DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 419, and 489

[CMS–1159–F2]

RIN 0938–AK54

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002

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

ACTION: Final rule.

SUMMARY: This final rule revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements, including relevant provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and changes arising from our continuing experience with this system. In addition, it describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. This final rule also announces a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments. These changes are applicable to services furnished on or after January 1, 2002.

EFFECTIVE DATE: This final rule is effective January 1, 2002 and is applicable to services furnished on or after January 1, 2002.

FOR FURTHER INFORMATION CONTACT: George Morey (410) 786–4653, for provider-based issues; and Nancy Edwards (410) 786–0378, for all other issues.

SUPPLEMENTARY INFORMATION:

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Information on the outpatient prospective payment system can be found on our homepage. You can access these data by using the following directions:

1. Go to CMS homepage (*http://www.cms.hhs.gov*).
2. Click on ''Professionals.''
3. Under the heading ''Physicians and Health Care Professionals,'' click on ''Medicare Coding and Payment Systems.''
4. Select Hospital Outpatient Prospective Payment System.

Or, you can go directly to the Hospital Outpatient Prospective Payment System page by typing the following: *http://www.hcfa.gov/medicare/hopsmain.htm.*

To assist readers in referencing sections contained in this document, we are providing the following table of contents.

Outline of Contents

Alphabetical List of Acronyms Appearing in the Proposed Rule

APC Ambulatory payment classification
APG Ambulatory patient group
ASC Ambulatory surgical center
AWP Average wholesale price
BBA 1997 Balanced Budget Act of 1997
BBRA 1999 Balanced Budget Refinement Act of 1999
BIPA 2000 Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CAH Critical access hospital
CAT Computerized axial tomography
CCI Correct Coding Initiative
CCR Cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CORF Comprehensive outpatient rehabilitation facility
CPI Consumer Price Index
CPT (Physician's) Current Procedural Terminology, Fourth Edition, 2001, copyrighted by the American Medical Association
DME Durable medical equipment
DMEPOS DME, prosthetics (which include prosthetic devices and implants), orthotics, and supplies
DRG Diagnosis-related group
EMTALA Emergency Medical Treatment and Active Labor Act
FDA Food and Drug Administration
FQHC Federally qualified health center
HCPCS Healthcare Common Procedure Coding System
HHA Home health agency
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect medical education
JCAHO Joint Commission on Accreditation of Healthcare Organizations
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OPPS Hospital outpatient prospective payment system
PPS Prospective payment system
RFA Regulatory Flexibility Act
RHC Rural health clinic
RRC Rural referral center
SCH Sole community hospital
SNF Skilled nursing facility

I. Background

A. Authority

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services. The Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, made major changes that affected the hospital outpatient PPS (OPPS). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), enacted on December 21, 2000, made further changes in the OPPS. The BIPA provisions that affect the OPPS are summarized below, in section I.C. The OPPS was first implemented for services furnished on or after August 1, 2000.

B. Summary of Rulemaking

- On September 8, 1998, we published a proposed rule (63 FR 47552) to establish in regulations a PPS for hospital outpatient services, to eliminate the formula-driven overpayment for certain hospital outpatient services, and to extend reductions in payment for costs of hospital outpatient services. On June 30, 1999, we published a correction notice (64 FR 35258) to correct a number of technical and typographic errors in the September 1998 proposed rule including the proposed amounts and factors used to determine the payment rates.
- On April 7, 2000, we published a final rule with comment period (65 FR 18438) that addressed the provisions of the PPS for hospital outpatient services scheduled to be effective for services furnished on or after July 1, 2000. Under this system, Medicare payment for hospital outpatient services included in the PPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of ambulatory payment classifications (APCs). The April 7 final rule with comment period also established requirements for provider departments and provider-based entities and prohibited 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 arrangement. In addition, this rule extended reductions in payment for costs of hospital outpatient services as required by the BBA of 1997 and amended by the BBRA of 1999. Medicare regulations governing the hospital OPPS are set forth at 42 CFR 419.
- On June 30, 2000, we published a notice (65 FR 40535) announcing a delay in implementation of the OPPS from July 1, 2000 to August 1, 2000.
- On August 3, 2000, we published an interim final rule with comment period (65 FR 47670) that modified criteria that we use to determine which medical devices are eligible for transitional pass-through payments. The August 3, 2000 rule also corrected and clarified certain provider-based provisions included in the April 7, 2000 rule.
- On November 13, 2000, we published an interim final rule with comment period (65 FR 67798). This rule provided for the annual update to the amounts and factors for OPPS payment rates effective for services furnished on or after January 1, 2001. We also responded to public comments on those portions of the April 7, 2000 final rule that implemented related provisions of the BBRA and public comments on the August 3, 2000 rule.
- On August 24, 2001, we published a proposed rule (66 FR 44672) that set forth proposed changes to the Medicare hospital OPPS and calendar year (CY) 2002 payment rates. It also set forth proposed changes to the amounts and factors used to determine these payment rates.

C. Summary of Changes in the August 24, 2001 Proposed Rule

On August 24, 2001, we published a proposed rule (66 FR 44672) that set forth proposed changes to the Medicare hospital OPPS and CY 2002 payment rates including changes to the amounts and factors used to determine these payment rates.

The following is a summary of the major changes that we proposed and the

issues we addressed in the August 24, 2001 proposed rule.

1. Changes Required by BIPA 2000

We proposed the following changes to the OPPS, to implement the provisions of BIPA 2000:

- Limit coinsurance to a specified percentage of APC payment amounts.
- Provide hold-harmless payments to children's hospitals.
- Provide separate APCs for services that use contrast agents and those that do not.
- Payment for glaucoma screening as a covered service.
- Payment for certain new technology used in diagnostic mammograms.

2. Additional Changes

We proposed the following additional changes to the OPPS:

- Add APCs, delete APCs, and modify the composition of services within some existing APCs.
- Add an APC group that would provide separate payment for observation services in limited circumstances to patients having specific diagnoses.
- Recalibrate the relative payment weights of the APCs.
- Update the conversion factor and wage index.
- Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights and the other required updates and adjustments.
- Make reductions in pass-through payments for specific drugs and categories of devices to account for the drug and device costs that are included in the APC payment for associated procedures and services.
- Apply a standard procedure to calculate copayment amounts when new APCs are created or when APC payment rates are increased or decreased as a result of recalibrated relative weights.
- Calculate outlier payments on a service-by-service basis beginning in 2002. We also proposed a methodology for allocating packaged services to individual APCs in determining costs of a service and we proposed to use a hospital's overall outpatient cost-to-charge ratio to convert charges to costs.
- Set the threshold for outlier payments to require costs to exceed 3 times the APC payment amount and payment at 50 percent of any excess costs above the threshold.
- Exclude hospitals located outside the 50 states, the District of Columbia and Puerto Rico from the OPPS.
- Exclude from payment under the OPPS certain services that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.
- Make conforming changes to regulations text to reflect the exclusion from the OPPS of certain items and services (for example, bad debts, direct medical education and certain certified registered nurse anesthetists services) that are paid on a cost basis.
- Update the payments for pass-through radiopharmaceuticals, drugs, and biologicals on a calendar year basis to reflect increases in AWP.
- Allow reprocessed single use devices to be considered eligible for pass-through payments if the reprocessing process for single use devices meets the FDA's most recent criteria.
- Revise the criteria we will use to determine whether a procedure or service is eligible to be assigned to a new technology APC.
- Revise the list of information that must be submitted to request assignment of a service or procedure to a new technology APC.
- Provide more flexibility in the amount of time a service may be paid under a new technology APC.
- A description of the Secretary's estimate of the total amount of pass-through payments for CY 2002 and the need for a pro rata reduction to those payments in that year.

3. Provider-Based Changes

We proposed to make changes to the provider-based regulations to reflect the provisions of section 404 of BIPA and to codify certain clarifications on provider-based status that were posted on the CMS Web site.

D. Public Comments Received in Response to the August 24, 2001 Proposed Rule

We received approximately 400 timely items of correspondence containing multiple comments on the proposed rule. Major issues addressed by the commenters included the following:

- The implementation of a uniform reduction in the transitional pass-through payments for CY 2002.
- Changes to APC classifications and weights for certain outpatient services including mammography, stereotactic radiosurgery and intensity modulated radiation therapy, and positive emission tomography (PET) scans.
- Changes to the eligibility criteria for payment as a new technology service.

On November 2, 2001, we published a final rule (66 FR 55857) that responded to the comments on the Secretary's estimate of the total amount of transitional pass-through payments for CY 2002 and the need for a uniform reduction in the pass-through payments for that year as well as comments on the proposed conversion factor for CY 2002. That final rule announced that the conversion factor for CY 2002 is $50.904 and that the Secretary is implementing a pro rata reduction in 2002 (expected to be between 65 and 70 percent) to each pass-through payment (we stated that we would announce the exact amount of the reduction before the beginning of 2002).

Summaries of the remaining public comments received and our responses to those comments are set forth below under the appropriate heading. In addition, we are announcing that the pro rata reduction is 68.9 percent.

II. Changes to the APC Groups and Relative Weights

Under the OPPS, we pay for hospital outpatient services on a rate per service basis that varies according to the APC group to which the service is assigned. Each APC weight represents the median hospital cost of the services included in that APC relative to the median hospital cost of the services included in APC 0601, Mid-Level Clinic Visits. As described in the April 7, 2000 final rule (65 FR 18484), the APC weights are scaled to APC 0601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less often than annually and to revise the groups and related payment adjustment factors to take into account changes in medical practice, changes in technology, and the addition of the new services, new cost data, and other relevant information. Section 1833(t)(9)(A) of the Act requires the Secretary, beginning in 2001, to consult with an outside panel of experts when annually reviewing and updating the APC groups and the relative weights.

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

unusual cases, such as low volume items and services.''

For the proposed rule and for this final rule, we analyzed the APC groups within this statutory framework.

A. Recommendations of the Advisory Panel on APC Groups

1. Establishment of the Advisory Panel

Section 1833(t)(9)(A) of the Act, which requires that we consult with an outside panel of experts when annually reviewing and updating the APC groups and the relative weights, specifies that the panel will act in an advisory capacity. The expert panel, which is to be composed of representatives of providers, is to review and advise us about the clinical integrity of the APC groups and their weights. The Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

On November 21, 2000, the Secretary signed the charter establishing an ''Advisory Panel on APC Groups'' (the Panel). The Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA) as amended (Public Law 92–463). To establish the Panel, we solicited members in a notice published in the **Federal Register** on December 5, 2000 (65 FR 75943). We received applications from more than 115 individuals nominating either themselves or a colleague. After carefully reviewing the applications, CMS chose 15 highly qualified individuals to serve on the Panel. The Panel was convened for the first time on February 27, February 28, and March 1, 2001. We published a notice in the **Federal Register** on February 12, 2001 (66 FR 9857) to announce the location and time of the Panel meeting, a list of agenda items, and that the meeting was open to the public. We also provided additional information through a press release and our website.

2. Specific Recommendations of the Advisory Panel and Our Responses

In the proposed rule, we summarized the issues considered by the Panel, the Panel's APC recommendations, and our subsequent action with regard to the Panel's recommendations. The data used by the Panel in making its recommendation are the 1996 claims that were used to set the APC weights and payment rates for CY 2000 and 2001. In the proposed rule, we provided a detailed summary of the Panel discussion and recommendations (66 FR 44675–44686). See the proposed rule for more details regarding these discussions.

As discussed below, the Panel sometimes declined to recommend a change in an APC even though the APC violated the 2 times rule. In section II.C.3 of this preamble, we discuss our policies regarding the 2 times rule based on the data we are using to recalibrate the 2002 APC relative weights (that is, claims for services furnished on or after July 1, 1999 and before July 1, 2000). That section also details the criteria we use in deciding to make an exception to the 2 times rule. We asked the Panel to review many of the exceptions we implemented in 2000 and 2001. The exceptions are referred to as ''violations of the 2 times'' rule in the following discussion.

We did not receive comments on the APC changes we proposed based on the recommendations of the Panel except for our proposal regarding stereotactic radiosurgery (APCs 0300 and 0302). We discuss that proposal in detail below along with the comments and our responses. For all other APC Panel proposed changes, we briefly discuss the Panel's recommendation, our proposal, and the final changes we have made. We also received comments on APCs and the assignment of codes to APCs for which we made no specific proposal in the proposed rule. We address those comments below in section II.A.3. of this preamble.

APC 0016: Level V Debridement & Destruction

APC 0017: Level VI Debridement & Destruction

We asked the Panel to review the current placement of CPT code 56501, Destruction of lesion(s), vulva; simple, any method, in APC 0016 because the APC violates the 2 times rule. Because the procedure is a simple destruction of skin and superficial subcutaneous tissues, we will not expect it to have a median cost of $500. Thus, we believe that the higher costs associated with this code were the result of incorrect coding. To ensure that procedures in APC 0016 comply with the 2 times rule, we asked the Panel to consider one of the following clinical options:

- Move CPT code 56501 to APC 0017.
- Retain CPT code 56501 in APC 0016 but split APC 0016 into three APCs to distinguish simple destruction lesions from extensive destruction lesions.

The Panel recommended the following:

- Move CPT code 56501 from APC 0016 to APC 0017.
- Move CPT code 46917 from APC 0014 to APC 0017.

After considerable discussion the Panel recommended these changes to achieve clinical coherence and resource similarity among the procedures assigned to these APCs. Because CPT code 46917 is performed using laser equipment and requires anesthesia, the Panel believed it appropriate to move this procedure to APC 0017. Although the Panel considered the reassignment of CPT code 54055 to APC 0017, it did not recommend this change. The Panel's recommended changes will group in APC 0017 simple destruction of lesion procedures that use laser or surgical techniques with extensive destruction of lesion procedures.

We proposed to accept the Panel's recommendation regarding CPT code 56501 and to revise the APC accordingly. We are adopting these changes in final; however, as shown below in Table 3, we are making additional changes to these APCs because of the 2 times rule.

APC 0024: Level I Skin Repair

APC 0025: Level II Skin Repair

APC 0026: Level III Skin Repair

APC 0027: Level IV Skin Repair

The composition of procedures in APCs 0025 and 0027 results in these APCs violating the 2 times rule. Therefore, we requested the Panel's advice in exploring other clinical options for reconfiguring the four skin repair APCs to achieve clinical and resource homogeneity among the procedures assigned to APCs 0025 and 0027 while retaining clinical and resource homogeneity for APCs 0024 and 0026. We asked the Panel to consider the following clinical options to achieve this result:

- Rearrange the procedures assigned to APCs 0024 through 0027 based on the size or the length of the skin incision.
- Rearrange the procedures assigned to APCs 0024 through 0027 based on the complexity of the repair, such as distinguishing repairs that involve layers of skin, flaps, or grafts from those that do not.

The Panel reviewed the various options presented, which were modeled based on the 1996 claims data used in constructing the current APC groups and payment rates. The Panel recommended the following:

- Make no changes to APCs 0024 and 0027.
- Reevaluate these APCs with new data when the Panel meets in 2002.
- The Panel, in preparation for the 2002 meeting, will discuss options with and gather clinical and utilization information from their respective hospitals regarding these procedures.

We proposed to accept the Panel's recommendations. We are adopting these recommendations as final; however, as discussed below in section II.C., we are making additional changes to these APCs based on the use of new data and application of the 2 times rule.

APC 0058: Level I Strapping and Casting Application

APC 0059: Level II Strapping and Casting Application

APC 0058 (which consists of the simpler casting, splinting, and strapping procedures) violates the 2 times rule. The median costs for high volume procedures in APC 0058 vary widely, ranging from $27 to $83. The median costs associated with presumably more resource-intensive procedures in APC 0059 are fairly uniform, ranging from $69 to $119. To limit the cost variation in APC 0058, we asked the Panel to consider the following options:

- Move the following four codes from APC 0058 to APC 0059: CPT code 29515, Application of short splint (calf to foot); CPT code 29520, Strapping; hip; CPT code 29530, Strapping; knee; and CPT code 29590, Denis-Brown splint strapping.
- Create a new APC to include a third level of strapping and casting application procedures by regrouping all procedures assigned to both APCs 0058 and 0059 based on the following clinical distinctions: removal/revision, strapping/splinting, and casting.
- Package certain CPT codes assigned to APC 0058 with relevant procedures.

The Panel recommended that we do the following:

- Make no changes to APC 0058.
- Provide appropriate education and guidance to hospitals regarding appropriate use and billing of codes in APC 0058.
- Resubmit APC 0058 to the Panel for reevaluation when later data are available.

We proposed to accept the Panel's recommendations except that we proposed to move CPT code 29515 to APC 0059 due to the 2 times rule and the newer data we are using for this rule. These changes have been adopted as final in this document.

APC 0079: Ventilation Initiation and Management

The codes in APC 0079 represent respiratory treatment and support provided in the outpatient setting. The cost variation among the assigned procedures in this APC raises concern about hospital coding practices. The median costs for these procedures range from $40 to $315. We asked the Panel to clarify whether these procedures are performed on outpatients or if they are performed on patients who come to the emergency room and are later admitted to the hospital as inpatients.

The Panel recommended the following:

- Remove CPT code 94660 from APC 0079 and create a new APC for this one procedure.

We proposed to accept the Panel's recommendation by creating a new APC 0065, CPAP Initiation. We have adopted this change in this final rule.

APC 0094: Resuscitation and Cardioversion

We requested the Panel's assistance in determining whether it is clinically appropriate to remove the cardioversion procedures from APC 0094 because the rest of the procedures assigned to APC 0094 are emergency procedures rather than elective. We proposed that the Panel consider the creation of a new APC for the cardioversion procedures or reassignment of the procedures to another APC that would be more appropriate in terms of clinical coherence and resource similarity. Splitting APC 0094 into two distinct groups, one for resuscitation procedures and the other for internal and external electrical cardioversion procedures, would not result in a significant difference in the APC payment rate for either of the new APCs.

The Panel recommended that the only action we take would be to move CPT code 92961, Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure) from APC 0094 to APC 0087, Cardiac Electrophysiology Recording/Mapping.

We proposed to accept the APC Panel recommendation. We are adopting this change as final.

APC 0102: Electronic Analysis of Pacemakers/Other Devices

The neurologic procedures included in APC 0102 (CPT codes 95970 through 95975), are significantly more complex than the routine cardiac pacemaker programming codes also assigned to this APC. Because we believe these codes are clinically different, we asked the Panel to consider the following:

- Create a new APC for the neurologic codes.
- Move the neurologic codes to APC 0215, Level I Nerve and Muscle Tests.

The Panel recommended the following reorganization of APC 0102 to better reflect clinical coherence:

- Split APC 0102 into four new APCs: one APC for analysis and programming of infusion pumps and CSF shunts; a second for analysis and programming of neurostimulators; a third for analysis and programming of pacemakers and internal loop recorders; and a fourth for analysis and programming of cardioverter-defibrillators.

We proposed to accept the Panel's recommendations and proposed to create four new APCs as follows:

APC 0689: Electronic Analysis of Cardioverter-Defibrillator
APC 0690: Electronic Analysis of Pacemakers and Other Cardiac Devices
APC 0691: Electronic Analysis of Programmable Shunts/Pumps
APC 0692: Electronic Analysis of Neurostimulator Pulse Generators.

We have made these changes final in this rule.

APC 0110: Transfusion

APC 0111: Blood Product Exchange

APC 0112: Extracorporeal Photopheresis

The procedures included in APC 0110 are those related only to the services associated with performing the blood transfusion and monitoring the patient during the transfusion; the costs associated with the blood products themselves are not included in APC 0110. We advised the Panel that we were not certain that cost data for blood transfusions excluded the costs of the blood products because the APC 0110 median cost of $289 seemed excessive. We expressed concern about hospital coding and billing practices for blood products, blood processing, storage, and transportation charges as represented in the 1996 data. We asked the Panel to advise us on how to clarify hospital billing and coding practices for blood transfusions; we also asked if the Panel members believe that the median costs for transfusion procedures include the costs for blood products and, if so, how the procedures should be adjusted to eliminate these costs.

After considerable discussion, the Panel recommended the following:

- Take no action on APC 0110.
- Move CPT code 36521 from APC 0111 to APC 0112 to achieve clinical coherence and resource similarity with photopheresis procedures included in APC 0112. However, the Panel cautioned that the payment for APC 0112 captured the cost of the entire procedure including the cost of the adsorption column. For this reason, any additional payment for the adsorption column through the transitional pass-through payment mechanism will be a duplicate payment. Therefore, the Panel asked that CMS address this problem when considering their recommendation.

We proposed to accept the Panel's recommendations. We noted that effective April 1, 2001, the Prosorba column is no longer eligible for a transitional pass-through payment (see PMA–01–40 issued on March 27, 2001).

We have adopted the proposed changes in final in this document.

APC 0116: Chemotherapy Administration by Other Technique Except Infusion

APC 0117: Chemotherapy Administration by Infusion Only

APC 0118: Chemotherapy Administration by Both Infusion and Other Technique

Based on previous comments we had received, we asked the Panel to review whether oral delivery of chemotherapy and delivery of chemotherapy by infusion pumps and reservoirs should be recognized for payment under the OPPS.

In summary, the Panel recommended the following:

- Allow hospitals to bill for patient education on the administration of oral anticancer agents under the appropriate clinic codes.
- Assign CPT codes 96520 and 96530 to a new APC.
- Continue to use the current HCPCS Level II Q codes for chemotherapy administration.
- There is no need to develop a new HCPCS code for ''extended chemotherapy infusions.''
- CMS should consider developing a new HCPCS code for flushing of ports and reservoirs.

We proposed to accept all the Panel's recommendations except for the recommendation regarding flushing of ports and reservoirs. Flushing is performed in conjunction with either a chemotherapy administration service or an outpatient clinic visit. In the first case, flushing is part of the chemotherapy administration and its costs are adequately captured in the costs of the chemotherapy administration code. In the second case, we believe that the costs of flushing are adequately captured in the costs of the clinic visit and need not be paid separately. We proposed to create a new APC 0125, Refilling of Infusion Pump.

We are adopting these changes as final in this rule.

APC 0123: Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant

In APC 0123, the 1996 median cost for CPT code 38230, Bone marrow harvesting for transplantation, was only $15. We believe that this cost is lower than the actual cost of the procedure. Further, we do not have sufficient data to determine how often bone marrow and stem cell transplant procedures are performed on an outpatient basis. For these reasons, we requested the Panel's advice in clarifying the resources used in performing the procedures assigned to APC 0123, and the extent to which these procedures are performed on an outpatient basis.

The Panel recommended the following:

- Make no changes in the procedures assigned to APC 0123 in the absence of sufficient data to support such modifications.
- The two presenters on this APC issue should submit cost data for the Panel to use in reevaluating this issue at its 2002 meeting.

We noted in the proposed rule that our analysis of the more recent claims data we are using to reclassify and recalibrate the APCs reveals a significant increase in costs for this APC resulting in a payment rate that is double the current rate. However, very few procedures (fewer than 20) were billed on an outpatient basis. As we indicated in the proposed rule, we will have the Panel review this APC again at their next meeting.

APC 0142: Small Intestine Endoscopy

APC 0143: Lower GI Endoscopy

APC 0145: Therapeutic Anoscopy

APC 0147: Level II Sigmoidoscopy

APC 0148: Level I Anal/Rectal Procedures

APC 0149: Level II Anal/Rectal Procedures

APC 0150: Level III Anal/Rectal Procedures

We presented these seven APCs to the Panel because of the inconsistencies in the median costs for some procedures included in APCs 0142, 0143, 0145, and 0147. We advised the Panel that our cost data do not show a progression of median costs proportional to increases in clinical complexity as we would expect. For example, the data indicate that a therapeutic anoscopy assigned to APC 0145 costs more than twice as much as a flexible or rigid sigmoidoscopy assigned to APC 0147. We stated our concern that cost disparity could provide incentives to use inappropriate procedures. Because of these concerns, we asked the Panel's advice in determining whether one of the following actions should be taken:

- Divide the codes in APC 0142 into separate APCs representing ileoscopy and small intestine procedures.
- Combine diagnostic anoscopy and Level I sigmoidoscopy.
- Merge APCs 0143, 0145, and 0147 into one APC.

We also asked the Panel whether the costs associated with codes in APC 0145 appeared to be valid.

The Panel recommended that we do the following:

- Make no changes to APCs 0142, 0143, 0145, and 0147.
- Provide information and guidance to better assist hospitals in understanding how to bill appropriately for services included in APCs 0142, 0143, 0145, and 0147.
- Resubmit these APCs to the Panel for review when newer data are available.

We proposed to accept the Panel's recommendations.

We have adopted these recommendations in this final rule.

APC 0151: Endoscopic Retrograde Cholangio-Pancreatography (ERCP)

We advised the Panel that we have received comments that indicate that it is inappropriate to assign both diagnostic and therapeutic ERCP procedures to the same APC. The commenters allege that virtually every hospital performs diagnostic ERCPs but only teaching hospitals perform therapeutic ERCPs. Based on our current data, if we created two APCs for ERCP procedures, the APC payment rate for therapeutic ERCPs would be lower than that for diagnostic ERCPs (approximately $526 and $535, respectively). Therefore, we requested the Panel's advice to help us determine whether to create separate APCs for diagnostic and therapeutic ERCP procedures.

The Panel recommended that we do the following:

- Do not reconfigure the ERCP procedures in APC 0151.
- Resubmit this issue to the Panel for review when more recent data are available.
- Explore the feasibility of using multiple claims rather than single claims to calculate appropriate APC payment rates for ERCP procedures.

We proposed to accept the Panel's recommendations. As we stated in the proposed rule, we are reviewing the potential for using multiple claims data for determining payment rates for ERCP procedures. As a first step in the process, in the proposed rule, we determined a payment rate for ERCP procedures based on both single claims for ERCP procedures and, because ERCP procedures are typically done under radiologic guidance, on claims that included both an ERCP procedure and a radiologic supervision or guidance procedure in this APC. We

accomplished this by changing the status indicator for radiologic guidance and supervision codes to ''N'', which results in these codes being packaged. Using these additional claims resulted in significantly increasing the number of claims used to determine the payment rate for this APC and in a much higher payment rate (about $780 in this final rule).

We will be presenting this issue again to the APC Panel at their next meeting.

APC 0160: Level I Cystourethroscopy and other Genitourinary Procedures

APC 0161: Level II Cystourethroscopy and other Genitourinary Procedures

APC 0162: Level III Cystourethroscopy and Other Genitourinary Procedures

APC 0163: Level IV Cystourethroscopy and Other Genitourinary Procedures
APC 0169: Lithotripsy

We advised the Panel that we had previously received a number of comments that advocated moving CPT code 52337, Cystoscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included), from APC 0162 to APC 0163. (We note that CPT code 52337 was deleted for 2001 and replaced with an identical CPT code, 52353. We will use the new code in the following discussion.) Because of these comments, we sought the Panel's advice in examining the clinical and resource distinctions between CPT code 52353 and other procedures assigned to APC 0162. Other information shared with the Panel noted that most of the procedures included in APC 0162 are complicated cystourethroscopies while those assigned to APC 0163 are largely prostate procedures.

The Panel recommended that we move CPT code 52353 from APC 0162 to APC 0169 because both codes 52353 and 50590 are lithotripsy procedures.

We reviewed the Panel discussion very carefully and noted the close vote. After careful consideration, we proposed to disagree with the Panel's recommendation and move code 52353 to APC 0163. The 1999–2000 cost data used for the proposed rule, which contained over 400 single claims for code 52353 (reported under code 52337) and over 6,000 single claims for code 50590, showed that the median cost for code 52353 is much more similar to the median cost of other procedures in APC 0163 than it is to the median cost of APC 0169. Although both codes involve lithotripsy, the type of equipment used in the two procedures is very different. Clinically, the surgical approach used for code 52353 and the resources used (e.g., anesthesia and operating room costs) are much more similar to other procedures in APC 0163 than to those for code 50590. Additionally, the median cost for code 50590, which was $700 higher than that of code 52353, is dependent on the widely variable arrangements hospitals make for use of the extracorporeal lithotriptor. Therefore, we believe that placing code 52353 in APC 0163 maintains its clinical coherence and similar use of resources.

Based on the updated 1999–2000 data base available for the final rule, we find that the cost relationship between codes 52353 and 50590 continues to reflect a difference. There are now almost 500 single claims for code 52353 and almost 7,000 single claims for code 50590. The median cost for 50590 remains about $700 higher than the median cost for code 52353. Therefore, we are adopting as final our proposal to move code 52353 to APC 0163.

APC 0191: Level I Female Reproductive Procedures

APC 0192: Level II Female Reproductive Procedures

APC 0193: Level III Female Reproductive Procedures

APC 0194: Level IV Female Reproductive Procedures

APC 0195: Level V Female Reproductive Procedures

This group of APCs was presented to the Panel because APC 0195 violates the 2 times rule. To facilitate the Panel's review of this issue, we distributed cost data on all the female reproductive procedures assigned to these five APCs. These data showed that the median costs for procedures assigned to APC 0195 ranged from a low of $365 to a high of $1,817. The CPT code 57288, Sling operation for stress incontinence (e.g., fascia or synthetic), which is assigned to APC 0195, has the highest median cost of the procedures in this group. We discussed with the Panel two clinical options for rearranging the procedures assigned to APC 0195 to comply with the 2 times rule. The first option would split APC 0195 into two separate APCs by separating vaginal procedures from abdominal procedures. The second option would split APC 0195 into three distinct APCs by retaining the separate APCs for abdominal and vaginal procedures and further distinguishing vaginal procedures based on whether they are simple or complex.

The Panel closely reviewed the four APCs for female reproductive procedures (APCs 0191, 0192, 0193, and 0194) to ensure each was clinically homogeneous. As a result of this review, the Panel recommended a number of changes for these APCs. These recommendations and those for APC 0195 are as follows:

- Move CPT codes 56350, Hysteroscopy, diagnostic, and 58555, Hysterosocopy, diagnostic/separate procedure, from APC 0191 to APC 0194 (In 2001, CPT code 56350 was replaced with CPT code 58555.)
- Divide APC 0195 into two APCs to distinguish vaginal procedures from abdominal procedures.
- Retain the following vaginal procedures in APC 0195:

CPT code	Descriptor
57555 ..	Excision of cervical stump, vaginal approach: with anterior and/or posterior repair.
58800 ..	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach.
58820 ..	Drainage of ovarian abscess; vaginal approach, open.
57310 ..	Closure of urethrovaginal fistula;
57320 ..	Closure of vesicovaginal fistula; vaginal approach
57530 ..	Trachelectomy (cervicectomy), amputation of cervix (separate procedure).
57291 ..	Construction of artificial vagina; without graft.
57220 ..	Plastic operation on urethral sphincter, vaginal approach (e.g., Kelly urethral plication).
57550 ..	Excision of cervical stump, vaginal approach.
57556 ..	Excision of cervical stump, vaginal approach; with repair of enterocele.
57289 ..	Pereyra procedure, including anterior colporrhapy.
57300 ..	Closure of rectovaginal fistula; vaginal or transanal approach.

CPT code	Descriptor
57284 ..	Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse).
57265 ..	Combined anteroposterior colporrhaphy; with enterocele repair.
57268 ..	Repair of enterocele vaginal approach (separate procedure).
56625 ..	Vulvectomy simple; complete.
58145 ..	Myomectomy excision of fibroid tumor of uterus, single or multiple (separate procedure); vaginal approach.
57260 ..	Combined anteroposterior colporrhaphy;
57240 ..	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele.
57250 ..	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy.
56620 ..	Vulvectomy simple; partial.
57522 ..	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision.

• Include the following abdominal procedures in a new APC titled ''Level VI Female Reproductive Procedures.''

CPT code	Descriptor
58920 ..	Wedge resection or bisection of ovary, unilateral or bilateral.
58900 ..	Biopsy of ovary, unilateral or bilateral (separate procedure).
58925 ..	Ovarian cystectomy, unilateral or bilateral.
57288 ..	Sling operation for stress incontinence (e.g., fascia or synthetic).
57287 ..	Removal or revision of sling for stress incontinence (e.g., fascia or synthetic).

• Move CPT code 57107 from APC 0194 to APC 0195, Level V Female Reproductive Procedures.

• Move CPT code 57109, Vaginectomy with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), from APC 0194 to the new APC, Level VI Female Reproductive Procedures.

We proposed to accept all of these Panel recommendations. These APCs would be reconfigured and renumbered as APCs 0188 to 0194. We also proposed to add new APCs for Level VII and Level VIII Female Reproductive Procedures (APCs 0195 and 0202, respectively) based on the 1999–2000 claims data and the 2 times rule. These proposed changes have been adopted as final in this document.

APC 0210: Spinal Tap

APC 0211: Level I Nervous System Injections

APC 0212: Level II Nervous System Injections

The Panel heard testimony from two presenters regarding the merits of modifying these three APCs. The first presenter, speaking on behalf of a manufacturer, discussed a new code for 2001, CPT code 64614, Chemodenervation of muscles; extremities and/or trunk muscles (e.g., for dystonia, cerebral palsy, multiple sclerosis).

The second presenter, representing a specialty society, proposed regrouping the procedures assigned to APCs 0210, 0211, and 0212 based on similar levels of complexity and median costs. The presenter's proposal also included reassignment to these APCs of interventional pain procedures currently assigned to APCs 040, Arthrocentesis and Ligament/Tendon Injection, 0105, Revision/Removal of Pacemakers, AICD, or Vascular Device, and 0971. The presenter proposed establishing the following five levels of interventional pain procedures by regrouping the procedures into new APCs as stated below:

• Level I Nerve Injections (to include Trigger Point, Joint, Other Injections, and Lower Complexity Nerve Blocks):

CPT code	Reassigned from APC
20550	040
20600	040
20605	040
20610	040
64612	0211
64613	0211
64614	0971
64400–64418	0211
64425	0211
64430	0211
64435	0211
64445	0211
64450	0211
64505	0211
64508	0211

• Level II Nerve Injections (to include Moderate Complexity Nerve Blocks and Epidurals):

CPT Code	Reassigned from APC
27096	0210
62270	0210
62272	0210
62273	0212
62310–62319	0212

• Level III Nerve Injections (to include Moderately High Complexity Epidurals, Facet Blocks, and Disk Injections):

CPT Code	Reassigned from APC
62280–62282	0212
62290	([1])
62291	([1])
64420–64421	0211
64470	0211
64472	0211
64475–64476	0211
64479	0211
64480	0211
64483–64484	0211
64510	0211
64520	0211
64530	0211
64630	0211
64640	0211

[1] Currently packaged.

• Level IV Nerve Injections (to include High Complexity Lysis of Adhesions, Neurolytic Procedures, Removal of Implantable Pumps and Stimulators):

CPT Code	Reassigned from APC
62263	0212
64600	0211
64605	0211
64610	0211
64620	0211
64622–64623	0211
64626–64627	0211
64680	0211
62355	0105
62365	0105

• Level V Nerve Injections (to include Highest Complexity Disk and Spinal Endoscopies): CPT code 62287, Aspiration or decompression procedure, percutaneous, of nucleus pulposus of invertebral disk, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous diskectomy, percutaneous laser diskectomy), reassigned from APC 0220, Level I Nerve Procedures.

The Panel recommended reassignment of CPT code 64614 from APC 0971 to APC 0211.

Concerning the suggested regrouping of interventional pain procedures, the Panel agreed that the recommended division of these procedures by clinical complexity would reflect resource use and was a reasonable approach to take. It was pointed out to the Panel that the costs for CPT codes 62290, Injection procedure for diskography, each level; lumbar, and 62291, Injection procedure for diskography, each level; cervical or thoracic, were packaged into the procedures with which they were billed. Therefore, the Panel concurred with the regrouping of procedures to establish

Levels I, II, III, and IV with the following exceptions:

- The Panel recommended that we not include CPT codes 62290 and 62291 in Level III because they are packaged injections and should not be unpackaged and paid separately.
- The Panel opposed moving CPT codes 62355, Removal of previously implanted intrathecal or epidural catheter, and 62365, Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion, from APC 0105 to Level IV Nerve Injections because they were neither clinically similar nor similar in resource use to the other codes assigned to this APC.
- The Panel opposed the creation of Level V Nerve Tests as it included only one code and recommended that CPT code 62287 remain in APC 220.
- We proposed to accept the Panel's recommendations for these services and we proposed to create new APCs 0203, 0204, 0206, and 0207 to accommodate these changes. We are adopting these proposed changes as final.

APC 0215: Level I Nerve and Muscle Tests

APC 0216: Level II Nerve and Muscle Tests

APC 0217: Level III Nerve and Muscle Tests

We advised the Panel that we had received a comment contending that assignment of CPT code 95863, Needle electromyography, three extremities with or without related paraspinal areas, to APC 0216 created an inappropriate incentive to perform tests on three extremities rather than two or four extremities. The payment of about $144 for APC 0216 is greater than the payment of about $58 for the same tests when performed on one, two, or four extremities. This is because CPT codes 95860, 95861, and 95864, Needle electromyography, one, two, and four extremities with or without related paraspinal areas, respectively, are assigned to APC 0215. We distributed data to the Panel that showed a median cost of about $141 for CPT code 95863, which is more than 3 times that of the median cost of $41 for CPT code 95864. We asked the Panel to consider the reassignment of CPT code 95863 from APC 0216 to APC 0215 and advised the Panel that, based on cost data available at the time of our meeting, this change could potentially reduce the payment for APC 0216. It was also noted that this change could result in a payment increase for APC 0215.

The Panel reviewed the cost data for APCs 0215 and 0216 and noted that the median costs for both CPT codes 95863 and 95864 appeared aberrant. Based on the information presented, the Panel recommended that we move CPT code 95863 from APC 0216 to APC 0215. We proposed to accept the Panel's recommendation with one exception. We proposed to revise these APCs based on the 1999–2000 cost data and the 2 times rule, and CPT code 95863 would be assigned to a reconfigured APC for Level II Nerve and Muscle Tests (APC 0218).

The changes we proposed to APCs 0215, 0216, and 0217 have been adopted as final in this document.

APC 0237: Level III Posterior Segment Eye Procedures

We advised the Panel that procedures assigned to APC 0237 are high volume procedures and rank among the top outpatient procedures billed under Medicare. We have received a number of comments disagreeing with the assignment of CPT code 67027, Implantation of intravitreal drug delivery system (e.g., ganciclovir implant), includes concomitant removal of vitreous, to APC 0237. This procedure was added to the CPT coding system after 1996 and, therefore, was not included in the 1996 data. We advised the Panel that ganciclovir, the drug implanted during this procedure, is paid separately as a transitional pass-through item. Because the drug is paid separately, it should not be included in determining whether the resources associated with the surgical procedure are similar to the resources required to perform the other procedures assigned to APC 0237. We advised the Panel that, of the procedures assigned to APC 0237, we believe that CPT code 67027 is related to codes 65260, 65265, and 67005, all of which involve removal of foreign bodies and vitreous from the eye. To ensure that CPT code 67027 is assigned to the appropriate APC, we asked the Panel to consider creation of a new APC, Level IV Posterior Segment Eye Procedures, for CPT codes 65260, 65265, 67005, and 67027. Based on the APC rates effective January 1, 2001, the suggested change could lower the APC rate for the four procedures by $400.

