4.2.

For the representative class of electric-coil cooking tops, standard level 1 would cause no change in life-cycle costs for the average consumer since it is the same as the baseline; standard levels 2 and 3 would reduce average life-cycle costs by \$3.2, and standard levels 4 and 5 would result in an increase in life-cycle cost of \$1.8. See Technical Support Document, Table 4.15.

The Department examined the effect of different discount rates (2, 6, and 15 percent) on the life-cycle cost curves. If the discount rate is increased to 15 percent, the life-cycle cost minimum occurs at the baseline. See TSD Table 4.1. Life-cycle cost sensitivity to changes in energy price and equipment price were analyzed. See Figure 4.10 and Table 4.10 in the TSD. This analysis shows that the life-cycle cost minimum using the lowest State energy price drops to standard level 1 for electric coil cooktops but remains unchanged for all other energy prices analyzed. The life cycle cost minimum remains unchanged for the highest State energy price, except for the case including both the highest State energy price and the highest equipment price, the LCC minimum occurs at max tech. Consequently, high state energy prices have no effect on the standard levels analyzed unless equipment prices are also high.

The net present value analysis, a measure of the net savings to society, indicates that for all classes of

⁶ These values, calculated in the Draft Report, were based on all classes of conventional cooktops, including gas cooktops.

conventional electric cooking tops, standard level 1 would produce a zero net present value; standard levels 2 and 3 would produce a net present value of \$0.03 billion, while standard levels 4 and 5 would produce negative net present values of \$0.09 billion and \$3.10 billion, respectively. See Technical Support Document, Table 3.6b.

Microwave Ovens. A life-cycle cost is calculated for a unit meeting each of the candidate standard levels. Of the five candidate standard levels, units meeting the baseline had the lowest consumer life-cycle cost for microwave ovens. See Technical Support Document, Table 4.8. Standard levels 1 through 4 would cause no reductions in life-cycle costs for the average affected consumer, since they are the same as the baseline for microwave ovens. Standard level 5 would increase average life-cycle costs by \$56.7. See Technical Support Document, Table 4.22.

The Department examined the effect of different discount rates (2, 6, and 15 percent) on the life-cycle cost curves and generally found little impact. Life-cycle cost sensitivity to changes in energy price and equipment price were analyzed. See Figure 4.14 and Tables 4.14 in the TSD. This analysis shows little impact.

The net present value analysis, a measure of the net savings to society, indicates that for microwave ovens, standard levels 1 through 4 would produce a zero net present value to consumers. The net present value for level 5 is a negative \$4.67 billion. See Technical Support Document, Table 3.6g.

3. Energy Savings

EPCA requires DOE to consider the total projected energy savings that result from revised standards. The Department forecasted energy consumption through the use of the LBL-REM. (See Appendix B of the TSD for a detailed discussion of the LBL-REM.) See section III. b. in today's rule for the energy savings of all efficiency levels.

4. Lessening of Utility or Performance of Products

In establishing classes of products and design options, the Department tried to eliminate from consideration any design option that would result in degradation of utility or performance. Thus, a separate class with a different efficiency standard was created for a product where the record indicated that the product included a utility or performance-related feature that affected energy efficiency. Five separate classes were analyzed; see Table 4-1 in today's rule. In this way, the Department

attempted to minimize the impact of amended standards on the utility and performance of conventional ovens, conventional cooking tops, and microwave ovens.

5. Impact of Lessening of Competition

The Energy Policy and Conservation Act directs the Department to consider the impact of any lessening of competition that is likely to result from the standards, as determined by the Attorney General.

In a letter dated September 16, 1994, the Department of Justice (DOJ) expressed concern about the effects the standards proposed in the 1994 Proposed Rule might have on industry. DOJ concluded that it is likely that competition in the manufacture and sale of commercial/professional-style or high-end ranges and ovens will be eliminated if the proposed standards are adopted. The Department of Justice also concluded that there is a possibility that the proposed standard could force one or more firms out of the manufacture of standard ranges thus lessening competition. (DOJ, No. 840 at 5.) The September 16, 1994, letter is printed at the end of today's rule.

The Department of Justice comments were based on the standards proposed in the 1994 Proposed Rule. Because today's rule is not promulgating new standards, there will not be significant adverse effects on industry.

6. Need of the Nation To Save Energy

Enhanced energy efficiency improves the Nation's energy security, strengthens the economy, and reduces the environmental impacts of energy production.

7. Other Factors

Decreasing future energy demand as a result of standards will decrease air pollution.

Conventional Ovens.⁷ Standards would result in a decrease in nitrogen oxide (NO_x) emissions. For standard level 1, over the years 2000 to 2030, the total estimated NO_x reduction would be approximately 11,000 tons. For standard levels 2-5, the estimated reductions would be approximately 23,000 tons,

15,000 tons, 227,000 tons, and 227,000 tons, respectively.

The estimated decreased need to control SO_x over the years 2000 to 2030 would be 12,000 tons, 25,000 tons, 17,000 tons, and 250,000 tons for levels 1-5, respectively.

Another consequence of the standards would be the reduction of carbon dioxide (CO₂) emissions. For standard level 1, over the years 2000 to 2030, the total estimated CO₂ reduction would be approximately 6 million tons. For standard levels 2-5, the estimated reductions would be 13 million tons, 8 million tons, 126 million tons, and 126 million tons, respectively.

Conventional Cooking Tops.⁸ Standards would result in a decrease in nitrogen oxide (NO_x) emissions. For standard level 1, over the years 2000 to 2030, the total estimated NO_x reduction would be zero. During this time period, there would be no reduction of NO_x emissions emitted by power plants. For standard levels 2-5, the reductions would be approximately 9,000 tons, 9,000 tons, 18,000 tons, and 80,000 tons, respectively.

The estimated decreased need to control SO_x over the years 2000 to 2030 would be 11,000 tons, 11,000 tons, 22,000 tons, and 99,000 tons for levels 2-5, respectively.

Another consequence of the standards would be the reduction of carbon dioxide (CO₂) emissions. For standard level 1, over the years 2000 to 2030, the total estimated CO₂ reduction would be zero because this standard level is at the baseline. During this time period, there would be no reduction of CO₂ emissions emitted by power plants in the United States. For standard levels 2-5, the reductions would be approximately 4 million tons, 4 million tons, 8 million tons, and 36 million tons, respectively.

Microwave Ovens: Standards would result in a decrease in nitrogen oxide (NO_x) emissions. For standard levels 1 through 4, over the years 2000 to 2030, the total estimated NO_x reduction would be zero. During this time period, those levels of efficiency improvement would cause no reduction of NO_x emissions from power plants in the

⁷The emissions calculated in the Draft Report Tables 7.6-7.10 were based on both gas and electric ovens. However, from the emissions reductions for standard levels 1 and 2 (for which gas ovens are at the baseline), the emissions reductions per quad can be approximated for electric ovens over the years 2000 to 2030. These approximations are 75 million tons CO₂ per quad, 135,000 tons NO_x per quad, and 150,000 tons SO₂ per quad. Decreases in SO₂ emissions will not occur because the Clean Air Act places a ceiling on SO₂ emissions that will be met under any regulatory regime. Therefore, these reductions should be interpreted as reduced costs to electricity generators for controlling SO₂.

⁸The emissions calculated in the Draft Report Tables 7.1-7.5 were based on both gas and electric cooktops. However, from the emissions reductions for standard level 2 (for which gas cooktops are at the baseline), the emissions reductions per quad can be approximated for electric cooktops over the years 2000 to 2030. These approximations are 80 million tons CO₂ per quad, 180,000 tons NO_x per quad, and 220,000 tons SO₂ per quad. Decreases in SO₂ emissions will not occur because the Clean Air Act places a ceiling on SO₂ emissions that will be met under any regulatory regime. Therefore, these reductions should be interpreted as reduced costs to electricity generators for controlling SO₂.

United States. For standard level 5, the reduction would be 48,000 tons. The highest peak annual reduction of these levels would be 0.08 percent. See Tables 7.11–7.15 in the TSD. Energy associated with these standards would also reduce the costs associated with SO_x compliance⁹.

Another consequence of the standards would be the reduction of carbon dioxide (CO₂) emissions. For standard levels 1 through 4, over the years 2000 to 2030, the total estimated CO₂ reduction would be zero. During this time period, there would be no reduction of CO₂ emissions emitted by power plants in the United States. For standard level 5, the reduction would be 25 million tons. The highest peak annual reduction of these levels would be 0.06 percent.

d. Payback Period

If the increase in initial price of an appliance due to a conservation standard would repay itself to the consumer in energy savings in less than three years, then it is presumed that such standard is economically justified.¹⁰ EPCA, § 325(o)(2)(B)(iii), 42 U.S.C. § 6295(o)(2)(B)(iii). This presumption of economic justification can be rebutted upon a proper showing. Failure to qualify for this presumption shall not be taken into consideration in determining whether a standard is economically justified. *Id.*

Conventional Ovens. Table 4–2 presents the payback periods¹¹ for the efficiency levels analyzed for the representative class of conventional ovens. For electric ovens, none of the trial standard levels satisfies the rebuttable presumption test, i.e., the additional price of purchasing a product will be less than three times the value

of the energy savings that the consumer will receive during the first year. See Table 4.18 and Supplemental Table 4.43 in the TSD.

TABLE 4–2.—PAYBACK PERIODS OF DESIGN OPTIONS (YEARS) FOR NON-SELF-CLEANING CONVENTIONAL OVENS

Standard level	Payback period
1	3 4.0
2	3 6.5
3	3 14.5
4	4 22
5	4 36

Conventional Cooking Tops. Table 4–3 presents the payback periods for the efficiency levels analyzed for the representative class of conventional cooking tops. For electric cooktops, none of the trial standard levels satisfies the rebuttable presumption test, i.e., the additional price of purchasing a product will be less than three times the value of the energy savings that the consumer will receive during the first year. See Table 4.15 in the TSD.

TABLE 4–3.—PAYBACK PERIODS OF DESIGN OPTIONS (YEARS) FOR CONVENTIONAL COOKING TOPS

Standard level	Payback period
1	N/A
2	6.5
3	6.5
4	13
5	13

Microwave Ovens. Table 4–4 presents the payback period for the efficiency levels analyzed for microwave ovens. For microwave ovens, none of the trial standard levels satisfies the rebuttable presumption test, i.e., the additional price of purchasing a product will be less than three times the value of the energy savings that the consumer will receive during the first year. See Table 4.22 in the TSD.

TABLE 4–4.—PAYBACK PERIODS OF DESIGN OPTIONS (YEARS) FOR MICROWAVE OVENS

Standard level	Payback period
1	N/A
2	N/A
3	N/A
4	N/A
5	79

e. Conclusion

1. Product Name Change

The Department is changing the name of this product from “kitchen ranges and ovens” to “cooking products.” This change is made because the term “kitchen ranges and ovens” does not accurately describe the products considered which include microwave ovens, conventional ranges, cooktops, and ovens. To be consistent with this change, the Department is adding a regulatory definition of “cooking products” that is the same as the existing definition of “kitchen ranges and ovens” to Title 10 CFR Part 430.2.

2. Standards

Section 325(o)(2)(A) of the Act specifies that the Department must establish standards that “achieve the maximum improvement in energy efficiency which the Secretary determines is technologically feasible and economically justified.” EPCA, § 325(o)(2)(A). Technologically feasible design options are “technologies which can be incorporated in commercial products or in working prototypes.” 10 CFR Part 430, Appendix A to Subpart C, 4(a)(4)(i). A standard level is economically justified if the benefits exceed the burdens. EPCA, § 325(o)(2)(B)(i).

A maximum technologically feasible (max tech) design option was identified for each class of cooking products. The max tech levels were derived by adding energy-conserving engineering design options to the baseline units for each of the respective classes in order of decreasing consumer payback. A complete discussion of each max tech level, and the design options included in each, is found in the *Engineering Analysis* in the TSD, Chapter 1. Table 5–1 presents the Department’s max tech performance levels for all classes of the subject products:

TABLE 5–1.—COOKING PRODUCTS MAXIMUM TECHNOLOGICALLY FEASIBLE LEVELS

Product class	Annual energy use
Electric oven, self-cleaning	213.7 kWh.
Electric oven, non-self-cleaning ..	162.4 kWh.
Microwave oven	132.4 kWh.
Electric cooktop, coil element	229.9 kWh.
Electric cooktop, smooth element	206.4 kWh.

⁹Decreases in SO₂ emissions will not occur because the Clean Air Act places a ceiling on SO₂ emissions that will be met under any regulatory regime. Therefore, these reductions should be interpreted as reduced costs to electricity generators for controlling SO₂. For microwave ovens at standard levels 1 through 4, over the years 2000 to 2030, the total estimated SO₂ reduction would be zero. For standard level 5, the need to control SO₂ would be reduced by an estimated 53,000 tons.

¹⁰For this calculation, the Department calculated cost-of-operation based on the DOE test procedures. Therefore, the consumer is assumed to be an “average” consumer as defined by the DOE test procedures. Consumers who use the products less than the test procedure assumes will experience a longer payback while those who use them more than the test procedure assumes will have a shorter payback.

¹¹These payback periods are weighted averages. They compare the portion of the projected distributions of designs in the base case that are less efficient than the standard level to the design at the standard level. Designs with energy consumption at or below the standard level are not affected by the standard and are excluded from the calculation of impacts.

Accordingly, DOE first considered the max tech level of efficiency, i.e., standard level 5.

*Conventional Ovens*¹². Of the standard levels analyzed, level 5 will save the most energy (1.68 quads between 2000 and 2030). In order to meet this standard, the Department assumes that the representative class of conventional ovens will incorporate improved door seals, reduced venting, increased and improved insulation, forced convection, an oven separator, would be biradiant and have reduced conduction losses. However, the payback at this standard level of 36 years for the representative class exceeds the 19-year product life. At this standard level, all classes have increased life-cycle costs and negative net present value. The Department therefore concludes that the burdens of standard level 5 for conventional ovens outweigh the benefits, and DOE rejects the standard level.

The next most stringent standard level is standard level 4. This standard level is projected to save 1.68 quads of energy. In order to meet this standard, the Department assumes that the representative class of conventional ovens will incorporate improved door seals, reduced venting, increased and improved insulation, and would be biradiant. However, for the representative class the payback at this standard level is 22 years. This standard level increases the life-cycle costs for both classes of electric ovens. In addition, this standard level results in a negative net present value for all classes of conventional ovens. The Department therefore concludes that the burdens of standard level 4 for conventional ovens outweigh the benefits, and DOE rejects the standard level.

The next most stringent standard level is standard level 3. This standard level is projected to save 0.03 quad of energy. In order to meet this standard, the Department assumes that all conventional electric ovens incorporate improved door seals, reduced venting, and improved insulation. The payback at this standard level is 14 years. This standard level increases the life-cycle costs for the representative class of electric ovens. The Department therefore concludes that the burdens of standard level 3 for conventional ovens outweigh the benefits, and DOE rejects the standard level.

The next most stringent standard level is standard level 2. In the Supplemental

Analysis prepared in Fall 1997, standard level 2 was projected to save 0.1 quad of energy. In order to meet this standard, the Department assumes that the representative class of conventional ovens will incorporate reduced venting and improved insulation. However, the savings estimates the Department used were based on the assumption that efficiency gains could be achieved by reducing the vent rate and improving the type of insulation used. As discussed in section "II. Discussion of Comments, reduced vent size" the Department has determined that there may not be energy savings from reduced venting. Thus, in order to evaluate the energy savings and consumer impacts of improved insulation only, the Department has considered the incremental differences between trial standard level 1 (which consisted of reduced venting) and trial standard level 2 (which adds improved insulation). Thus, standard level 1 essentially becomes the baseline for this evaluation. Excluding the effects of reduced venting on standard level 2 lowers the energy savings from the reported 0.1 quad to approximately 0.05 quad, reduces the life-cycle cost savings from the reported \$6 to approximately \$2, and increases the payback to from the reported 6.5 years to approximately 9 years (compared to the expected life of 19 years). Additionally, because currently ovens are not labeled or tested for energy consumption and therefore performance data on specific ovens does not exist, it is unknown whether all non-self-cleaning electric ovens would meet a specific performance standard by the addition of insulation alone. Consequently, there is a risk that in order to bring some electric non-self-cleaning ovens into compliance with a performance standard, manufacturers would need to use additional design options. The analysis found no other design options to be cost effective. The additional cost would be passed on to consumers. DOE could perform additional testing on electric non-self-cleaning ovens, but given the modest savings (.05 quad), the burden of performance and a certification program, as well as the adverse manufacturer and consumer impacts for ovens that might not achieve a performance standard by using insulation alone, DOE concluded that the burdens of standard level 2 outweigh the benefits, and DOE rejects the standard level.

The next most stringent standard level is standard level 1. In the Supplemental Analysis prepared in Fall 1997, standard level 1 was projected to save

0.05 quad of energy. In order to meet this standard, the Department assumes that the representative class of conventional ovens will incorporate reduced venting. As discussed in the "comments" section, the Department has determined that there would likely not be any energy savings from standard level 1. Therefore, the Department rejects standard level 1.

*Conventional Cooking Tops*¹³. Of the standard levels analyzed, level 5 will save the most energy (0.45 quad between 2000 and 2030). In order to meet this standard, the Department assumes that the representative class of conventional cooking tops will have reflective surfaces and would have improved element contact conductance. At this standard level, all classes have increased life-cycle costs and negative net present value. The Department therefore concludes that the burdens of standard level 5 for conventional cooktops outweigh the benefits, and DOE rejects the standard level.

The next most stringent standard level is standard level 4. This standard level is projected to save 0.1 quad of energy. In order to meet this standard, electric-coil cooking tops would have improved element contact conductance and reflective surfaces. However, this standard level results in a negative net present value and increased life-cycle costs for the representative class of conventional cooktops. The Department therefore concludes that the burdens of standard level 4 for conventional cooktops outweigh the benefits, and DOE rejects the standard level.