The Panel reviewed the data and did not believe it was sufficient to support the creation of a new APC for these four procedures. Therefore, the Panel recommended that APC 0237 remain intact and that more recent claims data be analyzed to determine whether CPT code 67027 is similar to the other procedures assigned to APC 0237.

Based on the 1999–2000 claims data, we have determined that the resources used for code 67027 are similar to other procedures in APC 0237. However, we will present APCs 0235, 0236, and 0237 to the Panel at their next meeting to determine whether any further changes should be made. We proposed to make various other changes to these APCs based on the new data and the 2 times rule, which we are incorporating as final in this document.

APC 0251: Level I ENT Procedures

This APC violates the 2 times rule because it consists of a wide variety of minor ENT procedures, many of which are low volume services or codes for nonspecific procedures. In order to correct this problem, we recommended to the Panel that this APC be split by surgical site (for example, nasal and oral). After reviewing cost data, the Panel agreed that the APC should be split but that current data were insufficient to determine how that split should be made. Therefore, the Panel asked that this APC, along with more recent cost data, be placed on the agenda at the next meeting.

We agree that this APC should be reviewed by the Panel at its next meeting. However, our review of the more recent cost data indicates that significant violations of the 2 times rule still exist. In order to correct this problem, but keep the APC as intact as possible, we proposed to move CPT codes 30300, Remove foreign body, intranasal; office type procedure, 40804, Removal of embedded foreign body, vestibule of mouth; simple, and 42809, Removal of foreign body from pharynx, to APC 0340, Minor Ancillary Procedures. This APC consists of procedures such as removal of earwax that require similar resources. Based on the latest 1999–2000 data, we find that the reasons for our proposed revision are still valid, therefore, we have incorporated those changes as final in this rule.

APC 0264: Level II Miscellaneous Radiology Procedures

We asked the Panel to review this APC because it violated the 2 times rule and consisted of a wide variety of unrelated procedures. Specifically, we believe that the costs associated with CPT codes 74740, Hysterosalpingography, radiological supervision and interpretation, and 76102, Radiologic examination, complex motion (e.g., hypercycloidal) body section (e.g., mastoid polytomography), other than with urography; bilateral, were aberrant and that we would significantly underpay these procedures if we moved them into a lower paying APC. We also asked the Panel to determine whether this APC

and APC 0263, Level I Miscellaneous Radiology Procedures, should be reconfigured by body system.

After considerable discussion, the Panel agreed that the procedures in these APCs were not clinically homogeneous; however, it recommended that we leave these APCs intact because the data do not support any more coherent reorganization. The Panel requested that this APC be placed on the agenda for the 2002 meeting.

We stated in the proposed rule that we agreed with the Panel's recommendations with the following revisions. First, BIPA requires us to assign procedures requiring contrast into different APCs from procedures not requiring contrast. This required changes to a number of radiologic APCs including APCs 0263 and 0264. In addition, we proposed to move CPT code 75940, Percutaneous Placement of IVC filter, radiologic supervision and interpretation, to a new APC 0187, Placement/Reposition Miscellaneous Catheters, because its costs were significantly higher than the costs of the procedures remaining in APC 0264.

We are adopting the changes discussed in the proposed rule as final. However, as discussed in a comment and response below in section II.A.3 of this preamble, we are revising the title and status indicator for APC 0187.

APC 0269: Echocardiogram Except Transesophageal

APC 0270: Transesophageal Echocardiogram

We asked the Panel to consider splitting these APCs based on whether or not 2D imaging is employed. After review of the data, the Panel recommended that we leave these APCs intact.

We proposed to leave APC 0270 intact except for the addition of two new codes for transesophageal echocardiography. We also proposed to split APC 0269 into two APCs, APC 0269, Level I Echocardiogram Except Transesophageal and APC 0697, Level II Echocardiogram Except Transesophageal. One APC (0269) would include comprehensive echocardiograms and the other APC (0697) would include limited/follow-up echocardiograms and doppler add-on procedures.

We have included these proposed changes in the APCs set forth in this final rule.

APC 0274: Myelography

We advised the Panel that APC 0274 is clinically homogeneous but that it violates the 2 times rule. Procedures assigned to this APC include radiological supervision and interpretation of diagnostic studies of central nervous system structures (e.g., spinal cord and spinal nerves) performed after injection of contrast material. We shared data with the Panel that showed the median costs for the procedures assigned to this APC ranged from a low of about $109 to a high of about $295. We asked the Panel's recommendation for reconfiguring APC 0274 to comply with the 2 times rule.

We informed the Panel members that we packaged the costs associated with radiologic injection codes into the radiological supervision and interpretation codes with which they were reported. The reason for doing this is that hospitals incur expenses for providing both services and they typically perform both an injection and a supervision and interpretation procedure on the same patient. Therefore, since neither an injection code nor a supervision and interpretation code should be billed alone, it would not be appropriate for us to use single claims data to determine the costs of performing these procedures. However, we are using single claims data in order to accurately determine the costs of performing procedures. Therefore, in order to accurately determine the costs of a complete radiologic procedure, we had to package the costs of the injection component into the cost of the supervision and interpretation component with which it was billed.

The Panel recommended the following:

- Make no changes to APC 0274.
- Review new cost data to determine whether payment would increase for APC 0274.

We proposed to accept the Panel's recommendation. We have made no further changes in this APC.

APC 0279: Level I Diagnostic Angiography and Venography

APC 0280: Level II Diagnostic Angiography and Venography

We presented these codes to the Panel for several reasons. APC 0279 violates the 2 times rule, there are numerous codes in these APCs with no cost data, there are numerous ''add on'' codes in these APCs, and many of these procedures were performed infrequently in the outpatient setting in 1996.

The Panel recommended the following:

- Create a new APC (APC 0287, Complex Venography) with the following CPT codes: 75831, 75840, 75842, 75860, 75870, 75872, and 75880.
- Move CPT codes 75960, 75961, 75964, 75968, 75970, 75978, 75992, and 75995 from APC 0279 to APC 0280.

We proposed to accept the Panel's recommendations. We noted that, as proposed, APC 0279 violated the 2 times rule because of the low cost data for CPT code 75660, Angiography, external carotid, unilateral selective, radiological supervision and interpretation. We believe that, for these procedures, these cost data are aberrant. This code is clinically similar to the other codes in APC 0279 and moving code 75660 to an APC with a lower weight could be an inappropriate APC assignment. Therefore, we stated in the proposed rule that we believe that an exception to the 2 times rule is warranted.

We are adopting the proposed changes as final. We note that APC 0279 continues to violate the 2 times rule due to the median cost of CPT code 75660. However, we continue to believe an exception is warranted.

APC 0300: Level I Radiation Therapy

APC 0302: Level III Radiation Therapy

As discussed in the proposed rule, we presented this APC to the technical advisory Panel because we had received comments that the assignment of CPT code 61793, Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator), one or more sessions, to APC 0302 would result in inappropriate payment for this service. Many commenters wrote that stereotactic radiosurgery and intensity modulated radiation therapy (IMRT) required significantly more staff time, treatment time, and resources than other types of radiation therapy. Other commenters disagreed with our decision, effective January 1, 2001, to discontinue recognizing CPT code 61793, and to create two HCPCS level 2 codes, G0173, Stereotactic radiosurgery, complete course of therapy in one session, and G0174, Intensity modulated radiation therapy (IMRT) plan, per session, to report both stereotactic radiosurgery and IMRT.

We reported to the Panel that the APC assignment of these G codes and their payment rate was based on our understanding that stereotactic radiosurgery was generally performed on an inpatient basis and delivered a complete course of treatment in a single session, while IMRT was performed on an outpatient basis and required several sessions to deliver a complete course of treatment. We also explained to the Panel that it was our understanding that multiple CPT codes were billed for each session of stereotactic radiosurgery and

IMRT. Therefore, we believed that the payment for APC 0302 was only a fraction of the total payment a hospital received for performing stereotactic radiosurgery or IMRT on an outpatient basis.

Radiosurgery equipment manufacturers, physician groups, and patient advocacy groups submitted comments and provided testimony to the APC Panel on these issues. These comments convinced us that we did not clearly understand either the relationship of IMRT to stereotactic radiosurgery or the various types of equipment used to perform these services.

We proposed a new coding structure to more accurately reflect the clinical use of these services and the resources required to perform them. In the proposed rule, we stated that there are essentially two services required to deliver stereotactic radiosurgery and IMRT. First, there is ''treatment planning,'' which includes such activities as determining the location of all normal and abnormal tissues, determining the amount of radiation to be delivered to the abnormal tissue, determining the dose tolerances of normal tissues, and determining how to deliver the required dose to abnormal tissue while delivering a dose to adjacent normal tissues within their range of tolerance. We noted that planning activities include the ability to manufacture various treatment devices for protection of normal tissue as well as the ability to ensure that the plan will deliver the intended doses to normal and abnormal tissue by simulating the treatment. Second, there is ''treatment delivery,'' which is the actual delivery of radiation to the patient in accordance with the treatment plan and includes such activities as adjusting the collimator (a device that filters the radiation beams), doing setup and verification images, treating one or more areas, and performing quality control.

We noted that treatment planning for IMRT requires specialized equipment including a duplicate of the actual equipment used to deliver the treatment, the ability to perform a CT scan, various disposable supplies, and involvement of various staff such as the physician, the physicist, the dosimetrist, and the radiation technologist. Treatment delivery requires specialized equipment to deliver the treatment and the involvement of the radiation technologist. The physician and physicist provide general oversight of this process.

Our proposal stated that although there are several types of equipment, produced by several manufacturers, used to accomplish this treatment, it was the consensus of the commenters and the Panel that the most useful way to categorize stereotactic radiosurgery and IMRT is by the source of radiation used for the treatment and not by the type of equipment used. One reason for this is that the clinical indications for stereotactic radiosurgery and IMRT overlap. Therefore, a single disease process can be treated by either modality but the cost of treatment varies by source of radiation used for the treatment. Second, while both stereotactic radiosurgery and IMRT can deliver a complete course of treatment in either one or multiple sessions, the cost of treatment delivery per session is relatively fixed, and is closely related to the source of radiation used for the treatment. On the basis of this understanding we made the following proposal: Appropriate APC assignment and payment were to be made by creating four HCPCS codes to describe these services.

The proposed codes are as follows:

- GXXX1 Multi-source photon stereotactic radiosurgery (Cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.
- GXXX2 Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, per lesion.
- G0174 Intensity modulated radiation therapy (IMRT) delivery to one or more treatment areas, multiple couch angles/fields/arcs custom collimated pencil-beams with treatment setup and verification images, complete course of therapy requiring more than one session, per session.
- G0178 Intensity modulated radiation therapy (IMRT) plan, including dose volume histograms for target and critical structure partial tolerances, inverse plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, per course of treatment.

We also proposed that HCPCS codes GXXX1, G0174, and G0178 have status indicators of S, while GXXX2 has a status indicator of T. We believe these are the correct status indicators because G0178 has a ''per session'' designation, while GXXX2 has a ''per lesion'' designation. This was based on our understanding that GXXX1 would not be billed on a ''per lesion'' basis as the planning process would take into account all lesions being treated and it would be extremely difficult to determine resource utilization for planning on a ''per lesion'' basis. Because the costs of performing GXXX1 will vary based on the number of lesions treated, payment would reflect a weighted average.

We based our proposal on our understanding that single-source photon stereotactic radiosurgery (or linear accelerator) planning and delivery are similar to IMRT planning and delivery in terms of clinical use and resource requirements. Therefore, we proposed to require coding for single-source photon stereotactic radiosurgery under HCPCS codes G0174 and G0178.

We also noted that the AMA is establishing codes for IMRT planning and treatment delivery for 2002 and we proposed to retire G0174 and G0178 (with the usual 90-day phase out) and recognize the applicable CPT codes when they are established in January 2002.

Because all activities required to perform stereotactic radiosurgery and IMRT were to be included in the codes described above, we proposed to discontinue the use of any other radiation therapy codes for activities involved with planning and delivery of stereotactic radiosurgery and IMRT for purposes of hospital billing in OPPS. Therefore, we also proposed continuing to not recognize CPT code 61793 for hospital billing purposes.

We believed that our proposal would not only simplify the reporting process for hospitals, but also appropriately recognize the clinical practice and resource requirements for stereotactic radiosurgery and IMRT.

We sought comments on our proposal, including the code titles, descriptors, and coding requirements discussed above. We also requested information regarding appropriate APC assignment and payment rates to inform our decision-making. We specifically asked for information regarding the costs of treatment delivery including any differences between the cost of a complete treatment in single versus multiple sessions.

Finally, we noted that several commenters had requested placement of the stereotactic delivery codes in surgical APCs, therefore, we requested clarification and support for these comments within the context of our coding proposal. Specifically, we were concerned that appropriate payment be made for GXXX2, which has a ''per lesion'' descriptor.

We received numerous comments on our proposal. These comments concerned our proposed coding scheme

and payment amounts as well as the need for separate codes recognizing linear accelerator-based radiosurgery. Many of the comments were part of a write-in campaign asking us to categorize radiosurgery as a surgical procedure and not a radiologic procedure. These letters also asserted that our payment amount for stereotactic radiosurgery should be $15,000. Below, we address each major issue raised by the commenters.

Comment: We received several comments regarding our coding proposal. The commenters indicated the following:

- Our proposed codes are duplicative of currently existing codes.
- We should recognize CPT code 61793 in the APC system.
- Our proposed codes would not allow billing for single session and fractionated linear accelerator-based radiosurgery.
- We incorrectly believe that multisession radiosurgery is similar in resource use to IMRT.
- We should delete our proposed codes for stereotactic radiosurgery planning and recognize CPT code 77295 for this purpose.
- CMS should clarify the other codes that would be billable with our proposed codes.
- Conflicting comments on whether the proposed code for stereotactic radiosurgery delivery should be ''per lesion'' or ''per session'' or ''per course of treatment.''

Commenters were also concerned about our ability to establish APC weights using claims that contained two significant procedures (e.g., stereotactic radiosurgery planning and stereotactic radiosurgery delivery).

Response: We reviewed all these comments very carefully. After completing our review, we have decided to make the following modifications to our proposed coding scheme:

- IMRT—We are not making any changes to our proposal for IMRT coding. We will delete the applicable G codes (G0174 and G0178) and recognize the new CPT codes for IMRT planning (code 77301) and IMRT delivery (code 77418) as established by the AMA.
- GXXX1—Under our proposal, GXXX1 (now G0242) would have been used only for Cobalt-based radiosurgery. After review of the comments, we believe that the planning for Cobalt-based and linear accelerator-based radiosurgery is similar both clinically and in terms of resource consumption. Therefore, at the next coding update, we will change the descriptor for this code to include linear accelerator-based radiosurgery planning. We do not know whether radiosurgery planning is similar clinically and in terms of resource consumption to CPT code 77295 (therapeutic radiology simulation-added field setting; three-dimensional). Use of G0242 will allow us to collect claims data and cost information that will aid us in determining whether G0242 is similar in resource use to 77295. However, we believe that tracking the utilization of G0242 as well as the codes with which it is submitted is very important for future APC reclassification and recalibration purposes, therefore, at this time, we do not intend to discontinue use of this code.
- GXXX2—Most of the comments concerned whether this code (now G0243) should be ''per lesion.'' After extensive review of the comments, we have determined that it is more appropriate for this code to be used ''per session'' or ''per course of treatment.'' We have concluded that the resource consumption for stereotactic treatment delivery varies significantly depending on the size, shape, and depth of the lesion(s) being treated. It is quite possible for the treatment of two superficial, spherical lesions to be less resource intensive than the treatment of a single, large, irregular lesion deep within the brain. Furthermore, the method of treatment and the manner in which the resources are used make a ''per lesion'' description inappropriate. For example, in Cobalt-based treatment, patients are administered ''spheres of dose'' and moved in and out of the machine after each ''sphere of dose.'' The number of ''spheres of dose'' per lesion varies widely so therefore ''per sphere of dose'' might be an alternative description for this service. However, we have concluded that any descriptor other than ''per session'' or ''per course of treatment'' will result in, or create the incentive to bill for, inappropriate payments for this service. Furthermore, it is our understanding that hospitals usually have a single charge for this service and that charge is based on the average resource use for all patients undergoing the procedure whether those patients have one, two, or more lesions treated. Because of the variability of treatment delivery per lesion, hospitals would be overpaid for multi-lesion patients if their charge is based on the average resource use over all patients. Finally, a ''per session'' description is more consistent with a prospective payment system. Because a ''per session'' payment reflects an average that includes all patients, unless a hospital specializes in treatment of multi-lesion patients, the OPPS payment is likely to be appropriate across all patient types. That is, the payment will be slightly higher than costs for single lesion treatments, and slightly lower than costs for multiple lesion treatments, averaging out over all patients.
- Linear accelerator-based radiosurgery—This treatment poses an especially difficult problem because linear accelerator-based radiosurgery can be delivered in a single dose like Cobalt-based treatment, or it can be delivered in fractions, with a maximum of five fractions. We do not have any cost information concerning the resource use of linear accelerator-based treatment delivery, but we do understand that there are two types of linear accelerator-based delivery of radiosurgery: ''gantry-based'' and ''image-directed.'' We do not know if the resource use of these two subtypes of linear accelerator based-radiosurgery is similar. Furthermore, we do not know whether the total resource consumption of fractionated radiosurgery delivered from a linear accelerator is different from the resource consumption of single dose radiosurgery delivered by a linear accelerator.

Therefore, in order to collect data on this procedure, we will designate current code G0173 for reporting single session radiosurgery delivered by a linear accelerator, either gantry-based or image-directed. At the next coding update, we will revise the descriptor for G0173 to reflect this change. Additionally, at the next coding update, we will create a new G code for use by facilities for fractionated radiosurgery delivered by a linear accelerator (either gantry-based or image-directed). The number of fractions will be limited to no more than five. Both G0173 and the new code for fractionated linear accelerator-based radiosurgery will be temporary while we collect cost and utilization data for these services. Once we have collected these data, we will determine whether permanent codes are needed.

In general, we have tried to strike a balance between recognizing clinically dissimilar treatments with individual codes and avoiding the creation of equipment-specific codes for purposes of the OPPS. We believe that the codes established in this final rule reflect this balance.

For multiple procedure claims, we do not believe there is a problem recognizing claims with more than one significant procedure to assist us in determining appropriate APC weights. We have analyzed all the claims in the 1999–2000 data base for CPT code 61793 to determine the codes with which it was billed and in what

frequencies. We have developed coding edits based on this claims analysis and, as discussed below, the payments for stereotactic radiosurgery reflect the median costs for all services that will be included in the payment for stereotactic radiosurgery planning and delivery. We have discussed these coding edits in great detail with the American Society for Therapeutic Radiology and Oncology (ASTRO) and they concur with the edits.

Comment: Many commenters asked us to place stereotactic radiosurgery in a ''surgical'' APC.

Response: We do not understand these comments. We realize that a neurosurgeon is present during stereotactic radiosurgery but, unlike the hospital inpatient PPS, we have no APC designation of ''surgical.'' We have interpreted this comment to mean that commenters do not want stereotactic radiosurgery to be in the same APC as IMRT or fractionated stereotactic radiosurgery. As discussed below, our new assignments of the codes to APCs will effectively create this change.

Comment: We received numerous comments concerning the status indicators we had proposed for the various radiosurgery procedures.

Response: In view of the change in the descriptor for G0243, we will be changing the status indicator for G0243 to ''S.'' This is because there will not be multiple units of this service billed and the costs for providing single dose stereotactic radiosurgery is relatively fixed and it would be inappropriate to give this procedure, as finalized, a ''T'' designation (that is, the multiple procedure reduction is not applicable).

Comment: Many comments addressed the payment rate for stereotactic radiosurgery and IMRT. Suggested amounts for payment of IMRT treatment planning and delivery varied from less than $300 to over $2,000 and suggested amounts for radiosurgery planning and treatment ranged from less than $1,000 to $15,000.

Response: We have no cost data specifically associated with IMRT upon which to base payment for IMRT. Therefore, we used information that provided the basis for IMRT payment under the physician fee schedule and we have established APC assignments that result in payment rates for IMRT planning and treatment delivery similar to payment under the physician fee schedule. We believe this is appropriate because the resource use for these procedures is similar in freestanding facilities and in hospitals. Because we have no claims data on the costs of IMRT, these procedures will be assigned to new technology APCs. As cost data are incorporated in the OPPS claims data base, they will be used to recalibrate the payment for these services and determine their future APC assignment. We would note that payment for IMRT planning includes payment for the following CPT codes: 77300, 77280–77295, 77305–77321. The only CPT codes that may be billed in addition to G0242 (IMRT planning) are the CPT codes 72332–72334 for treatment devices. We plan to incorporate the costs of those codes into IMRT planning when we have collected the cost data. The APC assignment for G0242 is APC 0714, New Technology—IX ($1250–$1500).

In order to determine appropriate payment amounts for both planning and treatment of stereotactic radiosurgery, we did an extensive analysis of our claims data base for code 61793 because that was the code used for stereotactic radiosurgery during 1999–2000. We collected all claims for 61793 and determined which CPT codes were billed with 61793 and the frequency with which each of those codes was billed with 61793. Within the subset of claims including CPT code 61793, we determined the median costs for 61793 and for each CPT code billed with 61793. In analyzing these claims, it was clear that 61793 was generally used to bill for treatment delivery and other codes were used, in combination, to bill for treatment planning. For example, 61793 was billed with 77300 on 57 percent of the claims, with either 77295 or 77290 on 62 percent of the claims, with either 77370 or 77336 on 77 percent of the claims (occasionally both of these codes were on the same claim), and with either 77305, 77315, or 77321 on 59 percent of the claims.

Based on these data, we have determined the total cost for stereotactic radiosurgery as follows: For stereotactic radiosurgery planning, we added the median costs (when billed with 61793) of 77295 (the most typical simulation code billed with 61793), 77300, 77370 (the most common physics consult billed with 61793), and 77315 (the most common dose plan billed with 61793) and will use the sum of these medians as the basis for our APC assignment for 2002. The medians of these codes are: $134.06 for 77300; $146.97 for 77370; $955.88 for 77295; and $206.56 for 77315. The total median cost for these codes is $1,443.47. Effective for services furnished on or after January 1, 2002, we will no longer allow these codes to be billed with stereotactic radiosurgery. No other codes were billed frequently enough with 61793 to justify including their costs in our stereotactic radiosurgery planning code. However, treatment device codes (77332–77334) were billed with 61793 on 42 percent of the claims, so we will allow one of those codes to be billed with each claim for stereotactic radiosurgery. We will consider incorporating their costs into the payment for stereotactic radiosurgery in the future. We note that the median cost of 77334 (the most common treatment device code billed with 61793) was $174.27 when it was billed with 61793.

CPT Code 20660, application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure), was billed with 61793 on only 23 percent of the claims. Because 20660 is required in order to perform stereotactic radiosurgery treatment, we will package the costs associated with 20660 into G0243, the radiosurgery treatment delivery code. We also note that 61793 was billed with an MRI of the brain on 71 percent of the claims. We will allow CTs and MRIs to be billed in addition to stereotactic radiosurgery planning.

For stereotactic radiosurgery delivery, we determined that the median cost of 61793 (using all claims) was $5,734.22 and will use that amount as the basis for our APC assignment for stereotactic radiosurgery for 2002. No other radiotherapy treatment code was billed frequently enough with 61793 to justify incorporation of its cost into our payment (that is, the treatment code most commonly billed with 61793 was 77470 (33 percent of the claims) and the next most common was 77412 (6 percent of the claims)). We will not allow billing of any other radiation treatment delivery codes with stereotactic radiosurgery treatment.

Therefore, we are assigning G0243 to APC 0721, New Technology—XVI ($5,000 to $6,000).

We will pay the same amount for linear accelerator-based stereotactic radiosurgery as for multiple source-based radiosurgery. For fractionated linear accelerator-based radiosurgery, we will divide the payment for single session radiosurgery by five and allow up to five payments. This will make total payment for fractionated linear accelerator based radiosurgery similar to linear accelerator-based single dose radiosurgery while allowing us to collect cost and utilization data for setting payments in 2003. Note that because application of a stereotactic frame is not required for linear accelerator-based radiosurgery, we will not be packaging the costs of code 20660 into the costs for linear accelerator-based radiosurgery.

Linear accelerator-based radiosurgery planning will be coded with the same

code as multiple source-based radiosurgery; therefore, the APC assignment will be the same as well. We note that all of these codes associated with radiosurgery are assigned to new technology APCs as we have no claim data on the procedures. Once we have collected data, the procedures will be assigned to other APCs.

The final APC assignments are as follows:

- 77301 is assigned to APC 0712
- 77418 is assigned to APC 0710
- G0173 is assigned to APC 0721
- G0242 is assigned to APC 0714
- G0243 is assigned to APC 0721.

APC 0311: Radiation Physics Services

APC 0312: Radio Element Application

APC 0313: Brachytherapy

We presented APC 0311 to the Panel because we believed our cost data for CPT codes 77336, Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy; 77370, Special medical radiation physics consultation; and 77399, Unlisted procedure, medical radiation physics, dosimetry, and treatment devices, and special services, were inaccurate. We were concerned that these procedures, particularly code 77370, were not being paid appropriately in APC 0311.

Presenters pointed out that, as with all radiation oncology services, the usual practice is to bill multiple CPT codes on the same date of service. Therefore, single claims were likely to be inaccurate bills and did not represent the true costs of the procedure. For this reason, presenters believed that using single claims to set payment rates for radiation oncology procedures was inappropriate and that we needed to develop a methodology that allowed the use of multiple claims data to set payment rates for these services.

For radiation physics consultation, presenters stated that the staff costs associated with CPT code 77370 were significantly greater than the costs of CPT codes 77336 and 77399. Therefore, they recommended that CPT codes 77336 and 77399 be moved from APC 0311 to APC 0304, Level I Therapeutic Radiation Treatment Preparation, and CPT code 77370 be moved from APC 0311 to APC 0305, Level II Therapeutic Radiation Treatment Preparation. The Panel agreed with this recommendation and we proposed to accept the Panel's recommendation. We also agreed that we should review the use of single claims to set payment rates for radiation oncology services. We plan to present this issue again at the 2002 Panel meeting.

We presented APCs 0312 and 0313 to the Panel because commenters were concerned that the payment rates were too low for the procedures assigned to the APCs and that there were insufficient data to set payment rates for these APCs. The Panel agreed that the issue regarding the use of single claim data affected the payment rates for these services. However, there were insufficient data for the Panel to make any recommendations regarding these APCs. The Panel did request to look at the issue of radiation oncology at its 2002 meeting.

Therefore, we proposed to make no changes to APCs 0312 and 0313 but will address radiation oncology issues at the Panel's 2002 meeting. We note that our updated claims data show very few single claims for procedures in these APCs. However, moving any of these procedures into other radiation oncology APCs would lower their payment rates. We are making no further changes to these APCs.

APC 0371: Allergy Injections

We presented this APC to the Panel because it violates the 2 times rule. The median costs for CPT codes 95115, Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection, and 95117, Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections, were lower than the median costs for the other services in this APC.

The Panel agreed that because codes 95115 and 95117 included administration of an injection only, the resource utilization for these services was lower than for the other services. The other services involve preparation of antigen and require more staff time and hospital resources to perform.

In order to create clinical and resource homogeneity, the Panel recommended that we create a new APC for codes 95115 and 95117 and that we leave the other services in APC 0371. We proposed to accept the Panel recommendation and create a new APC 0353, Level II Allergy Injections, and revise the title of APC 0371 to Level I Allergy Injections. These proposed changes are incorporated as final in this rule.

Observation Services

See the discussion on observation services in section II.C.4 of this preamble for the Panel's recommendations and our proposal as well as a discussion of the comments we received.

Inpatient Procedure List

See the discussion of the inpatient procedures list in section II.C.5 of this preamble for the Panel's recommendations and our proposal and a discussion of the comments we received on the list.

3. Other APC Issues

APC 0285: Positron Emission Tomography (PET)

Comment: Commenters expressed concern about the calculation of the payment rate for APC 0285, Positron Emission Tomography (PET), which includes PET for myocardial perfusion imaging. One specific concern is that single service claims are used to calculate relative weights although the applicable procedure codes for these studies are always linked to another diagnostic study and, therefore, they should not appear on single service claims. Second, the commenters are concerned that it is not appropriate to place both single study and multiple study PET procedures in the same APC.

Response: While the PET procedures are linked with a previous diagnostic procedure, the latter need not have been performed on the same day or in the same facility. Upon review of our claims data base, we find that nearly 50 percent of all claims for PET myocardial perfusion imaging studies are single service claims. We believe this to be a sufficient frequency for setting payment rates consistent with the overall methodology for setting rates in the OPPS. With regard to the second concern, after further analysis of claims, we concluded that there is not sufficient variation in the cost among the relevant codes, whether single or multiple studies, to warrant a change in the APC structure.

PET Scans Assigned to APC 0976: New Technology—Level VII ($750–$1000)

In the April 7, 2000 final rule, we assigned PET scans that use 18-flurodeoxyglucose (FDG) to APC 0980, New Technology—Level XII ($2000–$2500) because there were no claims for these procedures in the 1996 data used to establish the APC relative weights for 2000. However, based on the data from over 4,000 claims for services furnished between July 1, 1999 through June 30, 2000, the data base that was used to set the proposed APC weights, we found that the reported median costs for these procedures was closer to $900. Therefore, in the proposed rule, we

assigned the FDG PET scans to APC 0976, New Technology—Level VII ($750–$1000). We received a large number of comments on this proposed change.

Comment: Commenters expressed concern that the proposed APC assignment resulted in a much reduced payment rate for FDG PET scans. Many of these commenters expressed particular concern that the proposed rate of about $850 would not cover the cost of purchasing FDG in addition to the direct and indirect costs of a PET scan. The commenters requested that we review our data and the data they submitted and assign these procedures to a higher level new technology APC.

Response: As we discussed in detail in the April 7, 2002 final rule (65 FR 18476–78), the purpose of assigning a service to a new technology APC is to pay for a new technology based on its expected costs (as evidenced by data collected by us from various external sources) while we collect claims data that would allow assignment of the service to a clinically appropriate APC based on the actual resource use of the service. Our current policy is that a service remains in a new technology APC for 2 to 3 years while we collect the necessary claims data. (See section VI.G of this preamble for a discussion of changes we are making to this policy effective CY 2002.) Because FDG PET scans were assigned to a new technology APC at the implementation of the OPPS in August 2000, they will continue to be assigned to a new technology APC through 2002. However, when we reviewed the claims data in our 1999–2000 data base, there were about 5,000 single claims for these PET scans, with a median cost of about $900. Therefore, we proposed to move these procedures from APC 0980 to APC 0976.

As requested by the commenters and consistent with our policy on pricing services for assignment to new technology APCs, we reviewed the external data provided by the commenters as well as our claims data. These data suggest that our claims cost data may not have accurately captured the entire costs of the procedure, particularly the cost of the FDG. Based on our analysis, we believe that the cost of an FDG PET scan is between $1,200 and $1,800, with a midpoint of $1,500. According to our methodology for pricing new technology services, these services will be reassigned to APC 0978, New Technology—Level IX ($1250–$1500), which results in a payment rate of $1,375.

Cryoablation of the Prostate

Comment: We received several comments concerning our proposal to place CPT code 55873, cryosurgical ablation of the prostate, into APC 0163, Level IV Cystourethroscopy and other Genitourinary Procedures. Commenters believe that we had insufficient cost data to justify moving this code from its current assignment, APC 0980, New Technology—XI ($1750–$2000). They also believe that cryoablation of the prostate is not clinically similar to other procedures in APC 0163. One commenter requested moving code 55873 into either APC 0984, New Technology—XV ($3500–$5000) or 0132, Level III Laparoscopy.

Response: We have reviewed our 1999–2000 cost data for code 55873, and have 4 claims that show a median cost of just over $4,000, which includes the cost of the procedure as well as the associated devices. The devices associated with this procedure are eligible for transitional pass-through payments. After subtracting the estimated cost of the pass-through devices, we believe that the approximate expected cost of this procedure warrants its assignment to APC 0982 New Technology—XIII ($2500–$3000), with a status indicator of ''T.'' The devices associated with this procedure remain eligible for transitional pass-through payments in 2002 in addition to the APC payment amount.

Water-Induced Thermotherapy

Comment: We received a comment from the manufacturer of the equipment used for water-induced thermotherapy (a treatment for benign prostatic hyperplasia), CPT code 53853, that our proposal to assign this procedure in new technology APC 0977, New Technology—VIII ($1000–$1250) did not accurately reflect the costs and resources required to furnish this procedure. The commenter believes that 53853 should be placed in APC 0982, New Technology—XIII ($2500–$3000) with other minimally invasive thermotherapy treatments for benign prostatic hyperplasia.

Response: We disagree with the commenter and are finalizing our proposal. Based on the information provided by the commenters and our own clinical knowledge, we understand that the resources required to deliver water-induced thermotherapy are less than the resources required for the procedures assigned to APC 0982 (CPT codes 53850, transurethral destruction of prostate tissue; by microwave thermotherapy, and 53852, transurethral destruction of prostate tissue; by radiofrequency thermotherapy). Less intraoperative staff time and less equipment resources are required for 53853 than for the other procedures. In addition, unlike codes 53850 and 53852, which require sedation or regional anesthesia, code 53853 requires only local anesthesia. Finally, recovery time is shorter (in part because of the local anesthesia) and requires fewer facility resources. Therefore, we believe code 53853 is appropriately assigned to APC 0977.

Ultrasound Radiologic Guidance Codes

Comment: Several commenters inquired about a change in the proposed rule that resulted in the packaging of certain ultrasound and radiologic guidance codes. The commenters urged us to publish the data and rationale for these changes and recommended that the proposed changes not be made final, pending further review and a fuller discussion of the proposed changes. The commenters recommended separate rather than packaged payment for the guidance codes.

Response: As we explain above in section II.A.2 of this preamble under the discussion for APC 0151, we accepted the APC Panel's recommendation to consider the use of multiple claims data to determine payment rates for endoscopic retrograde cholangio-pancreatography (ERCP). The payment rate that we proposed for ERCP was based on both single claims for ERCP procedures and on claims that included both an ERCP procedure and a radiologic supervision or guidance procedure. That is, rather than making separate payment for the radiologic supervision and guidance furnished in connection with ERCP, we packaged those costs into the proposed rate for APC 0151.

Our experience using multiple procedure claims to price ERCP in accordance with the Panel's recommendation led us to consider other services that could be priced similarly. We believe that the following procedures assigned to APC 0268, Guidance Under Ultrasound, would never be performed alone, but would always be performed in connection with and be considered integral to the performance of another procedure: 76930, 76932, 76934, 76938, 76941, 76942, 76945, 76946, 76948, 76950, 76960, 76965, G0161. Therefore, if a claim listed one of the procedures in APC 0268 in addition to another procedure, we retained that claim in the pool of single-procedure bills used to calculate median costs for services within the various APCs. Costs

associated with the codes in APC 0268 were therefore packaged into the APCs of procedures with which they were billed between July 1, 1999 through June 30, 2000.

We continue to believe that the most appropriate way to pay for ultrasound guidance is to package its costs as part of the cost of performing the procedure for which the guidance is needed. Therefore, in the proposed rule, we assigned status indicator ''N'' to still active codes that had previously been in APC 0268. We applied the same principle to several radiologic guidance codes (76393, 19290, 19291, and 19295). We assigned status indicator ''N'' to these codes because they represent services that are always furnished in connection with another procedure. That is, they are integral to performing another procedure and would never be performed alone, as a single service. Therefore, costs associated with such radiologic guidance codes are more appropriately packaged than paid for separately.

It is crucial that hospitals bill charges for codes with status indicator ''N'' to ensure that costs for packaged services are appropriately captured in the APCs with which they are associated. For the 2003 OPPS update, we will consider proposing to package additional guidance services with whichever procedures they are billed, including the following:

76095, Stereotactic localization guidance for breast biopsy or needle placement.

76355, Computerized tomography guidance for stereotactic localization.

76360, Computerized tomography guidance for needle placement.

We will report to the Panel on our progress in treating bills with certain packaged services as single procedure claims. We will also include on the agenda of the next Panel meeting a follow-up discussion to review the services that we have packaged thus far and to consider other codes that would also be more appropriately paid as packaged rather than separate services. To identify all the procedures with which the ultrasound and radiologic guidance services are packaged would require a review of the raw outpatient claims that make up the 1999–2000 data that we are using to recalibrate the 2002 APC weights because we have previously packaged the guidance costs with whatever procedure they are billed in preparing the claims data base used for recalibration.

Breast Biopsy

Comment: A few commenters, including the manufacturer of a minimally invasive breast biopsy system, expressed concern that the higher APC relative weight for surgical breast biopsy procedures would discourage Medicare beneficiary access to less invasive procedures. The commenters were also concerned that the proposed payment for less invasive breast biopsy procedures was inadequate.

Response: As we discuss below in section II.D. of this preamble, the APC weights reflect hospital median costs (as determined from the charges reflected on claims submitted by hospitals) for a given procedure relative to the costs for other procedures. We expect that the costs for an open surgical procedure will be higher than those for less invasive procedures because open surgery is more resource intensive, especially in terms of recovery time, anesthesia, and nursing care. We do not agree that the higher relative weight for open surgical biopsy will serve as an incentive to perform this procedure rather than the less costly, less invasive options. The payment rate for the less invasive options are based on the costs of those procedures as reported by hospitals. We note that the payment rate for the breast biopsy procedure assigned to APC 0974, New Technology—Level V ($300–$500) (CPT code 19103, Percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) is higher in this final rule relative to the proposed rule (see the discussion in section II.D. of this preamble, below).

Comment: Several commenters questioned why the proposed rule indicated that CPT code 76095, Stereotactic localization guidance for breast biopsy, would be moved from APC 0264, Level II Miscellaneous Radiology Procedures, with a status indicator of ''X'' (ancillary service) to APC 0187, Placement/Repositioning Miscellaneous Catheters, with a status indicator of ''T'' (significant procedure, multiple procedure reduction applies). The commenters were concerned that the ''T'' status indicator would result in a lower payment for the procedure when it is billed with other procedures.

Response: We agree with commenters that the title for APC 0187 in the proposed rule is misleading given the procedures that are included within the APC. Therefore, in the final rule, we are changing the name of APC 0187 to ''Miscellaneous Placement/Repositioning''. We are also changing the status indicator for APC 0187 from ''T'' to ''X''. We created APC 0187 to pay more appropriately for certain guidance codes, including code 76095.

Status Indicators

Comment: A commenter asserted that some hospitals believe that procedure codes designated with status indicators of ''S,'' ''T,'' ''V,'' and ''X'' mean that the procedure must be performed in the outpatient setting.

Response: This is not the case. These status indicators were developed to assist us with our pricing policy in OPPS, not to dictate where the procedures could be performed. Although a status indicator of ''C'' means that the procedure will not be paid if performed in the outpatient setting, the status indicators paid under the OPPS do not dictate where that service or procedure is covered. We pay for any covered service or procedure performed in the inpatient setting as an inpatient service as long as the patient's condition merits admission to the hospital as an inpatient.

B. Additional APC Changes Resulting from BIPA Provisions

1. Coverage of Glaucoma Screening

Section 102 of the BIPA amended section 1861(s)(2) of the Act to provide payment for glaucoma screening for eligible Medicare beneficiaries, specifically, those with diabetes mellitus or a family history of glaucoma, and certain other individuals found to be at high risk for glaucoma as specified by our rulemaking. The implementation of this provision is discussed in detail in a separate final rule concerning the revisions in the physician fee schedule payment policy for CY 2002, published in the **Federal Register** on November 1, 2001 (66 FR 55272).

In order to implement section 102 of BIPA, we have established two new HCPCS codes for glaucoma screening:

- G0117—Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist.
- G0118—Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist or ophthalmologist.

We proposed to assign the glaucoma screening codes to APC 0230, Level I Eye Tests. We further proposed to instruct our fiscal intermediaries to make payment for glaucoma screening only if it is the sole ophthalmologic service for which the hospital submits a bill for a visit. That is, the services included in glaucoma screening (a dilated eye examination with an intraocular pressure measurement and direct opthalmoscopy or slit-lamp biomicroscopy) would generally be performed during the delivery of another opthalmologic service that is furnished on the same day. If the

beneficiary receives only a screening service, however, we would pay for it under APC 0230.

2. APCs for Contrast Enhanced Diagnostic Procedures

Section 430 of the BIPA amended section 1833(t)(2) of the Act to require the Secretary to create additional APC groups to classify procedures that utilize contrast agents separately from those that do not, effective for items and services furnished on or after July 1, 2001. On June 1, 2001, we issued a Program Memorandum, Transmittal A–01–73, in which we made numerous coding and grouping changes to implement this provision. (This transmittal can be found at *www.hcfa.gov/pubforms/transmit/AO173.pdf*) We removed the radiological procedures whose descriptors included either ''without contrast material'' or ''without contrast material followed by contrast material'' from APC groups 0282, Level I, Computerized Axial Tomography; APC 0283, Level II, Computerized Axial Tomography; and APC 0284, Magnetic Resonance Imaging. As a result, APCs 0283 and 0284 now include only imaging procedures that are performed with contrast materials. Additionally, reconfigured APC 0282 no longer includes radiological procedures that use contrast agents.

Effective for items or services furnished on or after July 1, 2001, we created six new APC groups for the procedures removed from APCs 0282, 0283, and 0284, as shown below. (Effective October 1, 2001, we eliminated APC 0338. Refer to Transmittal A–01–73 for a detailed description of this change.) For services furnished on or after July 1, 2001 and before January 1, 2002, the payment rates for the new imaging APCs are the same as those associated with the APCs from which the procedures were moved. For the proposed rule, we calculated separate weights for the new APCs based on the data available at the time for recalibration. In this final rule, we are establishing separate weights for the new APCs based on the final data used to recalibrate the weights for 2002.

TABLE 1.—APC GROUPS RECONFIGURED TO SEPARATE IMAGING PROCEDURES THAT USE CONTRAST MATERIAL FROM PROCEDURES THAT DO NOT USE CONTRAST MATERIAL

APC	SI	APC title
0282	S	Miscellaneous Computerized Axial Tomography.
0283	S	Computerized Axial Tomography with Contrast.
0284	S	Magnetic Resonance Imaging and Angiography with Contrast.
0332	S	Computerized Axial Tomography w/o Contrast.
0333	S	CT Angio and Computerized Axial Tomography w/o Contrast followed by with Contrast.
0335	S	Magnetic Resonance Imaging, Temporomandibular Joint.
0336	S	Magnetic Resonance Angiography and Imaging without Contrast.
0337	S	Magnetic Resonance Imaging and Angiography w/o Contrast followed by with Contrast.

The HCPCS codes that are reassigned to the new imaging APCs in this final rule are as follows:

APC	HCPCS	SI	Short descriptor
0282	76370	S	CAT scan for therapy guide.
	76375	S	3d/holograph reconstr add-on.
	76380	S	CAT scan for follow-up study.
	G0131	S	Ct scan, bone density study.
	G0132	S	Ct scan, bone density study.
0283	70460	S	Ct head/brain w/dye.
	70481	S	Ct orbit/ear/fossa w/dye.
	70487	S	Ct maxillofacial w/dye.
	70491	S	Ct soft tissue neck w/dye.
	71260	S	Ct thorax w/dye.
	72126	S	Ct neck spine w/dye.
	72129	S	Ct chest spine w/dye.
	72132	S	Ct lumbar spine w/dye.
	72193	S	Ct pelvis w/dye.
	73201	S	Ct upper extremity w/dye.
	73701	S	Ct lower extremity w/dye.
	74160	S	Ct abdomen w/dye.
	76355	S	CAT scan for localization
	76360	S	CAT scan for needle biopsy.
0284	70542	S	MRI orbit/face/neck w/dye.
	70545	S	Mr angiography head w/dye.
	70548	S	Mr angiography neck w/dye.
	70552	S	MRI brain w/dye.
	71551	S	MRI chest w/dye.
	72142	S	MRI neck spine w/dye.
	72147	S	MRI chest spine w/dye.
	72149	S	MRI lumbar spine w/dye.
	72196	S	MRI pelvis w/dye.
	73219	S	MRI upper extremity w/dye.
	73222	S	MRI joint upr extrem w/dye.
	73719	S	MRI lower extremity w/dye.
	73722	S	MRI joint of lwr extr w/dye.

APC	HCPCS	SI	Short descriptor
	74182	S	MRI abdomen w/dye.
	75553	S	Heart MRI for morph w/dye.
	C8900	S	MRA w/cont, abd.
	C8903	S	MRI w/cont, breast,uni.
	C8906	S	MRI w/cont, breast, bi.
	C8909	S	MRA w/cont, chest.
	C8912	S	MRA w/cont, lwr ext.
0332	70450	S	CAT scan of head or brain.
	70480	S	Ct orbit/ear/fossa w/o dye.
	70486	S	Ct maxillofacial w/o dye.
	70490	S	Ct soft tissue neck w/o dye.
	71250	S	Ct thorax w/o dye.
	72125	S	Ct neck spine w/o dye.
	72128	S	Ct chest spine w/o dye.
	72131	S	Ct lumbar spine w/o dye.
	72192	S	Ct pelvis w/o dye.
	73200	S	Ct upper extremity w/o dye.
	73700	S	Ct lower extremity w/o dye.
	74150	S	Ct abdomen w/o dye.
0333	70470	S	Ct head/brain w/o&w dye.
	70482	S	Ct orbit/ear/fossa w/o&w dye.
	70488	S	Ct maxillofacial w/o&w dye.
	70492	S	Ct sft tsue nck w/o & w/dye.
	70496	S	Ct angiography, head.
	70498	S	Ct angiography, neck.
	71270	S	Ct thorax w/o&w dye.
	71275	S	Ct angiography, chest.
	72127	S	Ct neck spine w/o&w dye.
	72130	S	Ct chest spine w/o&w dye.
	72133	S	Ct lumbar spine w/o&w dye.
	72191	S	Ct angiograph pelv w/o&w dye.
	72194	S	Ct pelvis w/o&w dye.
	73202	S	Ct uppr extremity w/o&w dye.
	73206	S	Ct angio upr extrm w/o&w dye.
	73702	S	Ct lwr extremity w/o&w dye.
	73706	S	Ct angio lwr extr w/o&w dye.
	74170	S	Ct abdomen w/o&w dye.
	74175	S	Ct angio abdom w/o&w dye.
	75635	S	Ct angio abdominal arteries.
0335	70336	S	Magnetic image, jaw joint.
	75554	S	Cardiac mri/function.
	75555	S	Cardiac mri/limited study.
	76390	S	Mr spectroscopy.
	76400	S	Magnetic image, bone marrow.
0336	70540	S	MRI orbit/face/neck w/o dye.
	70544	S	Mr angiography head w/o dye.
	70547	S	Mr angiography neck w/o dye.
	70551	S	MRI brain w/o dye.
	71550	S	MRI chest w/o dye.
	72141	S	MRI neck spine w/o dye.
	72146	S	MRI chest spine w/o dye.
	72148	S	MRI lumbar spine w/o dye.
	72195	S	MRI pelvis w/o dye.
	73218	S	MRI upper extremity w/o dye.
	73221	S	MRI joint upr extrem w/o dye.
	73718	S	MRI lower extremity w/o dye.
	73721	S	MRI joint of lwr extre w/o d.
	74181	S	MRI abdomen w/o dye.
	75552	S	Heart MRI for morph w/o dye.
	C8901	S	MRA w/o cont, abd.
	C8904	S	MRI w/o cont, breast, uni.
	C8910	S	MRA w/o cont, chest.
	C8913	S	MRA w/o cont, lwr ext.
0337	70543	S	MRI orbt/fac/nck w/o&w dye.
	70546	S	Mr angiograph head w/o&w dye.
	70549	S	Mr angiograph neck w/o&w dye.
	70553	S	MRI brain w/o&w dye.
	71552	S	MRI chest w/o&w dye.
	72156	S	MRI neck spine w/o&w dye.
	72157	S	MRI chest spine w/o&w dye.
	72158	S	MRI lumbar spine w/o&w dye.
	72197	S	MRI pelvis w/o&w dye.
	73220	S	MRI uppr extremity w/o&w dye.
	73223	S	MRI joint upr extr w/o&w dye.

APC	HCPCS	SI	Short descriptor
	73720	S	MRI lwr extremity w/o&w dye.
	73723	S	MRI joint lwr extr w/o&w dye.
	74183	S	MRI abdomen w/o&w dye.
	C8902	S	MRA w/o fol w/cont, abd.
	C8905	S	MRI w/o fol w/cont, brst, uni.
	C8908	S	MRI w/o fol w/cont, breast, bi.
	C8911	S	MRA w/o fol w/cont, chest.
	C8914	S	MRA w/o fol w/cont, lwr ext.

Refer to Addendum A or Addendum B of this final rule for the updated weights, payment rates, national unadjusted copayment, and minimum unadjusted copayment for all of the procedures listed above.

3. Coding and Payment for Mammography Services

a. Screening Mammography. Screening mammography means a radiologic procedure provided to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. Under Medicare, screening mammography services can be billed in three ways: (1) For the physician's interpretation of the results of the screening mammogram (that is, the professional component of mammography services); (2) for all services other than the physician's interpretation (that is, the technical component); or (3) for both the professional and technical components (global billing), although global billing is not permitted for services furnished in the hospital outpatient setting.

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) added section 1834(c) of the Act to provide for Part B coverage of screening mammography performed on or after January 1, 1991. Section 1834(c) of the Act governing those screenings did not include screening mammography under the physician fee schedule; it provided for payment under a separate statutory methodology. Payment for screening mammography services furnished in the hospital outpatient setting before January 1, 2002 is subject to the payment method set by the statute at section 1834(c) of the Act. When Medicare implemented the OPPS for services furnished beginning August 1, 2000, payment for screening mammography services continued to be based on the payment method set by the statute at section 1834(c) (the lower of hospital charges or the national payment limitation) of the Act and was not made under the OPPS.

Section 104 of BIPA amended section 1848(j)(3) of the Act to include screening mammography as a physician service. As a result of this amendment, the payment limit that is currently the basis for payment is replaced beginning January 1, 2002 by payment under the Medicare physician fee schedule. Payments for all services under the physician fee schedule are resource-based and have geographic adjustments that reflect cost differences among areas. A discussion of how payment for screening mammography services is determined under the physician fee schedule can be found in the final rule, ''Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002,'' published in the November 1, 2001 **Federal Register** (66 FR 55246). Beginning January 1, 2002, Medicare payment for screening mammography services furnished in a hospital outpatient setting is no longer the lower of hospital charges or the national payment limitation; however, payment will continue to be excluded from the OPPS. For screening mammography furnished in the outpatient setting, Medicare will pay hospitals the technical component amount established under the Medicare physician fee schedule.

Comment: A few commenters questioned why we had not established an APC or a payment rate for screening mammography in the proposed rule. One commenter expressed grave concern that our failure to include an APC for screening mammography in the proposed rule meant that Medicare beneficiaries would not be able to receive screening mammography services in the hospital outpatient setting. These commenters urged that we establish an APC for screening mammography services and that the payment rate be consistent with the cost of taking a screening mammogram in the hospital outpatient setting rather than the payment rate proposed for diagnostic mammograms in APC 0271, Mammography. One commenter, citing a survey conducted by a professional society, reported the average cost of doing a screening mammogram in a hospital to be about $97. Several commenters supported the physician fee schedule payment rate for screening mammography services as a more reasonable recognition of associated costs than the payment rate proposed for diagnostic mammography under APC 0271.

Response: The fact that we have not assigned the HCPCS codes for screening mammography services to an APC does not mean that Medicare does not pay hospitals for these services when they are furnished in the outpatient setting. Rather, as we explain in the April 7, 2000 final rule, we excluded screening mammography services from payment under the OPPS because they were already subject to an existing fee schedule or other prospectively determined payment rate (65 FR 18442). When the OPPS was implemented on August 1, 2000, screening mammography services were assigned payment status indicator ''A'' to specify that payment would be the ''lower of charge or national rate,'' consistent with section 1834(c)(3) of the Act (65 FR 18445).

As a result of section 104 of BIPA, which amended section 1848(j)(3) of the Act to define screening mammography as a physician service, Medicare payment for screening mammography services furnished on or after January 1, 2002 is no longer subject to the payment methodology established under section 1834(c) of the Act. Therefore, payment for both the professional and technical components of screening mammography services furnished on or after January 1, 2002 is made under the physician fee schedule. This means that, effective for services furnished on or after January 1, 2002, the payment amount to hospitals for screening mammography services furnished in the outpatient setting will be based on the amount established for the technical component of screening mammography under the physician fee schedule.

Hospitals are to use the following codes to bill for screening mammography services effective January 1, 2002:

- CPT code 76092, Screening mammography, bilateral (two view film study of each breast)

• HCPCS code G0202, Screening mammography, direct digital image, bilateral, all views

• CPT code 76085, Computer-aided detection add-on code for screening mammography (can only be billed with CPT code 76092)

We further discuss in section II.B.3.c, below, coding and payment for screening and diagnostic mammograms that use advanced new technologies.

Payment for screening mammography services furnished in a hospital outpatient department beginning January 1, 2002 is equal to 80 percent of the lower of the hospital's actual charge or the locality specific technical component payment amount under the physician fee schedule. Coinsurance equals 20 percent of the lower of the actual charge or the physician fee schedule amount. The Medicare Part B deductible does not apply to screening mammography. The November 1 physician fee schedule final rule lists the relative value units for screening mammography services and the physician fee schedule conversion factor for CY 2002 (66 FR 55334). In addition to the technical component payment made to the hospital, physicians are paid an additional amount for professional services furnished in connection with these procedures.

In this final rule, we are changing the descriptor of payment status indicator ''A'' for the screening mammography codes to ''Physician Fee Schedule'' to conform with the BIPA change.

b. Diagnostic Mammography. Medicare covers a radiological mammogram as a diagnostic test under the following conditions:

• A patient has distinct signs and symptoms for which a mammogram is indicated;

• A patient has a history of breast cancer; or

• A patient is asymptomatic, but on the basis of the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

Payment for a diagnostic mammogram furnished in a hospital outpatient setting is made under the OPPS. The following codes are used to report diagnostic mammography: CPT code 76090, Mammography; unilateral, and CPT code 76091, Mammography, bilateral are used to report a diagnostic mammogram. These two codes are assigned to APC 0271, Mammography, and we proposed no changes to the assignment of these codes in the proposed rule. (We discuss in section III.B.3.c, below, coding changes for the CY 2002 related to new technology mammography.)

In the proposed rule, the relative weight for APC 0271 was equal to 0.64. We recalibrated all the APC relative weights, including that for APC 0271, using claims data for services furnished beginning July 1, 1999 through June 30, 2000 in accordance with the process explained in the proposed rule (66 FR 44695).

Comment: We received numerous comments, many of which were the product of a ''write-in'' campaign, regarding the relative weight and payment rate proposed for APC 0271. The commenters asserted that the current payment rate for APC 0271 is inadequate to support the provision of mammography services in the hospital outpatient setting, and they expressed disbelief that the proposed payment rate for 2002 is lower than the current rate. Commenters expressed grave concern that the proposed payment rate for diagnostic mammography would have a generally negative impact on beneficiary access to mammography services. Many commenters cited a practice cost survey conducted by the American College of Radiology that indicated the average cost for performing a screening mammogram in a hospital outpatient setting to be $97. The commenters argued that diagnostic mammography is more complex technically and more resource intensive, requiring more than double the clinical labor, supply, and equipment inputs than those required for screening mammography. One commenter stated that the technical cost of providing screening mammography in the hospital setting is nearly twice the cost of providing the same service in a physician office setting.

Other commenters recommended that payment for all mammography services furnished in the outpatient setting, both screening and diagnostic, be paid under the physician fee schedule to eliminate the significant payment disparity that will result if the proposed OPPS rates for diagnostic mammography are implemented in 2002. Several commenters complained that we provided no rationale or data to show how the proposed payment rate for APC 0271 was calculated nor did we explain why the proposed payment for these services is lower than the current payment. Commenters urged that we recalculate the payment rate for APC 0271 to represent a payment rate that is reflective of the resources used to perform the procedure.

Response: We calculated the relative weight for APC 0271 in the April 7, 2000 final rule in accordance with the process we described in that rule (65 FR 18482), using, as required by the statute, claims from 1996 and data from the most recent available hospital cost reports. Because we did not recalibrate the relative weights for any APC groups in the November 13, 2000 final rule, the relative weight (0.70) for APC 0271 as well as the relative weights for the other APC groups have not changed since August 1, 2000.

Using 1999–2000 claims data, we recalibrated all the APC weights in the proposed rule in accordance with the process that we explained in that rule (66 FR 44695). The relative weight for every APC group changed for two reasons: the use of more recent claims data, and the statutory requirements for budget neutrality. Section 1833(t)(9)(B) of the Act requires that estimated spending for services covered under the OPPS be neither greater nor less than it would have been had the recalibration and reclassification changes not been made. Because of this, the weights and, therefore, the payment rates for a specific service may increase or decrease depending on the change in charges hospitals report for that service relative to the change in charges hospitals report for other outpatient services. The decrease in the relative weight for diagnostic mammography proposed for 2002 can be attributed to a decrease in the relative level of charges for diagnostic mammography that hospitals reported for services furnished from July 1, 1999 through June 30, 2000 compared to the relative level of charges hospitals reported for all other outpatient services furnished during the same period. However, that weight does reflect the hospital resources used to perform mammograms. We note that the weight for APC 0271 in both the proposed and final rules is calculated from the median cost of almost 900,000 single-procedure claims.

The weight for APC 0271 in this final rule is 0.60. This weight was recalibrated, like all of the APC weights in this final rule, in accordance with the methodology described in section II.D. of this preamble. We note that the weight for APC 0271, like the weights for all of the nondevice-related APCs, has decreased from the proposed weight. This decrease is the result of our incorporating a portion of the cost of pass-through devices into the base costs of the APCs with which the devices are associated. As we explained in the final rule published on November 2, 2001, the additional pass-through device costs that were incorporated into the base APC costs are not evenly distributed among the APCs, but rather are concentrated in a relatively small

number of APCs that include the procedures that use pass-through devices (66 FR 55862). Whereas the weights of these APCs increased as a result of the added device costs, in general, the weights for APCs that do not include device costs, such as APC 0271, decreased by approximately 8 percent. For a more detailed discussion of how the incorporation of device costs into the base APCs affects the relative weights, see sections II.D. and VII, below.

Unlike screening mammography, the statute makes no specific designation for the technical component of diagnostic mammography services furnished in the hospital outpatient setting to be defined as a physicians' service. Therefore, we believe that the payment for diagnostic mammography should be included in the OPPS.

Comment: Several commenters expressed concern that the reduced payment rate for diagnostic mammography would have an especially onerous and negative impact on small, low volume hospitals, most of which are located in rural areas. The commenters noted that although these small rural hospitals are generally the sole providers of mammography and radiology services to the surrounding communities, volume in these hospitals is nonetheless too low to offset the fixed costs incurred for certified staff and equipment.

Response: In order to limit potential reductions in payment to hospitals under the OPPS, section 1833(t)(7) of the Act requires us to provide transitional payment adjustments for hospitals whose OPPS payments are less than our estimate of the hospital's pre-BBA payments. Section 1833(t)(7)(D)(i) of the Act includes a special ''hold harmless'' provision, which applies to hospital outpatient services furnished before 2004 by hospitals that are located in a rural area and that have no more than 100 beds. Under section 1833(t)(7)(D)(i) of the Act, small rural hospitals will be paid a predetermined pre-BBA amount for services covered under the OPPS if payment under the OPPS would be less than the pre-BBA amount. This hold harmless provision establishes a payment floor until January 1, 2004 for small rural hospitals. These provisions should provide some measure of protection to small hospitals in rural areas to the extent that the reduced payment for diagnostic mammography services results in overall payment reductions.

c. Coding and Payment for New Technology Mammography Services. Section 104(d) of BIPA prescribes a payment methodology for both diagnostic and screening mammography furnished during the period April 1, 2001 through December 31, 2001 that use a new technology, as defined in section 104(d)(3) of BIPA. Section 104(d)(2) of BIPA directs the Secretary to determine, for mammography performed after 2001, whether the assignment of a new HCPCS code is appropriate for mammography that uses a new technology. The following codes have been established to identify the new technology mammography services and will be used effective January 1, 2002:

- *HCPCS code G0202,* Screening mammography producing direct digital image, bilateral, all views.
- *CPT code 76085,* Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography. (This code can only be billed with CPT code 76092, Screening mammography, bilateral.)
- *HCPCS code G0204,* Diagnostic mammography, direct digital image, bilateral, all views.
- *HCPCS code G0206,* Diagnostic mammography, direct digital image, unilateral, all views.
- *HCPCS code G0236,* Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography. (This code can only be billed with code CPT code 76090, Diagnostic mammography, unilateral, or CPT code 76091, Diagnostic mammography, bilateral.)

In the proposed rule, we assigned computer-aided detection (CAD) and full field digital mammography (FFDM) services used for diagnostic mammography to APC 0271. We proposed to assign payment status indicator ''A,'' designating that payment would be ''lower of charges or national rate,'' to the CAD and FFDM codes for screening mammography. Numerous commenters addressed our proposed payment for CAD and FFDM new technology mammography services. Their comments are summarized below.

Comment: One commenter recommended that CAD used in conjunction with film screening mammography be assigned to a new technology APC under the OPPS rather than being paid under the physician fee schedule. The commenter argued that although section 104(a) of BIPA provided for payment for screening mammography under the physician fee schedule, payment for a new technology such as CAD is provided under a separate BIPA provision, section 104(d)(3), and therefore is not linked to the physician fee schedule.

Response: We do not agree with the commenter's recommendation that CPT code 76085 for CAD used with screening mammography be assigned for payment to a new technology APC under the OPPS. Because CPT code 76085 is an add-on code that can be paid only when it is billed with CPT code 76092 for screening mammography, we believe it is more appropriate to pay for both CPT codes 76085 and 76092 under the physician fee schedule than to pay for them separately under two different payment systems.

Comment: Most commenters recommended assignment of CAD and FFDM services used with diagnostic mammography to a new technology APC on the grounds that no existing APC would be appropriate both clinically and in terms of payment for these services. Commenters were unanimous in opposing assignment of the CAD and FFDM services used for diagnostic mammography to APC 0271. Several commenters were concerned that payment for these services under the physician fee schedule was so much higher than that proposed under the OPPS.

Response: We agree that the new technology procedures associated with diagnostic mammography should be assigned to a new technology APC until we have collected cost data to make a more clinically and resource use appropriate APC assignment. Therefore, effective for services furnished on or after January 1, 2002, HCPCS codes G0204 and G0206 will be assigned to APC 0971 and HCPCS code G0236 will be assigned to APC 0970.

The difference in payment amounts for the new technology mammography services between the physician fee schedule and the OPPS is attributable to differences in the payment methodology required under the statute.

Final Action: See section II.B.3.a. for the codes used to bill for new technology screening mammography services. The following codes and APC groups are effective for new technology services used for diagnostic mammography beginning January 1, 2002:

HCPCS codes G0205 and G0207 are deleted.

Use HCPCS codes G0204 and G0206 for full field digital diagnostic mammography services; assigned to APC 0707.

Use HCPCS code G0236 for computer-assisted detection with CPT code 76090 and CPT code 76091 for diagnostic mammography; assigned to APC 0706.

C. Other Changes Affecting the APCs

1. Changes in Revenue Code Packaging

In the April 7, 2000 final rule, we described how, in calculating the per procedure and per visit costs to determine the median cost of an APC (and therefore its relative weight), we used the charges billed using the revenue codes that contained items that were integral to performing the procedure or visit (65 FR 18483). The complete list of the revenue centers by type of APC group was printed in the April 7, 2000 rule (65 FR 18484).

In the November 13, 2000 interim final rule, we made some changes to the list of revenue codes to reflect the charges associated with implantable devices (65 FR 67806 and 67825). We were later able to incorporate revenue codes 274 (prosthetic/orthotic devices), 275 (pacemaker), and 278 (other implants) in our database, and effective January 1, 2001, we updated the APC payment rates to reflect inclusion of this information.

As discussed in the proposed rule, we have continued to review and revise the list of revenue codes to be included in the database and we proposed several changes to the list of revenue codes that are packaged with the costs used to calculate the proposed APC rates. Some of these changes reflect the addition of revenue codes and others are a further refinement of our methodology. The following are the specific changes we proposed:

- Package additional revenue centers that may be used to bill for implantable devices (including durable medical equipment (DME) and brachytherapy seeds) with surgical procedures. These additional centers are revenue codes 280 (oncology), 289 (other oncology), 290 (DME), and 624 (investigational devices).
- Package revenue codes 280, 289, and 624 with other diagnostic and radiology services.
- Package the revenue codes for medical social services, 560 (medical social services) and 569 (other medical social services). These services are not paid separately in the hospital outpatient setting but often constitute discharge-planning services if provided with an outpatient service.
- Package revenue code 637 (self-administered drug (insulin administered in an emergency diabetic coma)) with medical visits. Although this is a self-administrable drug, it is covered when administered as described.
- Remove revenue code 723 (circumcision) from the list of packaged revenue codes because circumcision is a payable procedure under OPPS and should not be packaged.
- Package revenue code 942 (education/training) with medical visits and the category of ''All Other APC Groups.'' Patient training and education are generally not paid as a separate service under Medicare, but may be included as part of an otherwise payable service such as a medical visit. We believe that training and education services generally occur as part of a medical visit or psychiatric service.
- Remove the revenue codes in the range of 890 through 899 (donor bank), as these are no longer valid revenue codes.

Comment: One commenter disagreed with our proposal to package revenue code 942 (education/training). The commenter stated that such a policy would be inappropriate because revenue code 942 is the proper revenue code to use when billing diabetes training with HCPCS codes G0108 and G0109. If CMS does package that revenue code, the commenter wanted to know what revenue code should be billed for diabetes education.

Response: Although under OPPS we will package charges for education and training when billed with revenue code 942, training and education associated with diabetes management, identified by HCPCS codes G0108 and G0109, is not paid under the OPPS and, therefore, is not a packaged service. The list of packaged revenue codes contained in the proposed rule represents revenue codes that are packaged when they appear on a bill with an OPPS service and are not billed with a HCPCS code for a service, like diabetes education, which is paid by Medicare but paid outside of the OPPS.

Comment: One commenter questioned our proposal to package additional revenue centers that may be used to bill for implantable devices (including brachytherapy seeds) with surgical procedures. The commenter asked for details on how such packaging would be accomplished and specifically how we would account for the varying number of costly brachytherapy seeds used in each procedure.

Response: In determining the median cost of a procedure or service, we take into account the costs associated with any packaged revenue center that appears on a bill as well as the cost associated with the specific line item that reflects the HCPCS code for the procedure or service. Thus, when a hospital bills a charge for brachytherapy seeds using one of the revenue codes that are identified as a packaged revenue code, we convert that charge to a cost by multiplying the billed charge by the hospital-specific cost-to-charge ratio for the related cost center. The cost of the brachytherapy seeds is then added to all other costs on the bill that are attributable to the procedure to arrive at the cost of the bill. Under this methodology, the varying numbers of brachytherapy seeds used and the varying costs of the seeds are accurately captured in the median cost data we use to calculate median cost for the APC. That is, we would expect that the cost associated with a bill would reflect the number of seeds used in a particular procedure and the median cost for that procedure overall would be an average of the varying numbers of seeds used by hospitals.

2. Special Revenue Code Packaging for Specific Types of Procedures

We proposed that the same packaging used for surgical procedures be used for corneal tissue implant procedures in APC 0244, Corneal Transplant, except that organ acquisition revenue codes and the revenue codes used to bill implantable devices are not packaged with corneal implants.

There are certain other diagnostic procedures with CPT codes that are similar to surgical procedures. The cost of these procedures (HCPCS codes 92980–92996, 93501–93505, and 93510–93536) reflects both the revenue code packaging for ambulatory surgical center (ASC) and other surgery, as well as the revenue code packaging for other diagnostic services.

A complete listing of the revenue codes that we used for purposes of calculating median costs of services are shown below in Table 2.

Table 2.—Packaged Services by Revenue Code

Surgery

250	Pharmacy
251	Generic
252	Nongeneric
257	Nonprescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy, general class
262	IV Therapy/pharmacy services
263	IV Therapy/drug supply/delivery
264	IV Therapy/supplies
269	Other IV Therapy
270	M&S supplies
271	Nonsterile supplies
272	Sterile supplies
274	Prosthetic/orthotic devices
275	Pacemaker drug
276	Intraocular lens source drug
278	Other implants
279	Other M&S supplies
280	Oncology
289	Other oncology

762 Observation room
810 Organ acquisition
290 Durable medical equipment
370 Anesthesia
379 Other anesthesia
390 Blood storage and processing
399 Other blood storage and processing
560 Medical social services
569 Other medical social services
624 Investigational device (IDE)
630 Drugs requiring specific identification, general class
631 Single source
632 Multiple
633 Restrictive prescription
700 Cast room
709 Other cast room
710 Recovery room
719 Other recovery room
720 Labor room
721 Labor
819 Other organ acquisition

Medical Visit

250 Pharmacy
251 Generic
252 Nongeneric
257 Nonprescription drugs
258 IV solutions
259 Other pharmacy
270 M&S supplies
271 Nonsterile supplies
272 Sterile supplies
279 Other M&S supplies
560 Medical social services
569 Other medical social services
630 Drugs requiring specific identification, general class
631 Single source drug
632 Multiple source drug
633 Restrictive prescription
637 Self-administered drug (insulin admin. in emergency diabetic coma)
700 Cast room
709 Other cast room
762 Observation room
942 Education/training

Other Diagnostic

254 Pharmacy incident to other diagnostic
280 Oncology
289 Other oncology
372 Anesthesia incident to other diagnostic
560 Medical social services
569 Other medical social services
622 Supplies incident to other diagnostic
624 Investigational device (IDE)
710 Recovery room
719 Other recovery room
762 Observation room

Radiology

255 Pharmacy incident to radiology
280 Oncology
289 Other oncology
371 Anesthesia incident to radiology
560 Medical social services
569 Other medical social services
621 Supplies incident to radiology
624 Investigational device (IDE)
710 Recovery room
719 Other recovery room
762 Observation room

All Other APC Groups

250 Pharmacy
251 Generic
252 Nongeneric
257 Nonprescription drugs
258 IV Solutions
259 Other pharmacy
260 IV Therapy, general class
262 IV Therapy pharmacy services
263 IV Therapy drug/supply/delivery
264 IV Therapy supplies
269 Other IV therapy
270 M&S supplies
271 Nonsterile supplies
272 Sterile supplies
279 Other M&S supplies
560 Medical social services
569 Other medical social services
630 Drugs requiring specific identification, general class
631 Single source drug
632 Multiple source drug
633 Restrictive prescription
762 Observation room
942 Education/training

3. Limit on Variation of Costs of Services Classified Within a Group

Section 1833(t)(2) of the Act provides that the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost item or service within a group is more than 2 times greater than the lowest cost item or service within the same group. However, the Secretary may make exceptions to this limit on the variation of costs within each group in unusual cases such as low volume items and services. No exception may be made, however, in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act.

Based on the APC changes discussed above in this section of this preamble and our use of more current data to calculate the median cost of procedures classified to APCs, we reviewed all the APCs to determine which of them would not meet the 2 times limit. We use the following criteria when deciding whether to make exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.
- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragmentation.

For a detailed discussion of these criteria, refer to the April 7, 2000 final rule (65 FR 18457).

The proposed rule set forth a list of APCs that we proposed to exempt from the 2 times rule based on the criteria cited above (66 FR 44690). In cases in which compliance with the 2 times rule appeared to conflict with a recommendation of the APC Advisory Panel, we generally proposed to accept the Panel recommendation. This was because Panel recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine payment rates.

We received no comments on our proposal. The following is the final list of APCs we exempted from the 2 times rule. This list reflects the final APCs as recalibrated based on the updated 1999–2000 data base as well as the incorporation of 75 percent of the estimated cost of the pass-through devices (See section II.D).

List of APCs exempted from the ''two times'' requirement:

0001 Photochemotherapy
0004 Level I Needle Biopsy/Aspiration Except Bone Marrow
0043 Closed Treatment Fracture Finger/Toe/Trunk
0044 Closed Treatment Fracture/Dislocation Except Finger
0047 Arthroscopy without Prosthesis
0058 Level I Strapping and Cast Application
0060 Manipulation Therapy
0077 Level I Pulmonary Treatment
0093 Vascular Repair/Fistula Construction
0096 Non-Invasive Vascular Studies
0097 Cardiac Monitoring for 30 Days
0115 Cannula/Access Device Procedures
0121 Level I Tube Changes and Repositioning
0140 Esophageal Dilation without Endoscopy
0141 Upper GI Procedures
0142 Small Intestine Endoscopy
0147 Level II Sigmoidoscopy
0164 Level I Urinary and Anal Procedures
0165 Level III Urinary and Anal Procedures
0182 Insertion of Penile Prosthesis
0187 Placement/Repositioning Misc Catheters
0198 Pregnancy and Neonatal Care Procedures
0203 Level V Nerve Injections
0204 Level VI Nerve Injections
0207 Level IV Nerve Injections
0213 Extended EEG Studies and Sleep Studies, Level I

0215 Level I Nerve and Muscle Tests
0218 Level II Nerve and Muscle Tests
0233 Level II Anterior Segment Eye Procedures
0234 Level III Anterior Segment Eye Procedures
0237 Level III Posterior Segment Eye Procedures
0247 Laser Eye Procedures Except Retinal
0251 Level I ENT Procedures
0252 Level II ENT Procedures
0260 Level I Plain Film Except Teeth
0263 Level I Miscellaneous Radiology Procedures
0264 Level II Miscellaneous Radiology Procedures
0265 Level I Diagnostic Ultrasound Except Vascular
0279 Level I Angiography and Venography Except Extremity
0285 Positron Emission Tomography (PET)
0294 Level I Therapeutic Nuclear Medicine
0296 Level I Therapeutic Radiologic Procedures
0305 Level II Therapeutic Radiation Treatment Preparation
0322 Brief Individual Psychotherapy
0345 Level I Transfusion Laboratory Procedures
0354 Administration of Influenza/ Pneumonia Vaccine
0355 Level I Immunizations
0356 Level II Immunizations
0363 Otorhyinolaryngologic Function Tests
0364 Level I Audiometry
0373 Neuropsychological Testing
0600 Low Level Clinic Visits
0601 Mid Level Clinic Visits
0602 High Level Clinic Visits
0694 Level III Excision/Biopsy

4. Observation Services

Frequently, beneficiaries are placed in ''observation status'' in order to receive treatment or be monitored before making a decision concerning their next placement (that is, admit to the hospital or discharge to home). This occurs most frequently after surgery or a visit to the emergency department. In the proposed rule, we discussed the clinical and payment history of observation services. We also discussed at length the issues we considered in determining whether to make separate payment for observation services. For a more detailed discussion of our deliberations, see 66 FR 44690–91. After careful consideration, we proposed the following:

• To continue to package observation services into surgical procedures and most clinic and emergency visits.

• To create a single APC, APC 0339, Observation, to make separate payment for observation services for three medical conditions, chest pain, asthma, and congestive heart failure, when certain criteria (as described below) are met.

We also proposed to instruct hospitals that payment under APC 0339 for observation services would be subject to the following billing requirements and conditions:

• An emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) is billed in conjunction with each bill for observation services.

• Observation care is billed hourly for a minimum of 8 hours up to a maximum of 48 hours. We would not pay separately for any hours a beneficiary spends in observation over 24 hours, but all costs beyond 24 hours would be packaged into the APC payment for observation services.

• Observation time begins at the clock time appearing on the nurse's observation admission note. (We note that this coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit.)

• Observation time ends at the clock time documented in the physician's discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. (This time coincides with the end of the patient's period of monitoring or treatment in observation.)

• The beneficiary is under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes, timed, written, and signed by the physician.

• The medical record includes documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care. (These criteria may be either published generally accepted medical standards or established hospital-specific standards.)

• The hospital furnishes certain other diagnostic services along with observation services to ensure that separate payment is made only for those beneficiaries truly requiring observation care. We believe that these tests are typically performed on beneficiaries requiring observation care for the three specified conditions and they are medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and the appropriate disposition of a patient in observation care. The diagnostic tests are as follows:

• For chest pain, at least two sets of cardiac enzymes and two sequential electrocardiograms.

• For asthma, a peak expiratory flow rate (PEFR) (CPT code 94010) and nebulizer treatments.

• For congestive heart failure, a chest x-ray, an electrocardiogram, and pulse oximetry.

We proposed to make payment for APC 0339 only if the tests described above are billed on the same claim as the observation service. (We did not propose to require telemetry and other ongoing monitoring services as criteria to make separate payment for observation services. Although these services are often medically necessary to ensure prompt diagnosis of cardiac arrhythmias and other disorders, we do not believe they are necessary to support separate payment for observation services.) In the proposed rule, we listed the following ICD–9–CM diagnosis codes that hospitals would be required to bill to receive payment for APC 0339:

For Chest Pain:

411.1 Intermediate coronary syndrome
411.81 Coronary occlusion without myocardial infarction
411.0 Postmyocardial infarction syndrome
411.89 Other acute ischemic heart disease
413.0 Angina decubitus
413.1 Prinzmetal angina
413.9 Other and unspecified angina pectoris
786.05 Shortness of breath
786.50 Chest pain, unspecified
786.51 Precordial pain
786.52 Painful respiration
786.59 Other chest pain

For Asthma:

493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma with acute exacerbation
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma with acute exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma with acute exacerbation
493.91 Asthma, unspecified with status asthmaticus
493.92 Asthma, unspecified with acute exacerbation

For Congestive Heart Failure:

428.0 Congestive heart failure
428.1 Left heart failure
428.9 Heart failure, unspecified

In the proposed rule, we specified the following process to identify the appropriate median cost for APC 0339 (66 FR 44692). First, we identified in the 1999–2000 claims data all hospital outpatient claims for observation using revenue codes 760, 761, 762, and 769. We then selected the subset of these claims that were billed for patients with chest pain, asthma, and congestive heart failure. Because no standard method for coding these claims was in place in 1996, we identified all diagnosis codes that could reasonably have been used to classify beneficiaries as having chest pain, asthma, and congestive heart failure. We then verified that these beneficiaries received appropriate observation care for chest pain, asthma, or congestive heart failure by identifying the claims in which one or more of the tests identified above were performed. The median costs of these claims were used to establish the median costs of APC 0339.