The next most stringent standard level is standard level 3. In order to meet this standard, electric-coil cooking tops would have improved element contact conductance. This standard level is projected to save the average consumer approximately \$3 over the life of the product, using AEO 95 energy price forecasts. This standard level is projected to save 0.05 quad of energy; however, the Department has concerns as to whether this energy saving will be realized. Cooktops are somewhat unique in that they are completely controlled by the consumer. They are not thermostatically controlled, as are refrigerators, nor do they operate in a cyclical mode like a dishwasher. They are operated for an amount of time determined by the consumer to complete a cooking task. Given the small relative efficiency improvement of this design level, 4.3 percent, the

¹² Standard levels 1–3 were reanalyzed in the Supplemental Analysis (which used AEO 97 energy forecasts), and standard levels 4–5 were not reanalyzed and are based solely on the Draft Report, using AEO 95.

¹³ Cooktops and microwave ovens were not reanalyzed in the Supplemental Analysis, therefore they are based solely on the Draft Report, using AEO 95 energy forecasts.

savings would only be realized if consumers reduced their cooking times by 4.3 percent. While this is theoretically possible, especially for cooking tasks that have a possible definite end point such as boiling water or melting butter which would occur 4.3 percent faster, it seems highly questionable that consumer behavior would change for the majority of cooking tasks to perform them in 4.3 percent less time. The savings do not occur unless this consumer behavior change takes place. Given the questionable nature of the energy savings, the Department believes that the burdens of a testing and certification program and the possible manufacturer impacts for cooktops that might not achieve a performance standard outweigh the benefits of the standard. The Department concludes that the burdens of standard level 3 for conventional cooktops outweigh the benefits, and DOE rejects the standard level.

Standard level 2 is identical to standard level 3 for electric cooktops, and standard level 1 is at the baseline. Consequently, the Department is not issuing a standard for conventional cooktops because the burdens outweigh the benefits for all standard levels analyzed.

*Microwave Ovens*¹³. Of the standard levels analyzed, level 5 will save the most energy (0.33 quad between 2000 and 2030). In order to meet this standard, the Department assumes that all microwave ovens will incorporate reflective surfaces and more efficient power supplies, fans, and magnetrons. However, the payback at this standard level of 79 years exceeds the 10-year product life. In addition this level produces increased life-cycle costs and a negative net present value. The Department therefore concludes that the burdens of standard level 5 for microwave ovens outweigh the benefits, and DOE rejects the standard level.

Standard levels 1 through 4 are at the baseline. The Department is not issuing a standard for microwave ovens because the burdens outweigh the benefits for all standard levels analyzed.

After carefully considering the analysis, the Department is not issuing a standard for electric cooking products because the Department believes the burdens outweigh the benefits for all standard levels and all classes of these products.

IV. Procedural Issues and Regulatory Review

a. Review Under the National Environmental Policy Act

In issuing the proposed rule, the Department prepared an Environmental Assessment (EA) (DOE/EA-0819) that was published within the Technical Support Document for the Proposed Rule. (DOE/EE-0009, November 1993.) The environmental effects associated with various standard levels were found to be not significant, and a Finding of No Significant Impact (FONSI) was published. 59 FR 15869 (April 5, 1994). Because the Department is not issuing now a new standard for these products, there are no environmental impacts associated with today's rule.

b. Review Under Executive Order 12866, "Regulatory Planning and Review"

Today's rule has been determined not to be a "significant regulatory action," as defined in section 3(f) of Executive Order 12866, "Regulatory Planning and Review" (58 FR 51735), and has not been reviewed by the Office of Management and Budget.

c. Review Under the Regulatory Flexibility Act

The Regulatory Flexibility Act 081980 (Pub. L. 96-354), 5 U.S.C. 601 *et seq.*, requires an assessment of the impact of regulations on small businesses unless an agency certifies that the rule will not have a significant economic impact on a substantial number of small businesses and other small entities. Because the Department is not issuing a new standard, this final rule will not have significant economic impact on manufacturers of cooking products. DOE certifies that today's final rule will not have a significant economic impact on a substantial number of small entities.

d. Review Under the Paperwork Reduction Act

No new information or record keeping requirements are imposed by this rulemaking. Accordingly, no Office of Management and Budget clearance is required under the Paperwork Reduction Act. 44 U.S.C. 3501 *et seq.*

e. Review Under Executive Order 12988, "Civil Justice Reform"

With respect to the review of existing regulations and the promulgation of new regulations, section 3(a) of Executive Order 12988, "Civil Justice Reform," 61 FR 4729 (February 7, 1996), imposes on Executive agencies the general duty to adhere to the following requirements: (1) eliminate drafting errors and ambiguity; (2) write

regulations to minimize litigation; and (3) provide a clear legal standard for affected conduct rather than a general standard and promote simplification and burden reduction. With regard to the review required by section 3(a), section 3(b) of Executive Order 12988 specifically requires that Executive agencies make every reasonable effort to ensure that the regulation: (1) clearly specifies the preemptive effect, if any; (2) clearly specifies any effect on existing Federal law or regulation; (3) provides a clear legal standard for affected conduct while promoting simplification and burden reduction; (4) specifies the retroactive effect, if any; (5) adequately defines key terms; and (6) addresses other important issues affecting clarity and general draftsmanship under any guidelines issued by the Attorney General. Section 3(c) of Executive Order 12988 requires Executive agencies to review regulations in light of applicable standards in section 3(a) and section 3(b) to determine whether they are met or it is unreasonable to meet one or more of them. DOE reviewed today's final rule under the standards of section 3 of the Executive Order and determined that, to the extent permitted by law, the final regulations meet the relevant standards of Executive Order 12988.

f. "Takings" Assessment Review

It has been determined pursuant to Executive Order 12630, "Governmental Actions and Interference with Constitutionally Protected Property Rights," 53 FR 8859 (March 18, 1988) that this regulation would not result in any takings which might require compensation under the Fifth Amendment to the United States Constitution.

g. Federalism Review

Executive Order 12612, "Federalism," 52 FR 41685 (October 30, 1987) requires that regulations, rules, legislation, and any other policy actions be reviewed for any substantial direct effect on States, on the relationship between the Federal Government and the States, or on the distribution of power and responsibilities among various levels of government. If there are sufficient, substantial direct effects, then Executive Order 12612 requires preparation of a federalism assessment to be used in all decisions involved in promulgating and implementing a regulation or a rule. The Department finds that this final rule will not have a substantial direct effect on State governments.

h. Review Under the Unfunded Mandates Reform Act

With respect to a proposed regulatory action that may result in the expenditure by state, local, and tribal governments, in the aggregate, or the private sector of \$100 million or more in any one year, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires a Federal agency to publish estimates of the resulting costs, benefits and other effects on the national economy. 2 U.S.C. 1532(a), (b). Under section 205 of UMRA, the Department is obligated to identify and consider a reasonable number of regulatory alternatives before promulgating a rule for which a written statement under section 202 is required. DOE is required to select from those alternatives the most cost-effective and least burdensome alternative that achieves the objectives of the rule unless DOE publishes an explanation for doing otherwise or the selection of such an alternative is inconsistent with law. This final rule does not impose a Federal mandate on State, local, or tribal governments or on the private sector.

i. Review Under the Small Business Regulatory Enforcement Fairness Act of 1996

Consistent with Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996, 5 U.S.C. 801–808, DOE will submit to Congress a report regarding the issuance of today's final rule before the effective date set forth in the outset of this notice. The report will state that it has been determined that this rule is not a "major rule" as defined by 5 U.S.C. 804(a).

V. Department of Justice Views on the Proposed Rule.

September 16, 1994

Honorable Christine A. Ervin
Assistant Secretary for Energy Efficiency, and
Renewable Energy, United States
Department of Energy, Forrestal
Building, 1000 Independence Ave., S.W.,
Washington, D.C. 20585

Dear Ms. Ervin:

By letter dated March 14, 1994, the Department of Energy ("DOE") transmitted to the Attorney General a Notice of Proposed Rulemaking (59 FR 10464) addressing energy standards for eight classes of household appliances. Those classes are: room air conditioners, water heaters, direct heating equipment, mobile home furnaces, kitchen ranges and ovens, pool heaters, fluorescent lamp ballasts and television sets. Section 325 of the Energy Policy and Conservation Act, as amended in 1992 (42 U.S.C. 6295), ("the Act") requires the Attorney General to determine the impact, if any, of any lessening of competition likely to result from the proposed standards. This letter contains the

competitive impact determination of the Department of Justice. ("Department")

Summary

The evidence available to the Department does not indicate that any significant lessening of competition is likely to result from the imposition of the proposed standards for mobile home furnaces and pool heaters contained in the Notice. For television sets, fluorescent lamp ballasts and professional-style or high-end kitchen ranges it is the Department's judgement based on the available evidence that significant anticompetitive effects are likely to occur. For electric water heaters the evidence indicates that a significant anticompetitive effect could take place if sufficient time is not permitted firms to develop, produce and market products complying with the new standard. For microwave ovens, oil-fired water heaters, room air conditioners, and direct heating equipment the evidence indicates that anticompetitive effects could result; the Department is unable on the basis of the available evidence to determine whether such effects are likely. Finally, the evidence indicates that the cumulative effects of these and other regulatory standards could be to lessen competition in certain markets for household appliances.

In preparing these comments the Department has considered the Notice, the Technical Support Document (TSD) prepared by Lawrence Berkeley Laboratory, written comments and oral comments collected by the department in the time allowed and without the benefit of compulsory process.

Discussion

Adoption of standards requiring greater energy efficiency in household appliances could affect competition in a number of ways. First, by raising the cost of appliances and reducing design and feature choices, standards may lower demand. If standards impose costs on manufacturers that can not be passed to consumers they can lower manufacturers' rates of return. Either one or both of these effects could cause manufacturers to exist the market with the effect of lessening competition and raising prices. Second, imposition of standards may lessen or discourage competition in the design and development of new product features or technologies; such competition benefits consumers and the economy.

The record in this proceeding raises many factual issues relating, among other things, to the technical feasibility of certain standards, their economic impact on manufacturers and consumers and consumer reaction to the changes in products that they might require. In numerous instances, industry representatives and technical consultants retained by them have challenged assumptions and conclusions in the Notice and TSD. The Department is not in a position to resolve many of these contested issues on the basis of the available record. Accordingly, in some instances, the Department is unable to reach a conclusion about the impact of the proposed standards on competition.

Fluorescent Lamp Ballasts

One technical issue that has been raised is whether the proposed standards for

fluorescent lamp ballasts are attainable with currently available technology. Numerous ballast manufacturers assert that in many instances they are not. The Department concludes that the doubts raised about the technical feasibility of the standards are serious and affect a substantial number of ballast classes. Thus, if the proposed standards were adopted some or all manufacturers would likely have to cease the production of many products and competition in the sale of those products would cease or diminish.

Television Sets and Related Technologies

1. The weight of available evidence is that adoption of the proposed standard for television sets could force all or many manufacturers to revise their products to lessen the number and quality of their features. Many in the industry contend that the only way to produce products that will comply with the standard would be to reduce or eliminate features that consume electricity such as brighter pictures, remote control, picture-in-picture, improved sound and in-set program guides and other features presently being developed. Development and marketing of product improvements and new features has been an important factor driving competition in the market for television sets. Reducing or retarding the development of such features could substantially reduce demand for sets, retard development and refinement of technology, and reduce utility of the product.

Manufacturers might attempt to circumvent the proposed standard by letting features "migrate"—incorporating them in units to be sold separately or packaged with television sets. It is claimed that disaggregating features in this manner will decrease overall television energy efficiency. There is evidence that it could also lessen competition because the development and marketing of features in such attached units could be costly and cumbersome, among other things encountering receivers that receive cable signals.

There is evidence that the proposed standard for television sets could affect competition in other markets. Representatives of the television industry assert that as the "Information Highway" develops television manufacturers intend to expand the capabilities of their products to include new features to enable them to serve as in-home devices for data transmission and communication. They argue that the TV receiver, already located in virtually every American home, could be a uniquely efficient vehicle for the introduction of new data-processing and communication devices. The Department does not make final judgement on this contention but does conclude that, given the apparent difficulties in the marketing of new features as part of attached units, the standard is likely to retard the development of technology and inhibit the ability of television manufacturers to compete with computer manufacturers and other in the development of new technologies and features for the Information Highway.

Professional-Style and Standard Ranges

The Notice proposes a single set of standards for gas ovens and cooking tops in household ranges. There is substantial evidence that one category of home range cannot be manufactured to meet these proposed standards without losing so much of its distinct characteristics that it is no longer marketable. Professional-style or high-end ranges are products designed to provide some of the performance characteristics of professional or restaurant ranges for home kitchens. Some of these characteristics which differentiate them from standard kitchen ranges, such as high performance burners and ovens, involve considerably more energy consumption than do standard ranges; the special uses and appeal of these products, and their premium in price, depends in good measure on these features. Representatives of the range industry assert that high-end ranges cannot be modified to comply with the proposed standards without giving up so much of the special features of the product that they are no longer marketable. The Department concludes that it is likely that competition in the manufacture and sale of these products will be eliminated if the proposed standards are adopted.

While not as strong as the evidence relating to professional style ranges there is evidence challenging the conclusions in the TSD that the proposed standards for standard gas and electric range ovens and cooking tops will not require significant retooling or redesign and will have not more than minimal impact on manufacturers' long run rates of return on equity. The Association of Home Appliance Manufacturers contends that the standard could have a destructive impact on the range industry. It and various range manufacturers claim that design options suggested in the TSD are not effective and that compliance would require substantial investment in redesign and retooling. The Association also insists that suppliers of equipment and technology necessary to comply may not be able to respond simultaneously and evenly to range manufacturers, a problem that could impose a competitive handicap on some range manufacturers.

A range manufacturer has commented that compliance with the standard could seriously weaken it and its ability to compete. There is also evidence that the cumulative costs of compliance with this standard and with other and future appliance standards could induce or force "full line" appliance manufacturers to exit one or more of the markets that they serve. The range market is concentrated and, while there is conflicting evidence, the Department concludes that there is a possibility that this proposed standard could force one or more firms out of the manufacture of standard ranges thus lessening competition.

Microwave Ovens

The Notice and the TSD conclude that the proposed standard for microwave ovens will not involve any substantial redesign or retooling by manufacturers and will have little impact on their long run returns on equity. Representatives of the industry strongly challenge these conclusions. For example, a representative of MCD

Corporation has testified that compliance with the standard would require that her company, a manufacturer of microwaves, make large investments in retooling, and would threaten its viability. The Association of Home Appliance Manufacturers contends that the standard will in all likelihood eliminate all U.S. Production of microwaves and concentrate U.S. sales in the hands of one or two companies. The Department is not in a position to resolve all of the contested technical and financial issues but concludes that this proposed standard could force some significant producers from this concentrated market and substantially lessen competition in it.

Room Air Conditioners

The Notice and TSD conclude that this proposed standard will not involve substantial redesign or retooling and, while it may produce some reductions in the short run, will have little or no effect on manufacturers' long run returns on equity. This conclusion has been challenged by firms in the industry. There is evidence that some of the design options suggested in the Notice are less effective and more costly than the TSD assumes and that manufacturers may, among other things, need to redesign the chassis of some classes to comply with the standard. Such redesigns could add to unit installation costs, make units larger and more cumbersome to install, and otherwise depress demand. There is evidence that at least one product, the five thousand BTU unit, may cease to be manufactured if the standard is adopted. There are also unresolved issues about such matters as the availability and efficacy of some design options suggested in the TSD. The Department is not able to resolve these issues but concludes that the standard could have a substantial negative impact on demand and rates of return, and cause one or more firms to cease the manufacture and sale of some of these products, thus lessening competition.

Direct Heating Equipment

Manufacturers of direct heating equipment contend that this standard will seriously depress demand for their product and likely force some, perhaps all, manufacturers out of this business. Among other things, they contend that the TSD substantially underestimates the added costs of manufacture, and also the added installation costs for venting and wiring, that will be required. They insist that consumer cost increases will seriously depress demand for their product and that their profit margins will suffer because it will be impossible to pass on much of the increased manufacturing costs to consumers. The Department cannot resolve many of these issues but concludes that there is a possibility that several of the five companies that account for most of the production of these products might exit the market if the standard is adopted thus substantially lessening competition.

Water Heaters

Manufacturers of oil-fired heaters content that the proposed standard for their product class would threaten the survival of the product, likely forcing all or most producers out of this business. Some claim that it may

not be possible with presently available technology to design and manufacture a product that would comply. Manufacturers assert that the added costs of producing a product in compliance with the standard would, in any event, be considerably higher than the TSD indicates and that increases in price would very seriously depress consumer demand for this product. Five firms, two of them Canadian producers, account for most of the sales of this product in the U.S. The Department is not able to resolve all the questions raised regarding this standard; it concludes that there is at least a possibility that the standard might force one or more of these competitors to exit the U.S. market. Another firm has been taking steps to enter the oil-fired water heater market; adoption of the standard may deter it from doing so. The loss of one such firm could result in a substantial lessening of competition.

DOE's proposed standard for electric water heaters would, in effect, require that such products have an integral heat pump. DOE concedes that this would involve major changes and might cause one or more existing firms to cease the marketing of electric water heaters but believes that other firms such as air conditioner manufacturers may begin producing electric water heaters as a result of the standard. There are complex and unresolved issues as to what would happen to demand for electric water heaters if consumers were required to purchase heat pumps with them. It seems clear that the price of such units will be considerably higher than that of the electric resistance heaters that the standard would remove from the market, but the range of future prices, costs of installation and maintenance and degree of consumer acceptance of a product that has not been widely accepted until now are very difficult to predict. Heat pump water heaters may be useful and economically attractive to many consumers but serious issues have been raised in this proceeding as to whether certain kinds of consumers, such as households with relatively little demand for hot water, will derive a benefit from the product.

Even if the heat pump water heater is eventually widely accepted in the market the Department has concluded that it is likely that competition will be adversely affected for some period of time if adequate time is not permitted for the phasing in of the standard. Three millions units or more of electric resistance units are now sold annually in the U.S. Only a few thousand heat pump units are now produced annually in this country, by two firms. It could take a considerable time for other firms to design new product lines and being substantial new production capacity on line. There is also evidence from those with experience with the product that heat pump water heaters require special maintenance and servicing. Considerable time may be required for firms to develop and train adequate distribution and service networks if they are to compete effectively. If adequate time for phasing in the standard is not allowed, for a considerable period of time there could be fewer companies competing effectively in the electric water heater business than there are now, and competition in this concentrated market could be substantially lessened.