Finally, we stated that we would consider medical research submitted to support the benefits of observation services for conditions other than those we had proposed. This information will assist us in determining whether these other conditions meet the criteria we used to select the three conditions we proposed to include in APC 0339.

We received a large number of comments on this proposal. Many commenters commended our proposal to pay separately for observation services. However, other commenters either had questions about or suggestions on revising our proposal. Those comments and our responses appear below.

Comment: We received comments requesting that we expand the list of conditions for which we would make a separate payment for observation services. Some commenters listed specific conditions that should be added to the list (for example, abdominal pain, atrial fibrillation, or pyelonephritis) while others asserted that any condition a physician thought required observation should qualify for separate payment. One commenter submitted medical literature as supportive evidence that we should expand our list of conditions. One commenter argued that developing a restrictive list of conditions for which separate payment would be made is inconsistent with the medical literature and with InterQual, which publishes the criteria used by Peer Review Organizations to assess whether admission to the hospital as an inpatient is necessary.

Response: We wish to clarify that our proposal merely specified a list of conditions for which we would make separate payment for observation services. For all other conditions, payment for observation services would be packaged into the APC in which those services were provided. For example, if a patient with syncope goes to the emergency room and receives emergency services and observation services, the payment to the hospital for the emergency visit includes payment for the observation service. The payment rate calculated for clinic and emergency visits includes the packaged costs of observation services to the extent that those costs were included on the visit bills.

We have reviewed the commenters' suggestions for additional conditions and the medical literature that they submitted in support of their requests. At this time, we are finalizing our proposal without expanding the list of conditions for which separate observation payment will be made. As noted in the proposed rule, we believe that chest pain, asthma, and congestive heart failure are the only conditions that require a well-defined set of hospital services that are distinctly different from the services provided in a clinic or emergency service. Thus, they are the services for which a separately payable observation period is clinically appropriate. Given the clinically improper use of observation care by hospitals in the recent past, we want to minimize the risk of future improper use while ensuring a valid medical benefit to the patient for appropriate medical care. Therefore, we believe it is premature to expand the conditions for which we will separately pay for observation services. We want to observe the effect of separate payment for this limited set of conditions to determine what clinical and payment issues arise before expanding the list of conditions. Furthermore, an essential issue for Medicare is that separate payment for observation be made only when those services are clearly distinct and separate from prolonged clinic or emergency department care and when observation provides a distinct clinical benefit that cannot be obtained by sending the patient home or admitting the patient to the hospital. We believe that the medical literature demonstrates such a benefit exists for patients with chest pain, congestive heart failure, and asthma.

We will continue to review this issue and any information that is provided to us. If we believe an expansion of the list of conditions is appropriate, we will include such a proposal in a future proposed rule.

Comment: An association of hospitals provided an explanation of their concept of ''rapid treatment,'' which they distinguished from observation. They defined observation as a service required by managed care contracts that involves only physiologic monitoring, frequent nursing assessment, and the patient's routine daily medication.

Response: This level of care would not qualify as an observation service, either packaged or separately paid, under Medicare. We require that during observation, patients be actively assessed and, if necessary, treated in order to determine if they should be admitted or may be safely discharged.

Comment: Several commenters pointed out that correct coding guidelines allow hospitals to code the reason for a patient's visit in any one of several fields on the claim including the principal diagnosis field, the secondary diagnosis field, and the admitting diagnosis field. These commenters suggested that facilities be allowed to report the appropriate diagnosis code supporting the provision of observation services in the admitting, principal, or secondary diagnosis field.

Response: We agree with the commenters and will ensure that our software is designed to allow this.

Comment: Commenters argued that additional ICD–9–CM diagnosis codes for chest pain, congestive heart failure, and asthma be added to the proposed list of diagnoses qualifying observation care for separate payment. These included: for asthma: 493.00, 493.10, 493.20, 493.90; for congestive heart failure: 391.8, 398.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; for chest pain: codes for weakness, shortness of breath, palpitations, rapid heart beat, and syncope. One commenter asked that we include codes for chronic obstructive pulmonary disease (COPD) on the list of qualifying diagnoses. One commenter believes that 428.1 and 428.9 are not to be used for congestive heart failure and should be deleted from the list.

Response: With regard to the comments to add diagnosis codes for asthma, our proposal included codes for status asthmaticus and acute exacerbations of asthma. The codes suggested by the commenters are used for chronic, stable asthma, or unspecified asthma. Our clinical judgment is that these patients do not require active observation care that meets our definition and, thus, a separate payment is not warranted. Therefore, we have not revised our list of qualifying diagnoses for asthma.

With regard to the suggested codes to be added for congestive heart failure, we agree with the commenters and are adding the codes to the list.

With regard to the suggested codes for chest pain, we note that 786.05, Shortness of breath, was included on our proposed list of qualifying codes. If a patient has one of the other suggested symptoms (weakness, palpitations, rapid heartbeat, and syncope), it would be appropriate to use one of the proposed codes as the diagnosis (for example, 413.9, other and unspecified angina). Therefore, we believe the list we proposed covers the additions suggested by the commenter.

With regard to the requested deletions of codes 428.1 and 428.9, we disagree. Code 428.1 is specified for use in patients with acute pulmonary edema and 428.9 is used for patients with congestive heart failure without a specific diagnosis and both codes are therefore appropriately included on the list.

Comment: Several commenters believe that dedicated observation units would not be financially viable if only three conditions qualified for payment.

Response: We want to emphasize that we are making payment for all observation services provided in the outpatient setting. Payment for observation services not meeting the requirements for separate payment in APC 0339 is included in the payment for the clinic or emergency department visit. That is, the payment for each clinic or emergency department visit contains a payment for packaged observation services. This means that hospitals are being paid for observation every time a clinic or emergency visit is billed.

Our policy of separate payment for certain observation services is not intended to increase the total amount of money paid for observation services. Instead, our policy redistributes payments into a separate APC; the relative weight of the new APC for observation services reflects costs that would otherwise be reflected in the relative weights for other relevant APCs. Thus, the payments for clinic and emergency visits are slightly lower than would have been the case had we not created a separate payment for observation. The only hospitals that could be disadvantaged are those that provided observation care for packaged conditions to an unusually large number of patients. Hospitals with large numbers of observation cases for chest pain, asthma, and congestive heart failure will benefit from our new policy. Hospitals with an average number of observation cases will be neither advantaged nor disadvantaged by our new policy.

Comment: Some commenters believe it is inappropriate ''not to pay for observation'' for other conditions. Others argued that because pulse oximetry, one of the diagnostic tests we identified as a condition of separate payment for congestive heart failure, is a packaged service, it is not paid for and therefore cannot be reported on the bill. This would place hospitals in a ''Catch-22'' situation because they would be required to report pulse oximetry to be paid separately for observation but could not report pulse oximetry because it is packaged.

Response: These comments reflect a misunderstanding of what it means for a service to be ''packaged.'' The concept is perhaps most clearly understood in terms of the anesthesia used during surgery. The costs of the anesthesia drugs and administration are associated with the surgery with which they were billed, and become part of the payment for the surgery. It is understood that anesthesia is paid for, but not paid for separately from the surgical procedure. Similarly, we packaged the cost of observation whenever it was billed. It is packaged into surgical procedures as well as clinic and emergency visits. Each time a hospital bills for a procedure or visit, any associated observation cost is recognized. Because, according to the literature, observation is billed in fewer than 6 percent of emergency room visits, the cost is not always readily identifiable. However, we wish to emphasize that it is important for hospital bills to show that observation was provided and the charges associated with it. This is because the charges for packaged services might affect outlier and transitional corridor payments, and are used to update the APC weights. Thus, hospitals should report pulse oximetry on the bill even though it is not separately payable.

Comment: Surgeons reported that hospitals, believing that observation is not payable, would not allow postoperative observation for patients such as those who have undergone mastectomy or thyroidectomy.

Response: Surgery performed in the outpatient setting should not, as a rule, require a period of postoperative observation. As provided in section 230.6E of the Medicare Hospital Manual, standing orders for observation following outpatient surgery is not a covered service. In addition, that section states that the availability of an outpatient observation unit at a hospital is not a reason to perform, on an outpatient basis, surgeries for which an overnight stay is anticipated.

Although an occasional surgical case may require a longer recovery period, as a rule, surgical outpatients should not require observation. We note, however, that to the extent that observation care is provided to surgical patients, the cost of that care is packaged into the payment for the surgical APC.

Comment: There were many comments on the list of diagnostic tests required for separate payment for observation services. Several commenters pointed out that nebulizer treatments, by definition, are not diagnostic. These commenters also noted that observation of asthma patients need not involve nebulizer treatments (that is, some patients are treated with intravenous steroids or inhalers). Others indicated that pulse oximetry is a routine test and is not usually coded. Other commenters were concerned that the required tests would not all be performed within the period of observation; that is, some tests might be performed in the emergency department before admission to observation status.

Response: The requirement that certain diagnostic tests be performed in order to receive separate payment for observation services reflects our concern that observation not be considered a way to keep a patient in a ''holding pattern.'' We are aware that some patients are considered to be in observation overnight when they are placed in a bed on a nursing unit, with vital signs taken every 4 hours. This is not the service we recognize as observation, which we define as an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient, or if it resolves itself so that the patient may be discharged. The services we included on the list of required treatment were designed to indicate that an active assessment of the patient was being undertaken. We believe this is consistent with the clinical practice of observation.

We agree that nebulizer treatments are not diagnostic, and, although, based on the experience of our clinical staff, are frequently used in acute asthma, they need not be used for every asthma patient receiving observation services. We agree that occasionally patients may use their own inhaler or be given intravenous medications without nebulizer treatments. Thus, we are not including this treatment on the final list of services required for separate payment of observation. As discussed above, pulse oximetry, although packaged, should be reported on the bill when furnished.

We agree that some of the required diagnostic testing (for example, cardiac enzymes) may be performed as part of the emergency or clinic visit before the

beneficiary is admitted to observation status. We will ensure that our software identifies when the required diagnostic tests were performed in the clinic or emergency department as well as diagnostic tests performed during the period of observation.

Comment: Several commenters claimed that requiring specific clinical interventions for observation care was an intrusion into the practice of medicine.

Response: We disagree with the commenters. We are setting conditions only for separate payment for observation. All observation care that does not meet the criteria for classification into APC 0339 will continue to be paid as part of the service into which it is packaged. In order to ensure that we are making separate payment only when it is warranted, we are providing as a condition for separate payment that a minimal number of appropriate diagnostic tests must be performed. The hospital will continue to receive packaged payment for observation care for beneficiaries who require such care but for whom the required tests were not performed.

As stated above, we are withdrawing the proposed condition of administering nebulizer treatments. We will allow either pulse oximetry or peak expiratory flow rate to be performed as a requirement to receive separate payment for observation of asthma patients. We are finalizing our requirements for chest pain and congestive heart failure. We note that none of the commenters had any clinical disagreement with the designation of these specific tests. Their only concern stemmed from the misconception that these tests would be required to be performed in order to receive payment for observation care. We will closely follow the impact of these requirements and, if we believe that changes are necessary, we will propose them in a future rule.

Comment: Several commenters argued that packaging the first 8 hours of observation was arbitrary and would be difficult to document. We also received comments that we should eliminate our minimum time requirement for observation or reduce it to 6 hours. The following reasons were given for these comments: asthma patients do not require 8 hours of observation; no evaluation and management (E/M) service lasts for more than 1 hour and 45 minutes; and emergency visits typically last 3–4 hours so any potential for abuse of observation would be reduced with a minimum time requirement of 6 hours because 6 hours does not overlap with the length of a typical emergency visit.

Response: We believe it is important to ensure that payment for clinic and emergency department services does not duplicate payments for observation. We also want to make clear that we do not consider a long emergency room visit to be ''observation.'' We believe that observation is a specific type of service that should be specifically ordered by a physician and should involve specific goals and a plan of care that is distinct from the goals and plan of care for an emergency or clinic visit. We believe that requiring 8 hours of care as a condition for separate payment of observation is reasonable and will minimize confusion for hospitals. We will be including the first 8 hours of observation care as a packaged service and make payment as part of the clinic or emergency visit with which it occurs. Therefore, the payment rate for emergency and clinic visit will reflect the extent to which patients are observed for less than 8 hours. Although occasionally patients with asthma may require less than 8 hours of observation, we believe that intensity and variety of services provided to patients with an acute asthma exacerbation or status asthmaticus who require 8 or more hours of observation is different from the service provided when they require less than 8 hours of observation. The less intensive services provided to asthma patients who require less than 8 hours of observation is appropriately paid for as part of an emergency or clinic visit. We note that we received no comments disagreeing with our minimum time requirement for patients with chest pain and congestive heart failure. Finally, we believe that a clear requirement of 8 hours will allow hospitals to prospectively develop clinical protocols and plans of care facilitating the appropriate use of observation services. However, we will closely monitor the impact of the 8-hour time requirement and, if appropriate, consider changes for a future proposed rule.

Comment: Commenters raised concerns about our requirement that physicians write progress notes in the medical record. They believe that admission and discharge notes are generally sufficient to document observation care. The commenters also raised questions about determining when observation starts and ends, with one commenter describing the proposed documentation requirement as ''rigid and inflexible.'' Others expected documentation to be difficult in hospitals without emergency department staff or house staff. One commenter stated that specific requirements for determining the time observation stops would not reflect the variety of methods hospitals and physicians have to document time in the medical record. Commenters asserted that the period of treatment and monitoring can continue beyond the time that a discharge order is written by the physician or taken off by the nurse.

One commenter discussed the difficulty in determining when a patient is ''moved to observation status'' and the need for physicians to be able to write orders specifying discharge at a ''future time.'' Several commenters expressed concerns about requiring documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care because documenting use of risk stratification criteria would be burdensome and is not required for any other services.

Response: We appreciate these concerns and, although we are finalizing our proposal, we wish to clarify several aspects of these requirements to reassure commenters. With regard to writing progress notes, we wish to emphasize that the requirement is only to write ''appropriate'' progress notes. We understand that, in many cases, writing a progress note is unnecessary (because the admission and discharge notes are sufficient), while in other cases it is necessary to write progress notes because of the length and complexity of care provided or because of a change in the patient's condition. We wish to clarify that progress notes are not required in every case but only in those cases in which the physician deems it appropriate to write a progress note.

With regard to documenting the times that observation starts and ends, we have to balance the potential for improper billing of observation status against creating burdens for hospitals that will have to support their claims for observation treatment in the medical record. We believe that our policy strikes this balance appropriately. Typically both physicians' orders and nurses' removal of those orders are timed; therefore, we do not believe this requirement places a significant burden on physicians or hospitals because no change in the processes of care will be required. We do not believe that for chest pain, congestive heart failure, and asthma, orders are written for a future discharge time because those patients may not be discharged until treatment goals are met, and determining this requires current (not future) physician intervention (for example, to review lab tests or examine the patient).

An important reason we are requiring clocked time to determine the period of observation is because we want to minimize confusion and separate observation care from prolonged emergency or clinic visits. Our requirements will assist hospitals to prospectively ensure that observation is appropriately billed. Although it is possible that treatment and monitoring may continue for a significant period of time after a discharge order is written or taken off, we believe such an occurrence is the exception rather than the rule; additionally, it is frequently difficult to determine exactly when facility services are discontinued. One problem is that it is typical for those patients to remain in the observation area for a significant period of time after treatment is finished, most commonly because the patient is waiting for transportation home. As stated above, we need a bright line rule with regard to the stop time for observation.

With regard to documenting the use of risk stratification, we did not mean to require any extra documentation in the medical record. We just wish to put physicians and hospitals on notice as to what type of medical record evidence reviewers will use when reviewing claims for observation. We believe that a well-documented observation record will satisfy this requirement without any extra documentation. Therefore, we are clarifying that the manner in which documentation of risk stratification is made is at the discretion of the physician. As with all the criteria we are establishing for payment of APC 0339, we will monitor the effects of these requirements on the provision of observation care and consider making changes if appropriate.

Comment: We received a variety of comments asking for clarification as to how observation services should be reported; whether notes may be written by house staff or fellows; whether orders may be phoned in; whether additional diagnostic tests during observation would be paid for; how observation would be treated by local medical review policies; whether short inpatient stays for congestive heart failure and asthma would no longer be allowed; how billing would occur for patients who are admitted directly to a chest pain center without being seen in the emergency department; and whether payment for observation is made per hour or per day.

Response: Observation services should be tracked by the hour. If the number of hours is less than 8, then payment is packaged into the associated clinic or emergency visit. If more than 24 hours of observation are billed, payment for any time over 24 hours is packaged into the payment for 8 to 24 hours of observation. Therefore, the payment rate for observation will reflect those cases in which observation actually occurs for more than 24 hours. That is, just as the payment for emergency visits reflects payment for observation of up to 8 hours, so will payment for APC 0339 reflect payment for observation care up to 48 hours. Effective for services furnished on or after January 1, 2001, we have created a new HCPCS code for use with our new APC 0339 to help distinguish packaged observation form separately payable observation. The code is G0224, Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours. The previously available CPT codes for observation, 99234–99236, should continue to be used for packaged observation services.

With regard to house staff writing notes and orders, teaching physician rules apply to Part B payments for observation care. With regard to facility payments, observation may be billed if the notes are written by house staff. Physicians may phone in orders but if those orders are for admission or discharge to observation, they must be timed. Moreover, the physician must write admission and discharge notes in the medical record.

We note that we will pay separately for all nonpackaged diagnostic tests furnished to observation patients.

We will continue pay for inpatient admissions for chest pain, asthma, and congestive heart failure when appropriate and our observation payment policy is subject to local medical review policies.

With regard to direct admissions from physician offices, separate payment for observation will not be made unless a physician is present to order the initiation of observation services and to monitor the patient as clinically appropriate.

The following are the final requirements for billing G0244 and assignment to APC 0339.

The acceptable diagnosis codes are:

For Chest Pain

- 391.8 Other acute rheumatic heart disease
- 398.91 Rheumatic heart failure (congestive)
- 402.01 Malignant hypertensive heart disease with congestive heart failure
- 402.11 Benign hypertensive heart disease with congestive heart failure
- 402.91 Unspecified hypertensive heart disease with congestive heart failure
- 404.01 Malignant hypertensive heart and renal disease with congestive heart failure
- 404.03 Malignant hypertensive heart and renal disease with congestive heart and renal failure
- 404.11 Benign hypertensive heart and renal disease with congestive heart failure
- 404.13 Benign hypertensive heart and renal disease with congestive heart and renal failure
- 404.91 Unspecified hypertensive heart and renal disease with congestive heart failure
- 404.93 Unspecified hypertensive heart and renal disease with congestive heart and renal failure
- 411.1 Intermediate coronary syndrome
- 411.81 Coronary occlusion without myocardial infarction
- 411.0 Postmyocardial infarction syndrome
- 411.89 Other acute ischemic heart disease
- 413.0 Angina decubitus
- 413.1 Prinzmetal angina
- 413.9 Other and unspecified angina pectoris
- 786.05 Shortness of breath
- 786.50 Chest pain, unspecified
- 786.51 Precordial pain
- 786.52 Painful respiration
- 786.59 Other chest pain

For Asthma

- 493.01 Extrinsic asthma with status asthmaticus
- 493.02 Extrinsic asthma with acute exacerbation
- 493.11 Intrinsic asthma with status asthmaticus
- 493.12 Intrinsic asthma with acute exacerbation
- 493.21 Chronic obstructive asthma with status asthmaticus
- 493.22 Chronic obstructive asthma with acute exacerbation
- 493.91 Asthma, unspecified with status asthmaticus
- 493.92 Asthma, unspecified with acute exacerbation

For Congestive Heart Failure

- 428.0 Congestive heart failure
- 428.1 Left heart failure
- 428.9 Heart failure, unspecified

The required tests are as follows:

For chest pain, at least two sets of cardiac enzymes and two sequential electrocardiograms.

For asthma, a peak expiratory flow rate (PEFR) (CPT code 94010).

For congestive heart failure, a chest x-ray, an electrocardiogram, and pulse oximetry.

5. List of Procedures That Will Be Paid Only As Inpatient Procedures

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under OPPS. In the April 7, 2000 final rule, we defined a set of services that are typically provided only in an inpatient setting and, hence, would not be paid by Medicare under the OPPS (65 FR 18455). This set of services is referred to as the ''inpatient list.'' The inpatient list specifies those services that are appropriate to provide only in an inpatient setting and that, therefore, are only paid when provided in an inpatient setting. These are services that require inpatient care because of the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

At its February 2001 meeting, the APC Advisory Panel generally favored the elimination of the inpatient list. In the proposed rule, we stated that we disagreed with the position taken by the Panel and we proposed to continue the current policy of reviewing the HCPCS codes on the inpatient list and eliminating procedures from the list if they can be appropriately performed on the Medicare population in the outpatient setting. Our medical and policy staff, supplemented as appropriate by the APC Advisory Panel, would review comments submitted by the public and consider advances in medical practice in making decisions to remove codes from the list. We stated that we would continue to use the following criteria, which we discussed in the April 7, 2000 final rule, when deciding to remove codes from the list:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes we have already moved off the inpatient list (for example, the radiologic part of an interventional cardiology procedure).

In the proposed rule, we indicated that we would continue to update the list in response to comments as often as quarterly through program memoranda to reflect current advances in medical practice. We proposed no further changes to the inpatient list, which we set forth in Addendum E to the proposed rule.

Comment: Several specialty organizations, hospitals, and device manufacturers recommended that we remove certain procedures from the inpatient only list and assign them to APCs.

Response: We reviewed these requests in accordance with our previously published criteria and moved several of the procedures from the list. However, in our clinical judgment, the remainder of the procedures should not be moved. We are referring some of them to the APC Advisory Panel for review and further discussion at the next meeting. As noted in the proposed rule, we plan to continue updating the list on a quarterly basis, as needed. Set forth below is the list of procedures that commenters requested be moved off the inpatient list and the final action that we are taking in this rule.

Procedures That Remain Inpatient

- 34800—Endovascular repair of infrarenal abdominal aortic aneurysm or dissection
- 34802—Endovascular repair of infrarenal abdominal aortic aneurysm or dissection
- 34804—Endovascular repair of infrarenal abdominal aortic aneurysm or dissection
- 34808—Endovascular placement of iliac artery occlusion device
- 34812—Open femoral artery exposure for delivery of aortic endovascular prosthesis
- 34813—Placement of femoral-femoral prosthetic graft
- 34820—Occlusion during endovascular therapy
- 34825—Placement of proximal or distal extension prosthesis
- 34826—Infrarenal abdominal aortic aneurysm
- 33968—Removal of intra-aortic balloon assist device, percutaneous
- 44901—Incision and drainage of appendiceal abscess; percutaneous
- 49021—Drainage of peritoneal abscess or localized peritonitis; percutaneous
- 49041—Drainage of subdiaphragmatic or subphrenic abscess; percutaneous
- 49061—Drainage of retroperitoneal abscess; percutaneous
- 61624—Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

Procedures Referred to the APC Advisory Panel

- 21390—Open treatment of orbital floor blowout fracture
- 27216—Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation
- 27235—Percutaneous skeletal fixation of femoral fracture, proximal end, neck
- 32201—Pneumonostomy; with percutaneous drainage of abscess or cyst
- 47490—Percutaneous cholecystostomy
- 64820—Sympathectomy, digital arteries, with magnification, each digit
- 92986—Percutaneous balloon valvuloplasty; aortic valve
- 92987—Percutaneous balloon valvuloplasty; mitral valve
- 92990—Percutaneous balloon valvuloplasty; pulmonary valve
- 92997—Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
- 92998—Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (list separately in addition to code for primary procedure)

Procedures Moved to APCs

- 23440—Resection or transplantation of long tendon of biceps (APC 0052)
- 23470—Arthroplasty, glenohumeral joint; hemiarthroplasty (APC 0048)
- 47011—Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages (APC 0005)
- 48511—External drainage, pseudocyst of pancreas; percutaneous (APC 0005)
- 49200—Excision or destruction by any method of intra-abdominal or retroperitoneal tumors or cysts or endometriomas (APC 0130)
- 50021—Drainage of perirenal or renal abscess; percutaneous (APC 0005)
- 58823—Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (APC 0193)
- 61626—Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck extracranial, brachiocephalic branch) (APC 0081)
- 61791—Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (e.g., alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract (APC 0204)
- 63655—Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural (APC 0225)

6. Additional New Technology APC Groups

In the April 7, 2000 final rule, we created 15 new technology APC groups to pay for new technologies that do not meet the statutory requirements for

transitional pass-through payments and for which we have little or no data upon which to base assignment to an appropriate APC. APC groups 0970 through 0984 are the current new technology APCs. We currently assign services to a new technology APC for 2 to 3 years based solely on costs, without regard to clinical factors. This method of paying for new technologies allows us to gather data on their use for subsequent assignment to a clinically-based APC. Payment rates for the new technology APCs are based on the midpoint of ranges of possible costs.

After evaluating the costs of services in the new technology APCs, we proposed that APC 0982, which covers a range of costs from $2500 to $3500, be split into two APCs, as follows: APC 0982, which would encompass services whose costs fall between $2500 and $3000, and APC 0983, which would encompass those services whose costs fall between $3000 and $3500. APC 0984 would then encompass services whose costs fall between $3500 and $5000 and we would create a new APC, 0985, for services whose costs fall between $5000 and $6000. We believe that subdividing the current range of costs within APC 0982 would allow us to pay more accurately for the services in that cost range.

In section VI.G of this preamble, we describe several modifications and refinements to the criteria and process for assigning services to new technology APCs that we are implementing in this final rule.

We received no comments on adding a new technology APC group and have included this change in the final APCs. However, we note that in this final rule, we are making additional changes to the new technology APCs to improve our ability to pay appropriately for new technology services.

We are designating 16 additional APC groups, APCs 0706 through 0721, as new technology APCs and reassigning some services currently assigned to APC groups 0970 through 0985 so that, beginning with services furnished on or after January 1, 2002, there will be two parallel sets of new technology APCs. This is an administrative adjustment to distinguish between those new technology services designated with a status indicator of ''S'' and those designated ''T.'' The new APCs will allow us to assign to the same APC group procedures that are appropriately subject to a multiple procedure payment reduction (T) with those that should not be so discounted (S). Each set of new technology APC groups will have identical group titles, payment rates, and minimum unadjusted copayments, but a different status indicator. That is, the new technology APC groups 0970 through 0985 will, effective January 1, 2002, be assigned status indicator ''T'' and all services grouped in APCs 970 through 985 will be subject to the multiple procedure reduction. Each of the new technology APC groups 0706 through 0721 will be assigned status indicator ''S.'' Therefore, effective January 1, 2002, new technology services currently grouped under APC 0971, 0974, 0976, and 0981 are reassigned to APC 0707, 0710, 0712, and 0717, respectively, in order to retain the payment status indicator ''S.''

D. Recalibration of APC Weights for CY 2002

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually beginning in 2001 for application in 2002. In the April 7, 2000 final rule (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000 for each APC group. Except for some reweighting due to APC changes, these relative weights continued to be in effect for 2001. (See the November 13, 2000 interim final rule (65 FR 67824–67827).)

To recalibrate the relative APC weights for services furnished on or after January 1, 2002 and before January 1, 2003, we proposed to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the relative weights for 2002. That is, we would recalibrate the weights based on claims and cost report data for outpatient services. We proposed to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating the proposed APC relative weights for 2002, the most recent available claims data are the approximately 98 million final action claims for hospital outpatient department services furnished on or after July 1, 1999 and before July 1, 2000. We matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. The APC relative weights would continue to be based on the median hospital costs for services in the APC groups.

The methodology we followed to calculate the final APC relative weights for CY 2002 is similar to the proposed except that there are now over 107 million final action claims and as discussed below in section VII of this preamble, we have incorporated a portion of pass-through device costs into device-related procedures. That action has increased the median costs for those procedures. The methodology for calculating the final APC relative weights is as follows:

- We excluded from the data approximately 16.2 million claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with ESRD).
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs) and then by matching the CCRs to revenue centers used on the hospital's 1999–2000 outpatient bills. The CCRs included operating and capital costs but excluded costs paid on a reasonable cost basis that are described elsewhere in this preamble.
- We eliminated from the hospital CCR data 283 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, they make uniform charges for all services).
- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 67 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations.
- We excluded from our data approximately 2.1 million claims from the hospitals that we removed or trimmed from the hospital CCR data.
- We matched revenue centers from the remaining universe of approximately 89.1 million claims to CCRs of 5,672 hospitals.
- We separated the 89.1 million claims that we had matched with a cost report into two distinct groups: single-procedure claims and multiple-procedure claims. Single-procedure claims were those that included only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims included more than one HCPCS code that could be mapped to an APC. There were approximately 39.9 million single-procedure claims and 49.2 million multiple-procedure claims.
- To calculate median costs for services within an APC, we used only single-procedure bills. We did not use multiple-procedure claims because we are not able 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 is billed on a claim. Use of the single-procedure bills minimizes the risk of improperly assigning costs to the wrong procedure or visit.

• 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 not paid under the OPPS (for example, laboratory, ambulance, and therapy services).

• To calculate the per-service costs, we used the charges shown in the revenue centers that contained items integral to performing the service. These included those items that we previously discussed as being subject to our proposed packaging provision. For instance, in calculating the surgical procedure cost, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, and donor tissue, bone, and organ. For medical visit cost estimates, we included charges for items such as medical and surgical supplies, drugs, and observation in those instances in which it is still packaged. See sections II.C.1 and II.C.2 of this preamble for a discussion and complete listing of the revenue centers that we used to calculate per-service costs. In addition, for device-related procedures, we incorporated 75 percent of the estimated cost of the pass-through device into the per-service costs.

• We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the current FY 2002 hospital inpatient prospective payment system wage index published in the **Federal Register** on August 1, 2001 (65 FR 40038). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. A more detailed discussion of wage index adjustments is found in section III of this preamble.

• We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.

• We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the DRG weights for the hospital inpatient PPS. That is, we eliminated any bills with costs outside of 3 standard deviations from the geometric mean.

• After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including, to the extent possible, the proposed APC changes described elsewhere in this preamble.

• We calculated the median cost, weighted by procedure volume, for each APC.

• Using the weighted median APC costs, we calculated the relative payment weights for each APC. We scaled all the relative payment weights to APC 0601, Mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601, to derive the relative payment weight for each APC. The median cost for APC 0601 is $54.00.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes and wage index changes be made in a manner that ensures that aggregate payments under the OPPS for 2002 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2001 relative weights to aggregate payments using the CY 2002 final weights. Based on this comparison, in this final rule we are making an adjustment of 0.945 to the weights; that is, each weight is reduced by this factor (the scaler). The final weights for 2002, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B of the final rule.

We note that in the proposed rule, we inadvertently applied the weight adjustment factor of 1.022 to the relative weights of the new technology APCs. This was incorrect. The payment rates for the new technology APCs are based on the mid-point of the cost range represented by the APC. Therefore the payment rates should be static from year to year. In this final rule, the payment rates for APCs 0970–0985 correctly reflect no adjustment.

Comment: We received numerous comments regarding HCPCS codes and APC groups for which the payment rate proposed for 2002 is lower than the current payment rate. Commenters expressed concern that the proposed decrease in payment would have adverse effects both on beneficiary access to services and hospital solvency. Many commenters suggested that a lower rate was a data or a calculation error and requested that a particular weight be confirmed. Many commenters stated that because the lower proposed payment rate was inadequate to pay hospital costs for the service, we should adjust the rate to a more appropriate level.

Response: As explained above, the methodology we used to recalibrate the final 2002 relative weights is essentially the same methodology that we followed to recalibrate the weights in the August 24, 2001 proposed rule, with the exception of the additional step of folding pass-through device costs into certain base APC costs. (We discuss the reason for this additional step in the November 2, 2001 OPPS final rule (66 FR 55857).)

In both the proposed rule and this final rule, the relative weights for the APC groups change for two reasons: The use of more recent claims data, and the statutory requirements governing how payment for all services under the OPPS must be determined.

The use of more recent claims data: We calibrated the relative weights published in the April 7, 2000 final rule using, as required by the statute, claims from 1996 and data from the most recent available hospital cost reports. These relative payment weights were implemented on August 1, 2000 and they have remained largely unchanged throughout 2001. In the August 24 proposed rule, we proposed to use the same basic methodology to recalibrate the weights that we described in the April 7, 2000 final rule (65 FR 18482). But we also proposed to use the most recent available data, rather than 1996 data, to construct the database for calculating APC group weights. For 2002, the most recent data are from final action claims for hospital outpatient services furnished beginning July 1, 1999 through June 30, 2000. In recalibrating the final weights for 2002, we had the benefit of data from additional claims that had not been received when we recalibrated the relative payment weights for the August 24, 2001 proposed rule. We matched these claims to the most recent cost report filed by the various hospitals represented in the claims data. Hospital costs reflected in claims for the period July 1, 1999 through June 30, 2000 have

changed from those taken from 1996 claims.

Statutory requirements governing how payment for OPPS services is to be determined. Section 1833(t)(9)(B) of the Act requires that estimated spending for services covered under the OPPS be neither greater nor less than it would have been had we not recalibrated the APC weights nor made changes in the APC groups. Because of this, the weights and, therefore, the payment rates for a specific service may increase or decrease depending on the change in charges hospitals report for that service relative to the change in charges hospitals report for other outpatient services.

Under any prospective payment system or fee schedule that bases rates on a system of relative weights within limits imposed by a budget neutrality requirement, some weights will increase and others will decrease from year to year. A decrease in the relative weight for an APC is the result of a decrease in the relative level of charges for the services in that APC that hospitals reported for the period from July 1, 1999 through June 30, 2000, compared to the relative level of charges the same hospitals reported for all other outpatient services furnished during the same period. In addition, the application of the budget neutrality adjustment required by section 1833(t)(9)(B) of the Act will further decrease a relative weight if the adjustment is less than 1.000.

In this final rule, some weights are lower than what we had proposed. The further lowering of weights for some APCs is the result of our incorporating a portion of the cost of pass-through devices into the basic costs of the APCs with which the devices are associated. As we explained in the final rule published on November 2, 2001 (66 FR 55857), the portion of the pass-through device costs that were incorporated into APC costs are not evenly distributed among the APCs, but rather are concentrated in a relatively small number of APCs that include the procedures that use pass-through devices. Whereas the weights of these APCs have increased as a result of the added device costs, the weights for all APCs that do not include device costs have decreased.

In preparing the weights for this final rule, we were particularly attentive to APCs such as APC 0169, Lithotripsy, APC 0245, Level I Cataract Procedures without IOL Insert, and APC 0246, Cataract Procedures with IOL Insert, about which commenters had expressed concern. As a result, we have a high level of confidence in the appropriateness of the weights that are in this final rule. Therefore, we are not increasing the relative weight or payment rate for an APC group simply because its payment is lower in 2002 than it was in 2001 nor are we reducing the relative weight or payment rate for an APC group simply because its payment is higher in 2002 than it was in 2001.

III. Wage Index Changes

Under section 1833(t)(2)(D) of the Act, we are required to determine a wage adjustment factor to adjust for geographic wage differences, in a budget neutral manner, that portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the May 4, 2001 proposed Federal fiscal year (FY) 2002 hospital inpatient PPS wage index (66 FR 22646) to make wage adjustments in determining the proposed payment rates set forth in the proposed rule. We also proposed to use the final FY 2002 hospital inpatient wage index to calculate the final CY 2002 payment rates and coinsurance amounts for OPPS. We received no comments on this issue and are implementing our proposed policy in final.

The final FY 2002 hospital inpatient wage index published in the August 1, 2001 **Federal Register** (66 FR 39828) is reprinted in this final rule as Addendum H, Wage Index for Urban Areas; Addendum I, Wage Index for Rural Areas; and Addendum J, Wage Index for Hospitals That Are Reclassified. Those wage index values will be used to calculate the OPPS payment rates and coinsurance amounts for calendar year (CY) 2002.

IV. Copayment Changes

We note that in section 1833(t) of the Act, the terms ''*copayment*'' and ''*coinsurance*'' appear to be used interchangeably. To be consistent with CMS usage, we make a distinction between the two terms throughout this preamble. We are making conforming changes to part 419 of the regulations to reflect the following usage:

- ''*Coinsurance*'' means the percent of the Medicare-approved amount that beneficiaries pay for a service furnished in the hospital outpatient department (after they meet the Part B deductible).
- ''*Copayment*'' means the set dollar amount that beneficiaries pay under the OPPS. For example, if the payment rate for an APC is $200 and the beneficiary is responsible for paying $50, the copayment is $50 and the coinsurance is 25 percent.

A. BIPA 2000 Coinsurance Limit

As discussed in section I.C of this preamble, certain provisions of BIPA 2000 affect beneficiary copayment amounts under the OPPS. Section 111 of the BIPA added section 1833(t)(8)(C)(ii) of the Act, to accelerate the reduction of beneficiary copayment amounts, providing that, for services furnished on or after April 1, 2001 and before January 1, 2002, the national unadjusted coinsurance for an APC cannot exceed 57 percent of the APC payment rate. The statute provides for further reductions in future years so that the national unadjusted coinsurance for an APC cannot exceed 55 percent in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and thereafter.

We implemented the reduction in beneficiary copayments for 2001 effective April 1, 2001 through changes to the OPPS PRICER software used to calculate OPPS payments to hospitals from the Medicare Program and beneficiary copayments.

We proposed to revise § 419.41 to conform the regulations text to this provision.

We received no comments on this proposal and are implementing the required 55 percent limit on the national unadjusted coinsurance rate of the final APCs. We are also adopting as final the proposed changes to the regulations text.

B. Impact of BIPA 2000 Payment Rate Increase on Coinsurance

Under the statute as enacted by BBA 1997, APC payment rates for 2001 were to be based on the payment rates for 2000 increased by the inpatient hospital market basket percentage increase minus 1 percentage point; however, section 401 of the BIPA 2000 increased APC payment rates for 2001 to reflect an update based on the full market basket percentage increase. The Congress intended for the increased payment to be in effect for the entire calendar year 2001; however, to provide us sufficient time to make the change, the Congress adopted a special payment rule for 2001. Under section 401(c) of the BIPA, the payment rates in effect for services furnished on or after January 1, 2001 and before April 1, 2001 are the rates as determined under the statute prior to the enactment of BIPA. For services furnished on or after April 1, 2001 and before January 1, 2002 the payment rates reflect the full market basket update and are further increased by 0.32 percent to account for the timing delay in implementing the full market basket update for 2001. The 0.32 percent

increase is a temporary increase that applies only to the period April 1 through December 31, 2001 and is not considered in updating the OPPS conversion factor for 2002. The increase in APC payment rates for 2001 was implemented effective April 1, 2001 through changes to the OPPS PRICER software. We proposed to revise § 419.32 to conform to the statute.

The section 401 increase to the APC payment rates affected beneficiary copayments in several ways. In cases for which the beneficiary coinsurance was already based on 20 percent of the APC payment rate, the increase in the APC payment rate caused a corresponding increase in the copayment for the APC. For all other APCs, the copayment amount remained at the same level. In addition, because the minimum copayment amount for an APC, which is the lowest amount a provider may elect to charge if it chooses to reduce copayments for an APC, is based on 20 percent of the APC amount, the increase to an APC payment rate under section 401 of BIPA resulted in an increase to the minimum copayment amount for each APC.