Cumulative Effects of Regulation

Many of the manufacturers of appliances subject to the proposed standards manufacture several different types of appliance, each subject to those standards or to others authorized by the Act. As indicated above, there is evidence that compliance with some of these standards may require manufacturers to make considerable investments. It is anticipated that future standards for other appliances could require manufacturers to make similar investments. Full-line manufacturers such as General Electric, Whirlpool, Frigidaire, Amana and Maytag could thus be required to make changes in several product lines.

As the TSD recognizes, it is difficult for manufacturers to pass redesign and retooling costs on to consumers. And the impact of a single product redesign may fall more heavily on firms with small shares of the market since they must write off their costs against less sales volume. There is some evidence that firms, particularly the smaller ones, facing the prospect of repeated redesigns involving several different products, may be induced to cease manufacturing one or more of such product lines. Thus to a degree that we can not fully assess there is a possibility that the cumulative effect of these and future energy efficiency standards could be to lessen competition in one or more home appliance markets.

Sincerely yours,

Anne K. Bingaman,
Assistant Attorney General.

List of Subjects in 10 CFR Part 430

Administrative practice and procedure, Energy Conservation, Household appliances.

Issued in Washington, D.C., on July 22, 1998.

Dan W. Reicher,

Assistant Secretary, Energy Efficiency and Renewable Energy

For the reasons set forth in the preamble Part 430 of Chapter II of Title 10, Code of Federal Regulations, is amended as set forth below.

PART 430—ENERGY CONSERVATION PROGRAM FOR CONSUMER PRODUCTS

1. The authority citation for Part 430 continues to read as follows:

Authority: 42 U.S.C. 6291–6309; 28 U.S.C. 2461 note.

2. Section 430.2 of Subpart A is amended by removing the definitions for “kitchen ranges and ovens” and “other kitchen ranges and ovens” and adding, in alphabetical order, the definitions for “cooking products” and “other cooking products” to read as follows:

Subpart A—General Provisions**§ 430.2 Definitions.**

* * * * *

Cooking products means consumer products that are used as the major household cooking appliances. They are designed to cook or heat different types of food by one or more of the following sources of heat: gas, electricity, or microwave energy. Each product may

consist of a horizontal cooking top containing one or more surface units and/or one or more heating compartments. They must be one of the following classes: conventional ranges, conventional cooking tops, conventional ovens, microwave ovens, microwave/conventional ranges and other cooking products.

* * * * *

Other cooking products means any class of cooking products other than the conventional range, conventional cooking top, conventional oven, microwave oven, and microwave/conventional range classes.

* * * * *

3. Section 430.32 of Subpart C is amended by revising paragraph (j) to read as follows:

§ 430.32 Energy conservation standards and effective dates.

* * * * *

(j) Cooking Products. Gas cooking products with an electrical supply cord shall not be equipped with a constant burning pilot light. This standard is effective on January 1, 1990.

* * * * *

[FR Doc. 98–23886 Filed 9–4–98; 8:45 am]

BILLING CODE 6450–01–P

Final Rule

Tuesday
September 8, 1998

Part IV

**Department of
Energy**

**10 CFR Part 711
Personnel Assurance Program; Final Rule**

DEPARTMENT OF ENERGY

Personnel Assurance Program

10 CFR Part 711

RIN 1992-AA14

[Docket No. DP-RM-97-100]

Personnel Assurance Program; Final Rule

AGENCY: Department of Energy.

ACTION: Final rule.

SUMMARY: The Department of Energy (DOE or Department) today is publishing a final rule on Personnel Assurance Program (PAP) procedures and standards for DOE and DOE contractor employees who are assigned nuclear explosive duties at DOE facilities. The PAP is a systematic program, previously established by internal DOE directive, to prevent accidental or unauthorized detonation of nuclear explosives as a result of assignment of nuclear explosives duties to employees who have become emotionally, mentally, or physically incapacitated. The rule includes medical standards for evaluating DOE and contractor employees in the PAP.

EFFECTIVE DATE: This rule is effective October 8, 1998.

FOR FURTHER INFORMATION CONTACT: For further information concerning this final rule: Mr. Randall Weidman, U.S. Department of Energy, Office of Defense Programs (DP-21), 1000 Independence Ave., SW., Washington, D.C. 20585, (301) 903-3154.

SUPPLEMENTARY INFORMATION:

- I. Background
- II. Discussion of Public Comments and Regulatory Text
 - A. Subpart A: PAP Certification/Recertification, Temporary Removal/Reinstatement, and Revocation of PAP Certification
 - B. Subpart B: Medical Assessments for PAP Certification/Recertification
- III. Procedural Issues and Regulatory Review
 - A. Review Under Executive Order 12866
 - B. Review Under Executive Order 12612
 - C. Review Under the Regulatory Flexibility Act
 - D. Review Under the National Environmental Policy Act
 - E. Review Under the Paperwork Reduction Act
 - F. Review Under Executive Order 12988
 - G. Review Under the Unfunded Mandates Reform Act of 1995
 - H. Congressional Notification

I. Background

Pursuant to the Atomic Energy Act of 1954 (Act), DOE owns defense nuclear facilities in various locations in the United States which are operated by management and operating contractors

under DOE supervision. These facilities are involved in researching, testing, producing, disassembling, and transporting of nuclear explosives which, when mated with Department of Defense-provided delivery systems, become nuclear weapon systems.

Pursuant to section 161 of the Act, 42 U.S.C. 2201(b), (i)(3), and (p), DOE and its predecessor agencies have used some version of the PAP to certify, actively monitor, and periodically recertify personnel as suitable to perform nuclear explosive duties in a safe and reliable manner. PAP provides for disqualification of persons from performance of nuclear explosive duties who fail to meet PAP requirements for emotional, mental, and physical capability. In DOE's internal administrative directives, DOE Order 452.2, formerly DOE Order 5610.11, "SAFETY OF NUCLEAR EXPLOSIVE OPERATIONS," the term "Nuclear Explosive Duties" has been defined to include duties performed by DOE or contractor employees who have custody of or access to a nuclear explosive.

All PAP-certified employees are subject to continuous review and evaluation. The certification of such employees is subject to immediate review in light of facts and circumstances when an employee's behavior indicates a reliability risk that warrants protective action to neutralize a nuclear explosive hazard by having an individual immediately removed from nuclear explosive duties. Immediate removal does not constitute a determination that the individual is unsuitable for nuclear explosive duties, but rather indicates that the individual's suitability is in question.

In 1992, the Independent Guard Association of Nevada, Local No. 1, representing PAP-certifiable civilian security guards employed by Wackenhut Security, Inc., at DOE's Nevada Test Site, brought suit challenging DOE Order 5610.11, "NUCLEAR EXPLOSIVE SAFETY," which established the Department's nuclear explosive and weapons safety program, including the PAP. The DOE Order was challenged for failure to promulgate it through public notice and comment in compliance with the Administrative Procedure Act, 5 U.S.C. 553. In *Independent Guard Association of Nevada v. O'Leary*, No. CV-S-92-204-LDG-LRL (D. Nev. June 14, 1996), the District Court enjoined DOE from enforcing the requirements section (section 2) of DOE Order 5610.11, Chapter I, against contractor employees pending notice and comment rulemaking under 5 U.S.C. 553.

DOE published a notice of interim procedures and standards for the PAP on October 9, 1996 (61 FR 53018). The interim PAP procedures and standards were made effective immediately upon publication to mitigate the occupational and public safety risk during the period of time required to complete a public rulemaking proceeding.

On June 4, 1997, DOE published a notice of proposed rulemaking (NPR) to codify the PAP employee certification procedures and standards and other PAP-related policies, including the responsibilities of the Site Occupational Medical Director (SOMD) and other medical personnel. The proposed rule contained provisions that are similar to those in the notice of interim procedures and standards. The NPR also contained administrative procedures and standards for the conduct of medical assessments for PAP certification that were not included in the interim rule, but which generally conform to existing practice.

(Note: Unless otherwise indicated, references in this Supplementary Information section to "PAP certification," "certification," or "certification process," include annual recertification because generally the procedures and standards are the same.)

DOE received seven written comments on the proposed rule. Comments were received from two organizations that represent security guards (Independent Guard Association of Nevada, Local No. 1, and the National Council of Security Inspectors); an organization concerned about nuclear safety issues (Serious Texans Against Nuclear Dumping or STAND); the U.S. Equal Employment Opportunity Commission (two comments); the PAP Coordinator at one DOE facility; and an individual employed at another DOE facility. In addition, three individuals and a representative of the Independent Guard Association of Nevada presented oral comments on the proposed rule at public hearings that were held in Amarillo, Texas, and Las Vegas, Nevada, in July of 1997. DOE has carefully considered all of these comments in preparing this final rule.

II. Discussion of Public Comments

This part of the Supplementary Information section contains the Department's responses to issues raised in public comments on the proposed rule and an explanation of changes that DOE has made in this final rule in response to the public comments and as a result of additional internal review.

A. Subpart A: PAP Certification/Recertification, Temporary Removal/Reinstatement, and Revocation of PAP Certification

1. Definitions

In this final rule, DOE makes several changes to the definitions that apply to this part.

DOE has moved the definitions from proposed section 711.22, in subpart B, to section 711.3 to have all definitions in one location.

A definition of "PAP official" has been added to section 711.3 to clarify that the term includes any DOE manager or supervisor involved in the PAP certification process.

As proposed, the definition of "illegal drug" provided that the term would not apply to the use of a controlled substance in accordance with the terms of a valid prescription "or other uses authorized by law." In the final rule, DOE has revised the quoted phrase to read: "or other uses authorized by Federal law." This change is made to clarify that the definition of "illegal drug" used in this part would take precedence over any inconsistent state or local law.

2. General Provisions and Requirements

Two commenters objected to proposed section 711.4(b) which would have provided: "Nothing in this part shall be construed as prohibiting contractors from establishing stricter suitability standards for selecting candidates for nomination to DOE for certification or recertification in the PAP." DOE proposed this paragraph to make clear that by establishing procedures and standards for PAP certification, DOE did not intend to prevent contractors from establishing more stringent employment standards for their own business purposes. Commenters argued that this approach would result in contractors negotiating with labor organizations over PAP certification standards that would apply to their employees, and that this would produce non-uniform PAP standards. DOE does not agree with these arguments because decisions to certify or deny certification in the PAP will be made by DOE employees only in accordance with the procedures and standards in part 711. DOE employees will not use a more stringent contractor employment requirement, should any exist, in making a decision regarding a PAP individual's certification. Accordingly, DOE has not changed the substance of section 711.4(b).

These commenters also asked for clarification of proposed section 711.4(d), which provides that personnel

management actions involving an employee will be considered in making PAP certification decisions only if they are based on behavior that also affects an individual's suitability for the PAP. Stated another way, an individual's PAP certification will not be affected by any personnel management action involving the individual that is not based on behavior that raises a concern about the individual's suitability for the PAP. DOE believes the proposed language is clear and, therefore, section 711.4(d) is unchanged.

DOE has deleted proposed section 711.4(e), regarding evaluation for hallucinogen use because the substance of that provision is included in section 711.5(b)(5). This deletion from the section eliminates this redundancy.

One commenter, a PAP coordinator at a DOE facility, expressed concern that proposed section 711.5(b)(2), which would require that PAP individuals sign an acknowledgment and agreement to participate in the PAP, did not mention one form currently in use, the "Authorization and Consent to Release Personal Records in Connection with the Personnel Assurance Program" form. That form is not specifically referenced in the rule because DOE intends to consolidate the current agreement to participate and consent forms into a single form. DOE did not intend to suggest, by omitting reference to the consent to release personal records form, that DOE would not continue to require that PAP individuals consent to release of records.

Section 711.5(b)(5), and section 711.43 in subpart B, set forth a special policy for disqualification from the PAP for hallucinogen use. "Hallucinogen" is defined in section 711.3 so as to limit PAP-disqualifying hallucinogens to those hallucinogenic drugs or substances that cause flashbacks. The rule provides that use of a hallucinogen in the preceding 5 years is disqualifying. Hallucinogen use more than 5 years preceding the application for certification/recertification is not, in itself, an adequate basis for denying certification or recertification or for revocation of certification. The 5-year rule reflects a period of time that should elapse, as a protective practice, to minimize the likelihood of flashbacks. "Flashback" is the term used to describe a transient, spontaneous recurrence of certain aspects of a person's hallucinogen experience. Because flashbacks are sudden, often unpredictable, largely involuntary, dramatic alterations of emotional state, perception, sensation, and behavior, an accident could result if a flashback were to occur during the performance of a

hazardous task. Flashbacks may occur within a few days after hallucinogen use, or they may occur a few weeks, months, or even years later. In developing the 5-year rule, DOE consulted with experts at the Alcohol, Drug Abuse and Mental Health Administration of the Department of Health and Human Services. DOE placed the views, and a review of relevant studies, submitted by the National Institute on Drug Abuse, in the docket established for this rulemaking. Although an individual who used a hallucinogen more than 5 years earlier would be considered for nuclear explosive duties, section 711.43 provides that an individual who has used a hallucinogen must undergo a medical evaluation to determine reliability. In addition, the individual must have an acceptable job record and observed behavior.

DOE received comments on the hallucinogen policy, as provided in proposed section 711.5. As proposed, section 711.5(b)(5) stated that to be certified in the PAP, an individual "shall: (5) Not have used any hallucinogen in the preceding 5 years, and shall not be susceptible to flashbacks resulting from use of any hallucinogen more than 5 years before applying for certification or recertification." One commenter objected to the use of the word "susceptible," arguing that it would establish too subjective a standard for determining the risk of flashbacks occurring from hallucinogen use more than 5 years prior to filing of an application for certification or recertification. DOE has revised section 711.5(b)(5) to replace the word "susceptible" with the standard: "shall not have experienced a flashback". DOE believes this is a more measurable, yet sufficiently protective, standard.

A commenter questioned the adequacy of the requirement in proposed section 711.5(b)(6) that each individual in the PAP be tested for illegal drugs, on a random basis, "at least once each calendar year". The commenter expressed concern that the interval between drug tests could be much greater than once in each 12-month period. DOE did not intend the proposed rule to change existing practice regarding the frequency of drug testing. To clarify this in the final rule, DOE has included in sections 711.5(b)(6) and 711.5(b)(7) cross-references to the applicable requirements. For DOE employees, the applicable requirements for drug testing are in DOE Order 3792.3, "Drug-Free Federal Workplace Testing Implementation Program," and for

contractor employees, the applicable requirements are in 10 CFR Part 707, "Workplace Substance Abuse Programs at DOE Sites."

Section 711.5(d) provides that an individual will be denied certification, or will have his or her certification revoked, if drug testing confirms that the individual has used an illegal drug. A person who uses illegal drugs is not suitable for nuclear explosive duties. Proposed section 711.5(e) would have provided that an individual whose certification is revoked because of illegal drug use "may be reinstated in the PAP if the individual successfully completes a SOMD approved drug rehabilitation program as provided in § 711.42 of subpart B." One commenter argued that DOE should automatically reinstate an individual in the PAP following successful completion of an approved drug rehabilitation program. DOE has not adopted this comment because DOE cannot, for reasons of sound administration, hold open a position in the PAP for an individual who undertakes to complete a drug rehabilitation program. In addition, the PAP certifying official must base reinstatement decisions on a comprehensive evaluation of each individual case.

Section 711.6 sets forth requirements for the PAP certification process. Under section 711.6(b) each operations office manager who has jurisdiction over PAP certification shall issue implementing instructions that accomplish specified objectives. Because of the varied nature of the workforce at DOE sites, the rule does not dictate the implementation details, but rather sets forth performance standards to be achieved.

DOE received comments concerning the possible abuse of the certification process or misuse of information obtained in that process to retaliate against particular employees for actions unrelated to PAP suitability. One commenter alleged that the PAP or equivalent DOE programs have been used to stifle employee concerns and as a tool for reprisals against whistle-blowers. The commenter urged DOE to include safeguards in the rule to protect employees from misuse of information or the certification process.

While the rule gives individuals certain rights in the process for resolving PAP concerns, it does not include whistle-blower protection provisions because whistle-blower protection is provided in separate regulations. In 1992 DOE established a DOE Contractor Employee Protection Program which prescribes procedures for processing complaints by contractor employees that allege discriminatory

action by an employer in retaliation for the employee's disclosure of information related to health and safety, mismanagement, and other matters; for participation in proceedings before Congress or the Department; or for refusal to engage in illegal or dangerous activities. 57 FR 7533 (Mar. 3, 1992). The regulations are codified at 10 CFR part 708. DOE established the Contractor Employee Protection Program for employee complaints that are not covered by the whistle-blower protection program administered by the Department of Labor under 29 CFR part 24, "Procedures for the Handling of Discrimination Under Federal Employee Protection Statutes." On October 25, 1996, DOE published a Notice of Inquiry that invited public comment on experience under, and recommendations for improving, the DOE Contractor Employee Protection Program. 61 FR 55230. After considering the comments it received, DOE published a notice of proposed rulemaking on January 5, 1998, to amend part 708 (63 FR 374). DOE believes these existing laws and programs are adequate for hearing and resolving employee complaints of reprisals for actions involving health or safety violations and other violations of law.

One commenter objected to proposed section 711.6(b)(9), which would require that the operations office manager develop a mechanism for co-workers, supervisors, and managers to communicate concerns about PAP individuals' suitability for nuclear explosive duties. The commenter thinks a rule that obligates workers to share adverse information about co-workers with management will create distrust in the workplace.

The balance struck in the final rule between protection of individual rights and reporting of safety concerns is dictated by the nature of the work carried out at facilities or areas subject to the PAP. Employees in the PAP work with, or have access to, nuclear explosives, and an accident could result in severe injuries to personnel, loss of life, or damage to the environment. Therefore, it is necessary to require individuals in the PAP, as a condition of their employment, to report behavior or information about other employees that may raise a concern about an individual's ability to perform nuclear explosive duties in a safe and reliable manner. Moreover, PAP individuals must expect that other employees will report such information about them, and they are required to report such information about themselves. Section 711.5(b)(2) provides that individuals

who choose to work in the PAP must sign an agreement to participate and comply with PAP requirements.

While DOE has not made the change requested to section 711.6(b)(9), DOE has revised section 711.6(b)(5) to limit the persons who have access to information in a PAP individual's Personnel Security File.

DOE also received public comment on proposed section 711.9(b), which is a non-exclusive list of conditions and behavior that may raise PAP concerns and lead to removal of an individual from nuclear explosive duties. One commenter stated that some of the conditions or behavior listed in proposed section 711.9(b) are highly subjective and may be used by vindictive employees or managers to have employees removed from the PAP. The safety-sensitive nature of nuclear explosive duties requires that DOE grant supervisors latitude to decide if an individual's behavior or condition warrants temporary removal from the PAP pending a determination of suitability. The behavior and conditions listed in section 711.9(b) are illustrative of behavior or conditions that could cause a supervisor to question a PAP individual's ability to perform nuclear explosive duties in a safe and reliable manner. It is not possible to foreclose the possibility that a person would vindictively, or even falsely, provide derogatory information to a supervisor. It is important to recognize that temporary removal is a routine, but vital, protective measure to ensure the safety of personnel at these facilities. Moreover, under this final rule, temporary removal is followed by an elaborate process for fairly resolving concerns about an individual's suitability for the PAP.

Another commenter objected to proposed section 711.9(b)(2), concerning conduct "that is illegal or results in arrest or conviction," on the ground that DOE supervisors generally are not trained to determine what conduct is illegal. The commenter asked that the provision be limited to convictions. DOE has not accepted the suggestion to limit this provision to evidence of a conviction because an arrest for certain criminal activity could raise a concern about an individual's suitability for the PAP. However, DOE has revised section 711.9(b)(2) in the final rule by replacing the word "illegal" with the words "warrants referral for a criminal investigation." This change eliminates the requirement for a conclusion of law by the supervisor.

3. Procedures for Temporary Removal, Reinstatement in the PAP, and Denial or Revocation of PAP Certification

Two commenters objected to the omission in proposed section 711.12(b) of any deadline for completion of the PAP certifying official's evaluation and decision regarding the suitability of an individual who has been removed from nuclear explosive duties. DOE does not think it is desirable to place a time limit on the PAP certifying official's evaluation and suitability determination. The amount of time required to gather pertinent data and reach a decision regarding suitability for nuclear explosive duties will vary depending on the information or allegations that led to removal. DOE does not think the absence of a time limit will cause an individual to be in "limbo" for an extended time, as one commenter suggested. The need for the individual's services and the fact that removal does not affect the employee's pay or benefits are incentives for both the individual's employer and PAP officials to resolve the issues as quickly as possible.

Two commenters argued that an individual removed from nuclear explosive duties should be given a copy of the evaluation prepared by the PAP certifying official. The proposed section 711.12(d) already would require that the operations office manager prepare a written decision that includes the reasons and factual basis for the decision. DOE has revised the rule to clarify that the individual shall be given a copy of the operations office manager's reasons and factual support. Further, DOE has revised the rule to provide that an individual removed from nuclear explosive duties is entitled to a copy of the PAP certifying official's evaluation, unless the operations office manager determines that the release of that document or portions thereof, may be withheld under an exemption of the Privacy Act or the Freedom of Information Act.

Two commenters objected to proposed sections 711.12(g) and (h) because those provisions would require an individual who receives an initial decision from the operations office manager to choose either reconsideration by the operations office manager or a certification review hearing. In the commenters' view, an employee who chooses reconsideration is unfairly penalized by loss of the right to have a certification review hearing. DOE has not changed the rule in response to these comments because allowing individuals to request both reconsideration by the operations office

manager and a certification review hearing could unduly prolong the resolution of PAP certification issues.

The request for reconsideration provided in section 711.12(g)(2) and the certification review hearing under section 711.14 are dissimilar processes. The request for reconsideration procedure gives the individual an opportunity to provide to the operations office manager relevant information and statements on the matters in question. An individual may feel this opportunity is all that is needed, or may choose this informal process in order to obtain a quick administrative decision that, if unfavorable, could be challenged in a court proceeding. The certification hearing process, on the other hand, allows the individual to submit evidence on the relevant matters through presentation of witness testimony and cross-examination. Some individuals may decide that this option, although more costly, will be most effective in protecting their interests. An adverse decision resulting from either procedure may be appealed to the Assistant Secretary for Defense Programs and, ultimately, to a court. DOE believes the procedures established in the final rule adequately protect individual rights and, therefore, the final rule does not allow an individual to request both reconsideration and a certification review hearing.

A commenter objected to proposed section 711.14(c)(3), which permits the certification review hearing officer to receive and consider certain classified information that may be adverse to an individual without permitting the individual to cross-examine the source of the statement or information. These procedures, which are narrowly limited, originate in Executive Order No. 10865, "Safeguarding Classified Information Within Industry," reprinted as a note to 50 U.S.C. 435. They were included in the Personnel Assurance Program chapter of DOE Order No. 5610.11, "Nuclear Explosive Safety," and similar provisions are included in 10 CFR part 710, "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." DOE has retained section 711.14(c)(3) in the final rule because these exceptions to cross-examination are longstanding and necessary to protect the national security.

The same commenter objected to proposed section 711.15, which deals with the hearing officer's report and recommendation, because it does not make the hearing officer's submission binding on the operations office manager. The commenter argues that this process violates due process and

fundamental fairness. DOE has not changed the final rule to make the hearing officer's report and recommendation binding on the operations office manager under section 711.12(h). It is DOE's view that an evidentiary hearing presided over by an independent hearing officer, followed by an opportunity to appeal the operations office manager's decision to the Assistant Secretary for Defense Programs, constitutes a fair administrative process for resolving issues related to PAP certification.

B. Subpart B: Medical Assessments for PAP Certification/Recertification

DOE received no public comments on proposed sections 711.20—711.34, which cover the general applicability, purpose and scope of subpart B, definitions, and responsibilities and authorities of PAP officials. DOE has, after further consideration, made a number of minor changes to these sections. These changes include moving the definitions from section 711.22 to section 711.3; adding "physical" to the list in section 711.21; and deleting the requirement to participate as a member of the hostage negotiation team from section 711.31(c)(6).

DOE proposed in section 711.40 general medical standards that must be met by individuals certified in the PAP. Proposed section 711.40 (a)—(f) lists conditions or behavior that may, depending on the results of a medical assessment, disqualify an individual from performing nuclear explosive duties. One commenter pointed out that inclusion of the word "past" in proposed section 711.40(c), referring to use of illegal drugs, conflicts with the 5-year rule established by section 711.5. DOE agrees with this comment and has revised section 711.40(c) accordingly.

DOE received one comment on proposed section 711.41, which would establish requirements applicable to the PAP medical assessment process. The commenter stated that proposed section 711.41(d), which would require use of a generally accepted, self-reporting psychological inventory tool every third year in recertification medical assessments, would be inconsistent with the 2-year cycle for medical assessments for protective force personnel under 10 CFR part 1046. DOE plans to propose amendments to part 1046 in the near future, and expects that any inconsistency created by adoption of a 3-year cycle in this final rule will be eliminated by that rulemaking. All personnel who currently meet the 2-year psychological testing requirements of part 1046, as it currently exists, will

meet the psychological testing requirements of this rule.

DOE proposed in section 711.42 requirements for detecting and acting with regard to positive indications of drug abuse. DOE received a comment on proposed section 711.42(d), which would provide that an individual whose certification has been revoked may be reinstated in the PAP if the person successfully completes a SOMD-approved drug rehabilitation program and is subject to SOMD-directed unannounced tests for illegal drugs and counseling for 3 years. The commenter stated that such random drug testing may not be allowed by local collective bargaining agreements. DOE has not changed section 711.42 because the restrictions on random drug testing at DOE sites in 10 CFR part 707 do not apply to the situation covered in this section of the rule. Under today's rule, an individual whose PAP certification is revoked may be reinstated in the PAP if he or she accepts the conditions of the SOMD-approved drug rehabilitation program. Section 711.42(d) establishes unannounced drug testing as a component of such a program and, in order to take advantage of the rehabilitation opportunity, the individual must agree to the testing.

DOE received comments on proposed section 711.44 concerning medical assessment for alcohol use disorder. DOE proposed provisions that would prohibit alcohol consumption by PAP individuals within the 8-hour period immediately preceding nuclear explosive duties, and bar an individual from performing nuclear explosive duties for a minimum of 24 hours if a confirmatory breath alcohol test (BAT) result is at or above 0.02 percent alcohol concentration. These provisions are consistent with regulations promulgated by certain operating agencies of the Department of Transportation (DOT) to implement the Omnibus Transportation Employee Testing Act of 1991, Pub. L. No. 102-143, Title V. See, e.g., the Federal Highway Administration's requirements in 49 CFR 382.505(b).

Commenters representing security guards stated that they have no objection to the prohibition on alcohol consumption during the 8-hour period preceding scheduled work. However, they strongly oppose enforcing the rule against employees who are required by their employer to report to work without advance notice. According to these commenters, the 8-hour "no drinking" rule, coupled with the prohibition on working for 24 hours if the BAT exceeds 0.02 percent, would impair the ability of employers to meet staffing requirements. The President of the

Independent Guard Association of Nevada testified in a public hearing on the rule that, according to the medical department of a DOE prime contractor, a 225-pound person who stops drinking at 7:00 p.m. after having consumed three beers earlier on the same day could have an alcohol concentration of 0.02 percent at 6:00 a.m. the following day. Thus, if that person were forced to report for work early the second day, he or she would be taken off the work schedule for 24 hours even though the individual was not impaired. Transcript of Las Vegas Hearing, page 8 (testimony of Michael Cleghorn). Written comments suggested that employees could easily avoid unscheduled overtime work by drinking intentionally. This, they stated, would cause severe problems for employers because downsizing of protective forces limits their ability to find replacements.

DOE agrees with the commenters that it would be inappropriate to enforce an 8-hour "no drinking" rule against employees who are called up for unscheduled work. Therefore, the final rule is revised to limit its application to scheduled work. DOE will rely on breath alcohol testing under revised section 711.44(c) to ensure that employees required to report for unscheduled work do not exceed permissible alcohol concentration levels.

DOE does not agree with commenters that the 0.02 percent alcohol concentration standard is too rigid and not indicative of possible impairment. On February 15, 1994, DOT operating agencies promulgated alcohol testing regulations for the aviation, motor carrier, rail, transit, and pipeline transportation industries. The common preamble that DOT published for those rules discusses research and recommendations regarding the effects of blood alcohol that have been produced by expert bodies, including the National Highway Transportation Safety Administration, the National Transportation Safety Board, the National Academy of Sciences, and the Transportation Research Board. Common Rule, Final Rules on Limitation of Alcohol Use by Transportation Workers, 59 FR 7302, 7318-19 (Feb. 15, 1994). DOT concluded from this body of knowledge that while impairment of performance of safety-sensitive functions was clearly increased above 0.04 percent alcohol concentration, there was evidence of some impairment at levels as low as 0.02, the lowest level that can be reliably measured. Alcohol affects individuals differently and some individuals are impaired by any blood

alcohol. DOT, based on this evidence, adopted a standard that requires removal of an employee from a safety-sensitive position at any alcohol concentration of 0.02 percent or greater. The job tasks performed by individuals assigned nuclear explosive duties, including protective force personnel, are just as safety-sensitive as jobs performed by workers in the transportation industries. Therefore, DOE retains the 0.02 standard in the final rule.

In the final rule, DOE responds to the commenters' staffing concerns by providing more flexibility for dealing with employees who report for unscheduled work and test above 0.02 percent alcohol concentration. As proposed, section 711.44(e) would provide that an individual whose confirmatory BAT result is at or above 0.02 percent shall not be allowed to perform nuclear explosive duties for a minimum of 24 hours. In the final rule, DOE has renumbered proposed section 711.44(e) as section 711.44(f) and revised it to provide that in the case of unscheduled work, an employee whose test result is at or above 0.02 percent will be given the opportunity—but will not be required—to take another test when it is expected that the BAT would produce a result below the 0.02 percent alcohol concentration level. The employee then will be permitted to perform nuclear explosive duties if a result below 0.02 percent is obtained. DOE believes this approach will alleviate the problem envisioned by the commenters.

One commenter sought guidance on the identity and qualifications of persons who conduct breath alcohol testing of PAP individuals. The final rule specifies that alcohol tests are to be administered by a certified technician using an evidential-grade breath analysis device that conforms to National Highway Traffic Safety Administration model specifications for devices approved for use at the 0.02/0.04 percent concentration levels. DOE received comments recommending greater restrictions on the persons who conduct alcohol testing, but the commenter did not provide any evidence or factual support that would warrant additional restrictions.

In the final rule, DOE has added a new section 711.44(g) to clarify that PAP individuals whose jobs require commercial drivers licenses continue to be subject to DOT regulations on misuse of alcohol. They are subject to sanctions in regulations promulgated by the Federal Highway Administration, but DOE will take disciplinary action against such employees under its own authority.

Proposed section 711.45 sets forth requirements that apply to maintenance of medical records. DOE received comments from the U.S. Equal Employment Opportunity Commission (EEOC) on this section. At the request of the EEOC, DOE has revised proposed section 711.45(a) to clarify the long standing DOE practice that medical records must be kept separate from other personnel records. DOE also has added language to section 711.45(b), which was recommended by EEOC, to refer to the possible application to DOE contractors of the Americans with Disabilities Act and section 503 of the Rehabilitation Act, including the confidentiality provisions in the Department of Labor's implementing regulations. In addition, section 711.45(c)(3) provides that psychological records must be kept separate from other medical records.

III. Procedural Issues and Regulatory Review

A. Review Under Executive Order 12866

Today's regulatory action has been determined not to be a "significant regulatory action" under Executive Order 12866, "Regulatory Planning and Review," 58 FR 51735 (October 4, 1993). Accordingly, this rulemaking has not been reviewed by the Office of Information and Regulatory Affairs of the Office of Management and Budget (OMB).

B. Review Under Executive Order 12612

Executive Order 12612, "Federalism," 52 FR 41685 (October 30, 1987) requires that regulations, rules, legislation, and other policy actions be reviewed for any substantial direct effect on States, on the relationship between the National Government and the States, or in the distribution of power and responsibilities among various levels of government. If there are substantial effects, then the Executive Order requires the preparation of a federalism assessment to be used in all decisions involved in promulgating and implementing policy action. The Department has analyzed this rulemaking in accordance with the principles and criteria contained in Executive Order 12612, and has determined there are no federalism implications that would warrant the preparation of a federalism assessment. The rule published today will apply to DOE and DOE contractor personnel employed at defense nuclear facilities. It will not have a substantial direct effect on States, the relationship between the States and Federal Government, or the distribution of power and

responsibilities among various levels of government.

C. Review Under the Regulatory Flexibility Act

The Regulatory Flexibility Act, 5 U.S.C. 601-612, requires preparation of an initial regulatory flexibility analysis for every rule which by law must be proposed for public comment, unless the agency certifies that the rule, if promulgated, will not have a significant economic impact on a substantial number of small entities. Today's rule will affect a total of approximately 3,300 DOE and DOE contractor employees working at Government-owned or leased facilities. Only a small number of the employees work for a small entity. In addition, the DOE is formalizing a program that has been in place at DOE nuclear explosive facilities for over 30 years, so the economic impact of this proposed rule would be negligible. DOE certified in the notice of proposed rulemaking that the rule would not, if promulgated, have a significant economic impact on a substantial number of small entities. Public comment on this issue was invited, but none was received. DOE affirms its certification that the rule will not have a significant economic impact on a substantial number of small entities.

D. Review Under the National Environmental Policy Act

The final rule codifies and amends the PAP program, which has been in existence pursuant to DOE directives for approximately 30 years, and it relates to personnel qualifications that will have no impact on the environment. Categorical exclusions in the Department's regulations implementing the National Environmental Policy Act of 1969, 42 U.S.C. 4321 et seq., apply to this rulemaking. The applicable categorical exclusions are A1 and A5 in Appendix A to Subpart D, 10 CFR part 1021. The Department has therefore determined that neither an environmental assessment nor an environmental impact statement is required for this rulemaking.

E. Review Under the Paperwork Reduction Act

This rule does not contain a collection of information that requires the approval of the OMB under the Paperwork Reduction Act, 44 U.S.C. 3501, et seq. OMB has defined the term "information" to exclude certifications, consents, and acknowledgments that entail only minimal burden. 5 CFR 1320.3(h)(1).

F. Review Under Executive Order 12988

With respect to the review of existing regulations and the promulgation of new regulations, section 3(a) of Executive Order 12988, Civil Justice Reform, 61 FR 4729 (February 7, 1996), imposes on Executive agencies the general duty to adhere to the following requirements: (1) eliminate drafting errors and ambiguity; (2) write regulations to minimize litigation; and (3) provide a clear legal standard for affected conduct rather than a general standard and promote simplification and burden reduction. Section 3(b) of Executive Order 12988 specifically requires that Executive agencies make every reasonable effort to ensure that the regulation: (1) clearly specifies the preemptive effect, if any; (2) clearly specifies any effect on existing Federal law or regulation; (3) provides a clear legal standard for affected conduct while promoting simplification and burden reduction; (4) specifies the retroactive effect, if any; (5) adequately defines key terms; and (6) addresses other important issues affecting clarity and general draftsmanship under any guidelines issued by the Attorney General. Section 3(c) of Executive Order 12988 requires Executive agencies to review regulations in light of applicable standards in section 3(a) and section 3(b) to determine whether they are met or it is unreasonable to meet one or more of them. DOE has completed the required review and determined that, to the extent permitted by law, this rule meets the relevant standards of Executive Order 12988.

G. Review Under the Unfunded Mandates Reform Act of 1995

The Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1531 et seq., requires a federal agency to perform a detailed assessment of the costs and benefits of any rule imposing a federal mandate with costs to state, local or tribal governments, or to the private sector, of \$100 million or more. This final rule codifies existing procedures and standards that relate to certification of DOE personnel and DOE contractor personnel for nuclear explosive duties at DOE facilities. The rule does not impose a federal mandate requiring preparation of an assessment under the Unfunded Mandate Reform Act of 1995.