We received no comments on this issue, and we are implementing the changes to the regulations text in final.

C. Coinsurance and Copayment Changes Resulting From Change in an APC Group

National unadjusted copayment amounts for the original APCs that went into effect on August 1, 2000 were, by statute, based on 20 percent of the national median charge billed for services in the APC group during calendar year 1996, trended forward to 1999, but could be no lower than 20 percent of the APC payment rate. Although the BBA 1997 specified how copayments were to be determined initially, the statute does not specify how copayments are to be determined in the future as the APC groups are recalibrated or as individual services are reclassified from one APC group to another. In the proposed rule, we provided the method we intend to apply in determining copayments for new APCs (that is, those created after 2001) and for APCs that are revised because of recalibration and reclassification. We also discussed the issues we considered in developing a proposed approach to be used in determining copayments for new or revised APCs.

The following describes how we proposed to determine copayment amounts for new and revised APCs for 2002 and subsequent years:

1. If a newly created APC group consists of services that were not included in the 1996 data base or whose charges were not separately calculated in that data base (that is, the services were excluded or packaged) the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If recalibrating the relative payment weights results in an APC having a decrease in its payment rate for a subsequent year, the unadjusted copayment amount will be calculated so that the coinsurance percentage for the APC remains the same as it was before the payment rate decrease. For example, assume the APC had a payment rate of $100 and an unadjusted copayment amount of $50, resulting in a coinsurance percentage of 50 percent. If the new payment rate for the APC is lowered to $80, the copayment amount is calculated using the prior coinsurance percentage of 50 percent; therefore, the new copayment amount would be 50 percent of $80 or $40.

3. If recalibrating the relative payment weights results in an APC having an increase in its payment rate for a subsequent year, the unadjusted copayment amount would be calculated so that the copayment dollar amount for the APC remains the same as it was before the payment rate increase. That is, the unadjusted copayment amount would not change. For example, assume the APC had a payment rate of $100 and an unadjusted copayment amount of $60 (a coinsurance percentage of 60 percent). If the new payment rate for the APC is increased to $150, the unadjusted copayment amount would remain at $60 (a coinsurance percentage of 40 percent).

4. If a newly created APC group consists of services from two or more existing APCs, the unadjusted copayment amount would be calculated based on the lowest coinsurance percentage of the contributing APCs. For example, a new APC is created by moving some or all of the services from two existing APCs into the new APC. Assume that one contributing APC had a payment rate of $100 and an unadjusted copayment amount of $40, a coinsurance percentage of 40 percent. Assume the other contributing APC had a payment rate of $150 and an unadjusted copayment amount of $75, a coinsurance percentage of 50 percent. If the new APC had a payment rate of $130, the unadjusted copayment amount for the new APC would be based on a coinsurance percentage of 40. The unadjusted copayment amount for the new APC would be 40 percent of $130, or $52.

These changes will in general reduce beneficiary copayment for services in affected APCs. For 2002, we believe the size of these changes will be modest. If in the future the size of such changes appears likely to be large, we may revisit this policy.

5. If an APC payment rate is increased due to a conversion factor update, the unadjusted copayment amount for the APC would not change.

We received no comments on this proposal. Therefore, we are implementing the proposed methodology for calculating copayment amounts in this final rule.

V. Outlier Policy Changes

For OPPS services furnished before January 1, 2002, section 1833(t)(5)(D) of the Act explicitly authorizes the Secretary to apply the outlier payment provision based upon all of the OPPS services on a bill. We exercised that authority and, since the beginning of the OPPS on August 1, 2000, we have calculated outlier payments in the aggregate for all OPPS services that appear on a bill. However, beginning January 1, 2002, we proposed to calculate outlier payments based on each individual OPPS service. That is, we proposed to revise the aggregate method that we are currently using to calculate outlier payments and begin to determine outliers on a service-by-service basis for OPPS services furnished on or after January 1, 2002.

In the proposed rule, we discussed in detail the difficulties we faced with calculating outliers based on individual services. We also discussed possible solutions to those problems including requiring hospitals to submit separate bills for each OPPS service and allocating the charges for any packaged service among the individual OPPS services that appear on the bill. We stated that we prefer using one of the approaches that would allocate packaged charges among the APCs on a bill to avoid disruptive billing changes. We proposed that charges be allocated to each OPPS service based on the percent the APC payment rate for that service bears to the total APC rates for all OPPS services on the bill.

We also proposed to convert charges to costs for calculating outlier payments by continuing to apply a single overall hospital-specific cost-to-charge ratio instead of applying hospital-specific departmental cost-to-charge ratios. In the proposed rule, we explained that, for purposes of calculating outlier payments under the OPPS, the use of departmental cost-to-charge ratios is not feasible given currently available information because we do not have a way of defining, in a uniform manner that is accurate for all hospitals, which departmental cost-to charge ratio to

apply to a revenue code billed by a hospital. We also explained that collecting the data necessary to make it feasible to use departmental cost-to-charge ratios would impose significant burden and administrative costs on hospitals and our contractors. We then stated that given that outliers represent only 2 to 3 percent of total OPPS expenditures, we believe that the increased accuracy in calculating outlier payments that we could gain would not be sufficient to justify the significant additional administrative burden and cost that would be required. For this reason, we proposed to continue to apply a single hospital-specific outpatient cost-to-charge ratio to convert billed charges to costs for calculating outlier payments.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. We also explained that, for purposes of simulating payments to calculate outlier thresholds, we set the parameters for determining outlier payments as if the target were 2.5 percent. We believed that it would be likely that using simulation 1996 claims data would overstate the percentage of payments that would be made. Based on the simulations, we set a threshold for outlier payments at 2.5 times the claim cost and a payment percent of 75 percent of the cost above the threshold for both 2000 and 2001.

In setting the proposed CY 2002 outlier threshold and payment percentage, we accounted for the change to service level rather than claim level outlier calculation. We proposed to set the target for outlier payment at 2.0 percent as we had for CY 2001. We believe that the claims data we are using to set the 2002 payment rates reflect much better coding of services than did the 1996 data so we set the proposed threshold and proposed payment percentage based on simulations of payments so that the percentage of outlier payments under the simulations was 2.0 percent, rather than 2.5 percent as we did in simulating payments to set the outlier criteria for the April 7, 2000 final rule. Based on our simulations, the proposed threshold for 2002 is 3 times the service costs and the proposed payment percentage for costs above that threshold is set at 50 percent. Based on the simulations using the updated claims data from July 1, 1999 to June 30, 2000, the final threshold for 2002 is 3 times the service costs and the final payment percentage for costs above that threshold is set at 50 percent (the same as the proposed thresholds).

We received many comments on our proposed changes to the outlier policy, which are summarized below along with our responses.

Comment: Several commenters expressed concern that we proposed to increase the outlier threshold while lowering the payment percentage without providing sufficient analysis in the proposed rule to document and justify these changes. A number of commenters contended that the quality of the data is not sufficient to justify these dramatic changes and urged us to maintain the current threshold and payment percentage until better data become available. One commenter recommended that we either furnish hospitals with the information that explains the significant changes, providing an additional opportunity to comment, or maintain the current threshold and payment percentage amounts. Another commenter stated that, in the annual proposed and final rules for hospital inpatient PPS, the data to support any modifications to outlier payments are presented in detail and the commenter believes we should include similar information in the annual proposed and final OPPS rules.

Response: In the April 7, 2000 final rule (65 FR 18498), we described the general methodology that we use to set the outlier threshold and payment percentage. We use historical claims data and simulate payments for those claims by applying the payment rates and policies for the upcoming year. We calibrate the threshold and payment percentage by applying an iterative process in which we try different combinations of thresholds and payment percentages until an appropriate combination results in outlier payments under the simulation equal to the target percentage (for purposes of the simulation) of total OPPS payments under the simulation.

There are two major sources of the changes between the threshold and payment percentage for 2001 and these proposed 2002. First, the outlier payment simulations for the proposed rule reflected the proposed change in the outlier payment policy from a bill-level calculation to service-level calculation. Second, the outlier payment simulations for the proposed rule were based on updated claims data which were considerably more recent than the 1996 claims we used previously. We believe that the updated data reflect more accurate coding of the outpatient services hospitals furnished compared to the 1996 data.

When updated data or a change in policy (or, as in this case, both) dictate a significant change in the outlier parameters, we believe it is, in general, a better policy to adjust both the threshold and the outlier payment percentage. For 2002, an adjustment made only to the threshold amount would greatly limit the number of services that would qualify for an outlier payment. Conversely, an adjustment only to the outlier payment percentage would have significantly decreased the amount of the outlier payment made for the services that do qualify. By adjusting both of the parameters, we hope to strike a balance. That is, for 2002 as compared to 2001, we do not wish to drastically lower the number of services qualifying for outlier payment nor do we wish to significantly decrease the amount of payment hospitals may receive for services that qualify as outliers. Based on this premise, we both raised the outlier threshold and decreased the payment percentage in order to prevent, to the extent possible, large changes in the outlier payments made to hospitals.

Comment: One commenter stated that, because we provided no data to demonstrate that the target for CY 2001 would be exceeded, we should provide that if the proposed changes are put into place and actual outlier payments in 2002 are significantly less than the 2002 outlier target, the ''shortfall'' from 2001 and 2002 will be made up by increased outlier payments in subsequent years.

Response: The outlier threshold and payment percentage are determined each year based on our best estimate of what threshold and payment percentage are needed to achieve a certain level of outlier payments. For example, for CY 2002, we set the threshold and payment percentage based on estimates so that outlier payments are projected to equal 2.0 percent of total OPPS payments.

Section 1833(t)(5)(C) of the Act requires that the outlier payment estimate for a year be made by the Secretary before the beginning of the year. Consistent with our outlier policies in other prospective payment systems, we will not adjust outlier payments in subsequent years to account for an underestimation (or overestimation) of outlier payments in a previous year. The statute does not provide for such an adjustment. We set the outlier policies prospectively, using the best available data. Outlier payments, like many aspects of a prospective payment system, reflect estimates, and we believe it would be inappropriate to adjust the outlier payments (upward or downward) for a given year simply because an estimate for a previous year ultimately turned out to be inaccurate. If we underestimate or overestimate the percentage of outlier payments, the divergence of our estimate from actual experience may

provide information that might help us improve future estimates, but it would have no direct effect on the amount of outlier payments for any following year.

Comment: One commenter suggested that we lack reliable data on actual claims experience that are critical in determining which hospitals are receiving outlier payments and for which specific services. The commenter believes that once such data become available, they can be used to improve the APC system, reducing the overall need for outliers and to refine the outlier methodology to target outlier payments as most appropriate.

Response: As coding on outpatient claims improves, the median costs we use to calculate APC weights and, ultimately, APC payment rates will also more accurately reflect the resources associated with furnishing the services within each APC. It is possible that this may reduce the incidence of outlier payments for specific services as well as decrease the need for outlier payments across all services.

Comment: One commenter pointed out that the increase in the outlier threshold and the decrease in the percent of the excess costs that will be paid as an outlier payment are based on an outlier target of 2.0 percent of estimated total OPPS payments. In order to not penalize hospitals that treat high cost cases, the commenter recommended that the outlier target be set at 3.0 percent of estimated total OPPS payments.

Response: Section 1833(t)(5)(C) of the Act limits projected outlier payments for years prior to 2004 to no more than 2.5 percent of projected total OPPS payments. For CY 2002, we proposed to set the target for outlier payments at 2.0 percent. Although we could increase that amount to 2.5 percent, we have chosen not to do so because increasing the outlier target percentage would require a corresponding decrease to APC payment amounts due to budget neutrality. Given the decrease in many of the APC payment rates that results from the incorporation of 75 percent of device pass-through costs into the APCs (see section II.D. of this preamble), we believe it is appropriate not to increase the outlier target percentage so that there is no additional reduction in the APC payments. Once we have claims data that reflect payments made under the OPPS, our analysis of those data may lead us to revise our policy of setting the outlier target below the limit allowed.

Comment: One commenter estimated that the proposed changes in the threshold and the payment percentage would reduce outlier payments by as much as 50 percent. Several other commenters claimed that the proposed changes would result in drastic cuts in outlier payments to certain community mental health centers (CMHCs) in Louisiana and Mississippi. These commenters contended that the payment reductions would be so severe that CMHCs would be forced to close, thereby eliminating services for the seriously and persistently mentally ill. These commenters requested that the CY 2002 outlier payments for CMHCs continue to be calculated using the CY 2001 outlier threshold and payment percentage.

Another commenter asked that we provide data on outlier payments made since the implementation of the OPPS to provide greater information about the impact of outliers on cancer care. The commenter stated that, in the area of cancer care, hospital outpatient departments often provide the only access point for patients needing complex therapies or new therapies not yet specifically recognized by the coding system and outlier payments provide an important safeguard against any adverse impact of providing this care. The commenter specifically requested information on how the outlier payments have been applied to cancer patients across the country. If actual outlier payments are less than the 2.0 percent target, the commenter urged us to direct more of the outlier monies to cancer care or apply any difference between projected and actual outlier amounts to the transitional pass-through payments for drugs and devices.

Response: As discussed above, the difference between the 2001 and proposed 2002 outlier threshold and payment percentage arises from the use of newer claims data and the change to a service-level rather than claim-level outlier payment calculation. In accordance with section 1833(t)(5) of the act, we set a ''fixed'' threshold that applies to all OPPS services. Thus, we apply a uniform threshold to all OPPS services in a given calendar year; the statute does not provide for different thresholds for different classes of providers or different types of OPPS services. Similarly, we set the payment percentage prospectively before the beginning of each year and apply it to all OPPS services qualifying for outlier payments in that year.

Currently, we do not have adequate data for OPPS claims to perform a useful analysis of actual outlier payments under the OPPS, but we expect to discuss information on actual outlier payments in future regulation documents after sufficient information becomes available.

For the suggestion concerning the redistribution of outlier payments to pass-through drugs and devices, we note that the statute provides for both the outlier and transitional pass-through payments and establishes the 2.5 percent limits on those payments for the years before 2004 (when the limit for outliers increases to 3.0 percent and the limit for transitional pass-throughs decreases to 2.0 percent). Thus, we do not have the administrative authority to make the change that this commenter has recommended. Rather, legislative action would be required to make any of these changes.

Comment: Although some commenters were in favor of calculating outlier payments on an individual service basis, several commenters requested that we reconsider our proposal and recommended that we continue to use the aggregate bill method. Another commenter believes that the increased specificity gained under the proposed outlier methodology would not offset the additional costs and administrative burden to hospitals of making information system changes necessary to calculate and verify outlier payments. One commenter asserted that multiple service claims are not used in calculating the APC relative weights because we are unable to accurately allocate packaged items and services when more than one service is billed on a claim. The commenter is concerned that the same problem would occur with the proposed methodology for paying outliers and recommends that, to avoid inappropriate outlier payments, we should continue to calculate outliers on a claim-level basis until an equitable method of assigning packaged costs is developed.

Another commenter believes that the current methodology more accurately meets the intent of outlier payments, which is to pay facilities for unusual expenses incurred on behalf of patients, not specific line items or individual services. The commenter stated that the allocation of charges to develop service-by-service outliers presents an administrative problem to those hospitals that must significantly alter their systems in order to monitor and audit their payments.

Several commenters expressed concern that the proposed service-level approach could result in very few services qualifying for additional payment and asked for a delay in the policy. One hospital association requested a delay so it would have an opportunity to evaluate CYs 2000 and 2001 data to better understand the impact the change would have on its member hospitals. Another hospital

association believes that the data that are currently available (that is, data for services furnished prior to implementation of the OPPS) may not accurately reflect the financial impact of the proposed change and asked for a delay in calculating service-level outliers until OPPS data are available and can be provided to the hospital industry for analysis. Several commenters urged us to delay implementation of service-level outlier calculations until hospitals and fiscal intermediaries had adequate time to perform systems testing related to the change.

Response: We believe that calculating outliers on a service-by-service basis is the most appropriate way to calculate outliers for outpatient services. Outliers on a bill basis requires both the aggregation of costs and the aggregation of OPPS payments thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in no outlier payment being made. While service-based outliers are somewhat more complex to administer, under this method, outlier payments will be more appropriately directed to those specific services for which a hospital incurs significantly increased costs. We are revising the outpatient PRICER program to calculate outliers on a service-by-service basis, and we do not anticipate that our contractors will have any significant problems being able to calculate outlier payments under this revised policy.

Comment: Two commenters requested clarification concerning how outlier payments would be calculated on a service-by-service basis in the case of multiple surgical procedures appearing on the same claim when all of the surgical charges are combined into a single line on the claim. One commenter stated that if hospitals will be required to change the practice of combining surgical charges for all procedures on a single line item, they may require significant resources to comply with such a change.

Response: The commenters raise a valid concern. When a hospital performs several surgical procedures during the same operative session, it is an acceptable billing practice to show the entire charge for use of the operating room or treatment room on the line with one of the surgical HCPCS codes and zero charges on the lines with the remaining surgical HCPCS codes. We do not intend to require that hospitals change this practice. Hospitals will continue to have the option of splitting out the charges among the individual surgical procedures based on the resources that are attributable to each procedure or they may show a single combined charge with one of the surgical HCPCS codes and zero charges with the others. If the hospital chooses the latter option, in calculating outliers on a service-by-service basis, we will allocate the combined operating or treatment room charge among all of the surgical procedures on the bill. The charges will be allocated to each surgical procedure based on the proportion that the APC payment for the procedure bears to the total APC payments for all surgical procedures performed on that day.

Comment: One commenter supported calculating outliers on a service-by-service basis and agreed with using an overall cost-to-charge ratio, but disagreed with the proposal to allocate packaged services. Several commenters asserted that while it is not possible to directly assign packaged services to a payable procedure in all cases, it is possible in some cases. As an example, the commenters stated that on a claim with a surgical procedure and a visit or diagnostic service, it would be logical and reasonable to assign anesthesia, recovery room, and device charges completely to the surgical procedure, instead of allocating a portion to the visit or diagnostic service.

Another commenter recommended that we modify our proposal for allocating packaged services and develop a set of rules to directly assign the packaged services for those obvious situations when there is a clear relationship of the packaged item or service to the payable service or procedure.

Response: We believe that the policy the commenters are recommending is problematic. For example, anesthesia and recovery room services are not limited to surgical procedures but may also be billed with certain diagnostic procedures. Although we agree that we may in the future be able to improve the allocation of packaged services for a service-level outlier calculation, we also must be careful that the calculation does not become so complex that hospitals are unable to understand how their outlier payments have been determined. Therefore, we are not adopting the commenter's suggestion. We will however continue to analyze possible refinements to this policy.

Comment: One commenter acknowledged the complexities we would face in using a cost report line-specific method of calculating the cost-to-charge ratios (CCRs) for outlier payments but believes the issue warrants further study. The commenter contends that using line-specific CCRs is the only way to ensure that outlier payments are equitable on a service level.

Response: We agree with the commenter that applying appropriate departmental cost-to-charge ratios (CCRs) would generally be more accurate than using an overall outpatient CCR. However, as discussed above and in the proposed rule, it is currently unfeasible to use departmental cost-to-charge ratios for purposes of outlier payments under the OPPS because we currently do not have the necessary information. We continue to believe that the increased accuracy that would be achieved by use of departmental CCRs would not justify the significant administrative burden that would be placed on both hospitals and fiscal intermediaries.

Comment: A number of commenters raised concerns about the hospital-specific CCRs we have used since the beginning of OPPS to calculate outlier payments as well as transitional pass-through payments and interim transitional corridor payments. The commenters raised issues relating to the accuracy of CCR calculations, the basis of future CCR updates, and the timing of CCR updates.

Response: We are working on instructions to our fiscal intermediaries that will address both how and when the CCRs will be revised and updated and those instructions will be published in a forthcoming program memorandum.

VI. Other Policy Decisions and Proposed Changes

A. Change in Services Covered Within the Scope of the OPPS

Section 1833(t)(1)(B) of the Act defines the term ''covered OPD services'' that are to be paid under the OPPS. ''Covered OPD services'' are ''hospital outpatient services designated by the Secretary'' and include ''inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (1) is entitled to benefits under Part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (2) is not so entitled'' (that is, ''Part B-only'' services). ''Part B-only'' services are certain ancillary services furnished to inpatients for which the hospital receives payment under Medicare Part B. These services, which are specified in section 3110 of the Medicare Intermediary Manual and section 2255C of the Medicare Carriers Manual include diagnostic tests; X-ray and radioactive isotope therapy; surgical dressings, splints and casts; prosthetic

devices; and limb braces and trusses and artificial limbs and eyes.

In the April 7, 2000 final rule, we included inpatient ''Part B-only'' services within the definition of services payable under the OPPS (68 FR 18543). In the proposed rule, we discussed some hospitals' concerns about the administrative burden and prohibitive costs they would incur if they were to change their billing systems to accommodate OPPS requirements solely to receive payment for ''Part B-only'' services. We proposed to revise § 419.22 by adding paragraph (r) to exclude Part B-only services that are furnished to inpatients of hospitals that do no other billing for hospital outpatient services under Part B from payment under the OPPS.

We noted that under this proposed revision of the regulations, hospitals with outpatient departments would continue to bill under the OPPS for Part B-only services that they furnish to their inpatients. However, a hospital that does not have an outpatient department would be unable to bill under the OPPS for any Part B-only service the hospital furnished to its inpatients because those services would not fall within the scope of covered OPD services. If a hospital with no outpatient department is currently billing under the OPPS, the hospital would have to revert to its previous payment methodology for services furnished on or after January 1, 2002. That methodology would be an all-inclusive rate for hospitals paid that way prior to the implementation of OPPS and reasonable cost for other hospitals.

We received several comments on this proposal, which are summarized below.

Comment: Several commenters requested that the proposed change be made retroactive to the implementation of OPPS on August 1, 2000. These commenters observed that, without retroactive effect, the hospitals would be unable to bill for inpatient ancillary services provided to beneficiaries with Part B-only coverage during the period from August 1, 2000 until January 1, 2002. Another commenter contended that the proposed policy should have retroactive effect. The commenter raised two alternative reasons for this contention. One was that section 1833(t)(1)(B)(ii) of the Act should not have been interpreted to apply to inpatients who have exhausted their Part A coverage because of the 190-day lifetime limit on inpatient psychiatric days, because the statutory language refers only to hospital inpatients who have ''exhausted benefits for inpatient hospital services during a spell of illness.'' The other was that, allegedly, CMS had never designated through formal regulations those Part B services that are subject to the OPPS. Until such a rule is adopted, the commenter contended, no service provided on an inpatient basis to beneficiaries with Part B-only coverage can be subject to OPPS.

Response: Contrary to the assertion of the commenter, we have in fact designated those Part B services to be covered under the OPPS through formal regulations. In the April 7, 2000, final rule, we specifically included services furnished to inpatients who have exhausted their Part A benefits in the list of ''Services Included Within the Scope of the Hospital Outpatient PPS,'' and provided examples of those services (65 FR 18444). The statutory language gives the agency broad authority to define the services that are to be included under the OPPS. The statute broadly includes both ''hospital outpatient services designated by the Secretary'' and ''inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (1) is entitled to benefits under Part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (2) is not so entitled'' within the definition.

We designated Part B-only services as OPPS services through notice and comment rulemaking, and the policy has been in effect since the inception of OPPS. As discussed in the proposed rule, representatives of hospitals approached us *after* publication of the April 7, 2000 final rule to express concerns about the policy. We have considered those concerns, and we are changing the policy prospectively. We believe not only that applying the policy change on a prospective basis only is fair (particularly given that the current policy was established through notice and comment rulemaking) but also that applying the policy change on a retroactive basis would constitute impermissible retroactive rulemaking.

Comment: Several commenters requested that CMS clarify that those hospitals to which this change applies may resume billing under the per diem based methodology that they employed prior to the implementation of OPPS.

Response: As we stated in the proposed rule (66 FR 44699), ''If a hospital with no outpatient department is currently billing under the OPPS, the hospital would have to revert to its previous payment methodology for services furnished on or after January 1, 2002. That methodology would be an all-inclusive rate for hospitals paid that way prior to the implementation of OPPS and reasonable cost for other hospitals.'' The hospitals to which this change applies may therefore resume billing under the per diem or reasonable cost methodology that was applicable to them prior to the implementation of the OPPS.

Comment: One commenter asked that we recognize the situation of two other classes of hospitals. Some hospitals that have outpatient departments submit claims for only a limited range of outpatient services under Part B. Other hospitals have outpatient departments (for example, for children's psychiatric services) but submit no claims under Medicare Part B. The commenter contended that these hospitals do not have the capacity to bill for the full range of inpatient ancillary services under the OPPS.

Response: We believe that it is very important to restrict this exception to those hospitals that do not provide Medicare Part B services through an outpatient department. As stated in the April 7, 2000 final rule, in developing a hospital OPPS, we ''wanted to ensure that all services furnished in a hospital outpatient setting will be paid on a prospective basis.'' (65 FR 18442.) We believe that hospitals that have outpatient departments and that bill for some outpatient services under Part B should also be paid for the services in question under the OPPS. Therefore, those hospitals will not be excluded from billing under the OPPS. On the other hand, the exception will apply to those hospitals that do not bill under Medicare Part B, even if they have outpatient departments; that is, they do not treat Medicare beneficiaries in their outpatient departments.

Comment: Several commenters requested that CMS clarify whether the proposed provision in § 419.22(r) of the regulations would include therapy services (for example, physical therapy) so that the State psychiatric hospitals included in the exception could resume billing therapies at the per diem all-inclusive rate. The commenters pointed out that these services are currently included in the list of ancillary services under section 3110 of the Medicare Intermediary Manual and section 2255C of the Medicare Carrier Manual. In the proposed rule, CMS specified that the Part B-only services to which the proposed exception would apply were ancillary services listed in those manual sections, but did not specifically list the therapy services in the proposed rule. Some of these commenters raised the same question about diagnostic laboratory services, which CMS had also not specifically listed in the preamble text, but which are included in the list of ancillary services under section 3110

of the Medicare Intermediary Manual and section 2255C of the Medicare Carrier Manual.

Response: Section 1833(t)(1)(B)(iv) of the Act specifically excludes outpatient physical therapy, outpatient speech-language pathology, and outpatient occupational therapy from the definition of services payable under the OPPS. Therefore, we specifically did not include them in the list of Part-B only services to which the exception would apply in the proposed rule. These services are subject to fee schedules that were established prior to the OPPS.

We agree with the commenters that diagnostic laboratory services are included in the list of ancillary services that are excluded from the OPPS under this policy.

B. Categories of Hospitals Subject To and Excluded from the OPPS

Under § 419.20(b), certain hospitals in Maryland that qualify under section 1814(b)(3) of the Act for payment under the State's payment system are excluded from the OPPS. Critical access hospitals (CAHs), which are paid under a reasonable cost-based system as required under section 1834(g) of the Act, are also excluded. In addition, we stated in the April 7, 2000 final rule that the outpatient services provided by the hospitals of the Indian Health Services (IHS) will continue to be paid under separately established rates. We also noted that we intended to consult with the IHS and develop a plan to transition these hospitals into OPPS. With these exceptions, the OPPS applies to all other hospitals that participate in the Medicare program.

In the proposed rule, we noted that under the statute, hospitals located in Guam, Saipan, American Samoa, and the Virgin Islands are excluded from the hospital inpatient PPS. We proposed to revise § 419.20 of the regulations by adding paragraph (b)(3) to exclude these hospitals from OPPS consistent with their treatment under inpatient PPS. In addition, we proposed to revise paragraph (b)(4) of that section to include the hospitals of the IHS to clarify that they are excluded from OPPS until we develop a plan to include them. We noted that it might also be possible to include the hospitals in the territories in the OPPS in the future.

We received one comment on this proposal, as set forth below.

Comment: A commenter asked for clarification about the meaning of ''hospital of the Indian Health Service'' in the context of our proposal. The commenter requested that CMS define the term to include several classes of hospitals, not only those owned and operated by the IHS, but also those that are operated by Tribes and Tribal organizations, but owned or leased by the IHS.

Response: We agree with the commenter that clarification of the term ''hospital of the Indian Health Service'' is appropriate, and we are taking this opportunity to do so. Specifically, we will use here the definition at 42 CFR 413.65(l), where the term is defined to include facilities and organizations that, on or before April 7, 2000, furnished only services that were billed as if they were furnished by a hospital operated by the IHS or by a Tribe and that are: owned and operated by the Indian Health Service; owned by a Tribe or Tribal organization but leased from the Tribe or Tribal organization by the IHS under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes; or owned by the Indian Health Service but leased and operated by the Tribe or Tribal organization under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

C. Conforming Changes: Additional Payments on a Reasonable Cost Basis

Hospitals subject to the OPPS are paid for certain items and services that are outside the scope of the OPPS on a reasonable cost or other basis. Payments for the following services are made on a reasonable cost basis or otherwise applicable methodology:

a. The direct costs of medical education as described in § 413.86.

b. The costs of nursing and allied health programs as described in § 413.85.

c. The costs associated with interns and residents not in approved teaching programs as described in § 415.202.

d. The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based payment for teaching physicians under § 415.160.

e. The costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under § 412.113(c).

f. Bad debts for uncollectible deductible and coinsurance amounts as described in § 413.80(b).

g. Organ acquisition costs paid under Part B.

Interim payments for these services are made on a biweekly basis and final payments are determined at cost report settlement.

We proposed to revise § 419.2(c) to make conforming changes that reflect the exclusion of these costs from the OPPS rates.

We received one comment on this proposal, as follows.

Comment: The commenter supported the clarification, but requested a statement concerning how CMS will ensure that the appropriate interim biweekly payments for these services are made.

Response: We are working on appropriate operating instructions to our intermediaries with directions to ensure that the appropriate interim payments for these items and services are made.

D. Hospital Coding for Evaluation and Management Services

In the April 7, 2000 final rule, we emphasized the importance of each facility accurately assessing the intensity, resource use, and charges for evaluation and management (E/M) services, in order to ensure proper reporting of the service provided. In the proposed rule, we stated that we understand that facilities have developed several different systems for determining resource consumption to assign proper E/M codes. Some of these systems are based on clinical (''condition'') criteria, and others are based on weighted scoring criteria. We continue to believe that proper facility coding of E/M services is critical for assuring appropriate payments. In order to achieve this, we are interested in developing and implementing a standardized coding process for facility reporting of E/M services. This process could include the use of current HCPCS codes or the establishment of new HCPCS codes in conjunction with guidelines for facility coding.

In the proposed rule, we solicited comments from hospitals and other interested parties on this issue. We stated that we would submit these comments to the APC Advisory Panel and ask for the Panel's recommendations regarding the development and implementation of a facility coding process for E/M services. We will review both the public comments and the recommendations from the Panel and propose a coding process in the proposed rule for 2003.

E. Annual Drug Pricing Update

1. Payment for Drugs and Biologicals

Under the OPPS, we pay for drugs and biologicals in one of three ways.

a. Packaged Payment. As we explained in the April 7, 2000 final rule, we generally package the cost of drugs, biologicals, and pharmaceuticals into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished (65 FR 18450). No separate payment is made under the OPPS for drugs, biologicals, and pharmaceuticals whose costs are packaged into the APCs with which they are associated.

b. Transitional Pass-Through Payments for Eligible Drugs and Biologicals. As we also explained in the April 7, 2000 final rule and in section VII of this preamble, the BBRA 1999 provided for special transitional pass-through payments for a period of 2 to 3 years for the following drugs and biologicals:

- Current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act;
- Current drugs and biologic agents used for treatment of cancer;
- Current radiopharmaceutical drugs and biological products; and
- New drugs and biologic agents in instances where the item was not being paid for as a hospital outpatient service as of December 31, 1996, and where the cost of the item is ''not insignificant'' in relation to the hospital outpatient PPS payment amount.

In this context, ''current'' refers to those items for which hospital outpatient payment was being made on August 1, 2000, the date on which the OPPS was implemented. A ''new'' drug or biological is a product that was not paid as a hospital outpatient service before January 1, 1997 and for which the cost is not insignificant in relation to the payment for the APC to which it is assigned. In the proposed rule, we discussed in detail the statutory basis and payment methodology for transitional pass-through payments for drugs and biologicals. In addition, we included an illustration of the payment methodology.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act, that is, 95 percent of the applicable average wholesale price (AWP). Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through-eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between 95 percent of the applicable AWP and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological. Therefore, as we explained in the April 7, 2000 final rule (65 FR 18481), in order to determine the correct pass-through payment amount, we first had to determine the cost that was packaged for the drug or biological within its related APC. In order to determine this amount, we used the following methodology, which we also explained in the April 7, 2000 final rule.

When we implemented the OPPS on August 1, 2000, costs for drugs and biologicals eligible for transitional pass-through payment were, to the extent possible, not included in the payment rates for the APC groups into which they had been packaged prior to enactment of the BBRA 1999. That is, to the extent feasible, we removed from the APC groups into which they were packaged, the costs of as many of the pass-through eligible drugs and biologicals as we could identify in the 1996 claims data. Then, we assigned each drug and biological eligible for a pass-through payment to its own, separate APC group, the total payment rate for which was set at 95 percent of the applicable AWP.

Next, in order to establish the applicable beneficiary copayment amount and pass-through payment amount, we had to determine the cost of the pass-through eligible drug or biological that would have been included in the payment rate for its associated APC had the drug or biological been packaged. We used hospital acquisition costs as a proxy for the amount that would have been packaged, based on data taken from an external survey of hospital drug costs. (See the April 7, 2000 final rule (65 FR 18481).) We imputed the acquisition cost for the various drugs and biologicals in pass-through APCs by multiplying their applicable AWP by one of the following ratios. The following ratios are based on the survey data, and they represent, on average, hospital drug acquisition cost relative to AWP:

- For drugs with one manufacturer (sole-source), the ratio of acquisition cost to AWP equals 0.68.
- For drugs with more than one manufacturer (multi-source), the ratio of acquisition cost to AWP equals 0.61.
- For drugs with more than one manufacturer and with generic competitors, the ratio of acquisition cost to AWP equals 0.43.

In accordance with section 1833(t)(7) of the Act, we base beneficiary copayment amounts for pass-through drugs only on that portion of the drug's cost that would have been included in the payment amount for an associated APC had the drug been packaged. Therefore, having determined the hospital acquisition cost of the drug based on the ratios described above, we multiply the acquisition cost by 20 percent to calculate the beneficiary copayment for the pass-through drug or biological APCs. Finally, to calculate the actual pass-through payment amount, we subtract the hospital acquisition cost from the applicable 95 percent of AWP. The Medicare program payment is the sum of the acquisition cost and the pass-through amount, less the beneficiary copayment amount.

To illustrate this payment methodology, consider a current sole source drug with an average wholesale price (AWP) of $100 per dose. Under section 1842(o) of the Act, the total allowed payment for the drug is $95, that is, 95 percent of AWP. We impute the cost of the drug based on survey data, which indicate hospital acquisition costs for this type of drug on average to be 68 percent of its AWP (or $68). In the absence of the pass-through provisions, this cost would be packaged into the APC payment for the procedure or service with which the drug or biological is furnished. Therefore, we define the beneficiary coinsurance as 20 percent of the imputed cost of $68, resulting in a copayment amount of $13.60. The pass-through payment amount is $27 (the difference between 95 percent of AWP ($95) and the portion of the APC payment that is based on the cost of the drug ($68)). The total Medicare program payment in this example equals $81.40 (cost of the drug in the APC ($68) less beneficiary copayment ($13.60), plus pass-through payment ($27)). In the proposed rule, we clarified that, for purposes of calculating transitional pass-through payment amounts, we make no distinction between new and current drugs and biologicals. Rather, we assume that drugs and biologicals defined as ''new'' under section 1833(t)(6)(A)(iv)(I) of the Act, that is, for which payment was not being made as of December 31, 1996, nonetheless replace or are alternatives to drugs, biologicals, or therapies whose costs would have been reflected in our 1996 claims data and, thus, have been packaged into an associated APC. Therefore, we assume that our imputed acquisition cost, based on the external survey data, represents that portion of the APC payment attributable to new as well as current drugs and biologicals. For that reason, we are discontinuing use of the payment status indicator ''J'' that we introduced in the November 13,

2000 final rule to designate a ''new'' drug/biological pass-through. Instead, we stated that we would assign payment status indicator ''G'' to both current and new drugs that are eligible for pass-through payment under the OPPS. (Addendum D of this final rule lists the definition of the OPPS payment status indicators.)

c. Separate APCs for Drugs Not Eligible for Transitional Pass-Through Payment. There are some drugs and biologicals for which we did not yet have adequate cost data that are not eligible for transitional pass-through payments. Beginning with the April 7, 2000 final rule, we created separate APCs for these drugs and biologicals to allow separate payment so as not to discourage their use where appropriate.

We based the payment rate for these APCs on median hospital acquisition costs. To determine the hospital acquisition cost for the drugs, we imputed a cost using the same ratios of drug acquisition cost to AWP used in connection with calculating acquisition costs for transitional pass-through drug payments. That is, we multiplied the AWP for the drug by the applicable ratio (sole, multi, or generic source) based on data collected in an external survey of hospital drug acquisition costs.

We set beneficiary copayment amounts for these drugs APCs at 20 percent of the imputed acquisition cost. We use status indicator ''K'' to denote the APCs for drugs, biologicals, and pharmaceuticals that are paid separately from and in addition to the procedure or treatment with which they are associated yet are not eligible for transitional pass-through payment. Refer to Addendum A of this final rule to identify these APCs.

2. Annual Drug Pricing Update

a. Drugs Eligible for Pass-Through Payments. We used the AWPs reported in the Drug Topics Red Book to determine the payment rates for the pass-through drugs and biologicals. In the proposed rule we referred to a discussion in the November 13, 2000 interim final rule. When we developed that interim final rule, it was our understanding that, although there are quarterly updates to the AWPs in the Red Book, the annual update is published in April of each year. It was our intention to update the AWPs for drugs each July 1, the quarter following the annual publication, and we did use the April 2001 version of the Red Book to update the APC rates for drugs eligible for pass-through payments. The pass-through payment rates for drugs and biologicals updated for 2001 went into effect July 1, 2001 (Program Memorandum A–01–73, issued on June 1, 2001).

We found that doing an update for all the pass-through drugs and biologicals at mid-year was disruptive to both our computer systems and pricing software. Thus, we proposed to update the APC rates for drugs that are eligible for pass-through payments in 2002 using the July 2001 or October 2001 version of Red Book. The updated rates effective January 1, 2002 would remain in effect until we implement the next annual update in 2003, when we would again update the AWPs based on the latest quarterly version of the Red Book. This would place the update of pass-through drug prices on the same calendar year schedule as the other annual OPPS updates.

b. Drugs in Separate APCs Not Eligible for Pass-Through Payments. We used the conversion factor published in the November 13, 2000 final rule (65 FR 67827) to update, effective January 1, 2001, the APC rates for the drugs that are not eligible for pass-through payments that are in separate APCs. We also made payment adjustments to these APC groups effective April 1, 2001, as required by section 401(c) of the BIPA, which sets forth a special payment rule that had the effect of providing a full market basket update in 2001.