H. Congressional Notification

As required by 5 U.S.C. 801, DOE will report to Congress promulgation of this final rule prior to its effective date. The report will state that it has been determined that the rule is not a "major rule" as defined by 5 U.S.C. 804(2).

List of Subjects in 10 CFR Part 711

Administrative practice and procedure, Alcohol abuse, Drug abuse, Government contracts, Government employees, Health, Nuclear safety, and Occupational safety and health.

Issued in Washington, DC on August 31, 1998.

Victor H. Reis,

Assistant Secretary for Defense Programs.

For the reasons set forth in the preamble, Chapter III of title 10 of the Code of Federal Regulations is amended by adding new Part 711 to read as set forth below:

PART 711—PERSONNEL ASSURANCE PROGRAM (PAP)**Subpart A—PAP Certification/Recertification, Temporary Removal/Reinstatement, and Revocation of PAP Certification****SEC.**

- 711.1 Purpose.
- 711.2 Applicability.
- 711.3 Definitions.
- 711.4 General.
- 711.5 General requirements.
- 711.6 PAP certification process.
- 711.7 Maintenance of PAP personnel list.
- 711.8 PAP training requirements.
- 711.9 Supervisor reporting.
- 711.10 Individual reporting.
- 711.11 Immediate removal from nuclear explosive duties.
- 711.12 Action following removal from duties.
- 711.13 Appointment of a certification review hearing officer and legal counsel.
- 711.14 Certification review hearing.
- 711.15 Hearing officer's report and recommendation.
- 711.16 Appeal of the operations office manager's final decision.

Subpart B—Medical Assessments for PAP Certification/Recertification General Provisions

- 711.20 Applicability.
- 711.21 Purpose and scope.

Responsibilities and Authorities

- 711.30 Designated physician.
- 711.31 Designated psychologist.
- 711.32 Site Occupational Medical Director (SOMD).
- 711.33 Director, Office of Occupational Medicine and Medical Surveillance.
- 711.34 Operations office managers; Director, Transportation Safeguards Division.

Medical Assessment Process and Standards

- 711.40 Medical standards for certification.
- 711.41 Medical assessment process.
- 711.42 Medical assessment for drug abuse.
- 711.43 Evaluation of hallucinogen use.
- 711.44 Medical assessment for alcohol use disorder.
- 711.45 Maintenance of medical records.

Authority: 42 U.S.C. 2201(p), 7191.

Subpart A—PAP Certification/Recertification, Temporary Removal/Reinstatement, and Revocation of PAP Certification**§ 711.1 Purpose.**

The purpose of this part is to establish a Personnel Assurance Program (PAP) in DOE. The PAP is a human reliability program designed to ensure that individuals assigned to nuclear explosive duties do not have emotional, mental, or physical incapacities that could result in a threat to nuclear explosive safety. The PAP establishes the requirements and responsibilities for screening, selecting, and continuously evaluating employees assigned to or being considered for assignment to nuclear explosive duties.

§ 711.2 Applicability.

(a) This part applies to DOE Headquarters and field elements and DOE contractors that manage, oversee, or conduct nuclear explosive operations and associated activities, and to DOE and DOE contractor employees assigned to nuclear explosive duties.

(b) This part does not apply to responses to unplanned events (e.g., Accident Response Group activities), which are addressed in DOE 5530-Series Orders and DOE Order 151.1, "Comprehensive Emergency Management System."

§ 711.3 Definitions.

The following definitions are used in this part:

Access means proximity to a nuclear explosive that affords a person the opportunity to tamper with it or to cause it to detonate.

Alcohol use disorder means a maladaptive pattern in which a person's intake of alcohol is great enough to damage or adversely affect physical or mental health or personal, social, or occupational function; or when alcohol has become a prerequisite to normal function.

Certification means the formal action the PAP certifying official takes which permits an individual to be placed in the PAP and perform PAP duties. This action is taken once it has been determined an individual meets the requirements for certification under this part.

Contractor means the contractor and subcontractors at all tiers.

Designated physician means a licensed doctor of medicine or osteopathy who has been nominated by the SOMD and, with the concurrence of the Director, Office of Occupational Medicine and Medical Surveillance, approved by the operations office

manager, to provide professional expertise in the area of occupational medicine as it relates to the PAP.

Designated psychologist means a licensed Ph.D. or Psy.D. clinical psychologist who has been nominated by the SOMD and, with the concurrence of the Director, Office of Occupational Medicine and Medical Surveillance, approved by the operations office manager, to provide professional expertise in the area of psychological assessment as it relates to the PAP.

Diagnostic and Statistical Manual for Mental Disorders means the current version of the American Psychiatric Association's manual containing definitions of psychiatric terms and diagnostic criteria of mental disorders.

Director, Office of Occupational Medicine and Medical Surveillance, means the chief occupational medical officer of the DOE with responsibility for policy and quality assurance for DOE occupational medical programs.

Drug abuse means use of an illegal drug or misuse of legal drugs.

Flashback means a transient, spontaneous, and often unpredictable recurrence of aspects of a person's use of a hallucinogen that involves dramatic alteration of emotional state, perception, sensation, and behavior.

Hallucinogen means any hallucinogenic drug or substance that has the potential to cause flashbacks.

Illegal drug means a controlled substance, as specified in Schedules I through V of the Controlled Substances Act, 21 U.S.C. 811, 812. The term "illegal drug" does not apply to the use of a controlled substance in accordance with the terms of a valid prescription, or other uses authorized by Federal law.

Impaired or impairment means a decrease in functional capacity of a worker caused by a physical, mental, emotional, substance abuse, or behavioral disorder.

Job task analysis means a statement outlining the essential functions of a job and the potential exposures and hazards of an individual's specific job.

Medical assessment means an evaluation of a PAP individual's present health status and health risk factors by means of: (1) a medical history review; (2) the job task analysis; (3) a physical examination; (4) appropriate laboratory tests and measurements; and (5) appropriate psychological and psychiatric evaluations.

Medical Review Officer (MRO) means a licensed doctor of medicine or osteopathy who has knowledge of illegal drug use and other substance abuse disorders and has appropriate medical training to interpret drug test results.

The MRO may also be the designated physician and/or SOMD.

Nuclear explosive means an assembly containing fissionable and/or fusible materials and main charge high explosive parts or propellants capable of producing a nuclear detonation (e.g., a nuclear weapon or test device).

Nuclear explosive area means any area that contains a nuclear explosive or collocated pit and main charge high explosive parts.

Nuclear explosive duties means work assignments that allow custody of a nuclear explosive or access to a nuclear explosive device or area.

Occupational medical program means a DOE program that: (1) assists in the maintenance, monitoring, protection, and promotion of employee health through the skills of occupational medicine, psychology, and nursing; and (2) maintains a close interface with allied health disciplines, including industrial hygiene, health physics, and safety.

Operations office manager means the manager of a DOE operations office.

PAP certifying official or certifying official means the operations office manager or the manager's designee who certifies, recertifies, or reviews the circumstances of an individual's removal from nuclear explosive duties.

PAP individual means an individual being considered for assignment or assigned to perform nuclear explosive duties.

PAP official means any DOE employee who is involved in the PAP as a manager or supervisor or involved in the certification/recertification process.

Recertification means the formal action the PAP certifying official takes annually, not to exceed 12 months, which permits an individual to remain in the PAP and perform PAP duties. This action is taken once it has been determined an individual still meets the requirements of this part.

Reinstatement means the action the PAP certifying official takes once it has been determined an individual who has been temporarily removed from the PAP meets the certification requirements of this part and can be returned to the PAP and PAP duties.

Semi-structured interview means an interview by a designated psychologist who has the latitude to vary the focus and content of the questions depending upon the interviewee's responses.

Site Occupational Medical Director/SOMD means the physician responsible for the overall direction and operation of the site occupational medical program.

§711.4 General.

(a) PAP certification is required of each individual assigned to nuclear explosive duties in addition to any other job qualification requirements that may apply.

(b) Nothing in this part shall be construed as prohibiting contractors from establishing stricter employment standards for employees who are nominated to DOE for certification or recertification in the PAP.

(c) The failure of an individual to be certified or recertified in the PAP shall not, in itself, reflect on the individual's suitability for assignment to other duties or, in itself, be a cause for loss of pay or other benefits or other changes in employment status.

(d) Personnel management actions based on consideration of technical competence and other job qualification requirements shall be considered only if they are based on behavior that also affects an individual's suitability for the PAP.

(e) Except for the functions in § 711.12 (d), (e) and (h), an operations office manager may delegate PAP functions to a deputy manager, assistant manager, division director, and/or area office manager.

§711.5 General requirements.

(a) Each PAP individual shall be certified in the PAP before being assigned to nuclear explosive duties and shall be recertified annually, not to exceed 12 months between recertifications.

(b) To be certified or recertified in the PAP, an individual shall:

(1) Have an active DOE Q access authorization based upon a background investigation;

(2) Sign an acknowledgment and agreement to participate in the PAP on a form provided by DOE;

(3) Be interviewed and briefed on the importance of the nuclear explosive duty assignment and PAP objectives and requirements.

(4) Successfully complete an annual medical assessment for certification and recertification in accordance with Subpart B of this part;

(5) Not have used any hallucinogen in the preceding 5 years and shall not have experienced a flashback resulting from the use of any hallucinogen more than 5 years before applying for certification or recertification;

(6) If a DOE employee, be tested for illegal drugs at least once each calendar year in an unannounced and unpredictable manner under DOE Order 3792.3, "Drug-Free Federal Workplace Testing Implementation Program," and be subject to testing for cause or

reasonable suspicion or after an accident or an unsafe practice involving the individual and;

(7) If a DOE contractor employee, be tested for illegal drugs at least once each calendar year in an unannounced and unpredictable manner under 10 CFR part 707, "Workplace Substance Abuse Programs at DOE Sites," and be subject to testing for cause or reasonable suspicion or after an accident or an unsafe practice involving the individual.

(c) If an individual in the PAP refuses to submit a urine sample for illegal drug testing or attempts deception by substitution, adulteration, or other means, DOE immediately shall remove the individual from nuclear explosive duties.

(d) An individual will be denied PAP certification, or shall have his or her certification revoked, immediately, if use of an illegal drug is confirmed through drug testing, as provided in § 711.42 of Subpart B.

(e) An individual whose PAP certification is revoked for the use of illegal drugs will be considered for reinstatement in the PAP if the individual successfully completes an SOMD approved drug rehabilitation program, as provided in § 711.42 of Subpart B and a PAP position is available for which the individual is qualified.

(f) If an individual chooses not to participate in the PAP, he or she shall sign a refusal of consent form provided by DOE.

§711.6 PAP certification process.

(a) The PAP certifying official shall determine each PAP individual's suitability for certification or recertification in the PAP and review the circumstances concerning an individual's removal from nuclear explosive duties and possible reinstatement.

(b) Operations office managers who exercise jurisdiction over PAP certification shall issue instructions for implementing the PAP. At a minimum, the instructions shall provide for:

(1) Conducting a supervisory interview of each PAP individual, during which the supervisor shall determine the individual's willingness to accept the requirements and conditions of the PAP;

(2) Ensuring that each PAP individual undergoes a medical assessment under subpart B of this part;

(3) Ensuring that the personnel security file (PSF) of each PAP individual is reviewed by a DOE employee trained to identify PAP

concerns before the individual is certified or recertified;

(4) Ensuring that other available personnel data or information about each PAP individual is reviewed by an employee trained to identify PAP concerns before the individual is certified or recertified;

(5) Allowing the exchange of information about a PAP individual among responsible DOE officials during the certification, recertification, or certification review process. Any mental or behavioral issues which could impact an individual's ability to perform PAP duties may be provided to the SOMD, designated physician, and/or designated psychologist who have been previously identified for receipt of this information by the operations office manager or designee. In rare instances when information from an employee's PSF may be relevant, such information may be shared only with prior written approval of the manager or his/her designee. The Director, Office of Security Affairs, must be notified of the manager's decision to share PSF information, as well as the specific information provided and a brief summary of the circumstances. This notice should be provided as soon as practicable. Contractor medical personnel will not be allowed to view the PSF. Contractor medical personnel must not share any information obtained from the PSF with anyone who is not a DOE PAP official;

(6) Requesting certification or recertification of a contractor employee when the contractor has determined, on the basis of all available information, that the individual is suitable for the PAP. The contractor requesting certification or recertification shall, in writing, assure the PAP certifying official that all PAP certification requirements have been met;

(7) Addressing any requirement not met during the certification/recertification process, and requiring a contractor to provide any additional personal data or information in its possession that may have a bearing on the certification/recertification of an individual;

(8) Documenting certification and recertification of each PAP individual on a form provided by DOE;

(9) Developing a mechanism for co-workers, supervisors, and managers to communicate concerns about a PAP individual's suitability for nuclear explosive duties;

(10) Ensuring that PAP concerns are reported to an appropriate official, as specified in §§ 711.9 and 711.10, for timely resolution;

(11) Providing that the processing of a request for certification or recertification of an individual is terminated if the individual is no longer being considered for assignment to nuclear explosive duties or is no longer assigned to such duties. If, subsequently, the individual is considered for assignment to nuclear explosive duties, the certification or recertification process must be completely redone; and

(12) Using recertification to return an individual whose certification has exceeded 12 months, and thus expired, to the PAP, once it has been determined an individual still meets the requirements of this part.

§ 711.7 Maintenance of PAP personnel list.

Operations office managers who exercise jurisdiction over PAP certification and recertification shall establish procedures for developing and maintaining a current list of DOE and contractor personnel certified in the PAP. The list is to be used for program administration and is not an authorization for personnel to perform nuclear explosive duties. The list shall be promptly updated and verified on a quarterly basis under the supervision of the operations office manager.

§ 711.8 PAP training requirements.

(a) Operations office managers shall ensure that each individual who is assigned to nuclear explosive duties receives special training in PAP objectives, policies, and requirements.

(b) Operations office managers shall ensure that DOE and contractor supervisory personnel and PAP certifying officials receive training that includes:

(1) A detailed explanation of nuclear explosive duties and nuclear explosive safety;

(2) Instruction on PAP objectives, policies, and requirements;

(3) Instruction on the early identification of behavior that may indicate a degradation in reliability or judgment; and

(4) Special emphasis on the importance of timely reporting of any PAP concern to appropriate personnel.

(c) Operations office managers shall ensure that medical personnel who perform medical assessments receive, before performing PAP responsibilities, training that includes:

(1) A detailed explanation of nuclear explosive duties and nuclear explosive safety;

(2) Instruction on PAP objectives, policies, and requirements;

(3) An orientation on nuclear explosive duties and the work

environment applicable to that of the PAP employee;

(4) Annual professional training on current issues and concerns relative to psychological assessment; and

(5) Special emphasis on the importance of timely reporting of any PAP concern to appropriate personnel.

(d) Operations office managers shall establish and maintain a system for documenting the training received by PAP-certified individuals, supervisors of PAP personnel, and medical personnel with PAP-related duties.

§ 711.9 Supervisor reporting.

(a) Supervisors shall document and report to a PAP official and the SOMD, if appropriate, any observed or reported behavior or condition of an individual that causes the supervisor to have a reasonable belief that the individual's ability to perform assigned tasks in a safe and reliable manner may be impaired.

(b) Behavior and conditions that could indicate unsuitability for the PAP include, but are not limited to, the following:

(1) Psychological or physical disorders that impair performance of assigned duties;

(2) Conduct that warrants referral for a criminal investigation or results in arrest or conviction;

(3) Indications of deceitful or delinquent behavior;

(4) Attempted or threatened destruction of property or life;

(5) Suicidal tendencies or attempted suicide;

(6) Use of illegal drugs or the abuse of legal drugs or other substances;

(7) Alcohol use disorder;

(8) Recurring financial irresponsibility;

(9) Irresponsibility in performing assigned duties;

(10) Inability to deal with stress, or the appearance of being under unusual stress;

(11) Failure to understand work directives, hostility or aggression toward fellow workers or authority, uncontrolled anger, violation of safety or security procedures, or repeated absenteeism; and

(12) Significant behavioral changes, moodiness, depression, or other evidence of loss of emotional control.

§ 711.10 Individual reporting.

(a) An individual in the PAP shall report any observed or reported behavior or condition of another PAP individual that could indicate the individual's unsuitability for nuclear explosive duties, including the behaviors and conditions listed in

§ 711.9, to a supervisor, the SOMD, or other PAP official.

(b) An individual in the PAP shall report any behavior or condition, including any behavior or condition listed in § 711.9, that may affect his or her own suitability for nuclear explosive duties to a supervisor, the SOMD, or other PAP official.

§ 711.11 Immediate removal from nuclear explosive duties.

(a) A supervisor who has a reasonable belief that an individual in the PAP is not suitable for nuclear explosive duties shall immediately remove that individual from those duties pending a determination of the individual's suitability. The supervisor shall, at a minimum:

(1) Require the individual to stop performing nuclear explosive duties;

(2) Take action to ensure the individual is denied access to nuclear explosive areas; and

(3) Notify the individual, in writing, the reason for these actions.

(b) A supervisor who removes an individual from nuclear explosive duties shall notify the PAP certifying official of the action and the reasons that led to the removal of the individual from nuclear explosive duties as soon as possible, and shall forward this information, in writing, to the PAP certifying official within 24 hours from the time the individual is removed from duties.

(c) Immediate removal of an individual from nuclear explosive duties is an interim, precautionary action and does not constitute a determination that the individual is not fit for nuclear explosive duties. Removal from nuclear explosive duties shall not, in itself, be cause for loss of pay or other benefits or other changes in employment status.

§ 711.12 Action following removal from duties.

(a) *Temporary removal.* If a PAP certifying official receives a supervisor's written notice of the immediate removal of an individual from nuclear explosive duties, the certifying official shall direct the removal of the individual from PAP duties pending an evaluation and determination regarding the individual's suitability for nuclear explosive duties. The applicable DOE personnel security office shall be notified if removal is based on a security concern.

(b) *Evaluation.* The PAP certifying official shall conduct an evaluation of the circumstances or information that led the supervisor to remove the individual from nuclear explosive duties. The PAP certifying official shall

prepare a written report of the evaluation that includes the certifying official's determination regarding the individual's suitability for continuing PAP certification.

(c) *PAP certifying official's action.* (1) If the PAP certifying official determines that an individual who has been removed temporarily from nuclear explosive duties continues to meet the requirements for certification in the PAP, the certifying official shall:

(i) Notify the operations office manager of the determination; and

(ii) Notify the individual's supervisor of the determination and direct that the individual be allowed to return to nuclear explosive duties.

(2) If the PAP certifying official determines that an individual who has been temporarily removed from PAP duties does not meet the requirements for certification, the certifying official shall refer the matter to the operations office manager for action. The certifying official shall submit the evaluation report to the operations office manager and a recommendation that the individual's PAP certification be revoked.

(d) *Operations office manager's initial decision.* After receipt of a PAP certifying official's evaluation report and recommendation for revoking an individual's PAP certification, the operations office manager shall take one of the following actions:

(1) Direct that the individual be reinstated in the PAP and, in writing, explain the reasons and factual basis for the action;

(2) Direct the revocation of the individual's PAP certification and, in writing, explain the reasons and factual basis for the decision; or

(3) Direct continuation of the temporary removal pending completion of specified actions (e.g., medical assessment, security evaluation, treatment) to resolve the concerns about the individual's suitability for the PAP.

(e) In the event of a revocation, pursuant to § 711.12(d)(2), or suspension pursuant to § 711.12(d)(3), the operations office manager shall provide the individual a copy of the PAP certifying official's evaluation report. The manager may withhold such report, or portions thereof, to the extent that he/she determines that the report, or portions thereof, may be exempt from access by the individual under the Privacy Act or the Freedom of Information Act.

(f) *Reinstatement after completion of specified actions.* An individual directed by the operations office manager to take specified actions to resolve PAP concerns shall be

reevaluated by the certifying official after those actions have been completed. After considering the PAP certifying official's evaluation report and recommendation, the operations office manager shall direct either:

(1) Reinstatement of the individual in the PAP; or

(2) Revocation of the individual's PAP certification.

(g) *Notification of operations office manager's initial decision.* The operations office manager shall send by certified mail, return receipt requested, a written decision, including rationale, to an individual who is denied certification or recertification. The operations office manager's decision shall be accompanied by notification to the individual, in writing, of the procedures in paragraph (g) of this section and §§ 711.14—711.16 pertaining to reconsideration or a hearing on the operation office manager's decision.

(h) *Request for reconsideration or certification review hearing.* An individual who receives notification of an operation office manager's decision to deny or revoke his or her PAP certification may choose one of the following options:

(1) Take no action;

(2) Submit a written request to the operations office manager for reconsideration of the decision to deny or revoke certification. The request shall include the individual's response to any information that gave rise to a concern about the individual's suitability for nuclear explosive duties. The statement shall be signed under oath or affirmation before a notary public, and must be sent by certified mail to the operations office manager within 20 working days after the individual received notice of the operations office manager's decision; or

(3) Submit a written request to the operations office manager for a certification review hearing. The request for a hearing must be sent by certified mail to the operations office manager within 20 working days after the individual receives notice of the operations office manager's decision.

(i) *Operations office manager's decision after reconsideration or hearing.* (1) If an individual requests reconsideration by the operations office manager but not a certification review hearing, the operations office manager shall, within 20 working days after receipt of the individual's request, send by certified mail, return receipt requested, to the individual a final decision as to suitability based upon the individual's response and other relevant

information available to the operations office manager.

(2) If an individual requests a certification review hearing, the operations office manager shall decide the matter after receipt of the certification review hearing officer's report and recommendation, as provided in § 711.15. The operations office manager shall, within 20 working days after receiving the hearing officer's report and recommendation, send by certified mail, return receipt requested, the operations office manager's final decision to the individual, accompanied by a copy of the hearing officer's report and recommendation, and the transcript of the certification review proceedings.

§ 711.13 Appointment of a certification review hearing officer and legal counsel.

(a) After receiving an individual's request for a certification review hearing, the operations office manager shall promptly appoint a certification review hearing officer. The hearing officer shall:

(1) Be a DOE attorney or a hearing official from the DOE Office of Hearings and Appeals and have a DOE Q access authorization; and

(2) Have no prior involvement in the matter or be directly supervised by any person who is involved in the matter.

(b) The operations office manager shall also appoint a DOE attorney as counsel for DOE, who shall assist the hearing officer by:

(1) Obtaining evidence;

(2) Arranging for the appearance of witnesses;

(3) Examining and cross-examining witnesses; and

(4) Notifying the individual in writing, at least 7 working days in advance of the hearing, of the scheduled place, date, and hour where the hearing will take place.

§ 711.14 Certification review hearing.

(a) The certification review hearing officer shall conduct the proceedings in an orderly and impartial manner to protect the interests of both the Government and the individual.

(b) An individual who requests a certification review hearing shall have the right to appear personally before the hearing officer; to present evidence in his or her own behalf, through witnesses or by documents, or by both; and be accompanied and represented at the hearing by counsel of the individual's choosing or any other person and at the individual's own expense.

(c) In conducting the proceedings, the certification review hearing officer shall:

(1) Receive all information relating to the individual's fitness for PAP

certification through witnesses or documentation;

(2) Ensure that the individual is permitted to offer information in his or her behalf; to call, examine, and except as provided in paragraph (c)(3) of this section, cross-examine witnesses and other persons who have made written or oral statements, and to present and examine documentary evidence;

(3) Have the option to receive and consider oral or written statements adverse to the individual without affording the individual the opportunity to cross-examine the person making the statement in either of the following circumstances:

(i) The substance of the statement was contained in the individual's personnel security file and the head of the Federal agency supplying the statement certifies that the person who furnished the information is a confidential informant who has been engaged in obtaining intelligence information for the Government, and that the disclosure of that person's identity would substantially harm the national security; or

(ii) The substance of the statement was contained in the individual's personnel security file and the Assistant Secretary for Defense Programs or designee for that particular purpose has determined, after considering information furnished by the investigative agency concerning the reliability of the person and the accuracy of the statement, that —

(A) The statement appears to be reliable and material;

(B) Failure of the hearing officer to receive and consider such statement would substantially harm the national security; and

(C) The person who furnished the information cannot appear to testify due to death or severe illness, or due to some other good cause as determined only by the Assistant Secretary for Defense Programs;

(4) Ensure that if the procedures in paragraph (c)(3) of this section are used, the individual is given a description of the information, which shall be as comprehensive and detailed as the national security permits. In addition, if a statement is received under paragraph (c)(3)(ii) of this section, the identity of the person making the statement and the information to be considered shall be made available to the individual. The hearing officer shall give appropriate consideration to the fact that the individual did not have an opportunity to cross-examine such person;

(5) Require the testimony of the individual and all witnesses be given under oath or affirmation;

(6) Request that the Assistant Secretary for Defense Programs issue subpoenas for witnesses to attend the hearing or for the production of specific documents or other physical evidence; and

(7) Ensure that a transcript of the certification review proceedings is made.

§ 711.15 Hearing officer's report and recommendation.

Not later than 30 working days after the conclusion of the hearing, the certification review hearing officer shall forward written findings, a supporting statement of reasons, and recommendation regarding the individual's suitability for certification or recertification in the PAP to the operations office manager. The hearing officer's report and recommendation shall be accompanied by a copy of the record of the proceedings.

§ 711.16 Appeal of the operations office manager's final decision.

(a) An individual who has been denied PAP certification or recertification, or whose certification has been revoked, may appeal the operations office manager's decision to the Assistant Secretary for Defense Programs. The appeal must be sent to the Assistant Secretary for Defense Programs, by certified mail, no later than 20 working days after the individual receives the operations office manager's decision.

(b) An individual who appeals an operations office manager's decision to the Assistant Secretary for Defense Programs must submit the appeal and a written supporting statement to the Assistant Secretary for Defense Programs through the operations office manager and the Deputy Assistant Secretary for Military Application and Stockpile Management. The individual must also submit:

(1) A copy of the operations office manager's final decision and any related documentation; and

(2) If a certification review hearing was conducted, a copy of the hearing officer's report and recommendation and the record of the proceedings.

(c) Within 20 working days of the receipt of an individual's appeal and supporting documents, the Assistant Secretary for Defense Programs shall review all of the information and issue a written decision in the matter. The decision of the Assistant Secretary for Defense Programs shall be final for DOE.

(d) If an individual does not appeal to the Assistant Secretary for Defense Programs within the time specified in paragraph (a) of this section, the

operations office manager's decision shall be the final decision.

Subpart B—Medical Assessments for PAP Certification and Recertification

General Provisions

§ 711.20 Applicability.

The purpose of this subpart is to establish standards and procedures for conducting medical assessments of DOE and DOE contractor employees in the PAP.

§ 711.21 Purpose and scope.

The standards and procedures set forth in this part are necessary for DOE to:

(a) Identify the presence of any mental, emotional, physical, or behavioral characteristics or conditions that present or are likely to present an unacceptable impairment in judgment, reliability, or fitness of an individual to perform nuclear explosive duties safely and reliably;

(b) Facilitate the early diagnosis and treatment of disease or impairment and to foster accommodation and rehabilitation of a disabled individual with the intent of returning the individual to assigned nuclear explosive duties;

(c) Determine what functions an employee may be able to perform and to facilitate the proper placement of employees; and (d) Provide for continuing monitoring of the health status of employees in order to facilitate early detection and correction of adverse health effects, trends, or patterns.

Responsibilities and Authorities

§ 711.30 Designated physician.

(a) The designated physician shall be qualified to provide professional expertise in the area of occupational medicine as it relates to the PAP. The designated physician may serve in other capacities, including Medical Review Officer.

(b) The designated physician shall:

(1) Be a physician who is a graduate of an accredited school of medicine or osteopathy;

(2) Have a valid, unrestricted state license to practice medicine in the state where PAP medical assessments occur;

(3) Have met the applicable PAP training requirements; and (4) Be eligible for DOE access authorization.

(c) The designated physician shall be responsible for the medical assessments of PAP individuals, including determining which components of the medical assessments may be performed by other qualified personnel. Although

a portion of the assessment may be performed by another physician, physician's assistant, or nurse practitioner, the designated physician remains responsible for:

(1) Supervising the evaluation process;

(2) Interpreting the results of evaluations;

(3) Documenting medical conditions that may disqualify an individual from the PAP;

(4) Providing medical assessment information to the designated psychologist to assist in determining psychological fitness;

(5) Determining, in conjunction with DOE, if appropriate, the location and date of the next required medical assessment, thereby establishing the period of certification; and (6) Signing a recommendation as to the medical fitness of an individual for certification or recertification.

(d) The designated physician shall immediately report to the SOMD any of the following about himself or herself:

(1) Initiation of an adverse action by any state medical licensing board or any other professional licensing board;

(2) Initiation of an adverse action by any federal regulatory board since the last designation;

(3) The withdrawal of the privilege to practice by any institution;

(4) Being named a defendant in any criminal proceedings (felony or misdemeanor) since the last designation;

(5) Being evaluated or treated for alcohol use disorder or drug dependency or abuse since the last designation; or

(6) Occurrence of a physical or mental health condition since the last designation that might affect his or her ability to perform professional duties.

§ 711.31 Designated psychologist.

(a) The designated psychologist shall report to the SOMD and shall determine the psychological fitness of an individual to participate in the PAP. The results of this evaluation shall be provided only to the designated physician or the SOMD.

(b) The designated psychologist shall:

(1) Hold a doctoral degree from a clinical psychology program that includes a 1-year clinical internship approved by the American Psychological Association or an equivalent program;

(2) Have accumulated a minimum of 3 years postdoctoral clinical experience with a major emphasis in psychological assessment;

(3) Have a valid, unrestricted state license to practice clinical psychology

in the state where PAP medical assessments occur;

(4) Have met the applicable PAP training requirements; and

(5) Be eligible for DOE access authorization.

(c) The designated psychologist shall be responsible for the performance of all psychological evaluations of PAP individuals, and otherwise as directed by the SOMD. In addition, the designated psychologist shall:

(1) Designate which components of the psychological evaluation may be performed by other qualified personnel;

(2) Upon request of management, assess the psychological fitness of personnel for PAP duties in specific work settings and recommend referrals as indicated;

(3) Conduct and coordinate educational and training seminars, workshops, and meetings to enhance PAP individual and supervisor awareness of mental health issues;

(4) Establish personal workplace contact with supervisors and workers to help them identify psychologically distressed PAP individuals; and

(5) Make referrals for psychiatric, psychological, substance abuse, personal or family problems, and monitor the progress of individuals so referred.

(d) The designated psychologist shall immediately report to the SOMD any of the following about himself or herself:

(1) Initiation of an adverse action by any state medical licensing board or any other professional licensing board;

(2) Initiation of an adverse action by any federal regulatory board since the last designation;

(3) The withdrawal of the privilege to practice by any institution;

(4) Being named a defendant in any criminal proceeding (felony or misdemeanor) since the last designation;

(5) Being evaluated or treated for alcohol use disorder or drug dependency or abuse since the last designation; or

(6) Occurrence of a physical or mental health condition that might affect his or her ability to perform professional duties since the last designation.

§ 711.32 Site Occupational Medical Director (SOMD).

(a) The SOMD shall nominate a physician to serve as the designated physician and a clinical psychologist to serve as the designated psychologist. The nominations shall be sent through the operations office to the Director, Office of Occupational Medicine and Medical Surveillance. Each nomination shall describe the nominee's relevant

training, experience, and licensure, and shall include a curriculum vitae and a copy of the nominee's current state or district license.

(b) The SOMD shall submit a renomination report biennially through the operations office manager to the Director, Office of Occupational Medicine and Medical Surveillance. This report shall be submitted at least 60 days before the second anniversary of the initial designation or of the last redesignation, whichever applies. The report shall include:

(1) A statement evaluating the performance of the designated physician and designated psychologist during the previous designation period;

(2) A summary of all PAP-relevant training, including postgraduate education, that the designated physician and designated psychologist has completed since the last designation; and

(3) A copy of the valid, unrestricted state or district license of the designated physician and designated psychologist.

(c) The SOMD shall submit, annually, to the Director, Office of Occupational Medicine and Medical Surveillance, through the operations office manager, a written report summarizing PAP medical activity during the previous year. The SOMD shall comply with any DOE directives specifying the form or contents of the annual report.

(d) The SOMD shall investigate any reports of problems regarding a designated physician or designated psychologist, and the SOMD may suspend either official from PAP-related duties. If the SOMD suspends either official, the SOMD shall notify the Director, Office of Occupational Medicine and Medical Surveillance and the operations office manager, and provide supporting documentation and reasons for the action.

§ 711.33 Director, Office of Occupational Medicine and Medical Surveillance.

The Director, Office of Occupational Medicine and Medical Surveillance, shall:

(a) Develop policies, standards, and guidance related to the medical aspects of the PAP, including the psychological testing inventory to be used;

(b) Review the qualifications of designated physicians and designated psychologists, and concur or nonconcur in their designations by sending a statement to the responsible program office and the operations office, with an informational copy to the SOMD;

(c) Provide technical assistance on medical aspects of the PAP to all DOE elements and DOE contractors; and

(d) Concur or nonconcur with the medical bases of decisions rendered on appeals of PAP certification decisions.

§ 711.34 Operations office managers; Director, Transportation Safeguards Division.

Operations office managers and the Director, Transportation Safeguards Division, shall approve, upon the nomination of the SOMD and concurrence of the Director, Office of Occupational Medicine and Medical Surveillance, physicians and psychologists to serve as designated physicians and designated psychologists.

Medical Assessment Process and Standards

§ 711.40 Medical standards for certification.

To be certified in the PAP, an individual shall be free of any mental, emotional, or physical condition or behavioral characteristics or conditions that present or are likely to present an unacceptable impairment in judgement, reliability, or fitness of an individual to perform nuclear explosive duties safely and reliably. The designated physician, with the assistance of the designated psychologist, shall determine the existence or nature of any of the following:

(a) Physical or medical disabilities such as visual acuity, defective color vision, impaired hearing, musculoskeletal deformities, and neuromuscular impairment;

(b) Mental disorders or behavioral problems, including substance use disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders;

(c) Use of illegal drugs or the abuse of legal drugs or other substances, as identified by self-reporting, or by medical or psychological evaluation or testing;

(d) Alcohol use disorder;

(e) Threat of suicide, homicide, or physical harm; or

(f) Cardiovascular disease, endocrine disease, cerebrovascular or other neurologic disease, or the use of drugs for the treatment of such conditions that may adversely affect the judgment or ability of an individual to perform assigned duties in a safe and reliable manner.

§ 711.41 Medical assessment process.

(a) The designated physician, under the supervision of the SOMD, shall be responsible for the medical assessment of PAP individuals. In carrying out this responsibility, the designated physician or the SOMD shall integrate the medical

evaluations, available drug testing results, psychological evaluations, any psychiatric evaluations, and any other relevant information to determine an individual's overall medical qualification for assigned duties.

(b) Employers shall provide a job task analysis or detailed statement of duties for each PAP individual to both the designated physician and the designated psychologist before each medical assessment and psychological evaluation. PAP medical assessments and psychological evaluations shall not be performed if a job task analysis or detailed statement of duties has not been provided.

(c) The designated physician shall consider a PAP individual's fitness for nuclear explosive duties at the time of each medical contact, including:

(1) Medical assessments for initial certification, annual recertification, and evaluations for reinstatement following temporary removal from the PAP;

(2) Intermediate evaluations, including job transfer evaluations, evaluations upon self-referral, and referral by management;

(3) Routine medical contacts, including routine return-to-work evaluations and occupational and nonoccupational health counseling sessions; and

(4) A review of current, legal drug use.

(d) Psychological evaluations shall be conducted:

(1) For initial certification. This psychological evaluation consists of a generally accepted, self-reporting psychological inventory tool approved by the Director, Office of Occupational Medicine and Medical Surveillance, and a semi-structured interview.