For 2002, we proposed to recalibrate the weights for the APCs for drugs that are not pass-through items and make the other adjustments applicable to the APC groups that we discuss in sections III, IV, and VIII of this preamble.

We received several comments on our discussion of the payment for drugs under the OPPS. These comments are summarized below.

Comment: One commenter expressed concern that the ''three methodologies for drug payment reductions in the proposed rule'' may not take into account the most recent data. The commenter requested an estimate of the magnitude of the expected reduction, and the data used to develop the estimate.

Response: We did not propose three methodologies for drug payment reductions in the proposed rule. Rather we described, in greater detail than we have previously, the three methods by which drug costs are paid under the OPPS. In the final rule that we published on November 2, 2001 (66 FR 55857), we announced that we would be implementing a reduction in the payments made for one category of drugs, namely those drugs that qualify for transitional pass-through payments. As we described in that final rule, this reduction is applied on a uniform basis to all pass-through payments (including payments for devices) and is required to enforce a statutory limit on the size of those estimated payments relative to the estimate of all spending under the OPPS.

Comment: One commenter was confused by an apparent discrepancy between our description of how the pass-through payment amount for a drug is calculated and our example of how the amount is calculated. The description indicated that the beneficiary coinsurance is subtracted from the applicable 95 percent of AWP and imputed acquisition cost, but the example did not include this subtraction.

Response: We regret that the written description was not entirely clear. The example was accurate. The pass-through payment is the difference between 95 percent of AWP and imputed acquisition cost. The beneficiary coinsurance is 20 percent of the imputed acquisition cost. The Medicare program payment is the pass-through amount, plus the imputed acquisition cost, minus the beneficiary copayment. Total payment to the hospital is the pass-through amount, plus the imputed acquisition cost, plus the beneficiary copayment. In our example (see above), the AWP for the drug was $100, and 95 percent of AWP was thus $95. The imputed acquisition cost for the drug was 68 percent of AWP, or $68. Beneficiary coinsurance was 20 percent of $68, or $13.60. The Medicare program payment is $27 (the pass-through amount), plus $68 (the imputed acquisition cost), minus $13.60 (the beneficiary copayment), for a total of $81.40. Total payment to the hospital is $81.40 (the Medicare program payment) plus $13.60 (the beneficiary copayment), for a total of $95.

Comment: Several commenters objected that our drug pricing is based on annual updates using 6-month old data and on ratios of drug acquisition costs to AWP that derive from outdated and limited data. Some of these commenters objected to the use of the acquisition cost study to establish the ratios of drug acquisition costs to AWP. One commenter asked that CMS clarify why the new system is too complex to undertake quarterly updates of drug prices.

Response: We are placing the updates for the drugs that are eligible for pass-through payments on the same annual update schedule as the rest of the OPPS. We will always use the most recent available version of the Red Book in doing this update. Assuming that the October Red Book becomes available in time for use in the final rule establishing the annual OPPS updates, our drug

pricing may be based on data that are only 3 months old when it becomes effective. In any event, it is not unusual for updates to prospective payment systems to reflect data that are 6 months old or older. We have always considered the use of the study-derived ratios of drug costs to AWP to be an interim measure until we are able to obtain data on hospitals' actual costs for drugs from claims. We anticipate having this data available for use in setting payment rates for 2003. Revisions to our payment systems require a long lead-time, and thus it would be very difficult to implement more than one update in a year. We note that rate-based payment systems are commonly updated annually, and we see no compelling reason why the update of drug prices under the OPPS should be updated more frequently than the other payment rates under the system.

Comment: Several commenters requested more information about the methodology that CMS uses to compute payment rates for drugs, radiopharmaceuticals, and biologicals, particularly those that are not sole source.

Response: We employ the methodology provided in 42 CFR § 405.517(c) to determine the payment rates. Specifically, we compute the median price of each drug, radiopharmaceutical, or biological, using the median price of the generic versions or the lowest of the prices of the brand versions from the Red Book. (For drugs with both generic and brand manufacturers, we use the lower cost of the two.) For the denominator, we employ measures of dosage and concentration that are compatible with the HCPCS code descriptor. We also consider route of administration (for example, intravenous or perenteral) and dose. As an example, if drug A has a descriptor of 10 mg As the dose, we usually utilize the AWP for 5 mg and 10 mg doses, but not for 25 mg or 50 mg doses. This is because the latter two doses could not be administered to provide a 10 mg dose. If drug B has a descriptor for 25 mg injection and the drug is manufactured in 5 mg per ml, 25 mg per ml, and 50 mg per ml concentrations, we would utilize the AWP for the 25 and 50 mg per ml concentrations, but not the 5 mg per ml concentration. This is because we would not expect a beneficiary to receive a 5 ml injection, which would be necessary to utilize the lowest concentration dose to provide 25 mg of the drug at the 5 mg per ml concentration.

However, we lack precise information for many drugs in the Red Book concerning the size of vials/ampules and the numbers of vials/ampules per packaging. In these cases, we are unable to employ this methodology, and we simply use the list price. We are continuously seeking further information on these drugs, and we will revise the pricing as we obtain additional information.

Comment: Several commenters called our attention to instances in which the Medicare payment is higher than the cost for certain drugs, especially radiopharmaceuticals.

Response: We thank the commenters for bringing these cases to our attention. We have experienced some difficulty in determining appropriate payment rates for radiopharmaceuticals due to several factors. First, the Red Book lacks information concerning the dosage per vial after the elements are compounded to create the radioactive substance, the numbers of doses that can be obtained per vial, and the cost per vial when more than one dose may be given from the vial. Nuclear medicine experts have informed us that multiple doses for multiple patients can often be obtained with one vial and that we have often unnecessarily assumed the cost for the entire vial. At the same time, there are circumstances in which an entire vial is appropriately charged for one patient. We have made the appropriate modifications for those agents that have been identified to us. We welcome any additional information that would help us to ensure that payment rates reflect as accurately as possible the cost and usage of these agents.

Comment: One commenter requested that CMS clarify whether repackaged products are included in its calculations.

Response: There is no separate calculation for any repackaging process. We use only AWPs to calculate drugs and biological prices.

Comment: One commenter asked us to clarify how we pay for the pharmacy overhead costs associated with administering drugs. The commenter expressed concern that the data in the survey of drug costs did not capture these costs.

Response: For the drugs paid for under the OPPS, hospitals can bill both for the drug and for the administration of the drug. The overhead cost is captured in the administration codes, along with the costs of all drugs that are not paid for separately. Each time a drug is billed with an administration code, the total payment thus includes the acquisition cost for the billed drug, the packaged cost of all other drugs, and the overhead costs.

F. Definition of Single-Use Devices

Our definition of a device eligible for pass-through payment includes a criterion whereby eligible devices are used for one patient only and are single use (65 FR 47674, August 3, 2000). In the November 13, 2000 interim final rule, we stated, in response to a comment, that additional pass-through payments would not be made for devices that are reprocessed or reused because they are not single-use items. We further indicated that hospitals submitting pass-through claims for these devices might be considered to be engaging in fraudulent billing practices (65 FR 67822).

In the proposed rule, we discussed issues that have come to our attention regarding reprocessed single-use devices. We noted that the FDA published guidance for the reprocessing of single-use devices (FDA's ''Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals,'' issued August 14, 2000). This document presents a phased-in regulatory scheme for reprocessed devices. We proposed to follow FDA's guidance on reprocessed single-use devices. We stated that we would consider reprocessed single-use devices that are otherwise eligible for pass-through payment as part of a category of devices to be eligible for that payment if they meet FDA's most recent regulatory criteria on single-use devices. Also, reprocessed devices must meet any FDA guidance or other regulatory requirements in the future regarding single use. We proposed to consider reprocessed devices adhering to these guidelines as having met our criterion of approval or clearance by the FDA. We have met with and will continue to meet and coordinate with the FDA concerning that Federal agency's definition and regulation of single-use devices. We also stated our expectation that hospital charges on claims submitted for pass-through payments for reprocessed single-use devices would reflect the lower cost of these devices.

We received several comments on this proposal, which are summarized below.

Comment: One commenter expressed agreement with our decision to allow hospitals to submit claims for pass-through payment for reprocessed devices, as long as the device is reprocessed in accordance with FDA policy on reprocessing.

Response: We appreciate the comment. It is important to emphasize that, in order to qualify for pass-through payment, a reprocessed device must clearly fit into one of the currently open device categories established for pass-

through payment. We also expect that the charges for the reprocessed device will accurately reflect any lower cost of reprocessed devices.

Comment: One commenter recommended that CMS not expect hospitals to charge less for reprocessed devices, claiming that paying hospitals less for reprocessed devices would perpetuate an incentive to use new devices instead of reprocessed devices.

Response: We disagree. Hospitals would not necessarily have a greater incentive to use new devices if their charges for reprocessed devices are in accordance with their costs. If the charges reflect the lower costs of the reprocessed devices to the hospital, the margins for reprocessed versus new devices should remain relatively constant. This would not create an incentive for hospitals to use either new or reprocessed devices. On the other hand, if hospitals to charge the same amount for reprocessed and original devices, this would inflate the margins of pass-through payment for reprocessed devices and create an incentive to use reprocessed over new devices.

Comment: Several commenters asked that CMS clarify how we will implement and enforce our pass-through payment policy for reprocessed single-use devices. A device manufacturer pointed out that Pre-Market Approval and 510k submissions for approval of reprocessed single-use devices are still pending with the FDA, awaiting final decisions. These commenters also asked how CMS would prohibit noncompliant single-use devices from receiving Medicare payment.

Response: As we indicated in the proposed rule, we will follow the most recent FDA guidance or regulatory criteria on the issue of reprocessed single-use devices. When the FDA requires reprocessors, including hospitals, to have FDA approval or clearance regarding safety and effectiveness, prior to use in a health setting. Hospitals must adhere to these requirements, and will not be entitled to receive a pass-though payment if they do not comply. We will employ our standard procedures for claims reviews to enforce these requirements.

Comment: One commenter recommended that CMS develop and implement a tracking mechanism to differentiate and collect data on reprocessed versus original device costs and use. This commenter also recommended either creating a modifier or establishing pairs of categories for original and reprocessed devices.

Response: Reprocessed devices will be subsumed under the same categories as the original devices, and the average cost for the category will accurately reflect the cost of reprocessed and new devices. We do not believe that it is practical or advisable to create special modifiers or categories for items that will be receiving pass-though payments for only a limited period of time.

Comment: One commenter recommended that CMS provide hospitals with guidance on how to adjust their charges for reprocessed devices eligible for pass-through payment, taking into account the costs of reprocessing and amortization of the initial cost of the device.

Response: We expect those hospitals' charges for reprocessed single-use devices will reflect their costs, just as in the case of the first-use devices. The device's full cost to the hospital is reflected in the payment the first time it is used for a Medicare patient. The cost of the reprocessed device to the hospital will already include the cost of reprocessing. No amortization of the initial cost of the device will apply for single use devices, since they are intended for one time use only.

G. Criteria for New Technology APCs

1. Background

In the April 7, 2000 final rule (68 FR 18477), we created a set of new technology APCs to pay for certain new technology services under the OPPS. New technology APCs are intended to pay for new technology services that are not addressed by the transitional pass-through provisions of the BBRA 1999 and BIPA 2000. New technology APCs are defined on the basis of costs and not the clinical characteristics of a service. The payment rate for each new technology APC is based on the midpoint of a range of costs.

The new technology APCs that were implemented on August 1, 2000 were populated with 11 new technology services. We stated in the April 7, 2000 rule that we will pay for an item or service under a new technology APC for at least 2 years but no more than 3 years, consistent with the term of transitional pass-through payments. After that period of time, during the annual APC update cycle, we stated that we will move the item or service into the existing APC structure based on its clinical attributes and, based on claims data, its resource costs. For a new technology APC, the beneficiary coinsurance is 20 percent of the APC payment rate.

In the April 7, 2000 rule, we specified an application process and the information that must be supplied for us to consider a request for payment under the new technology APCs (65 FR 18478). We also described the five criteria we would use to determine whether a service is eligible for assignment to a new technology APC group. These criteria, which we are currently using, are as follows:

- The item or service is one that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the service could not have been adequately represented in 1996 data.
- The item or service does not qualify for an additional payment under the transitional pass-through payments provided for by section 1833(t)(6) of the Act as a current orphan drug, as a current cancer therapy drug or biological or brachytherapy, as a current radiopharmaceutical drug or biological product, or as a new medical device, drug, or biological.
- The item or service has a HCPCS code.
- The item or service falls within the scope of Medicare benefits under section 1832(a) of the Act.
- The item or service is determined to be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act.

2. Modifications to the Criteria and Process for Assigning Services to New Technology APCs

Based on the experience we have gained and data we have collected since publication of the April 7, 2000 final rule, we proposed in the August 24 proposed rule to revise—(1) the definition of what is appropriately paid for under the new technology APCs; (2) the criteria for determining whether a service may be paid under the new technology APCs; (3) the information that we will require to determine eligibility for assignment to a new technology APC; and 4) the length of time we will pay for a service in a new technology APC.

We invited comment on the changes to the definition, criteria, application process, and timeframe that we proposed for services and procedures that may qualify for assignment to a new technology APC under the OPPS. We received numerous comments on the proposed changes, primarily from drug and device manufacturers and their trade associations, but also from medical specialty societies and hospital associations. Although several commenters supported the changes that we proposed, most commenters expressed concern that the new requirements might make it extremely difficult or virtually impossible for any new technology to qualify for

assignment to a new technology APC. Many commenters urged us to maintain flexibility in approving services and products for new technology APCs rather than adhering to rigid criteria. The comments are summarized below.

a. Services Paid Under New Technology APCs. We proposed to limit eligibility for placement in new technology APCs to complete services or procedures. That is, items, materials, supplies, apparatuses, instruments, implements, or equipment that are used to accomplish a more comprehensive service or procedure would not be eligible for placement in a new technology APC. Devices or any drug, biologic, radiopharmaceutical, product, or commodity for which payment could be made under the transitional pass-through provisions would continue to be excluded from assignment to a new technology APC. We proposed to limit new technology APCs to comprehensive services or procedures that are truly new. In addition, we clarified that we do not consider a different approach to an existing treatment or procedure to qualify a service for assignment to a new technology APC.

A few commenters supported our proposal to limit eligibility to complete services and procedures, and to exclude changes to an existing service or procedure from new technology APCs. They cited this approach as a means of better controlling and managing payment and improving the predictability of cost estimates for new services or procedures under the OPPS. However, most commenters were opposed to these proposals. (In our responses to comments in this section VI.G., we use ''HCPCS code'' to mean a Level II HCPCS/National Code and ''CPT code'' to mean a Level I HCPCS code.)

Comment: One commenter was concerned that the new criteria for identifying devices that will be eligible for assignment to a new technology APC will make it more difficult for new devices to qualify.

Response: The commenter is correct. The changes that we proposed are intended to clarify, sharpen, and refine the scope of what we assign and pay for under a new technology APC. We want to clarify that new technology APCs are *not* meant to be the payment vehicle for items that can be paid under a transitional pass-through device category. Nor are new technology APCs meant to be a means of paying for drugs, biologicals, or radiopharmaceutical drugs that are otherwise eligible for transitional pass-through payments. The cost of a device that is not eligible for transitional pass-through payment and that is not associated with a comprehensive service or treatment eligible for assignment to a new technology APC will become incorporated into the weight of the APC or APCs associated with its use as hospitals begin to use it. The same is true for other items, supplies, and equipment that are furnished incident to a service or procedure and are used as a tool or serve as an aid in performing a variety of procedures.

Comment: A number of commenters were opposed to limiting new technology APCs to services and procedures that are ''truly new'' because what constitutes ''truly new'' is vague and difficult to define and does not reflect the significant advances in medical technology that are incremental and build on existing technology or procedures. One commenter argued that transformational technology often changes significantly the *way* that a procedure is done, for example, changing a traditionally human resource (for example, labor) or time intensive procedure to one that is technology intensive. Commenters were concerned that the requirement that a new technology be ''truly new'' could result in lack of adequate payment for important new therapies and severely limit patient access to such therapies. For example, a new interventional radiology or other minimally invasive procedure such as the recent advances in endovascular techniques and device technology that replace traditional open surgery could be viewed as a ''different approach to an existing treatment'' and therefore not qualify for assignment to a new technology APC. One commenter concluded that this requirement would limit new technology APCs to inpatient procedures that move to an outpatient setting or procedures that are fundamentally different enough to qualify for a new CPT code. Many commenters recommended that innovation that improves current procedures be recognized and paid for in addition to ''truly new'' services. Several commenters stated that we should publish the definition of ''truly new'' in the **Federal Register** for public comment before implementing this criterion.

Response: In fact, we do want to limit new technology APCs to those services that would be eligible for a new HCPCS code. For example, there are existing codes for wound repair which hospitals have been using to bill for Medicare services for many years. The use of a new, expensive instrument for tissue debridement or a new, expensive wound dressing does not in and of itself warrant creation of a new HCPCS code to describe the instrument or dressing; rather, the existing wound repair code appropriately describes the service that is being furnished, that is, the service is a wound repair, regardless of whether or not a new instrument or a new wound dressing is involved. We would consider it inappropriate to pay for the wound repair performed with the new, expensive dressing or instrument under a new technology APC because an APC group that includes the wound repair procedure already exists. (However, we note that the dressing or instrument could qualify for transitional pass-through payments.) Similarly, the invention of a new endoscope or new suturing material would not qualify for a new technology APC unless the procedure in which it is used cannot be appropriately billed under an existing code.

By contrast, new services such as cryosurgery of the prostate, coronary artery brachytherapy, and 3-D electrophysiologic mapping of the heart are not adequately described with current codes, and they do not fit appropriately within an existing APC group. The new technology APCs are intended to address appropriate payment for these latter types of services, which cannot be accurately described by existing codes and are not similar either clinically or in terms of resource use with an existing APC group.

We want to ensure appropriate allocation of Medicare expenditures and access for our beneficiaries to breakthrough technologies. The appropriate method of reflecting changes in the costs of supplies and equipment used to provide existing services is to incorporate those changes into the payment for such services during the yearly reclassification and recalibration of the APCs. We believe it is appropriate for those new technologies that can be appropriately reported by existing codes and do not qualify for transitional pass-through payments to be grouped with older technologies, and have their costs gradually incorporated into APCs when APC weights are adjusted.

In summary, the most important criterion that will determine whether a technology is ''truly new'' and appropriate for a new technology APC is the inability to appropriately, and without redundancy, describe the new, complete (or comprehensive) service with any combination of existing HCPCS and CPT codes. We acknowledge the need to critically evaluate, on an ongoing basis, our criteria for new technology APCs. We remind interested parties that eligibility

of a procedure for a temporary HCPCS code and assignment to a new technology APC does not guarantee that a permanent code will ultimately be approved for the service or procedure. Conversely, the fact that a new CPT or HCPCS code has been assigned to a service or procedure does not automatically qualify it for placement in a new technology APC unless it meets the criteria we have established for this purpose.

Comment: A few commenters indicated that we need to better define ''complete services or procedures'' and ''a more comprehensive service'' with a clearer explanation of the underlying intent and examples to clarify when assignment to a new technology APC would be appropriate and when it would not. A couple of commenters stated that our proposal to permit only ''complete'' or ''comprehensive'' services or procedures to qualify for assignment to a new technology APC is contrary to the underlying concepts of the OPPS. These commenters argued that hospital outpatient departments, in order to provide a ''complete'' or ''comprehensive'' service, are allowed and expected to bill the appropriate set of CPT and HCPCS codes that combine to describe a particular service, often resulting in claims with multiple codes matched to multiple APCs. The same commenters asserted that a new technology or procedure will likely consist of multiple codes and multiple APCs and that this can be most effectively evaluated as part of the data collection during the period that the technology or procedure is assigned to a new technology APC. One commenter stated that medical technologies, even when considered transformational, are not usually ''complete services and procedures.''

Response: These comments focus on our concept of the type of services appropriate for assignment to new technology APCs under the OPPS. A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate or cryosurgery of the prostate) or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy). In the latter case, the new technology procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end. Drugs, supplies, devices, and equipment in and of themselves are not a distinct procedure with a beginning, middle, and end. Rather, drugs, supplies, devices, and equipment are used in the performance of a procedure. Therefore, taken individually and apart from the procedure or service with which they are used, these items will not be eligible for new technology APCs. (As noted above, these items may qualify for transitional pass-through payments.) Furthermore, unbundled components that are integral to a service or procedure (for example, preparing a patient for surgery or preparation and application of a wound dressing for wound care) are not eligible for consideration for a new technology APC.

We understand that hospitals frequently bill multiple codes to describe multiple services furnished to a given patient. Therefore, we are not making eligibility for new technology APCs contingent on whether hospitals would bill other HCPCS codes in conjunction with a proposed new technology procedure. However, we reiterate that the inability to describe appropriately, and without redundancy, a complete (or comprehensive) service with any combination of current CPT or HCPCS codes is crucial to determining eligibility for a new technology APC. It is possible that a procedure for which assignment to a new technology APC is sought can only be described by several current codes and the applicant believes it is important to establish a single HCPCS code to describe the procedure in a more comprehensive manner (for example, stereotactic radiosurgery or intensity modulated radiotherapy). We agree with this and will consider creating such new HCPCS codes if reporting a combination of current codes does not adequately describe the service or does not properly account for the resources used to deliver the comprehensive service.

In short, we consider that a ''truly new'' service is one that cannot be appropriately described by existing HCPCS codes and that a new HCPCS code needs to be established in order to describe the new procedure.

Claims for services assigned to new technology APCs should include, in addition to other HCPCS codes billed, the appropriate revenue codes and charges for the resources required to deliver the service. We evaluate these data to identify the complete package of resources required to perform the new technology service, the cost of this package of services, and, subsequently, the extent to which the new technology service is, or is not, consistent with services in an existing APC. If, over time, our claims data indicate that the package of resources and the clinical components of the new technology are unique and bear no similarity to services in any existing APC, we may create a separate APC for the new technology service when it is reassigned from a new technology APC. Examples of services that are currently in new technology APCs due to lack of data include water-induced thermotherapy, coronary artery thrombectomy, and coronary artery brachytherapy.

Comment: Several commenters stated that we should eliminate the proposed criteria for defining services eligible for new technology APCs and suggested, instead, that we be flexible and work closely with manufacturers, providers, the APC Panel, and other experts ''to consider circumstances unique to the individual technology'' when determining whether a new technology APC is appropriate.

Response: We will continue to work with manufacturers and their representative associations, with hospitals, with the APC Panel, with other experts, and with applicants as we evaluate requests for new technology APC assignments and determine which are appropriate for new technology APCs. The review of an application for new technology APC assignment by our medical officers and clinical experts is a dynamic, interactive process that involves ongoing consultation with the applicant, with hospitals and physicians who are furnishing the service or who participated in clinical trials, with the manufacturers of the new technology, and with other agencies such as the FDA that may have pertinent information. We believe that the criteria that we proposed serve to inform, guide, and expedite the review process and help to guard against inappropriate assignment of services to a new technology APC simply on the basis of those services being characterized as ''new.''

Comment: One commenter recommended that an applicant be the one to determine whether to seek pass-through payment for a drug used as part of the service or new technology APC status for the entire service, including the drug.

Response: We agree. Application for pass-through payment or new technology APC status is voluntary and the determination of which application(s) to submit is left solely to the interested party. However, as part of the review process, we would expect to work with the applicant to arrive at the most appropriate classification for the service under consideration.

Comment: Several commenters recommended that we further clarify the proposed criteria to ensure that all new technologies and services that do not

qualify for pass-through status and that would not be adequately paid under existing APCs can be assigned to new technology APCs. These commenters also recommended that, when a pass-through category expires, we consider reclassifying medical devices in the expired category into a new technology APC to give beneficiaries seamless access to expensive new medical technology.

Response: As we discussed above, devices eligible for pass-through payments fall outside the scope of services appropriate for new technology APCs. As data associated with pass-through items are collected and incorporated into the APCs with which they are associated, they will be reflected in the weight of the APC. The services assigned to the new technology APCs are those for which we do not have adequate data to make an appropriate APC assignment. Thus, it would not be appropriate to assign a pass-through device for which we have collected data to a new technology APC.

b. Criteria for Assignment to New Technology APC. In the proposed rule, we proposed that the following criteria be used to determine whether a service be assigned to a new technology APC. These proposals represent modifications to criteria that are based on changes in data (we are no longer using 1996 data to set payment rates) and our continuing experience with the system of assigning new technology APCs.

- The service is one that could not have been adequately represented in the claims data being used for the most current annual payment update. (Current criterion based on 1996 data.)
- The service does not qualify for an additional payment under the transitional pass-through provisions. (This criterion is unchanged.)
- The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs. We believe it is unnecessary to assign a new service to a new technology APC if it may be appropriately placed in a current APC. (This criterion for assignment to a new technology APC is implied but not explicitly stated in the April 7, 2000 final rule.)
- The service falls within the scope of Medicare benefits under section 1832(a) of the Act. (This criterion is unchanged.)
- The service is determined to be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act. (This criterion is unchanged.)

We further proposed to delete the criterion that the service must have a HCPCS code in order to be assigned to a new technology APC. We wish to clarify that our proposal to delete the criterion that a service must have a HCPCS code refers to the discussion in the April 7, 2000 final rule which implied that assignment of a HCPCS code through the annual HCPCS cycle is required. On the contrary, as we state throughout this section, in order to be considered for a new technology APC, a truly new service cannot be adequately described by existing codes. Therefore, in the absence of an appropriate HCPCS code, we would consider creating a HCPCS code that describes the new technology service. These HCPCS codes would be solely for hospitals to use when billing under the OPPS.

Most commenters supported the proposal not to require a HCPCS code for products or services in order to be considered for assignment to a new technology APC. The few commenters that addressed the proposed criterion that would define a new technology APC service as one that could not have been adequately represented in the claims data being used for the most current annual payment update (rather than on 1996 claims data) concurred with the proposed change; no one opposed the change. The remaining comments on these proposed criteria are summarized below.

Comment: One commenter wanted to confirm our intention to assign a new service or procedure to an existing APC only in those instances where a clinically similar APC exists and the associated APC payment rate meets or exceeds the cost of furnishing the new technology service as itemized in the application for a new technology APC.

Response: Our experience to date in evaluating requests for new technology APC classification prompted us to propose changes regarding the information that would be required in an application. One of the principal reasons that we proposed to require submission of a clinical vignette, including a detailed description of the resources used to furnish the service, was to enable us to determine whether a clinically similar APC exists and whether the APC payment rate adequately addresses the costs associated with the nominated new technology service. However, we will not limit our determination of the cost of the procedure to information submitted by the applicant. Our staff will obtain information on cost from other appropriate sources before making a determination of the cost of the procedure to hospitals.

Comment: A number of commenters strongly opposed the criterion excluding any service involving a new drug or biological that qualifies for transitional pass-through payment from possible eligibility as a new technology APC. Commenters stated that continuing to exclude drugs or biologicals eligible for pass-through payments from being eligible for a new technology APC seems to suggest that an entirely new service that includes a new drug would only be eligible for pass-through payments for the drug, rather than the entire service being eligible for payment under a new technology APC. Under this criterion, novel treatments such as those in the growing field of radioimmunotherapy that involve both a new drug and new procedures for both calculating appropriate dosages and administering treatment would not be paid as a new technology APC. Instead, the hospital would be paid for the cost of the drug through the applicable pass-through payment, which may result in underpaying hospitals for the total package of items and services associated with the treatment.

Commenters requested that we clarify that a brand new service in which a pass-through drug or device is used could be eligible for either a pass-through payment for the drug or device or for a new technology APC for the entire service and that we permit a new technology that includes the provision of a new drug or biological to be eligible for payments under a new technology APC. A few commenters recommended that we eliminate this requirement altogether and allow new medical device technology to be included in new tech APCs.

Response: In the April 7, 2000 final rule we adopted a criterion that provided that an item or service that qualifies as a transitional pass-through item would not be considered for assignment to a new technology APC. We proposed to retain that criterion without modification. We have *never* intended new technology APCs to be a substitute payment vehicle for individual items that qualify for payment under a transitional pass-through device category. Nor are new technology APCs meant to be the means of payment for drugs, biologicals, or radiopharmaceutical drugs that are otherwise eligible for transitional pass-through payments. From the outset of the OPPS, our policy regarding payment for devices, drugs, and biologicals that do not qualify for transitional pass-through payment has been to package payment with the items' associated APCs, with the exception of a few drugs for which we had insufficient data.

Many commenters expressed concern and disagreement with this criterion. We believe the commenters misunderstood our explanation of this

criterion. Therefore, we reiterate that we have never intended to disqualify from assignment to a new technology APC a truly new, comprehensive service, procedure, or therapy that involves the use of a drug or device which, on its own, might also qualify for a transitional pass-through payment. That is, a truly new, comprehensive service could qualify for assignment to a new technology APC even if it involves a device or drug that could, on its own, qualify for a pass-through payment.

Take, for example, a case in which a drug that qualifies for a pass-through payment is integral to a service that may be considered a new, comprehensive procedure or service appropriate for a new technology APC. In this case, an interested party has several options. The first option is to simply submit a request for the drug pass-through payment. Under this option, the therapy or procedure or service associated with administration of the drug would be paid through an existing APC that most closely approximates the service clinically and in terms of resources. (In this option, if the new service associated with the drug can be appropriately described by one or more existing HCPCS codes, it is possible that the new service might not qualify for a new technology APC.) A second option would be for the interested party to apply for a pass-through payment for the drug and submit a separate application for assignment of the therapy or procedure associated with administration of the drug to a new technology APC. A third option is to submit an application to have the *entire* service, *including* the potential pass-through drug, which is an integral part of the service, assigned to a new technology APC. In that case, the cost of the drug would be taken into account and packaged with the other costs associated with the service so that the drug cost is reflected and accounted for within the new technology APC payment rate for the service. We believe the third option represents a simple, unburdensome approach that would ensure timely and appropriate payment in a new technology APC for a new service that includes administration of a new drug or biological and that meets the other criteria for a new technology APC. For both options two and three, we would first consider whether assigning a new HCPCS code is appropriate and, if it is, we would then determine whether the new code should be assigned to an existing APC. If not, we would assign it to a new technology APC.

c. Revision of Application for New Technology Status. In the August 24 proposed rule we proposed to change the information that interested parties must submit to have a service or procedure considered for assignment to a new technology APC. Specifically, to be considered, we proposed to require that requests include the following information:

- The name by which the service is most commonly known. We currently require only the trade/brand name.
- A clinical vignette, including patient diagnoses that the service is intended to treat, the typical patient, and a description of what resources are used to furnish the service by both the facility and the physician. For example, for a surgical procedure this would include staff, operating room, and recovery room services as well as equipment, supplies, and devices, etc. This criterion would replace the criterion that requires a detailed description of the clinical application of the service.
- A list of any drugs or devices used as part of the service that require approval from the Food and Drug Administration (FDA) and information to document receipt of FDA approval/clearances and the date obtained.
- A description of where the service is currently being performed (by location) and the approximate number of patients receiving the service in each location.
- An estimate of the number of physicians who are furnishing the service nationally and the specialties they represent.
- Information about the clinical use and efficacy of the service such as peer-reviewed articles.
- The CPT or HCPCS Level II code(s) that are currently being used to report the service and an explanation of why use of these HCPCS codes is inadequate to report the service under the OPPS.
- A list of the CPT or HCPCS Level II codes for all items and procedures that are an integral part of the service. This list should include codes for all procedures and services that, if coded in addition to the code for the service under consideration for new technology status, would represent unbundling.
- A list of all CPT and HCPCS Level II codes that would typically be reported in addition to the service.
- A proposal for a new HCPCS code, including a descriptor and rationale for why the descriptor is appropriate. The proposal should include the reason why the service does not have a CPT or HCPCS Level II code, and why the CPT or HCPCS Level II code or codes currently used to describe the service are inadequate.
- An itemized list of the costs incurred by a hospital to furnish the new technology service, including labor, equipment, supplies, overhead, etc. (This criterion is unchanged.)
- The name, address, and telephone number of the party making the request. (This criterion is unchanged.)
- Other information as CMS may require to evaluate specific requests. (This criterion is unchanged.)

One commenter stated that, on the whole, the proposed changes to the information that interested parties must submit to have a service or procedures considered for assignment to a new technology APC seem reasonable and designed to minimize the need for time-consuming requests for supplemental information from applicants. Other comments on the proposed changes are summarized below.

Comment: A few commenters stated that the significant amount of additional data required to file an application is unnecessarily burdensome, and, in some cases, may not be available when new products are launched. In particular, one commenter was concerned that the information needed to provide a clinical vignette (patient diagnoses that the service is intended to treat, the typical patient, a description of resources used to furnish the service such as staff, equipment, supplies, and similar facility and professional resources) may not always be available when a new product is launched. The commenter was also concerned that upcoming implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will make providers reluctant to furnish necessary data to manufacturers. The need for consent releases and storage retention required by the HIPAA regulations are added administrative costs that will have to be incurred. Instead, the commenter recommended that we request a detailed description of the service which, if possible, includes the resources used during the procedure.

Response: Our experience with new technology applications has revealed the critical need for the information on clinical factors and resource utilization that is described as part of a ''clinical vignette.'' Without this information, it is difficult to understand what the nominated service involves in both clinical and resource terms. We need the fullest possible description of every aspect of the service to help us understand how it is being furnished in hospitals and the costs associated with the service. This information is indispensable in assessing the appropriate payment rate for the

nominated service. We believe that those seeking to apply for new technology APC status for a service will have sufficient expertise and experience with the service to enable them to furnish the full and detailed description of the service that is required as part of the clinical vignette. Based on our experience to date in reviewing applications for new technology APCs, there is strong evidence that close cooperative working relationships exist among manufacturers, hospitals, and clinicians who seek to have a service assigned to a new technology APC. When we have had to ask for additional information of the type we proposed to require for future applications, this information has been readily available and promptly supplied.

Comment: One commenter stated that the requirement for ''a description of where the service is currently being performed (by location) and the approximate number of patients receiving the service in each location'' appears excessive if all that is sought through this requirement is the identification of medical contacts. A commenter expressed concern that having to identify all facilities or physicians performing the procedure would in many cases appear to be administratively excessive and a potential breach of confidentiality. A commenter recommended that, if medical contacts are desired, the requirement should be for the names, contact information and approximate number of patients treated for a ''representative'' sample of facilities and/or physicians performing the procedure or service who are willing to serve as such contacts.

Response: While this requirement would furnish us with medical contacts, it also provides us with other significant information. For example, knowing the locations where the service is being performed and the approximate number of patients receiving the service provides insight into the extent to which the service is being performed (rarely, occasionally, or frequently); the types of hospitals where it is being performed (small rural or suburban hospitals, large urban teaching hospitals); and a geographic profile of where the service is currently available. We believe it is crucial to our evaluation of nominated procedures that we have a detailed understanding of, among other things, the indications and contraindications for the procedure, the current utilization of the procedure, the patient populations for which the procedure is performed, the types of hospitals where it is performed, the sites (for example, inpatient hospital, physician office) and locations (for example, teaching hospitals, community hospitals) where the procedure is performed. Without such information, we cannot make an appropriate determination as to whether the procedure is ''truly new''. This information, along with information about the specialties of physicians performing the service, assists our medical advisors and clinicians in their evaluation of whether or not the service should be assigned to a new technology APC.

Comment: One commenter wanted assurance that ''information about the clinical use and efficacy of the service such as peer-reviewed articles' would be referred to the Office of Clinical Standards and Quality if the intent of this new requirement were to determine whether the new technology should be ''covered.''

Response: The purpose of this requirement is to help us better understand the clinical dimensions of the service. Neither assignment of one or more new HCPCS code(s) to a procedure or assignment of a procedure to a new technology APC assures that Medicare will cover the procedure. In order for a procedure to be covered by Medicare, it must be determined, either locally, or nationally, that the procedure is medically reasonable and necessary. Information about how to obtain a national coverage decision is posted on the CMS website at http://www.hcfa.gov/coverage. To receive Medicare payment, services must be considered reasonable and necessary and each use of a service is subject to medical review for determination of whether its use was reasonable and necessary.

d. Length of Time in a New Technology APC. We proposed to change the period of time during which a service may be paid under a new technology APC. We noted that although section 1833(t)(6)(B) of the Act, as amended by section 201 of BBRA 1999, sets a 2 to 3 year period of payment for transitional pass-through payments, this requirement does not extend to new technology APCs. We proposed to modify the time frame that we established for new technology APCs in the April 7, 2000 final rule and to retain a service within a new technology APC group until we have acquired adequate data that allow us to assign the service to a clinically appropriate APC. This policy would allow us to move a service from a new technology APC in less than 2 years if sufficient data were available and would also allow us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision had not been collected.

Comment: One commenter supported eliminating the 2 to 3 year assignment to a new tech APC, which would give CMS greater flexibility to base future payment on adequate pricing data that could take less than 2 or more than 3 years to collect.

Several commenters stated that we should clarify at the time of the assignment to the new technology APC how the decision will be made to move it into a permanent APC. Specifically, these commenters indicated that we should publish the methodology used to reassign services from new technology APCs into existing APC categories, including how we will evaluate clinical and cost data to determine whether or not a service in a new technology APC should be reassigned to an existing APC.

Most commenters supported keeping a procedure in a new technology APC for a minimum of 2 years of data collection to ensure that an adequate claims database is available to make appropriate decisions about ultimate APC assignment, structuring, packaging, and payment. These commenters noted that limited procedure volume and coding confusion immediately following market release of a new technology could limit the amount of useful data that would be available in the first year.

Response: We agree with commenters that adequate claims data is more important than completion of a fixed time span for determining when to reassign a new technology APC service. We expect that, practically speaking, we will need a full year of available claims data. We use the same methodology to reassign services from a new technology APC to an existing APC group, or to a new APC group if that is indicated, that we use in our annual review of all APC weights and assignments. That is, we review claims-based charge and utilization data and the most recent available cost report data. This process may include consulting the APC Advisory Panel for its recommendations regarding appropriate APC assignments.

Comment: Several commenters urged us not to reassign new medical procedures from one new technology APC to another during the yearly updates to the APC system absent current and complete data. These commenters asserted that during the period when a new procedure is assigned to a new technology APC, there may be reasons why claims data used for the annual updates to the APC system are not representative of actual hospital experience in providing the service. Therefore, we should recognize that the reasons that support a multi-

year assignment to a new technology APC, that is, the need to gather data, also argue for caution in moving services from one new technology APC (and payment rate) to another.

Response: In general, we agree that once a device has been assigned to a new technology APC, it will remain there until we have collected the data necessary to move it to a clinically appropriate APC. However, we have on occasion, made an assignment to a new technology APC based on information that later was found to have been inaccurate. In those cases, we believe that it is appropriate to move the service to the new technology APC that better reflects the cost. We note that when we have made these changes in the past, services were moved to higher-paying APCs as well as lower-paying APCs.

Comment: One commenter urged that any new criteria that we adopt be applied prospectively to those applications submitted after the effective date of the final rules.

Response: Changes in the criteria and application process for assigning services to a new technology APC will be made prospectively, effective upon implementation of this final rule.

Comment: Although the new technology APCs and pass-through device categories were to be updated on a quarterly basis, many applications have taken much longer to process. CMS should establish a mechanism to process applications in a timely manner. One commenter suggested monthly updates.