(2) For recertification. This psychological evaluation consists of a semi-structured interview.

(3) Every third year. The medical assessment for recertification shall include a generally accepted self-reporting psychological inventory tool approved by the Director, Office of Occupational Medicine and Medical Surveillance.

(4) Additional psychological or psychiatric evaluations may be required by the SOMD when needed to resolve PAP concerns.

(e) Following absences requiring return-to-work evaluations under applicable DOE directives, the designated physician, with assistance from the designated psychologist, shall determine whether a psychological evaluation is necessary.

(f)(1) Except as provided in paragraph (f)(2) of this section, the designated physician shall forward the completed medical assessment of a PAP individual

to the SOMD, who shall send a recommendation based on the assessment simultaneously to the individual's PAP administrative organization and to the PAP certifying official.

(2) If the designated physician determines that a currently certified individual no longer meets the PAP standards, the designated physician shall immediately, orally, inform the PAP certifying official and the PAP individual's administrative organization, following up in writing as appropriate.

(g) Only the designated physician, subject to informing the SOMD, shall make a medical recommendation for return to work and work accommodations for PAP individuals.

(h) The following documentation is required for routine use in the PAP after treatment of an individual for any disqualifying condition:

(1) A summary of the diagnosis, treatment, current status, and prognosis to be furnished to the designated physician;

(2) The medical opinion of the designated physician advising the individual's supervisor on whether the individual is able to return to work in either a PAP or non-PAP capacity; and

(3) Any periodic monitoring plan approved by the designated physician, the designated psychologist, and the SOMD, that is used to evaluate the reliability of the employee.

§ 711.42 Medical assessment for drug abuse.

(a) Except as otherwise provided by this section, a medical assessment for illegal drug use by DOE employees shall be conducted under DOE Order 3792.3, "Drug-Free Federal Workplace Testing Implementation Program," or any successor order issued by DOE.

(b) Except as otherwise provided by this section, a medical assessment for illegal drug use by DOE contractor employees shall be conducted under 10 CFR part 707, "Workplace Substance Abuse Programs at DOE Sites."

(c) In each case of drug abuse, the SOMD, in consultation with the designated psychologist, shall evaluate the individual for evidence of psychological impairment and make a recommendation to the PAP certifying official as to the individual's reliability.

(d) If an individual successfully completes an SOMD-approved drug rehabilitation program, DOE may reinstate the individual in the PAP based on the SOMD's follow-up evaluation and recommendation. The individual reinstated will be subject to SOMD-directed unannounced tests for

illegal drugs and relevant counseling for 3 years.

§ 711.43 Evaluation for hallucinogen use.

If DOE determines that a PAP individual has used any hallucinogen, the individual shall not be eligible for certification or recertification unless:

(a) Five years have passed since the last use of the hallucinogen;

(b) A medical evaluation, including a psychological test, is performed to determine that the individual is reliable; and

(c) The individual has a record of acceptable job performance and observed behavior.

§ 711.44 Medical assessment for alcohol use disorder.

(a) If alcohol abuse is suspected, an individual shall be examined for evidence of alcohol use disorder. If the examination produces evidence of alcohol use disorder, additional evaluation shall be conducted, which may include psychological evaluation.

(b) Alcohol consumption is prohibited within an 8-hour period preceding scheduled work and during the performance of nuclear explosive duties.

(c) Individuals in the PAP, including individuals who report for unscheduled work, may be tested for cause or reasonable suspicion of alcohol use or after an accident or an unsafe practice involving the individual.

(d) DOE shall implement or require the contractor to implement procedures that will ensure that persons called in to perform unscheduled work are fit to perform the tasks assigned.

(e) Tests for alcohol must be administered by a certified Breath Alcohol Technician using an evidential-grade breath analysis device approved for use at the 0.02/0.04 cut-off levels that conforms to the Department of Transportation's (DOT) National Highway Traffic Safety Administration (NHTSA) model specifications (58 FR 48705, September 17, 1993), and the most recent "Conforming Products List" issued by NHTSA which are available from the Office of Traffic Safety Programs, Washington, DC.

(f) An individual whose confirmatory breath alcohol test result is at or above an alcohol concentration of 0.02 percent shall not be allowed to perform nuclear explosive duties until the individual's alcohol concentration is below 0.02 percent using an evidential-grade breath analysis device described in section 711.44(e).

(g) Individuals subject to alcohol testing under DOT regulations shall be subject to the sanctions promulgated by

the Federal Highway Administration rule. Appropriate disciplinary action will be taken under DOE's authority.

(h) Individuals refusing to submit to a breath alcohol test shall be immediately removed from nuclear explosive duties.

(i) The SOMD, in conjunction with the designated psychologist, shall evaluate each case of alcohol use disorder for evidence of psychological impairment and provide the PAP certifying official a recommendation as to the individual's reliability.

(j) After successfully completing an SOMD-approved alcohol treatment program, DOE may reinstate an individual in the PAP based on the SOMD's follow-up evaluation and recommendation.

§ 711.45 Maintenance of medical records.

(a) Medical records produced or used in the PAP certification process shall be collected and maintained on separate forms and in separate medical files, and be treated as a confidential medical record.

(b) The medical records of PAP individuals shall be maintained in accordance with the Privacy Act, 5 U.S.C. 552a and DOE implementing regulations in 10 CFR Part 1008; the Department of Labor's regulations on access to employee exposure and medical records, 29 CFR 1910.1020; and applicable DOE directives. DOE contractors also may be subject to § 503 of the Rehabilitation Act, 29 U.S.C. 793, and its implementing rules, including confidentiality provisions at 29 CFR 60-741.23(d).

(c) The psychological record of a PAP individual shall be considered a component of the medical record. The psychological record shall:

(1) Contain any clinical reports, test protocols and data, notes of employee contacts and correspondence, and other information pertaining to an individual's contact with a psychologist;

(2) Be stored in a secure location in the custody of the designated psychologist;

(3) Be kept separate from other medical record documents, with access limited to the SOMD, the designated physician, the designated psychologist, or other persons who are authorized by law or regulation to have access; and

(4) Be retained indefinitely.

(d) The records of alcohol and drug testing shall be maintained in accordance with 42 CFR part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," and 10 CFR

part 707, “Workplace Substance Abuse
Programs at DOE Sites.”

[FR Doc. 98-23885 Filed 9-4-98; 8:45 am]

BILLING CODE 6450-01-P

Federal Register

Tuesday
September 8, 1998

Part V

**Environmental
Protection Agency**

40 CFR Parts 142 and 135

**Public Water System Program; Removal
of Obsolete Rule and Safe Drinking
Water Public Water System Program;
Citizen Collection Action; Notice of
Complaint Seeking Review of Penalty
Order; Rule and Proposed Rule**

ENVIRONMENTAL PROTECTION AGENCY**40 CFR Part 142**

[FRL-6121-7]

Public Water System Program; Removal of Obsolete Rule**AGENCY:** Environmental Protection Agency.**ACTION:** Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is today amending its regulations to remove from the Code of Federal Regulations (CFR) rules pertaining to the issuance of proposed administrative compliance orders pursuant to Section 1414(g)(2) of the Safe Drinking Water Act, as amended in 1986 (1986 Act). Enactment of the Safe Drinking Water Act Amendments of 1996 (1996 Act) eliminated the statutory requirement in the 1986 Act that administrative compliance orders against violators of the Public Water Systems program be issued only after proposal and subsequent opportunity for public hearing.

EFFECTIVE DATE: This final rule takes effect on September 8, 1998. In accordance with 40 CFR 23.7, this regulation will be considered final Agency action for purposes of judicial review at 1:00 p.m. eastern time on September 8, 1998.

FOR FURTHER INFORMATION CONTACT: David Drelich (2243A), Water Enforcement Division, Office of Enforcement and Compliance Assurance, 401 M Street SW., Washington, DC 20460, (202) 564-2949.

SUPPLEMENTARY INFORMATION:**I. Background**

The 1986 Act amended Section 1414 of the Safe Drinking Water Act (SDWA) to provide for the issuance of administrative compliance orders against violators of the regulations implementing the public water supply system (PWSS) program:

(g) Administrative order requiring compliance; notice and hearing * * *

(2) An order issued under this subsection shall not take effect *until after notice and opportunity for public hearing and*, in the case of a State having primary enforcement responsibility for public water systems in that State, until after the Administrator has provided the State with an opportunity to confer with the Administrator regarding the *proposed order*. A copy of any order *proposed to be issued* under this subsection shall be sent to the appropriate State agency of the State involved if the State has primary enforcement responsibility for public water systems in that State. Any order issued under

this subsection shall state with reasonable specificity the nature of the violation. In any case in which an order under this subsection is issued to a corporation, a copy of such order shall be issued to appropriate corporate officers. [Emphasis supplied.]

Section 1414(g)(2) of 1986 Act; 42 U.S.C. 300g-3(g)(2) (1995). The emphasized language in the citation above was repealed by the 1996 Act. Safe Drinking Water Act, as amended 1996; Sec. 113(a)(3)(B), Pub. L. 104-182; 110 Stat. 1613 (42 U.S.C. 300g-3(g)(2)) (1996). The repeal has the effect of eliminating the requirement for the issuance of a proposed PWSS compliance order, as well as the notice and opportunity for a public hearing on the proposal.

The hearings described in the regulations being deleted today were promulgated as 40 CFR Part 142 Subpart J on January 30, 1991. See 56 FR 3755. The procedures being deleted today are information-gathering rather than adjudicatory in nature. This was noted in the proposed rulemaking for the regulations: "The procedures proposed for section 1414(g)(2) compliance orders provide an opportunity for informal, information-gathering, nonadjudicatory hearings prior to the issuance of the orders." 54 FR 29517 (July 12, 1989). Because PWS compliance orders do not result in the deprivation of any constitutionally protected interest, see generally *Mathews v. Eldridge*, 424 U.S. 319 (1976) and Preamble to 40 CFR Part 142, Subpart J (1991), the opportunity for hearings on the proposed orders was not constitutionally mandated.

EPA has issued numerous proposed administrative compliance orders in this program, and has received relatively few requests for public hearings. It is unaware of any such hearings now pending. If the deletion of Subpart J occurs during the pendency of such an information-gathering hearing, EPA has the discretion to go forward with the hearing, although it would no longer be mandated by law.

One provision of Subpart J being deleted today, 40 CFR 142.208, provides that any penalty sought by the Administrator pursuant to Section 1414(g)(3)(B) of the SDWA (relating to penalty complaints for violations of PWS administrative compliance orders) shall be assessed pursuant to the procedures set forth at 40 CFR part 22. This provision is consistent with the statutory instructions in an unamended sentence of Section 1414(g)(3)(B), which provided that such an administrative penalty was to be assessed "after notice and opportunity for a hearing on the record in accordance with section 554 of Title 5." 42 U.S.C. 300g-3(g)(3)(B). Part

22 establishes procedures consistent with the requirements set forth by the Administrative Procedure Act, 5 U.S.C. 551 *et seq.* (APA). Section 1414(g)(3)(B) of the SDWA, as amended by the 1996 Act, however, now states

In a case in which a civil penalty sought by the Administrator under this paragraph [§ 1414(g)] does not exceed \$5,000, the penalty shall be assessed by the Administrator after notice and opportunity for a public hearing (unless the person against whom the penalty is assessed requests a hearing on the record in accordance with section 554 of title 5, United States Code). In a case in which a civil penalty sought by the Administrator under this paragraph exceeds \$5,000, but does not exceed \$25,000, the penalty shall be assessed by the Administrator after notice and opportunity for a hearing on the record in accordance with section 554 of title 5, United States Code.

The Agency has proposed to amend 40 CFR part 22 to implement this new provision of law in permanent form. See 63 FR 9464 (February 25, 1998). Consequently, Section 142.208 is being deleted. In the interim period between the deletion of this section and a final promulgation of conforming amendments to 40 CFR part 22, EPA will continue to use the part 22 procedures as guidance when on the record hearings are required by the terms of Section 1414(g)(3)(B), and will provide interim guidance on what procedures EPA shall follow in instances of non-APA adjudicatory hearings.

II. Good Cause Exemption from Notice-and-Comment Rulemaking Procedures

The Administrative Procedure Act general requires agencies to provide prior notice and opportunity for public comment before issuing a final rule. 5 U.S.C. 553(b). Rules are exempt from this requirement if the issuing agency finds for good cause that notice and comment are unnecessary. 5 U.S.C. 553(b)(3)(B).

EPA has determined that providing prior notice and opportunity for comment on the deletion of these rules from the CFR is unnecessary. The statutory requirement underlying the promulgation of these regulations has been repealed. As discussed above, EPA is unaware of any hearing pending under these rules, but during this interim period may nonetheless continue to provide the opportunity for such an information-gathering hearing even in the absence of this regulatory subpart.

For the same reasons, EPA believes there is good cause for deleting these rules from the CFR effective immediately. See 5 U.S.C. 553(d).

III. Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a "significant" regulatory action. It also does not impose any federal mandate on State, local or tribal governments or the private sector within the meaning of the Unfunded Mandates Act of 1995. Further, this action would not impose any requirements under the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*, require prior consultation with State officials as specified by Executive Order 12875 (58 FR 58093, October 28, 1993), or involve special consideration of environmental justice related issues as required by Executive Order 12898 (59 FR 7629, February 16, 1994).

The Agency has determined that this rule is not subject to the Regulatory Flexibility Act ("RFA"), which generally requires any agency to conduct a regulatory flexibility analysis of any significant impact the rule will have on a substantial number of small entities. By its terms, the RFA applies

only to rules subject to notice-and-comment rulemaking requirements under the Administrative Procedure Act ("APA") or any other statute. As explained above, this rule is not subject to notice and comment requirements under the APA or any other statute.

The Agency has nonetheless assessed the potential of this rule to adversely impact small entities. Because this rule change does not effect any change in the law applicable to small entities, but only concerns Agency practice and procedure, it has no adverse impact on small entities.

Pursuant to 5 U.S.C. 801(a)(1)(A), as added by the Small Business Regulatory Enforcement Fairness Act of 1996, EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives and the Comptroller General of the General Accounting Office; however, in accordance with 5 U.S.C. 808(2), this rule is effective on September 8, 1998. This rule is not a

"major rule" as defined in 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 142

Environmental protection,
Administrative practice and procedure.

Dated: August 24, 1998.

Carol M. Browner,
Administrator.

For the reasons set out in the preamble, title 40, chapter I of the Code of Federal Regulations is amended as follows:

PART 142—[AMENDED]

1. The authority citation for part 142 continues to read as follows:

Authority: 42 U.S.C. 300g, 300g-1, 300g-2, 300g-3, 300g-4, 300g-5, 300g-6, 300j-4, and 300j-9.

2. Part 142 is amended by removing and reserving Subpart J (§§ 142.201 through 142.208).

[FR Doc. 98-23204 Filed 9-4-98; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 135

[FRL-6121-6]

RIN 2020-AA35

Safe Drinking Water Public Water System Program; Citizen Collection Action; Notice of Complaint Seeking Review of Penalty Order

AGENCY: Environmental Protection Agency.

ACTION: Proposed rule.

SUMMARY: The Safe Drinking Water Act Amendments of 1996 ("1996 Amendments") amended Section 1449 of the Safe Drinking Water Act (SDWA) to authorize any person to bring suit to collect for the United States an outstanding penalty assessed by the Administrator that a federal agency has failed to pay for at least eighteen months. The Amendments also require as a precondition to the collection action that the citizen plaintiff shall give sixty days' notice of its complaint to the Attorney General and the federal agency, and that the Administrator shall prescribe the manner of such notice by regulation.

EPA is today proposing regulations governing the manner in which parties in citizen suits must provide such sixty day notice under this new provision.

The 1996 Amendments also amended Section 1447 of the SDWA to authorize any interested person to obtain review of an administrative penalty order issued under that section of the law by filing a complaint with either the United States District Court for the District of Columbia or the United States District Court for the district in which the violation is alleged to have occurred within the thirty day period beginning on the date the penalty order becomes final, and by requiring such a person to simultaneously send a copy of the complaint by certified mail to the Administrator and to the Attorney General.

EPA is also today proposing regulations governing the manner in which such a petitioner must provide copies of such a complaint.

DATES: Comments on the proposed rule must be received by October 23, 1998.

ADDRESSES: Send comments to: David Drelich (2243A), Water Enforcement Division, Office of Enforcement and Compliance Assurance, U.S. Environmental Protection Agency, 401 M Street, S.W. Washington, D.C. 20460. Persons may, upon reasonable notice, inspect all comments and the record of

this rulemaking at Room 3124A, Ariel Rios Building, 12th and Pennsylvania Avenue, N.W. during normal Agency working hours.

FOR FURTHER INFORMATION CONTACT: David Drelich at (202) 564-2949, or at the address provided above.

SUPPLEMENTARY INFORMATION: Section 1449 of the Safe Drinking Water Act (SDWA or the Act) (42 U.S.C. 300j-8) authorizes any person on his own behalf to commence a civil action against any federal agency that fails to pay an administrative penalty by eighteen months after the effective date of such an administrative penalty order issued under the Act by the Administrator. No such action may be commenced under this citizen suit provision prior to 60 days after the citizen plaintiff has given notice to the Attorney General and the federal agency of the intent to file the collection action.

Specifically, Congress amended SDWA Section 1449(a), 42 U.S.C. 300j-8(a), by adding to it a paragraph (a)(3) that reads:

"(3) for the collection of a penalty by the United States Government (and associated costs and interest) against any Federal agency that fails, by the date that is 18 months after the effective date of a final order to pay a penalty assessed by the Administrator under section 300j-8 of this title [sic],¹ to pay the penalty."

Congress also amended Section 1449(b) of the Act, 42 U.S.C. 300j-8(b), by striking the period at the end of paragraph (2) and inserting "; or" and by adding the following new paragraph (3):

"under subsection (a)(3) prior to 60 days after the plaintiff has given notice of such action to the Attorney General and to the Federal agency."

Section 1449(b) provides that notice must be given in the manner prescribed by the Administrator. As a result, EPA is today proposing to amend 40 CFR part 135 to spell out how notice is to be given for such citizen collection actions, as well as for other citizen suits

¹ Since "section 300j-8 of this title" is self-referential and has no collateral relevance to administrative enforcement against Federal agencies, EPA understands this reference to be a typographical error, intended instead to refer to section 300j-6 of title 42 (Section 1447 of the Act), which includes the pertinent provision relating to the Agency's imposition of an administrative civil penalty against a Federal agency. 3 C. Sands, Sutherlands Statutes and Statutory Construction § 60.01-.05 (4th ed. 1973) (all words of a law are to be read to have an effect). A predecessor cross-reference in the earlier Committee Print of the Conference Report of the 1996 SDWA Amendments was unhelpful; it referred to a different, unrelated provision that EPA also understands to have been a typographical error. That reference was to Section 1429(b) of the Act, which relates to the State Groundwater Protection Grants program.

authorized under the SDWA. See amended Section 1449(b). Pursuant to this statutory duty, even though the citizen suit notice requirement of Section 1449(b)(3) is self implementing, the Environmental Protection Agency (EPA or the Agency) is proposing to amend 40 CFR part 135 in order to clarify the statutory requirement and to ensure that the amendment will be implemented consistently. Procedures for those other types of citizen suits are set forth at 40 CFR part 135, subpart B, and were first published at 54 FR 20771 (May 12, 1989). One purpose of this proposed rulemaking is to propose notice procedures that will be consistent with 40 CFR part 135, subpart B.

Today's proposed rule is straightforward. Citizen plaintiffs are required to send copies of sixty day notices to the Attorney General of the United States and to the officer of the federal agency who is already in receipt of the unpaid administrative penalty order.

Penalties and interest paid as a result of a citizen suit collection action accrue to the United States Treasury pursuant to the Miscellaneous Receipts Act, 31 U.S.C. 3302. Payment of a penalty elsewhere would violate the Anti-Deficiency Act, 31 U.S.C. 1512. This limitation does not affect payment of associated costs (such as court costs and attorneys' fees).

Section 1447 of the Act authorizes any interested person to obtain review of an administrative penalty order issued under that section of the law by filing a complaint with either the United States District Court for the District of Columbia or the United States District Court for the district in which the violation is alleged to have occurred within the thirty day period beginning on the date the penalty order becomes final, and by requiring such a person to simultaneously send a copy of the complaint by certified mail to the Administrator and to the Attorney General.

The Conference Report, Section 129(a), amended SDWA Section 1447 in relevant part as follows:

Section 1447 (42 U.S.C. 300j-6) is amended by striking subsection * * *

(b) and inserting the following:

* * * * *

"(4) PUBLIC REVIEW. —

"(A) IN GENERAL. —Any interested person may obtain review of an administrative penalty order issued under this subsection. The review may be obtained in the United States District Court for the District of Columbia or in the United States District Court for the district in which the violation is alleged to have occurred by the filing of a complaint with the court within

the 30-day period beginning on the date the penalty order becomes final. The person filing the complaint shall simultaneously send a copy of the complaint by certified mail to the Administrator and the Attorney General."

Consequently, and even though this provision of law is self implementing, the Agency is also proposing to amend 40 CFR Part 135 in order to clarify the statutory requirement and to ensure that the amendment will be implemented consistently. One purpose of this rulemaking is to propose complaint service procedures that are consistent both with Section 1447 of the SDWA and the procedures set forth in subpart A of part 135 (concerning complaint service under the Clean Water Act). Today's proposal is simply stated: Petitioners for judicial review of a Section 1447 administrative penalty order are to send copies of the complaint to the appropriate federal officials by certified mail on the same day that they are sent to, or filed with, the appropriate district court.

Paperwork Reduction Act

EPA has not prepared an information collection request under the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*) for the reporting requirements contained in this rule. EPA has received very few notices of citizens suits under the SDWA annually. The public reporting burden for individuals complying with this rule is estimated to average one hour or less. If the number of notices under SDWA section 1449(b)(3) or complaints under SDWA section 1447(b) received by the United States substantially increases in succeeding years, EPA will prepare and solicit comment on an information collection request for today's rule, in accordance with 5 CFR 1320.14. In the meantime, any comments on the estimate of burden or any other aspect of the information collection requirements contained in this rule, including suggestions to reduce the burden, should be sent to: Chief, Information Policy Branch (PM-223), U.S. Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460 or Director, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Regulatory Impact Analysis

The Administrator has determined that this is a minor regulation under the terms of E.O. 12291 and does not require a regulatory impact analysis.

Other Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this proposed

action is not a "significant regulatory action" and is therefore not subject to review by the Office of Management and Budget. In addition, the proposal would not impose any enforceable duty or contain any unfunded mandate as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), or require prior consultation with State officials as specified by Executive Order 12875 (58 FR 58093, October 28, 1993), or involve special consideration of environmental justice related issues as required by Executive Order 12898 (59 FR 7629, February 16, 1994). Further, today's proposal would not raise any environmental safety or health issue for children as described in Executive Order 13045 (Children's Health Protection).

Under the Regulatory Flexibility Act (RFA), 5 U.S.C. 601 *et seq.*, as amended by SBREFA, whenever EPA is required by section 553 of the Administrative Procedure Act or any other law to publish a general notice of rulemaking for any proposed rule, EPA generally must prepare an initial regulatory flexibility analysis describing the impact of the rule on small entities. Under section 605(b) of the RFA, however, if EPA certifies that the proposed rule will not have a significant economic impact on a substantial number of small entities, EPA is not required to prepare the analysis.

The changes to citizen suit procedures proposed today affect only federal facilities, and therefore will have no impact on small entities if EPA adopts them. Consequently, pursuant to section 605(b) of the RFA, the Administrator certifies that this proposed rule, if promulgated, will not have a significant impact on a substantial number of small entities.

This proposed regulation has been reviewed by the Office of Management and Budget.

List of Subjects in 40 CFR Part 135

Environmental protection, Administrative practice and procedure, water pollution control.

Dated: August 24, 1998.

Carol M. Browner,
Administrator.

It is proposed that part 135 of title 40, chapter I of the Code of Federal Regulations be amended as follows:

PART 135—[AMENDED]

1. The authority citation for part 135 is revised to read as follows:

Authority: Subpart A issued under sec. 504, Pub. L. 100-4; 101 Stat. 7 (33 U.S.C. 1365). Subpart B issued under sec. 129, Pub.

L. 104-182; 110 Stat. 1613 (42 U.S.C. 300j-8).

2. Section 135.10 is amended, by designating the existing text as paragraph (a); by adding paragraphs (b) and (c); and, by revising in newly designated paragraph (a) the phrase "The purpose of this subpart" to read "One purpose of this subpart", to read as follows:

§135.10 Purpose.

* * * * *

(b) Section 1449 of the Act authorizes any person, upon no less than sixty days notice, to commence a civil action for the collection of a penalty by the United States Government (and associated costs and interest) against any federal agency that fails, by a date that is 18 months after the effective date of a final order to pay a penalty assessed by the Administrator under the Act, to pay the penalty. No citizen suit may be commenced under this provision prior to both 18 months after the effective date of a final order to a federal agency to pay a penalty assessed by the Administrator under the Act and sixty days' written notice of such action to both the Attorney General and the federal agency owing the assessed penalty. One purpose of this subpart is to prescribe procedures for giving such notice.

(c) Section 1447 of the Act authorizes any interested person to obtain judicial review of an administrative penalty order issued under that section in the United States District Court for the District of Columbia or in the United States District Court for the district in which the violation is alleged to have occurred by filing a complaint with the court within the thirty day period beginning on the date the penalty order becomes final, and requires such person to simultaneously send a copy of the complaint by certified mail to the Administrator and the Attorney General. One purpose of this subpart is to prescribe procedures for the service of copies of such a complaint upon the Administrator and the Attorney General.

3. Section 135.11 is amended by redesignating paragraph (c) as paragraph (d) and adding a new paragraph (c) to read as follows:

§135.11 Service of notice.

* * * * *

(c) Service of notice of intent to file suit pursuant to section 1449(a)(3) of the Act shall be accomplished by certified mail, return receipt requested, addressed to, or by personal service upon, all federal agency officials named by the Administrator as responsible in their official capacity for the payment of

the uncollected penalty order, if any, and the chief executive officer of such agency, and by sending a copy of the notice by certified mail to the Attorney General of the United States.

* * * * *

4. Section 135.12 is amended by redesignating paragraph (c) as paragraph (d) and adding a new paragraph (c) to read as follows:

§ 135.12 Contents of notice.

* * * * *

(c) *Collection action.* Notice regarding an alleged failure of a federal agency to have paid an administrative penalty, by a date that is 18 months after the effective date of a final order by the Administrator assessing such a penalty under the Act, shall include a copy of the final EPA order assessing the penalty, shall state the date that is 18 months following the effective date of

such order, and shall state the full name, address and telephone number of the person giving notice.

* * * * *

5. Section 135.13 is amended by revising the phrase “section 1449(a)(1) or (a)(2)” to read “section 1449(a) of the Act” and by adding the following sentence after the first sentence:

Notice may be given under section 1449(b) at any time after the effective date of a final order by EPA assessing a penalty against a federal agency, if the penalty has not been paid. * * *

§ 135.13 Timing of notice.

* * * * *

6. A new § 135.14 is added to read as follows:

§ 135.14 Service of Complaint Seeking Review of Penalty Order

(a) An interested person filing a complaint seeking review of an

administrative penalty order issued pursuant to section 1447(b)(4) of the Act shall by certified mail send a copy of such complaint to the Administrator of the Environmental Protection Agency, the Regional Administrator of the EPA Region in which the violations are alleged to have occurred, and the Attorney General of the United States.

(b) Such petitioner shall by certified mail send a copy of the complaint on the same date on which the plaintiff files the complaint with the court.

(c) In addition to complying with the service requirements of this subsection, such petitioner shall serve the complaint on the appropriate officials of the United States in accordance with relevant Federal law and court rules affecting service on defendants.

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3 (1997 Compilation and Parts 100 and 101)	(869-034-00002-9)	19.00	¹ Jan. 1, 1998
4	(869-034-00003-7)	7.00	⁵ Jan. 1, 1998
5 Parts:			
1-699	(869-034-00004-5)	35.00	Jan. 1, 1998
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1200-End, 6 (6 Reserved)	(869-034-00006-1)	39.00	Jan. 1, 1998
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500-899	(869-034-00102-5)	40.00	July 1, 1998	1, 1-1 to 1-10		13.00	3 July 1, 1984
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30 Parts:				18, Vol. III, Parts 20-52		13.00	3 July 1, 1984
1-199	(869-034-00109-2)	33.00	July 1, 1998	19-100		13.00	3 July 1, 1984
200-699	(869-032-00110-3)	28.00	July 1, 1997	1-100	(869-034-00157-2)	13.00	July 1, 1998
700-End	(869-032-00111-1)	32.00	July 1, 1997	101	(869-032-00157-0)	36.00	July 1, 1997
31 Parts:				102-200	(869-032-00158-8)	17.00	July 1, 1997
0-199	(869-034-00112-2)	20.00	July 1, 1998	201-End	(869-032-00159-6)	15.00	July 1, 1997
200-End	(869-032-00113-8)	42.00	July 1, 1997	42 Parts:			
32 Parts:				1-399	(869-032-00160-0)	32.00	Oct. 1, 1997
1-39, Vol. I		15.00	2 July 1, 1984	400-429	(869-032-00161-8)	35.00	Oct. 1, 1997
1-39, Vol. II		19.00	2 July 1, 1984	430-End	(869-032-00162-6)	50.00	Oct. 1, 1997
1-39, Vol. III		18.00	2 July 1, 1984	43 Parts:			
1-190	(869-032-00114-6)	42.00	July 1, 1997	1-999	(869-032-00163-4)	31.00	Oct. 1, 1997
191-399	(869-032-00115-4)	51.00	July 1, 1997	1000-end	(869-032-00164-2)	50.00	Oct. 1, 1997
400-629	(869-032-00116-2)	33.00	July 1, 1997	44	(869-032-00165-1)	31.00	Oct. 1, 1997
630-699	(869-032-00117-1)	22.00	July 1, 1997	45 Parts:			
700-799	(869-032-00118-9)	28.00	July 1, 1997	1-199	(869-032-00166-9)	30.00	Oct. 1, 1997
800-End	(869-032-00119-7)	27.00	July 1, 1997	200-499	(869-032-00167-7)	18.00	Oct. 1, 1997
33 Parts:				500-1199	(869-032-00168-5)	29.00	Oct. 1, 1997
1-124	(869-032-00120-1)	27.00	July 1, 1997	1200-End	(869-032-00169-3)	39.00	Oct. 1, 1997
125-199	(869-032-00121-9)	36.00	July 1, 1997	46 Parts:			
200-End	(869-034-00122-0)	30.00	July 1, 1998	1-40	(869-032-00170-7)	26.00	Oct. 1, 1997
34 Parts:				41-69	(869-032-00171-5)	22.00	Oct. 1, 1997
1-299	(869-032-00123-5)	28.00	July 1, 1997	70-89	(869-032-00172-3)	11.00	Oct. 1, 1997
300-399	(869-032-00124-3)	27.00	July 1, 1997	90-139	(869-032-00173-1)	27.00	Oct. 1, 1997
400-End	(869-032-00125-1)	44.00	July 1, 1997	140-155	(869-032-00174-0)	15.00	Oct. 1, 1997
35	(869-032-00126-0)	15.00	July 1, 1997	156-165	(869-032-00175-8)	20.00	Oct. 1, 1997
36 Parts				166-199	(869-032-00176-6)	26.00	Oct. 1, 1997
1-199	(869-034-00127-1)	20.00	July 1, 1998	200-499	(869-032-00177-4)	21.00	Oct. 1, 1997
200-299	(869-032-00128-6)	21.00	July 1, 1997	500-End	(869-032-00178-2)	17.00	Oct. 1, 1997
300-End	(869-032-00129-4)	34.00	July 1, 1997	47 Parts:			
37	(869-032-00130-8)	27.00	July 1, 1997	0-19	(869-032-00179-1)	34.00	Oct. 1, 1997
38 Parts:				20-39	(869-032-00180-4)	27.00	Oct. 1, 1997
0-17	(869-034-00131-9)	34.00	July 1, 1998	40-69	(869-032-00181-2)	23.00	Oct. 1, 1997
18-End	(869-032-00132-4)	38.00	July 1, 1997	70-79	(869-032-00182-1)	33.00	Oct. 1, 1997
39	(869-034-00133-5)	23.00	July 1, 1998	80-End	(869-032-00183-9)	43.00	Oct. 1, 1997
40 Parts:				48 Chapters:			
1-49	(869-032-00134-1)	31.00	July 1, 1997	1 (Parts 1-51)	(869-032-00184-7)	53.00	Oct. 1, 1997
50-51	(869-032-00135-9)	23.00	July 1, 1997	1 (Parts 52-99)	(869-032-00185-5)	29.00	Oct. 1, 1997
52 (52.01-52.1018)	(869-032-00136-7)	27.00	July 1, 1997	2 (Parts 201-299)	(869-032-00186-3)	35.00	Oct. 1, 1997
52 (52.1019-End)	(869-032-00137-5)	32.00	July 1, 1997	3-6	(869-032-00187-1)	29.00	Oct. 1, 1997
53-59	(869-032-00138-3)	14.00	July 1, 1997	7-14	(869-032-00188-0)	32.00	Oct. 1, 1997
60	(869-032-00139-1)	52.00	July 1, 1997	15-28	(869-032-00189-8)	33.00	Oct. 1, 1997
61-62	(869-032-00140-5)	19.00	July 1, 1997	29-End	(869-032-00190-1)	25.00	Oct. 1, 1997
63-71	(869-032-00141-3)	57.00	July 1, 1997	49 Parts:			
64-71	(869-034-00142-4)	11.00	July 1, 1998	1-99	(869-032-00191-0)	31.00	Oct. 1, 1997
72-80	(869-032-00142-1)	35.00	July 1, 1997	100-185	(869-032-00192-8)	50.00	Oct. 1, 1997
81-85	(869-032-00143-0)	32.00	July 1, 1997	186-199	(869-032-00193-6)	11.00	Oct. 1, 1997
86	(869-032-00144-8)	50.00	July 1, 1997	200-399	(869-032-00194-4)	43.00	Oct. 1, 1997
87-135	(869-032-00145-6)	40.00	July 1, 1997	400-999	(869-032-00195-2)	49.00	Oct. 1, 1997
136-149	(869-032-00146-4)	35.00	July 1, 1997	1000-1199	(869-032-00196-1)	19.00	Oct. 1, 1997
150-189	(869-032-00147-2)	32.00	July 1, 1997	1200-End	(869-032-00197-9)	14.00	Oct. 1, 1997
190-259	(869-032-00148-1)	22.00	July 1, 1997	50 Parts:			
260-265	(869-032-00149-9)	29.00	July 1, 1997	1-199	(869-032-00198-7)	41.00	Oct. 1, 1997
				200-599	(869-032-00199-5)	22.00	Oct. 1, 1997
				600-End	(869-032-00200-2)	29.00	Oct. 1, 1997

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¹ Because Title 3 is an annual compilation, this volume and all previous volumes should be retained as a permanent reference source.

² The July 1, 1985 edition of 32 CFR Parts 1-189 contains a note only for Parts 1-39 inclusive. For the full text of the Defense Acquisition Regulations in Parts 1-39, consult the three CFR volumes issued as of July 1, 1984, containing those parts.

³ The July 1, 1985 edition of 41 CFR Chapters 1-100 contains a note only for Chapters 1 to 49 inclusive. For the full text of procurement regulations in Chapters 1 to 49, consult the eleven CFR volumes issued as of July 1, 1984 containing those chapters.

⁴ No amendments to this volume were promulgated during the period July 1, 1996 to June 30, 1997. The volume issued July 1, 1996, should be retained.

⁵ No amendments to this volume were promulgated during the period January 1, 1997 through December 31, 1997. The CFR volume issued as of January 1, 1997 should be retained.

⁶ No amendments to this volume were promulgated during the period April 1, 1997, through April 1, 1998. The CFR volume issued as of April 1, 1997, should be retained.