Response: The volume of applications and changes we have had to make in the OPPS following enactment of BIPA have combined to stretch our resources to the maximum. Also, the need to seek additional information to enable us to complete a thorough and rigorous evaluation of applications for new technology APC assignments has often caused delays in making a final determination. We believe the additional information that we proposed to require in an application for new technology APC status will assist us in completing our reviews and making final determinations in a timely manner. CMS and our fiscal intermediaries' systems constraints preclude making updates more frequently than quarterly.

Comment: One commenter stated that the amount of information provided in the proposed rule does not satisfy the requirement of the Administrative Procedures Act that the public be informed and allowed to comment on major regulatory changes. The commenter requested full disclosure of data, methodology and options considered prior to implementation of the methodology with a suitable time of at least 60 days for public comment. The commenter requested that we retain the criteria established in the April 2000 final rule but that we eliminate the need for a HCPCS code.

Response: We believe that our description of the proposed changes to the criteria and application process for new technology APCs allowed ample opportunity for substantive comment, and we did receive numerous substantive comments on the proposed changes. In addition, changes in the process and information required to apply for new technology APC status under the OPPS are subject to provisions of the Paperwork Reduction Act (PRA) of 1995, as further explained in section XII of this final rule.

Final Action: We are making final the changes we proposed regarding the definition of what is appropriately paid for under a new technology APC, the criteria for determining assignment to a new APC, the information that must be supplied for a request to be considered, and the period of time during which payment in a new technology APC can be made. The schedule for submission of applications and the process and information required for a new technology APC designation is posted on the CMS website at http://www.hcfa.gov/medlearn.

VII. Transitional Pass-Through Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain innovative medical devices, drugs, and biologicals. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act; current drugs, biologic agents, and brachytherapy devices used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. Transitional pass-through payments are also required for new medical devices, drugs, and biologic agents that were not being paid for as a hospital outpatient service as of December 31, 1996 and whose cost is ''not insignificant'' in relation to the OPPS payment for the procedures or services associated with the new device, drug, or biological. Under the statute, transitional pass-through payments are to be made for at least 2 years but not more than 3 years.

Section 402 of BIPA, which was enacted on December 21, 2000, made several changes to section 1833(t)(6) of the Act. First, section 1833(t)(6)(B)(i) of the Act, as amended, requires us to establish by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. We fulfilled this requirement through the issuance on March 22, 2001 of two Program Memoranda, Transmittals A–01–40 and A–01–41. These Program Memoranda can be found on the CMS homepage at *www.hcfa.gov/pubforms/transmit/A0140.pdf* and *www.hcfa.gov/pubforms/transmit/A0141.pdf,* respectively. We note that section 1833(t)(6)(B)(i)(II) of the Act explicitly authorizes the Secretary to establish initial categories by program memorandum.

Transmittal A–01–41 includes a list of the initial device categories and a crosswalk of all the item-specific C-codes for individual devices that were approved for transitional pass-through payments as of January 20, 2001 to the initial category code by which the device is to be billed beginning April 1, 2001.

Section 1833(t)(6)(B)(ii) of the Act also requires us to establish, through rulemaking, criteria that will be used to create additional categories, other than those established initially. On November 2, 2001, we published an interim final rule with comment that established the criteria for new categories (66 FR 55850).

Transitional pass-through categories are for devices only; they do not apply to drugs or biologicals. The regulations governing transitional pass-through payments for eligible drugs and biologicals remain unchanged. The process to apply for transitional pass-through payment for eligible drugs and biological agents, including radiopharmaceuticals, can be found in the April 7, 2000 **Federal Register** (65 FR 18481) and on the CMS web site at *http://www.hcfa.gov/medlearn/appdead.htm.* If we revise the application instructions in any way, we will post the revisions on our web site and submit the changes for the Office of Management and Budget (OMB) review under the Paperwork Reduction Act. The application process for new categories can be found on the CMS web site at http://www.hcfa.gov//medicare/newcatapp1030f.rtf.

B. Discussion of Pro Rata Reduction

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for a given year to an ''applicable percentage'' of projected total payments under the hospital OPPS. For a year before 2004,

the applicable percentage is 2.5 percent; for 2004 and subsequent years, the applicable percentage is specified by the Secretary up to 2.0 percent. If the Secretary estimates before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a (prospective) uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded.

As discussed above, on November 2, 2001, we published a final rule that announced the implementation of a pro rata reduction for CY 2002. That document describes the methodology for estimating pass-through payments and indicates that we expected the reduction would be between 65 and 70 percent. Based on the final APC weights, which incorporate 75 percent of the estimated device pass-through costs, the final pro rata reduction is 68.9 percent.

C. Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

As discussed in the proposed rule, in the November 13, 2000 interim final rule (65 FR 67806 and 67825), we had excluded costs in revenue codes 274 (Prosthetic/orthotic devices), 275 (Pacemaker), and 278 (Other implants) from the calculation of APC payment rates. This was because, before enactment of the BBRA 1999, we had proposed to pay for implantable devices outside of the OPPS. After the enactment of the BBRA, it was not feasible to revise our database to include these revenue codes in developing the April 7, 2000 final rule. We were able to make the necessary revisions and adjustments in time for implementation on January 1, 2001. When we packaged costs from these revenue codes to recalculate APC rates for 2001, to comply with the BBRA 1999 requirement, the median costs for a handful of procedures related to pacemakers and neurostimulators significantly increased. Therefore, we restructured the affected APCs to account for these changes in procedure level median costs.

Under section 1833(t)(6)(D)(ii) of the Act, as added by the BBRA 1999 and redesignated by BIPA, the amount of additional payment for an eligible device is the amount by which the hospital's cost exceeds the portion of the otherwise applicable APC payment amount that the Secretary determines is associated with the device. Thus, beginning January 1, 2001, for eligible devices, we deducted from transitional pass-through payments the dollar increase in the rates for the new APCs for procedures associated with the devices. Effective April 1, 2001, we revised our policy to subtract the dollar amount from the otherwise applicable pass-through payment for each category of device. The dollar amount subtracted in 2001 from transitional pass-through payments for affected categories of devices is as follows:

TABLE 4.—CY 2001 REDUCTIONS TO PASS-THROUGH PAYMENTS TO OFFSET DEVICE-RELATED COSTS PACKAGED IN ASSOCIATED APC GROUPS

For item billed under HCPCS code. * * *	Subtract from the pass-through payment the following amount:
C1767 Generator, neurostimulator (implantable)	$643.73
C1778 Lead, neurostimulator (implantable)	501.27
C1785 Pacemaker, dual chamber, rate-responsive (implantable)	2,843.00
C1786 Pacemaker, single chamber, rate-responsive (implantable)	2,843.00
C1816 Receiver and/or transmitter, neurostimulator (implantable)	537.83
C2619 Pacemaker, dual chamber, non rate-responsive (implantable)	2,843.00
C2620 Pacemaker, single chamber, non rate-responsive (implantable)	2,843.00

The increase in certain APC rates for device costs on January 1, 2001 was offset by the simultaneous reduction of the associated pass-through payments. Payments for the procedures in the affected APCs that did not include a pass-through device increased for 2001 and for procedures that did include devices, total payment for the procedure plus the device or devices did not change.

For 2002, we estimated in the proposed rule the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments. This amount will be deducted from the pass-through payments for those devices as required by the statute. Since the deductions to the pass-through payments for costs included in APCs for 2002 are included in the recalibration of the weights and the ''fixed pool'' of dollars for outpatient services, the total payment for the procedure plus device or devices will be reduced rather than remain constant as they did in 2001.

We described our methodology for calculating these reductions for the proposed rule. First, we reviewed the APCs to determine which of them contained services that are associated with a category of devices eligible for a transitional pass-through payment. We then estimated the portion of the costs in those APCs that could reasonably be attributed to the cost of pass-through devices as follows:

- For each procedure associated with a pass-through device or devices, we examined all single-service bills (that is, bills that include services payable only under one APC) to determine utilization patterns for specific revenue centers that would reasonably be used for device-related charges in revenue codes 272 (sterile supplies), 275 (pacemakers), and 278 (other implants).
- We removed the costs in those revenue codes to calculate a cost for the bill net of device-related costs (reduced cost). For example, the average bill cost (in 1999–2000 dollars) for insertion of a cardiac pacemaker (CPT 33208) was $5,733. The average cost associated with revenue code 275 was $4,163, so the reduced cost for the procedure was $1,570. We calculated the ratio of the reduced cost ($1,570) to the full bill costs ($5,733), and we applied that ratio to the costs on any bills for CPT 33208 that did not use revenue code 275 to establish reduced cost at the procedure code level across all claims.
- To determine the reduced cost at the APC level and that portion of the APC payment rate associated with device costs, we calculated the median cost of the reduced cost bills for each relevant APC. For this calculation of the median, we allowed the full costs of bills for services in the APC that were not associated with pass-through devices.
- We calculated, for the APC, the percentage difference between the APC median of full cost or unreduced bills and the APC median where some or all of the bills had reduced costs. We applied this percent difference to the proposed APC payment rate in order to calculate the share of that rate attributable to the device or devices associated with procedures in the APC.

In column 3 of Table 5, we show the amount of the offset that we have computed with this methodology for each of the 25 APCs that we determined to have device costs represented in their rates. We note that the list of 25 APCs with device costs in their rates has changed slightly since the publication of the proposed rule. Specifically, APC 0185, Removal or Repair of Penile

Prosthesis, is no longer on the list, and APC 0259, Level VI ENT Procedures, has been added to the list. These changes result from the application of the limit on the variation of costs of services classified within a group (the ''two-times'' rule). APC 0185 has been deleted due to the application of this rule. The device-related procedures that had been included with APC 0185 have been incorporated into APC 0259. As a result, APC 0259 has been added to the list of APCs with device costs reflected in their rates, on the basis of the same costs that had been included in APC 0185.

We received several comments on this proposal, which are summarized below.

Comment: Several commenters asked for clarification of the methodology used in selecting the 25 APCs for which we calculated reductions.

Response: We described our methodology for selecting the 25 APCs in some detail in the proposed rule (66 FR 44706). As we stated there, we reviewed the APCs to determine which of them contained services that are associated with a category of devices eligible for a transitional pass-through payment. We carefully examined those APCs with a high frequency of claims in the data, and those that were associated with high-cost devices. We selected those APCs with patterns of billing that could be reasonably associated with devices, that is, with charges in revenue centers that are likely to be used for devices (revenue codes 272 (sterile supplies), 275 (pacemakers), and 278 (other implants)).

Comment: Several commenters noted that for 11 of the 25 APCs for which we have identified offsets, the amount of the proposed APC payment for 2002 has either decreased or increased by less than the amount of the offset. For these 11 APCs, Medicare's combined payments for the device and procedure would thus be reduced effective January 1, 2002.

Response: The estimate of the offset did not affect the APC rates. Any changes in the APC rates were due to the recalibration of the relative weights using the 1999–2000 data. The offset amount will be subtracted from the pass-through payment amount that would have been made otherwise. Thus, the combined payment for the device and procedure is necessarily reduced for all 25 APCs relative to what the payment would have been in 2002 without the offset. In other words, payments for all 25 device/procedure combinations would have been higher in 2002 by the amount of the offset if we had not identified the packaged costs and applied the offset. We assume, however, that the commenter means that payments for the device/procedure combinations associated with 11 of the 25 APCs will decrease in 2002 relative to the combined payments in 2001. Relative to the payments for 2001, the combined payment for the device and procedure could increase or decrease due to a number of factors affecting the relative weights for the APCs and the costs of the devices themselves. In the cases identified by the commenter, these factors decreased the proposed rates, or increased those rates by less than the amount of the offset, and thus decreased the payment in 2002 for the device/procedure combination relative to the payment for the combination in 2001.

Comment: One commenter endorsed the idea of making a reduction in pass-through payments for the costs already represented in the APC rates. However, the commenter expressed concern that reducing the pass-through payment will likely result in underpayments to hospitals that are using the associated devices with procedures, and overpayments to hospitals performing procedures without using the associated devices.

Response: We are not certain that the commenter understands how the pass-through offset works. The purpose of this measure is to ensure that the Medicare program pays only for the incremental costs of the new technology, over and above what is already represented in the APC rate for the associated procedure. The offset is applied only when a hospital bills for a device or other pass-through item in conjunction with billing for a procedure in an associated APC. When a hospital bills for a pass-through item along with a procedure, the hospital receives the full APC payment for the procedure. The offset is subtracted from the cost of the pass-through item. The hospital thus receives payment for the cost of the pass-through item over and above the offset amount. Without applying the offset, hospitals would be paid twice for the same costs. There is thus no underpayment for hospitals that are using pass-through items. When a hospital does not bill for a pass-through item with an APC, the hospital receives the full APC payment but no pass-through payment. The offset is not applied in the absence of a bill for a pass-through item. There is thus no overpayment for hospitals that are not using pass-through items. The hospital is paid only for the technology costs incorporated into the base APC rate, not for the incremental costs of new technologies.

Comment: One commenter raised a question about a possible consequence of applying predetermined amounts to subtract from pass-through payments as offsets for the device-related costs already included in the APC rates. The commenter observed that use of a hospital-wide cost-to-charge ratio in determining the amount of a pass-through payment makes it possible for the predetermined offset amount to exceed the calculated cost of a device to the hospital. The commenter therefore recommended that the reduction for the costs included in the APC rates never exceed the amount of the pass-through payment.

Response: We agree that the application of the pass-through offset should never result in a negative payment amount to the hospital. Our systems do not in fact compute pass-through payment amounts of less than zero.

Comment: One commenter recommended that, if we implement a pro rata reduction in the transitional pass-through payments, the same percentage reduction should be applied to the offsets for the technology costs already represented in the APCs associated with pass-through items. Such a reduction in the offset would help hospitals to maintain beneficiary access to new technology services in the event of a substantial pro rata reduction.

Response: The statute provides for applying a pro rata reduction only to the pass-through payments themselves, not to the offsets that are required to account for the costs that are represented in the payment rates for associated APCs. Reducing the offset would also increase the estimate of pass-through spending and require a larger pro rata reduction. We are therefore unable to accept the commenter's recommendation. We note, however, that the pro rata reduction is applied to the pass-through payment amount only *after* the offset.

Comment: One commenter endorsed the concept of incorporating pass-through device costs into their associated APCs, but raised a specific question about the device costs associated with APC 0182, Insertion of Penile Prosthesis. The commenter contended that a review of the median cost files suggests that numerous claims could not have included device costs, even though the whole point of the procedure is to implant a device. As a result, the commenter contended that both the pass-through offset for the device and any upward adjustment to incorporate device costs into the APC can only be understated. Two commenters inquired about APC 0108, Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads. The

commenter contended that the $5,768 that we have determined as representing device costs in that APC is far too low, since the average device costs between $22,000 and $23,000 in 1996.

Response: The first commenter is mistaken in thinking that we published a methodology for incorporating device costs into the APCs in the proposed rule. Rather, we published a methodology for identifying device costs that are *already* represented in the rates. (We published a methodology for incorporating device costs into the APCs in the November 2, 2001 final rule announcing the CY 2002 conversion factor and the pro rata reduction of transitional pass-through payments (66 FR 55857).) In developing our estimate of the device costs included in the APC rates, we used that portion of hospital costs that were allocated to those revenue centers in which device charges were likely to be billed. Hospitals have considerable flexibility in determining which revenue centers to assign charges, and we believe that in many cases they have allocated device charges to general supply centers. We are unable to separate the device charges from the other charges assigned to those revenue centers. We were thus unable to use costs from those centers in developing our estimates of the device costs associated with the APC rates. As a result, our estimate of the device costs in the APC rates might conceivably be understated. We believe that it does represent, however, a reasonably conservative estimate. We do not know the source of the other commenter's information about the cost for a specific device, but we believe that our offsets accurately capture the costs for device costs that are included in the current APC rates, net of all discounts, rebates, etc.

Comment: Several commenters questioned whether we would deduct from pass-through payments the full amount of the offset for the device costs reflected in associated APCs in cases where the payment for the associated APC is reduced due to the multiple procedures discount. Some of these commenters also recommended a methodology for making an appropriate adjustment. Specifically, they recommended that the multiple procedure discount be applied only to the nondevice-related portion of the APC payment amount.

Response: We agree with the commenters that the full pass-through offset should not be applied when the APC associated with the use of the device is subject to the multiple procedure discount of 50 percent. The purpose of the offset is to ensure that the program is not making double payment for any portion of the cost associated with the use of a pass-through item. The offset should therefore reflect that portion of the cost for the pass-through item actually reflected in the payment that is received for the associated APC. We believe that the most straightforward methodology for applying this principle is simply to reduce the offset amount by 50 percent whenever the multiple procedure discount applies to the associated APC.

Comment: One commenter asked how the offset is applied when one pass-through device is billed with more than one of the 25 APCs in which we have identified costs associated with pass-through items. And conversely, the commenter wondered what happens when two or more devices are billed with only one of the 25 APCs with offsets.

Response: The purpose of the offset is to avoid paying twice for costs that are represented both in the APC rates and in the costs of pass-through items. When one pass-through device is billed with two or more APCs with device-related costs, we would be double paying for some costs if we applied only one offset to the pass-through payment. We therefore apply all the offsets for the APCs on a bill when only one device is billed. As we have discussed above, however, the offset for the second APC would be reduced by 50 percent when the multiple service discount applies to that APC. Conversely, the offset is applied only once when one APC is billed, no matter how many devices are billed along with the APC. To apply the offset more than once would be to double-count the pass-through costs represented in that APC.

We employed the following methodology in incorporating 75 percent of the device pass-through costs into the costs that are used to establish the APC relative weights. We used a crosswalk that we developed as part of the methodology for estimating total pass-through spending as the basis for determining the device costs that are to be included in setting the relative weight for each APC. This crosswalk matches devices to the primary procedures in which they are used. In developing the total pass-through estimate, we used this crosswalk to produce a device package for each APC associated with device use, based on the one or more devices used in the procedures included in the APC. We then adjusted the costs of each package by subtracting the costs already represented in the payment amount for the APC. (These are the costs that are shown in column 3 of Table 5 below.) In order to account for these costs in determining the new relative weights, we added 75 percent of the costs in this adjusted package to the costs at the claim level for each procedure that uses the package of devices in the APC. At this point, we determined a revised median cost for the APC. That new median cost in turn was used as the basis for calculating the APC's new relative weight.

It is important to note that the median cost of an APC will not necessarily increase by the same amount as the costs that are folded into the APC. The middle number (that is, the median) in the ordered sequence of the costs for services in an APC would only vary by the same amount as the folded-in costs if every number in the sequence were increased by the amount of those folded-in costs. However, as we explained in the November 2, 2001 final rule concerning the pro rata reduction on transitional pass-through payments (FR 66 55862–5863), the device costs folded into an APC will not be uniformly distributed among the procedures in that APC. This is because procedures in an APC may require different types or numbers of devices, and some procedures may not require devices at all. Therefore, the increase in median cost for an APC is unlikely to exactly equal the amount of the costs folded into the APC. In the November 2, 2001 final rule, we also discuss in detail how the increase in APC rates due to the incorporation of these pass-through costs will be offset against the 2002 pass-through payments.

Table 5 shows the amount of the offsets that we will apply for each APC that contains device costs. Column 4 of Table 5 shows the amount of the offset for each APC into which costs have been folded employing the methodology we have just described. Column 5 then shows the total offset that is to be applied for each APC. For the 25 APCs in which we had previously identified device costs, the amount of the offset in column 5 is the sum of the amount in column 3 (the amount of the offset due to the device costs that we had previously identified in the APC) and the amount in column 4 (the amount of the offset due to the costs that have just been folded in). For all the other APCs listed in the table, the amounts in column 4 and column 5 are identical (and there is no entry in column 3). This is because we had not previously identified device costs that were already represented in the payment amounts for these APCs.

TABLE 5.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

APC	Description	Device costs already reflected in APC rate	Additional device costs folded into APC rate	Total office for device costs
1	2	3	4	5
0032	Insertion of Central Venous/Arterial Catheter	$73.79	$276.41	$350.20
0046	Open/Percutaneous Treatment Fracture or Dislocation	NA	91.63	91.63
0048	Arthroplasty with Prosthesis	NA	501.91	501.91
0057	Bunion Procedures	NA	155.76	155.76
0070	Thoracentesis/Lavage Procedures	NA	24.94	24.94
0080	Diagnostic Cardiac Catheterization	164.27	124.21	288.48
0081	Non-Coronary Angioplasty or Atherectomy	307.06	353.78	660.84
0082	Coronary Atherectomy	242.95	1,187.08	1,430.03
0083	Coronary Angioplasty	528.64	365.49	894.13
0084	Level I Electrophysiologic Evaluation	NA	9,783.24	9,783.24
0085	Level II Electrophysiologic Evaluation	NA	580.82	580.82
0086	Ablate Heart Dysrhythm Focus	NA	1,299.58	1,299.58
0087	Cardiac Electrophysiologic Recording/Mapping	NA	1,964.38	1,964.38
0088	Thrombectomy	162.72	251.47	414.19
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	3,175.70	3,242.08	6,417.78
0090	Insertion/Replacement of Pacemaker Pulse Generator	2,921.06	2,196.00	5,117.06
0094	Resuscitation and Cardioversion	NA	17.31	17.31
0103	Miscellaneous Vascular Procedures	NA	202.60	202.60
0104	Transcatheter Placement of Intracoronary Stents	428.16	798.68	1,226.84
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	657.59	1,038.44	1,696.03
0107	Insertion of Cardioverter-Defibrillator	6,803.85	10,987.63	17,791.48
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	6,940.27	19,438.20	26,378.47
0111	Blood Product Exchange	NA	203.11	203.11
0115	Cannula/Access Device Procedures	NA	121.15	121.15
0117	Chemotherapy Administration by Infusion Only	NA	29.02	29.02
0118	Chemotherapy Administration by Both Infusion and Other Technique	NA	27.49	27.49
0119	Implantation of Devices	NA	3,325.05	3,325.05
0120	Infusion Therapy Except Chemotherapy	NA	34.10	34.10
0121	Level I Tube Changes and Repositioning	NA	5.09	5.09
0122	Level II Tube Changes and Repositioning	72.55	212.27	284.82
0124	Revision of Implanted Infusion Pump	NA	3,282.80	3,282.80
0144	Diagnostic Anoscopy	NA	126.75	126.75
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	60.92	0.00	60.92
0152	Percutaneous Biliary Endoscopic Procedures	107.61	0.00	107.61
0153	Peritoneal and Abdominal Procedures	NA	33.60	33.60
0154	Hernia/Hydrocele Procedures	108.11	369.57	477.68
0161	Level II Cystourethroscopy and other Genitourinary Procedures	NA	7.12	7.12
0162	Level III Cystourethroscopy and other Genitourinary Procedures	NA	312.55	312.55
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	NA	889.80	889.80
0179	Urinary Incontinence Procedures	NA	3,359.66	3,359.66
0182	Insertion of Penile Prosthesis	2,238.90	543.66	2,782.56
0202	Level VIII Female Reproductive Proc	505.32	1,215.08	1,720.40
0203	Level V Nerve Injections	NA	416.39	416.39
0207	Level IV Nerve Injections	NA	61.60	61.60
0222	Implantation of Neurological Device	4,458.57	9,510.40	13,968.97
0223	Implantation of Pain Management Device	421.33	3,307.74	3,729.07
0225	Implantation of Neurostimulator Electrodes	1,182.00	11,862.15	13,044.15
0226	Implantation of Drug Infusion Reservoir	NA	3,341.85	3,341.85
0227	Implantation of Drug Infusion Device	3,810.46	2,354.31	6,164.77
0229	Transcatherter Placement of Intravascular Shunts	1,074.41	391.45	1,465.86
0237	Level III Posterior Segment Eye Procedures	NA	138.46	138.46
0246	Cataract Procedures with IOL Insert	146.82	0.00	146.82
0248	Laser Retinal Procedures	NA	1,262.93	1,262.93
0259	Level VI ENT Procedures	12,407.52	3,724.65	16,132.17
0264	Level II Miscellaneous Radiology Procedures	NA	60.06	60.06
0312	Radioelement Applications	NA	1,201.84	1,201.84
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	NA	208.20	208.20
0686	Level V Skin Repair	NA	458.65	458.65
0687	Revision/Removal of Neurostimulator Electrodes	NA	1,432.44	1,432.44
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	NA	6,195.52	6,195.52
0692	Electronic Analysis of Neurostimulator Pulse Generators	NA	639.86	639.86

VIII. Conversion Factor Update for CY 2002

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act, as redesignated by section 401 of the BIPA, provides that for 2002, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act, reduced by one percentage point. Further, section 401 of the BIPA increased the conversion factor for 2001 to reflect an update equal to the full market basket percentage increase amount.

In the November 2, 2001 final rule, we announced that the conversion factor for CY 2002 is $50.904 (66 FR 55864) based on an increase factor of 2.3 percent for 2002 and a wage index budget neutrality adjustment of 0.9936.

IX. Summary of and Responses to MedPAC Recommendations

On March 1, 2001 the Medicare Payment Advisory Commission (MedPAC) issued its annual report to Congress, including several recommendations related to the OPPS. In the August 24, 2001 proposed rule, we responded to these recommendations (66 FR 44707–44708).

MedPAC Recommendation: MedPAC has offered two recommendations regarding the update to the conversion factor in the OPPS. The first recommendation is that the Secretary should not use an expenditure target to update the conversion factor. The second recommendation is that Congress should require an annual update of the conversion factor in the OPPS that is based on the relevant factors influencing the costs of efficiently providing hospital outpatient care, and not just the change in input prices.

Response: Section 1833(t)(3)(C)(ii) of the Act requires the Secretary to update the conversion factor annually. Under section 1833(t)(3)(C)(iv) of the Act the update is equal to the hospital market basket percentage increase applicable under the hospital inpatient PPS, minus one percentage point for the years 2000 and 2002. The Secretary has the authority under section 1833(t)(3)(C)(iv) of the Act to substitute a market basket that is specific to hospital outpatient services. Finally, section 1833(t)(2)(F) of the Act requires the Secretary to develop a method for controlling unnecessary increases in the volume of covered hospital outpatient services, and section 1833(t)(9)(C) of the Act authorizes the Secretary to adjust the update to the conversion factor if the volume of services increased beyond the amount established under section 1833(t)(2)(F) of the Act.

In the September 8, 1998 proposed rule on the OPPS, we indicated that we were considering the option of developing an outpatient-specific market basket and invited comments on possible sources of data suitable for constructing one (63 FR 47579). We received no comments in response to this invitation, and we therefore announced in the April 7, 2000 final rule that we would update the conversion factor by the hospital inpatient market basket increase, minus one percentage point, for the years 2000, 2001, and 2002 (65 FR 18502). As required by section 401(c) of the BIPA, we made payment adjustments effective April 1, 2001 under a special payment rule that has had the effect of providing a full market basket update in 2001. We are, however, working with a contractor to study the option of developing an outpatient-specific market basket and would welcome comments and recommendations regarding appropriate data sources. We will also study the feasibility of developing appropriate adjustments for factors that influence the costs of efficiently providing hospital outpatient care, such as productivity increases and the introduction of new technologies, and the availability of appropriate sources of data for calculating the factors.

In the September 8, 1998 proposed rule on the OPPS, we proposed employing a modified version of the physicians' sustainable growth rate system (SGR) as an adjustment in the update framework to control for excess increases in the volume of covered outpatient services (63 FR 47586–47587). In response to comments on this proposal, we announced in the April 7, 2000 final rule that we had decided to delay implementation of a volume control mechanism, and to continue to study the options with a contractor (65 FR 18503). We will take MedPAC's recommendation into consideration in making a decision, and before implementing volume control mechanism we will publish a proposed rule with an opportunity for public comment.

MedPAC Recommendation: MedPAC recommends that the Secretary should develop formalized procedures in the OPPS for expeditiously assigning codes, updating relative weights, and investigating the need for service classification changes to recognize the costs of new and substantially improved technologies.

Response: Beginning with the April 7, 2000 final rule implementing the OPPS, we have outlined a comprehensive process to recognize the costs of new technology in the new system. One component of this process is the provision for pass-through payments for devices, drugs, and biologicals (see the discussion in conjunction with the next MedPAC recommendation). The other component is the creation of new APC groups to accommodate payment for new technology services that are not eligible for transitional pass-through payments. We assign new technology services that cannot be appropriately placed within existing APC groups to new technology APC groups, using costs alone (rather than costs plus clinical coherence) as the basis for the assignment. We describe revised criteria for assignment to a new technology group in section VI.G. of this preamble. When it is necessary, creation of new technology APC groups involves establishment of new codes. New codes are established through a well-ordered process that operates on an annual cycle. The cycle starts with submission of information by interested parties no later than April 1 of each year and ends with the announcement of new codes in October. As we stated previously, in the absence of an appropriate HCPCS code, we would consider creating a HCPCS code that describes the procedure or service. These codes would be solely for hospitals to use when billing under the OPPS.

We have also provided a mechanism for moving these services from the new technology APCs to clinically related APCs as part of the annual update of the APC groups. As described in section VI of this preamble, a service is retained within a new technology APC group until we have acquired adequate data that allow us to assign the service to an appropriate APC. We use the annual APC update cycle to assign the service to an existing APC that is similar both clinically and in terms of resource costs. If no such APC exists, we create a new APC for the service.

MedPAC Recommendation: MedPAC recommends that pass-through payments for specific technologies should be made in the OPPS only when a technology is new or substantially improved and adds substantially to the cost of care in an APC. MedPAC believes that the definition of ''new'' should not include items whose costs were included in the 1996 data used to set the OPPS payment rates.

Response: The statute requires that, under the OPPS, transitional pass-through payments are made for certain drugs, devices, and biologicals. The

items designated by the statute to receive these pass-through payments include the following:

- Current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act.
- Current drugs and biologicals used for the treatment of cancer, and brachytherapy and temperature monitored cryoablation devices used for the treatment of cancer.
- Current radiopharmaceutical drugs and biologicals.
- New drugs and biologicals in instances in which the item was not being paid as a hospital outpatient service as of December 31, 1996, and when the cost of the item is ''not insignificant'' in relation to the OPPS payment amount.
- Effective April 1, 2001, categories of Medical devices when the cost of the category is ''not insignificant'' in relation to the OPPS payment amount.

We are publishing a separate interim final rule in which we lay out the criteria for establishing categories of devices eligible for pass-through payments.

Section 1833(t)(6) of the Act provides that once a category is established, a specific device may receive a pass-through payment for 2 to 3 years if the device is described by an existing category, regardless of whether it was being paid as a hospital outpatient service as of December 31, 1996 or its cost meets the ''not insignificant'' criterion. Thus, the statute allows for certain devices that do not meet MedPAC's recommended limitation on a ''new'' device to receive transitional pass-through payments. However, no categories are created on the basis of devices that were paid for on or before December 31, 1996. That is, while devices paid for on or before December 31, 1996 can be included in a category, we would establish a category only on the basis of devices that were not being paid as hospital outpatient services as of December 31, 1996.

MedPAC Recommendation: MedPAC recommends that pass-through payments for specific technologies in the OPPS should be made on a budget-neutral basis and that the costs of new or substantially improved technologies should be factored into the update of the outpatient conversion factor.

Response: The statute requires that the transitional pass-through payments for drugs, devices, and biologicals be made on a budget neutral basis. Estimated pass-through payments are limited under the statute to 2.5 percent (and up to 2.0 percent for 2004 and thereafter) of estimated total program payments for covered hospital outpatient services. We adjust the conversion factor to account for the proportion of total program payments for covered hospital outpatient services, up to the statutory limit, that we estimate will be made in pass-through payments. As we have discussed in response to MedPAC's recommendation concerning an update framework for the OPPS conversion factor, we will study the feasibility of including appropriate adjustments for factors, including introduction of new technologies, that influence the costs of efficiently providing hospital outpatient care within such a framework.

MedPAC Recommendation: MedPAC recommends that the Congress should continue the reduction in outpatient coinsurance to achieve a 20 percent coinsurance rate by 2010.

Response: For most services that Medicare covers, the program is responsible for 80 percent of the total payment amount, and beneficiaries pay 20 percent. However, under the cost-based payment system in place for outpatient services before the OPPS, beneficiaries paid 20 percent of the hospital's charges for these services. As a result, coinsurance was often more than 20 percent of the total payment amount for the services.

The BBA established a formula under the OPPS that was designed to reduce coinsurance gradually to 20 percent of the total payment amount. Under this formula, a national copayment amount was set for each service category, and that amount is to remain frozen as payment rates increase until the coinsurance percentage falls to 20 percent for all services. On average, beneficiaries paid about 16 percent less in copayments for hospital outpatient services during 2000 under the OPPS than they would have paid under the previous system. However, it is true that the coinsurance remains higher than 20 percent of the Medicare payment amount for many services.

Subsequent legislation has placed caps on the coinsurance percentages to speed up this process. Specifically, section 111 of BIPA amended section 1833(t)(8)(C)(ii) of the Act to reduce beneficiary coinsurance liability by phasing in a cap on the coinsurance percentage for each service. Starting on April 1, 2001, coinsurance for a single service furnished in 2001 cannot exceed 57 percent of the total payment amount for the service. The cap will be 55 percent in 2002 and 2003, and will be reduced by 5 percentage points each year from 2004 to 2006 until coinsurance is limited to 40 percent of the total payment for each service. The underlying process for decreasing coinsurance will also continue during this period (see discussion in section IV.A. of this preamble). However, MedPAC projects that under current law, it would take until 2029 to reach the goal of 20 percent coinsurance for all services.

We agree with MedPAC's goal of continuing the reduction in outpatient coinsurance, and we would welcome enactment of a practical measure to do so.

We received no comments on our responses to the MedPAC recommendations.

X. Provider-Based Issues

A. Background and April 7, 2000 Regulations

On April 7, 2000, we published a final rule specifying the criteria that must be met for a determination regarding provider-based status (65 FR 18504). Since the beginning of the Medicare program, some providers, which we refer to as ''main providers,'' have functioned as a single entity while owning and operating multiple departments, locations, and facilities. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare for those services.

The regulations at § 413.65 define provider-based status as ''the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.'' Section 413.65(b)(2) states that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations at § 413.65(d). Among these criteria are the requirements that the main provider and the facility must have common licensure (when appropriate), the facility must operate under the ownership and control of the main provider, and the facility must be located in the immediate vicinity of the main provider.

The effective date of these regulations was originally set at October 10, 2000, but was subsequently delayed and is now in effect for cost reporting periods beginning on or after January 10, 2001. Program instructions on provider-based status issued before that date, found in Section 2446 of the Provider Reimbursement Manual—Part 1 (PRM–

1), Section 2004 of the Medicare State Operations Manual (SOM), and CMS Program Memorandum (PM) A–99–24, will apply to any facility for periods before the new regulations become applicable to it. (Some of these instructions will not be applied because they have been superseded by specific legislation on provider-based status, as described in item X.C below).

B. Provider-Based Issues/Frequently Asked Questions

Following publication of the April 7, 2000 final rule, we received many requests for clarification of policies on specific issues related to provider-based status. In response, we published a list of ''Frequently Asked Questions'' and the answers to them on the CMS web site at *www.hcfa.gov/medlearn/provqa.htm.* (This document can also be obtained by contacting the CMS (formerly, HCFA) Regional Office.) These Qs and As did not revise the regulatory criteria, but do provide subregulatory guidance for their implementation.

C. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554)

On December 21, 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) was enacted. Section 404 of BIPA contains provisions that significantly affect the provider-based regulations at § 413.65. Section 404 includes a grandfathering provision for facilities treated as provider-based on October 1, 2000; alternative criteria for meeting the geographic location requirement; and criteria for temporary treatment as provider-based.

1. Two-Year ''Grandfathering''

Under section 404(a) of BIPA, any facilities or organizations that were ''treated'' as provider-based in relation to any hospital or CAH on October 1, 2000 will continue to be treated as such until October 1, 2002. For the purpose of this provision, we interpret ''treated as provider-based'' to include those facilities with formal CMS determinations, as well as those facilities without formal CMS determinations that were being paid as provider-based as of October 1, 2000. As a result, existing provider-based facilities and organizations may retain that status without meeting the criteria in the regulations under §§ 413.65(d), (e), (f), and (h) until October 1, 2002. These provisions concern provider-based status requirements, joint ventures, management contracts, and services under arrangement. Thus, the provider-based facilities and organizations affected under section 404(a) of BIPA are not required to submit an application for or obtain a provider-based status determination in order to continue receiving reimbursement as provider-based during this period.

These provider-based facilities and organizations will not be exempt from the Emergency Medical Treatment and Active Labor Act (EMTALA) responsibilities of provider-based facilities and organizations (revised § 489.24(b) and new § 489.24(i)) or from the obligations of hospital outpatient departments and hospital-based entities in § 413.65(g), such as the responsibility of off-campus facilities provide written notices to Medicare beneficiaries of coinsurance liability. These rules are not pre-empted by the grandfather provisions of BIPA section 404 because they do not set forth criteria that must be met for provider-based status as a department of a hospital, but instead identify responsibilities that flow from that status. These responsibilities become effective for hospitals on the first day of the hospital's cost reporting period beginning on or after January 10, 2001.

2. Geographic Location Criteria

Section 404(b) of BIPA provides that those facilities or organizations that are not included in the grandfathering provision at section 404(a) are deemed to comply with the ''immediate vicinity'' requirements of the new regulations under § 413.65(d)(7) if they are located not more than 35 miles from the main campus of the hospital or critical access hospital. Therefore, those facilities located within 35 miles of the main provider satisfy the immediate vicinity requirement as an alternative to meeting the ''75/75 test'' under § 413.65(d)(7).

In addition, BIPA provides that certain facilities or organizations are deemed to comply with the requirements for geographic proximity (either the ''75/75 test'' or the ''35-mile test'') if they are owned and operated by a main provider that is a hospital with a disproportionate share adjustment percentage greater than 11.75 percent and is (1) owned or operated by a unit of State or local government, (2) a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or (3) a private hospital that has a contract with a State or local government that includes the operation of clinics of the hospital to ensure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare or Medicaid.

These geographic location criteria are permanent. While those facilities or organizations treated as provider-based on October 1, 2000 are covered by the 2-year grandfathering provision noted above, the geographic location criteria at section 404(b) of BIPA and the regulations at § 413.65(d)(7) will apply to facilities or organizations not treated as provider-based as of that date, effective with the hospital's cost reporting period beginning on or after January 10, 2001. Beginning October 1, 2002, these criteria will also apply to the grandfathered facilities.

3. Criteria for Temporary Treatment as Provider-Based

Section 404(c) of BIPA also provides that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000 and before October 1, 2002 shall be treated as having provider-based status for any period before a determination is made. Thus, recovery for overpayments will not be made retroactively for noncompliance with the provider-based criteria once a request for a determination during that time period has been made. For hospitals that do not qualify for grandfathering under section 404(a) of BIPA, a request for provider-based status should be submitted to the appropriate CMS Regional Office (RO). Until a uniform application is available, at a minimum, the request should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation to demonstrate compliance with the provider-based status criteria in effect at the time the application is submitted. Once such a request has been submitted on or after October 1, 2000, and before October 1, 2002, CMS will treat the facility or organization as being provider-based from the date it began operating as provider-based (as long as that date is on or after October 1, 2000) until the effective date of a CMS determination that the facility or organization is not provider-based.

Facilities requesting a provider-based status determination on or after October 1, 2002 will not be covered by the provision concerning temporary treatment as provider-based in section 404(c) of BIPA. Thus, as stated in § 413.65(n), CMS ROs will make provider-based status effective as of the earliest date on which a request for determination has been made and all requirements for provider-based status in effect as of the date of the request are shown to have been met, not on the date

of the formal CMS determination. If a facility or organization does not qualify for provider-based status and CMS learns that the provider has treated the facility or organization as provider-based without having obtained a provider-based determination under applicable regulations, CMS will review all payments and may seek recovery for overpayments in accordance with the regulations at § 413.65(j), including overpayments made for the period of time between submission of the request or application for provider-based status and the issuance of a formal CMS determination.

D. Commitment To Re-Examine EMTALA Applicability to Off-Campus Hospital Locations, and to Further Revise Provider-Based Regulations

As explained in the proposed rule published on August 24, 2001, (p. 44709) we are aware that many hospitals and physicians continue to have significant concerns with our policy on the applicability of EMTALA to provider-based facilities and organizations. We intend to re-examine these regulations and, in particular, reconsider the appropriateness of applying EMTALA to off-campus locations. We plan to review these regulations with a view toward ensuring that these locations are treated in ways that are appropriate to the responsibility for EMTALA compliance of the hospital as a whole. At the same time, we want to ensure that those departments that Medicare pays as hospital-based departments are appropriately integrated with the hospital as a whole. Because of these considerations, we stated in the preamble to our August 24, 2001 proposals that we intend to publish a proposed rule to address these issues more fully.

In response to our statements, we received several comments, which are summarized below.

Comment: Several commenters expressed approval of the statement, in the preamble to the August 24, 2001 proposed rule, that CMS plans to reconsider the appropriateness of applying EMTALA to off-campus hospital locations. The commenters offered to work with CMS in establishing further policy in this area.

Response: We appreciate the commenters' support, and look forward to working with them on these important issues.

Comment: One commenter stated that since CMS is planning to reconsider the appropriateness of applying EMTALA to off-campus hospital locations it should, while the review is taking place, either withdraw the regulations requiring EMTALA compliance at off-campus hospital facilities, or not implement those regulations.

Response: We agree that the issues need to be reviewed carefully. EMTALA affords important protections to individuals who come to hospitals to seek care for possible emergency medical conditions. Thus, any change in the scope of the EMTALA regulations must be considered very thoroughly before it is undertaken. At the same time, we are well aware that many hospitals continue to be concerned about what they view as the excessive financial and administrative burden of complying with EMTALA at off-campus locations. In view of the complexity of the issues under view, and in consideration of the very significant impact that any change could have on the health and safety of hospital patients, we remain convinced that it would not be appropriate to anticipate the conclusion of that review by withdrawing or rescinding the regulations at this time. For the same reason, we are not adopting the suggestion that we suspend implementation of the current regulations.

Comment: Several commenters recommended that CMS publish additional regulations clarifying various issues related to the criteria for provider-based status. The commenters offered to work with CMS in establishing further policy in this area.

Response: We appreciate the commenters' support, and look forward to working with them on these important issues.

E. Changes to Provider-Based Regulations

To fully implement the provisions of section 404 of BIPA and to codify the clarifications currently stated only in the Qs and As on provider-based status, as described above, we proposed to revise the regulations as follows.

1. Clarification of Requirements for Adequate Cost Data and Cost Finding (§ 413.24(d))

As part of the April 7, 2000, final rule implementing the prospective payment system for hospital outpatient services to Medicare beneficiaries, under § 413.24, Adequate Cost Data and Cost Finding, we added a new paragraph (d)(6), entitled ''Management Contracts.'' Since publication of the final rule, we have received several questions concerning the new paragraph.

In response to these questions, we proposed to revise that paragraph to clarify its meaning. In addition, for further clarity, we proposed to revise the coding and title of that material. We proposed to redesignate § 413.24(d)(6)(i) as § 413.24(d)(6) and § 413.24(d)(6)(ii) as § 413.24(d)(7). As revised, paragraph (d)(6) would address the situation when the main provider in a provider-based complex purchases services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center that duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Therefore, when a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the provider cannot be separately identified, the costs of the services purchased through a contract for the provider-based entity or provider department must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

For costs of services furnished to free-standing entities, we proposed to clarify in revised § 413.24(d)(7), that the costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

This revision is not a change in the policy, but instead is a clarification to the policy set forth in the April 7, 2000

final rule. We received no comments on this proposal and are adopting it without change.

2. Scope and Definitions (§ 413.65(a))

In Q/A 9 published on the CMS (formerly, HCFA) web site at *www.hcfa.gov/medlearn/provqa.htm,*we identified specific types of facilities for which provider-based determinations would not be made, since their status would not affect either Medicare payment levels or beneficiary liability. (This document may also be obtained by contacting the CMS (formerly, HCFA) Regional Office.) The facilities identified in Q/A 9 are ambulatory surgical centers (ASCs); comprehensive outpatient rehabilitation facilities (CORFs); home health agencies (HHAs); skilled nursing facilities (SNFs); hospices; inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services; independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests; facilities furnishing only physical, occupational or speech therapy to ambulatory patients, for as long as the $1500 annual cap on coverage of physical, occupational, and speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation; and end-stage renal disease (ESRD) facilities. Determinations for ESRD facilities are made under § 413.174.

We proposed to revise the regulations at § 413.65(a) to clarify that these facilities are not subject to the provider-based requirements and that provider-based determinations will not be made for them.

We received a few comments on this proposal, which are summarized below.

Comment: One commenter expressed approval of the proposed revision, but suggested that we expand the list of facilities or organizations for which provider-based status is not required to include specific types of neonatal intensive care units and outpatient departments providing specialty pediatric care. The commenter believed such a change would permit these facilities to be treated as provider-based after the grandfather provisions of BIPA section 404 expire, even though they do not meet all criteria in 42 CFR 413.65(d).

Response: In Q/A 9 published on the CMS web site at *www.hcfa.gov/medlearn/provqa.htm* we identified specific types of facilities for which provider-based determinations will not be made because any determinations regarding their status would not affect either Medicare payment levels or beneficiary liability. In the August 24, 2001 proposed rule, we proposed to codify this list of facilities. Because the comment was submitted in response to this part of our proposal, we considered it in that context. However, the commenter did not succeed in establishing that the units and specialized outpatient departments meet the criteria for inclusion on a list of facilities for which a determination about provider-based status would not affect either Medicare payment levels or beneficiary liability. (On the contrary, the commenter argued that if determinations were made on such units and departments, payments would be reduced significantly.) Moreover, the primary focus of the comment is not to ask that no determinations be made for these units and departments, but instead that those facilities be treated as provider-based even though they do not meet some or all of the provider-based criteria in § 413.65(d). We did not propose to extend provider-based status to such facilities (except insofar as BIPA section 404 requires us to do so), nor can such a proposal be logically inferred from the provisions included in the proposed rule. Thus, while we reviewed this comment with interest, we did not adopt it. We received no other comments on this proposed revision and are adopting it without change.

3. BIPA Provisions on Grandfathering and Temporary Treatment as Provider-Based (§§ 413.65(b)(2) and (b)(5))

Currently, § 413.65(b)(2) states that a main provider or a facility must contact CMS (formerly, HCFA), and CMS must determine that the facility is provider-based before the main provider bills for services of the facility as if the facility were provider-based, or before it includes costs of those services on its cost report. However, as explained earlier, sections 404(a) and (c) of BIPA require that certain facilities be grandfathered for a 2-year period, and that facilities applying between October 1, 2000 and October 1, 2002 for provider-based status with respect to a hospital be given provider-based status on a temporary basis, pending a decision on their applications. To implement these provisions, we proposed to revise the regulations in § 413.65(b)(2) to state that if a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002, and the requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of § 413.65 will not apply to that hospital or CAH with respect to that facility until October 1, 2002. We further proposed that for purposes of paragraph (b)(2), a facility would be considered to have been treated as provider-based on October 1, 2000, if on that date it either had a written determination from CMS (formerly, HCFA) that it was provider-based as of that date, or was billing and being paid as a provider-based department or entity of the hospital.

In addition, we proposed to add a new § 413.65(b)(2) to state that a facility for which a determination of provider-based status in relation to a hospital or CAH is requested on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS (formerly, HCFA) determines that the facility does not qualify for provider-based status.

We received one comment on this proposal, which is summarized below.

Comment: One commenter stated that our proposed revision to these sections does not adequately implement section 404(c) of BIPA, in that it would require temporary treatment as provider-based for a facility or organization for which such status is requested on or before October 1, 2000 only from October 1, 2000 forward. The commenter believes this is inappropriate because section 404(c) of BIPA provides that such a facility or organization is to be treated as provider-based for ''any period before a determination is made.'' Under the commenter's recommended interpretation of the provision, such temporary treatment would also be available for any period before October 1, 2000.

Response: We believe this interpretation of the provision is overly literal, and does not accurately reflect the role of paragraph (c) in the total statutory scheme established by section 404 of BIPA. Section 404(a)(1) describes the treatment to be accorded to facilities treated as provider-based on October 1, 2000, by providing that such facilities will continue to be treated as provider-based until October 1, 2002. Thus, paragraph (a) of section 404 addresses the situation of facilities that existed and were treated as provider based on October 1, 2000. Section 404(c) of BIPA complements this provision by mandating a grace period for those facilities seeking provider-based status determinations on or after October 1, 2000 that either (i) existed on October 1, 2000 but were not treated as provider-based, or (ii) did not exist as of October

1, 2000 (that is, were opened after that date). Taken together, paragraphs (a) and (c) specify the treatment to be given to facilities treated as provider-based on the reference date of October 1, 2000 and to those facilities for which provider-based status is sought within 2 years after the reference date. However, we find no indication that the statute was intended to extend provider-based status for any period before the reference date. Such an extension would not be necessary to protect a provider from possible retroactive liability based on possible delay in considering a provider-based application, and could inappropriately prevent collection of overpayments incurred well before October 1, 2000. Thus, we did not adopt this comment.

We received no other comments on this proposal and we are adopting it without change.

4. Reporting (§ 413.65(c)(1))

Currently, § 413.65(c) states that a main provider that creates or 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 CMS (formerly, HCFA) if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization in the provider's cost report would increase the total costs on the provider's cost report by at least 5 percent, 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. Concern has been expressed that such reporting would duplicate the requirement for obtaining approval of a facility as provider-based before billing its services that way or including its costs on the cost report of the main provider (current § 413.65(b)(2)). To prevent any unnecessary duplicate reporting, we proposed to delete the current requirement from § 413.65(c)(1). We proposed, however, to retain the requirement that a main provider that has had one or more facilities considered provider-based also report to CMS (formerly, HCFA) any material change in the relationship between it and any provider-based facility, such as a change in ownership of the facility or entry into a new or different management contract that could affect the provider-based status of the facility.

We received one comment on this proposal, which is summarized below.

Comment: A commenter stated that more guidance is needed on the rules regarding reporting to CMS any significant changes in the relationship between a main provider and its provider-based facilities. The commenter asked that we explain the meaning of ''significant changes,'' prescribe the format of such reporting, and specify to whom such reports are to be made.

Response: Although the commenter refers to reporting any significant changes, the regulations at § 413.65(c)(1) speak of reporting any ''material'' changes in the relationship between it and any provider-based facility. As explained in the August 24, 2001 proposed rule, we would consider a ''material'' change to be anything that may interfere with compliance with the provider-based rules. The August 24, 2001 document further explains that such a change may include but is not limited to a change of ownership, entry into a new or different management contract, or change in the financial operations of the facility or the main provider. The main provider may report such material changes in the form of a letter submitted to its CMS Regional Office with a copy to its fiscal intermediary. While we are responding in this preamble to the commenter's questions and hope that this information is helpful, we do not believe it is essential to include this level of detail in the Code of Federal Regulations. Therefore, we did not revise the regulations based on this comment.

We received no other comments on the proposal and are adopting it without change.

5. Geographic Location Criteria (§ 413.65(d)(7))

As explained earlier in X.C.2 of this preamble, section 404(b) of BIPA mandates that facilities seeking provider-based status be considered to meet any geographic location criteria if they are located not more than 35 miles from the main campus of the hospital or CAH to which they wish to be based, or meet other specific criteria relating to their ownership and operation. To implement this provision, we proposed to revise § 413.65(d)(7) to state that a facility will meet provider-based location criteria if it and the main provider are located on the same campus, or if one of the following three criteria are met:

- The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider.
- The facility or organization is owned and operated by a hospital or CAH that—

(A) Is owned or operated by a unit of State or local government;

(B) Is a public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) Is a private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to ensure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan); and

(D) Has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act.

- The facility meets the criteria currently set forth in § 413.65(d)(7)(i) for service to the same patient population as the main provider.

We received no comments on this proposal and we are adopting it without change.

6. Notice to Beneficiaries of Coinsurance Liability (§ 413.65(g)(7))

Currently § 413.65(g)(7) states that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital has a duty to provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand.

We clarified in the preamble to an interim final rule with comment period published on August 3, 2000 (65 FR 47670) that if the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains the fact that the beneficiary will incur a coinsurance liability to the hospital that they would not incur if the facility were not provider-based. The interim final rule further explained that the hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual

services furnished by the hospital if the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

We proposed to amend § 413.65(g)(7) to include this clarifying language. We received no comments on this proposal, and we are adopting it without change.

7. Clarification of Protocols for Off-Campus Departments (§ 489.24(i)(2)(ii))

Currently, § 489.24(i) specifies the anti-dumping obligations that hospitals have for individuals who come to off-campus hospital departments for the examination or treatment of a potential emergency medical condition. These obligations are sometimes known as EMTALA obligations, after the Emergency Medical Treatment and Labor Act, which is the legislation that first imposed the obligations. Currently, hospitals are responsible for ensuring that personnel at their off-campus departments are trained and given appropriate protocols for the handling of emergency cases.

In the case of off-campus departments not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus before arranging an appropriate transfer to a medical facility other than the main hospital.

Some concern had been expressed that taking the time needed to make such contacts might inappropriately delay the appropriate transfer of emergency patients in cases in which the patient's condition was deteriorating rapidly. In response to this concern, we clarified in the preamble to the interim final rule with comment period published on August 3, 2000 cited above (65 FR 47670) that in any case of the kind described in § 489.24(i)(2)(ii), the contact with emergency personnel at the main hospital campus should be made either concurrently with or after the actions needed to arrange an appropriate transfer, if, prior to transfer, contacting the main hospital campus would significantly jeopardize the individual's life or health. This does not relieve the off-campus department of the responsibility for making the contact, but only clarifies that the contact may be delayed in specific cases in which doing otherwise would endanger a patient subject to EMTALA protection.

We proposed to amend § 489.24(i)(2)(ii) to include this clarifying language. We received two comments on this proposal, which are summarized below.

Comment: Two commenters expressed approval of the change and recommended that it be adopted in the final rule. However, the commenter recommended that we further clarify the rule by spelling out the circumstances under which personnel at off-campus locations would be expected to call EMS before seeking guidance from the emergency department staff at the main campus delay.

Response: As noted above, we plan to reconsider the general issue of the appropriateness of applying EMTALA to off-campus hospital locations. We will consider the commenter's specific suggestion in the course of that more general review. Therefore, we have not made any change in the final rule based on this comment.

Comment: One commenter expressed approval of the proposed clarification at § 489.24(i)(2)(ii), under which personnel in off-campus departments that are not routinely staffed with physicians, RNs, or LPNs, may delay contacting the main hospital's emergency department according to protocols if, prior to transfer, contacting the main hospital campus would significantly jeopardize the individual's life or health. However, the commenter pointed out that the introductory paragraph of § 489.24(i)(2) applies the protocol requirement to all off-campus departments (whether or not staffed by physicians and nurses). Therefore, the commenter suggested that we move this provision to the introductory paragraph of § 489.24(i)(2), and so that it will apply to all off-campus departments. The commenter believes that this change would be consistent with the policy stated by CMS on its website (CMS EMTALA guidance, 7/20/01, Q/A ##7 and 13–16).

Response: We agree that it would be appropriate, and consistent with our policy in this area, to apply this provision concerning the delay of contact in certain situations to all off-campus departments. As the commeter suggested, we are amending § 489.24(i)(2) to include the clarifying language that had been proposed at § 489.24(i)(2)(ii).

8. Other Changes

In addition to the changes cited previously, we proposed to make the following conforming and clarifying changes:

• Correcting date references in §§ 413.65(i)(1)(i) and (i)(2), in order to take into account the effective date of the current regulations.

• Substituting ''CMS'' for ''HCFA'' throughout the revised sections of part 413, to reflect the renaming of the Health Care Financing Administration (HCFA) as the Centers for Medicare & Medicaid Services (CMS).

We received no comments on these proposals and are adopting them without change.

F. Comments on Other Issues

We also received a number of comments recommending various changes in the provider-based regulations that were not in our August 24, proposed rule and cannot logically be inferred from those proposals. While we read these comments with interest, we have not made any changes in the final rule based on them.

XI. Summary of the Final Rule

This final rule revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements, including relevant provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and changes arising from our continuing experience with this system. In addition, it describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. This final rule also announces a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments.

This final rule finalizes a number of policies discussed in the August 24, 2001 proposed rule as follows:

• We are implementing BIPA provisions that affect the OPPS in 2002, including the following:

+ The national coinsurance rate for OPPS services is limited to 55 percent of the APC payment rate established for a procedure or service.

+ Children s hospitals receive the same hold-harmless protection accorded to cancer hospitals under BBRA.

+ Special payment provisions for certain services, including screening for glaucoma, payment for contrast agents, and new technology diagnostic mammography.

• We adjust payments to hospitals for geographic wage differences, as required by the statute, using the FY 2002 hospital inpatient PPS wage index. We have recalibrated the APC weights, also as required by the statute, using median costs drawn from claims data for hospital services furnished on or after July 1, 1999 through June 30, 2000.

• The methodology that we followed to calculate the final APC relative weights for CY 2002 is similar to the proposed methodology except that we have incorporated pass-through device

costs in device-related procedures. Specifically, we have incorporated 75 percent of the estimated cost for pass-through devices into the base APC costs.

• We have revised and updated the APC groups in accordance with several factors. These changes would affect more than half of the approximately 340 existing APC groups.

• As a result of consultations with the advisory panel on APC groups, we have reviewed and are accepting a number of the Panel's recommendations. In some cases, we have made additional changes to the APCs based on the use of new data and application of the 2 times rule.

• We have received recommendations from commenters and interested parties to establish separate APCs for observation services. As proposed, we are creating a new APC to make separate payment for observation services for patients with chest pain, asthma, and congestive heart failure, when certain clinical criteria are met. We have made some minor changes based on public comment.

• Based on public comment, we made several modifications to our proposed coding scheme for stereotactic radiosurgery.

• We have revised the criteria for the new technology APC groups that we created to allow payment at an appropriate level for new technologies that do not meet the statutory requirements for pass-through payments. These changes are intended to allow us to reserve these special new technology APC groups for services that are a new, ''complete'' procedure and not just modifications of existing technologies.

• We are changing the aggregate method currently used for calculating outlier payments and will begin determining outliers on an APC-by-APC basis rather than the entire bill. To do this, we allocate packaged items on a bill to APCs based on their relative weight.

• We are excluding from the OPPS the Part B-only services furnished to inpatients of hospitals that do no other billing for hospital outpatient services under Part B. This is in response to complaints we received from State psychiatric hospitals that did not have outpatient departments and, therefore, bill under OPPS only for inpatients. This policy would exempt them from having to make costly revisions to their billing systems.

• We are excluding from the OPPS hospitals that are located outside the 50 States or the District of Columbia or Puerto Rico, that is, hospitals in Guam, Saipan, American Samoa, and the Virgin Islands. This policy is consistent with their current exclusion from the inpatient PPS and will also save these hospitals from billing system revisions.

• We will continue to use a list of certain procedures that are designated as inpatient procedures and therefore are not paid by Medicare under the OPPS. Based on comments, we have made minor changes to this list.

• We are revising the regulations affecting provider-based entities to implement technical BIPA provisions on grandfathering, temporary treatment as provider-based, and certain geographic location criteria; and to clarify requirements for adequate cost data and cost finding, certain reporting requirements, requirements regarding notice to beneficiaries of coinsurance liability, and clarification of anti-patient dumping rules (EMTALA obligations) in off-campus departments.

• In response to public comments regarding provider-based issues, we are moving the provision concerning the delay of contact in certain situations to the introductory paragraph of § 489.24(i)(2) so that it will apply to all off-campus departments.

• In addition, we are making editorial and technical revisions to our regulations. We made minor editorial changes in paragraphs (b)(2), (b)(4), (b)(5), (c), (d)(7)(iv), and (g)(7) of § 413.65. In § 413.65(i)(2), we modified the presentation of our language to more clearly present our policy.

XII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-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.

Sections 413.65 and 419.42 of this final rule contain information collection requirements that are subject to review by OMB under the Paperwork Reduction Act of 1995. However, §§ 413.65 and 419.42 have been approved by OMB under approval number 0938–0798, with a current expiration date of August 31, 2003 and OMB approval number 0938–0802, with a current expiration date of December 31, 2001.

Process and Information Required To Apply for Transitional Pass-through Payment for Eligible Drugs and Biological Agents, Including Radiopharmaceuticals, Under the Hospital Outpatient Prospective Payment System

The application itself for Transitional Pass-Through Payment for Eligible Drugs and Biological Agents, Including Radiopharmaceuticals, may be found at <*www.hcfa.gov*>. Transitional pass-through categories are for devices only; they do not apply to drugs or biologicals. The regulations governing transitional pass-through payments for eligible drugs and biologicals remain unchanged. The process to apply for transitional pass-through payment for eligible drugs and biological agents, including radiopharmaceuticals, can be found in the April 7, 2000 **Federal Register** (65 FR 18481) and on the CMS web site at *http://www.hcfa.gov/medlearn/appdead.htm*. If we revise the application instructions in any way, we will post the revisions on our web site and submit the changes for the Office of Management and Budget (OMB) review under the Paperwork Reduction Act. The application process for new categories can be found on the CMS web site at http://www.hcfa.gov//medicare/newcatapp1030f.rtf.

We estimate that approximately 100 entities will file an application yearly. We believe it will take each of these entities around 16 hours to gather the necessary information and fill out the application.

We have submitted a copy of this final rule to OMB for its review of the information collection requirement described above. The requirement is not effective until it has been approved by OMB.

XIV. Regulatory Impact Analysis

A. General

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993; Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980; Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize

net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

The provisions of this final rule do not result in impacts that exceed $100 million per year. The effects of the changes in this rule are redistributional and do not result in additional expenditures. The impacts discussed below reflect the effects of the final rule published on November 2, 2001. Therefore, this final rule is not an economically significant rule under Executive Order 12866, nor a major rule under 5 U.S.C. 804(2).

We note, however, that on November 2, 2001, we published a final rule that announced the updated conversion factor for payments under the OPPS (66 FR 55857). As discussed in more detail in that document, we estimated that the total impact of the changes for CY 2002 payments compared to CY 2001 payments as set forth in the November 2 rule would be approximately a $450 million increase (66 FR 55864).

The RFA requires agencies to determine whether a rule will have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 to $25 million or less annually (see 65 FR 69432). For purposes of the RFA, all providers of hospital outpatient services are considered small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 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 that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100 beds, or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals.

It is clear that the changes in this final rule affect both a substantial number of rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a regulatory impact analysis.

Section 202 of the Unfunded Mandate Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule does not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this final rule in accordance with Executive Order 13132, Federalism, and have determined that it will not have any negative impact on the rights, roles, and responsibilities of State, local or tribal governments.

B. Changes in This Final Rule

In this final rule, we are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments used to determine the APC payment rates. In addition, we must review the clinical integrity of payment groups and the relative weights at least annually. Accordingly, in this final rule, we are updating the wage index adjustment for hospital outpatient services furnished beginning January 1, 2002. We are also revising the relative APC payment weights based on claims data from July 1, 1999 through June 30, 2000. Finally, we are beginning to calculate outlier payments on an APC-specific basis rather than the current method of calculating outlier payments for each claim. In addition, as an administrative action, we have incorporated 75 percent of the estimated cost of the pass-through devices into the base APC rates.

As described in the preamble, budget neutrality adjustments are made to the weights to assure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. In addition, the parameters for outlier payments have been modified so that outlier payments for 2002 are projected to equal the established policy target of 2.0 percent of total payments. Because we are not revising the target percentage, there is no estimated aggregate impact from modifying the method of determining outlier payments.

The impact of the wage index, APC reclassification and recalibration, and outlier changes do vary somewhat by hospital group. Estimates of these impacts are displayed on Table 6.

We received no specific comments on the impact analysis. However, in commenting on certain proposed policies, commenters sometimes referred to the impact of a policy on hospitals or a specific group of hospitals. We have addressed these comments elsewhere in the preamble to this final rule. The following is a discussion of how the final policies set forth in this rule affect hospitals and beneficiaries. As an informational matter, the impact of changes set forth in Table 6 include the impact of the update to the conversion factor, which was implemented in the November 2 final rule.

C. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes as well as statutory changes effective for 2002, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters. Finally, we do not model the impact of the transitional corridor payments, which protect hospitals from losses in 2002 compared to their 1996 payments. We are unable to model this impact because we do not yet have filed cost reports from hospitals for the services furnished under the PPS. The raw cost report data are generally not available until at least 7 months after the end of the cost reporting period.

D. Estimated Impacts of This Final Rule on Hospital Payments

Column 5 in Table 6 represents the full impact on each hospital group of all the changes for 2002. Columns 2 through 4 in the table reflect the independent effects of the change in the wage index, the APC reclassification and recalibration changes (including the incorporation of pass-through device

costs), and the change in outlier method, respectively.

In general, the wage index changes favor rural hospitals, particularly the largest in bed size and volume. The only rural hospitals that would experience a negative impact due to wage index changes are those in the Pacific Region, a decrease of 0.1 percent. Conversely, the urban hospitals are generally negatively affected by these changes, with the largest effect on those with 500 or more beds (a 0.5 percent decrease) and those in the Middle Atlantic (a 0.5 percent decrease) and West South Central (a 0.9 percent decrease) Regions.

We estimate that the APC reclassification and recalibration changes have generally an opposite impact from the wage index, causing increases in payments for all urban hospitals except those with fewer than 200 beds and volumes of fewer than 21,000 services per year and those located in the New England (a 0.6 percent decrease), Middle Atlantic (a 0.8 percent decrease), and Puerto Rico (an 8.1 percent decrease) Regions.

The incorporation of 75 percent of the estimated costs of pass-through devices into the base APC rates has a relatively large negative effect on rural hospitals. In the proposed rule, the estimated impact of the APC reclassification and recalibration changes on rural hospitals was a 1.5 percent decrease in payments. With the incorporation of the device costs, the impact is now estimated to be a 3.8 percent decrease. This impact does not include the effects of any additional transitional corridor payments to rural hospitals. The negative effect is particularly pronounced for rural hospitals with fewer than 100 beds (a decrease of 5.6 percent for hospitals with fewer than 50 beds and a 4.9 percent decrease for hospitals with 50–99 beds). This impact is due to the large increase in payment rates for device-related APCs and the corresponding decrease in nondevice-related APCs, as discussed in more detail above in section II.C. of this preamble. The decrease in the payment rates for clinic visits and diagnostic and preventive services affect rural hospitals disproportionately because they perform far more of these services as compared to the device-related APCs for which payment rates have increased. These impact estimates do not reflect the effects of the hold harmless transitional corridor payments in 2002 for the smallest rural hospitals.

We also note that it is not the large academic medical centers that are most positively affected by the incorporation of pass-through device costs. While the group of hospitals that receives the largest increase in payments is hospitals with 500 or more beds (a 3.4 percent increase), minor teaching hospitals will receive an increase of only 2.0 percent and major teaching hospitals, an increase of 0.5 percent.

Although teaching hospitals perform many device-related procedures, they also provide a very large number of clinic and emergency room visits, both of which will experience a projected decrease in payment rates of approximately 8 percent. In fact, teaching hospitals that do not also receive disproportionate share payments will experience a projected decrease of 2.1 percent. The largest negative impact for urban hospitals is for those with no teaching adjustment that also do not serve a disproportionate share of low-income patients. Even though this is a relatively small group of hospitals, their payments are projected to decrease by 15.5 percent.

The change in outlier policy to an APC-specific payment has a slight negative effect on rural hospitals as a group (a 0.1 percent decrease), no effect on urban hospitals as a group, and slight negative effects on all small hospitals (fewer than 100 beds) as well as those with lower volumes of services. For urban hospitals, other than a projected increase in payments of 0.3 percent for hospitals in the Middle Atlantic Region, no geographic group of hospitals is affected by more than 0.1 percent. For rural hospitals, the Middle Atlantic Region will also experience a positive impact, a 0.2 percent increase. For the rest of the regions, rural hospitals will experience no more than a 0.2 percent decrease, except for hospitals in the Pacific Region, where there is no impact.

The overall projected increase in payments for urban hospitals (3.0 percent) is greater than the average increase for all hospitals (2.3 percent). However, due to the large decrease in payments attributable to the APC changes, rural hospitals will experience an average decrease in payments of 0.7 percent. While rural hospitals gain 1.0 percent from the wage index change, they lose a combined 3.9 percent from the APC changes (–3.8 percent) and the change in method of determining outlier payments (a slight decrease of 0.1 percent). These impacts do not include the effects of any additional transitional corridor payments to rural hospitals. Rural hospitals with 100 or more beds will experience an overall increase in payments, however, those with fewer than 100 beds are projected to receive large decreases in payments (–3.5 percent for hospitals with fewer than 50 beds and –2.4 percent for those with 50 to 99 beds). We note that these smallest rural hospitals will be protected by the hold harmless transitional corridor payments for 2002. That is, their Medicare payment margin for services furnished under the OPPS cannot be less than their margin for the services in 1996.

In both urban and rural areas, hospitals that provide a higher volume of outpatient services are projected to receive a larger increase in payments than lower volume hospitals. In rural areas, hospitals with volumes of fewer than 5,000 services are projected to experience a relatively large decline in payments (–3.6 percent). The less favorable impact for the low volume hospitals is attributable to the APC changes and the change in outlier method. For example, rural hospitals providing fewer than 5000 services are projected to lose a combined 6 percent due to these changes.

Urban hospitals in all regions except Puerto Rico (with a decrease of 5.1 percent) receive an increase on overall payments. The lowest increase is in the Middle Atlantic Region, where hospitals are projected to receive a 1.2 percent increase in payments. Except for increases for hospitals in the South Atlantic (0.3 percent) and West South Central (0.5) Regions and no change in the Mountain Region, rural hospitals experience an overall loss in payments. Again, this is due to the decrease in payments as a result of the APC changes.

Major teaching hospitals are projected to experience a smaller increase in overall payments (2.4 percent) than do hospitals with the less intensive teaching programs due to the negative impacts of the wage index (–0.4 percent), a relatively small increase due to the APC recalibration (0.5 percent), and outlier changes (–0.2 percent). Among hospitals with varying shares of low-income patients, those with a DSH patient percentage of zero experience a large decrease in payments because of the APC changes (–7.6 percent) and the outlier changes (–0.3 percent). For hospitals with a greater than 0 percent of low-income patients, the impact on all hospitals is positive, with the lowest increase of 0.3 percent attributable to hospitals with the highest share.

E. Estimated Impacts of This Final Rule on Beneficiary Copayments

In general, the increase in the APC rates for procedures that use pass-through devices results in increased copayments for beneficiaries who receive those procedures. Many of the device-related APC rates (approximately 50 APCs) have increased by over 100

percent and a small number by over 750 percent. Under the statute, the copayment amount for an APC cannot be less than 20 percent of the payment rate. Therefore, beneficiaries will experience an increase in copayments for most of the device-related APCs. This increase is countered by small decreases in the copayments for some other APCs, particularly clinic and emergency room visits.

One important thing to note is that beneficiaries receive far more clinic and emergency visits in a year than they do device-related procedures. For example, in the 1999–2000 claims data base, there are almost 7 million low-level clinic visits, over 3 million mid-level clinic visits, and almost 2 million high-level clinic visits. However, for APC 0084, Level I Electrophysiologic Evaluation (the device-related APC with the largest increase), there were only about 7,000 procedures performed. Thus, the number of services received by beneficiaries with small decreases in copayments far outweighs the number of services for which they will incur some incremental costs.

In addition, we note that section 1833(t)(8)(C)(i) of the Act places a limit on the copayment amount for any procedure; that is, the copayment may not be more than the applicable inpatient hospital deductible for the year in which the procedure is performed. For CY 2002, the inpatient deductible is $812. We further note that the complete incorporation of the costs of the current pass-through devices into the base APCs must be done in CY 2003. Therefore, any increase in copayments that occur in 2002 are a transition to increases that must, by statute, occur in 2003. Finally, as discussed in section IV. C above, we have minimized the effects of changes in APC groupings on beneficiary coinsurance and copayments.

TABLE 6.—IMPACT OF CHANGES FOR CY 2002 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of additional transitional corridors payments]

	Number of hosps [1] (1)	New wage index [2] (2)	APC/WGTS/ 75% fold in [3] (3)	New outlier policy [4] (4)	All CY2002 changes [5] (5)
All Hospitals	5,084	0.0	0.0	0.0	2.3
Non-Tefra Hospitals	4,671	0.0	0.0	0.0	2.3
Urban Hosps	2,550	-0.2	1.0	0.0	3.0
Large Urban (GT 1 Mill.)	1,459	-0.4	0.8	0.1	2.7
Other Urban (LE 1 Mill.)	1,091	0.0	1.3	0.0	3.5
Rural Hosps	2,121	1.0	-3.8	-0.1	-0.7
Beds (Urban):					
0–99 Beds	646	-0.1	-3.2	-0.1	-1.2
100–199 Beds	908	-0.2	-1.2	0.0	0.9
200–299 Beds	490	-0.2	0.8	0.0	2.8
300–499 Beds	363	-0.2	2.9	0.0	5.0
500 + Beds	143	-0.5	3.4	0.1	5.3
Beds (Rural):					
0–49 Beds	1,278	0.2	-5.6	-0.2	-3.5
50–99 Beds	508	0.4	-4.9	-0.1	-2.4
100–149 Beds	196	1.5	-3.0	-0.1	0.6
150–199 Beds	73	1.5	-1.6	-0.1	2.0
200 + Beds	66	2.3	-1.7	0.0	2.8
Volume (Urban)					
LT 5,000	307	-0.4	0.7	-0.2	2.3
5,000–10,999	445	-0.3	-2.4	0.0	-0.5
11,000–20,999	570	-0.3	-0.9	0.0	1.1
21,000–42,999	739	-0.3	1.0	0.0	3.0
GT 42,999	489	-0.2	1.8	0.0	4.0
Volume (Rural):					
LT 5,000	945	0.3	-5.6	-0.4	-3.6
5,000–10,999	602	0.2	-5.7	-0.2	-3.5
11,000–20,999	332	0.7	-3.9	-0.1	-1.2
21,000–42,999	198	1.4	-2.5	0.0	1.1
GT 42,999	44	2.3	-2.2	0.0	2.3
Region (Urban):					
New England	135	0.6	-0.6	0.0	2.2
Middle Atlantic	379	-0.5	-0.8	0.3	1.2
South Atlantic	386	-0.1	2.8	0.0	5.0
East North Cent	441	-0.4	0.1	0.0	1.9
East South Cent	154	1.2	2.1	-0.1	5.5
West North Cent	181	-0.4	1.5	0.0	3.3
West South Cent	321	-0.9	2.1	-0.1	3.4
Mountain	128	-0.1	2.4	0.0	4.5
Pacific	386	-0.4	1.6	-0.1	3.5
Puerto Rico	39	1.0	-8.1	-0.1	-5.1
Region (Rural):					
New England	52	0.0	-4.1	-0.1	-2.1
Middle Atlantic	74	0.5	-4.9	0.2	-2.0
South Atlantic	270	1.4	-3.2	-0.1	0.3
East North Cent	279	1.1	-4.6	-0.1	-1.5
East South Cent	250	1.3	-3.8	-0.1	-0.4

TABLE 6.—IMPACT OF CHANGES FOR CY 2002 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of additional transitional corridors payments]

	Number of hosps [1] (1)	New wage index [2] (2)	APC/WGTS/ 75% fold in [3] (3)	New outlier policy [4] (4)	All CY2002 changes [5] (5)
West North Cent	506	1.2	-3.9	-0.2	-0.9
West South Cent	328	1.5	-3.0	-0.1	0.5
Mountain	215	1.3	-3.2	-0.2	0.0
Pacific	142	-0.8	-2.8	0.0	-1.5
Puerto Rico	5	4.5	-6.8	-0.1	-0.5
Teaching Status:					
Non-Teaching	3,576	0.2	-1.4	0.0	0.9
Minor	803	0.0	2.0	0.0	4.4
Major	291	-0.4	0.5	0.0	2.4
DSH Patient Percent:					
0	32	0.7	-7.6	-1.3	-6.4
GT 0–0.10	1,261	0.0	0.2	0.0	2.5
0.10–0.16	1,035	0.1	-0.1	0.1	2.4
0.16–0.23	869	-0.1	0.6	0.0	2.7
0.23–0.35	786	0.1	0.3	-0.1	2.6
GE 0.35	688	-0.2	-1.6	-0.1	0.3
Urban IME/DSH:					
IME & DSH	1,000	-0.3	1.8	0.1	3.8
IME/No DSH	3	0.0	-2.1	-2.0	-2.3
No IME/DSH	1,531	-0.2	-0.1	0.0	2.0
No IME/No DSH	16	0.8	-15.5	-0.3	-13.2
Rural Hosp. Types:					
No Special Status	794	0.2	-4.8	-0.1	-2.6
RRC	172	2.1	-2.0	0.0	2.3
SCH/Each	666	0.4	-4.8	-0.1	-2.4
MDH	329	0.2	-6.2	-0.3	-4.2
SCH and RRC	71	2.0	-2.1	-0.1	2.0
Type of Ownership:					
Voluntary	2,774	0.0	0.2	0.0	2.4
Proprietary	757	0.0	1.0	0.0	3.3
Government	1,140	0.3	-1.7	-0.1	0.6
Specialty Hospitals:					
Eye and Ear	12	0.8	-4.8	0.0	-1.8
Trauma	151	-0.1	1.5	0.0	3.7
Cancer	10	-1.3	-0.4	0.4	0.7
Tefra Hospitals (Not Included on Other Lines):					
Rehab	169	0.3	7.5	-0.3	9.2
Psych	103	-0.7	-7.4	-1.7	-7.8
LTC	99	-0.7	-4.3	-0.4	-3.3
Children	42	-0.6	-0.9	-1.0	-0.5

Note: For CY 2002, under the OPPS transitional corridor policy cancer, children's, and rural hospitals with 100 or fewer beds are held harmless compared to their 1996 payment margin for these services. All other hospitals are protected to some extent when their payment margins are less than they were in 1996 (see § 419.70(b)). These additional payments are not reflected below.

[1] Some data necessary to classify hospitals by category were missing; thus, the total number of hospitals in each category may not equal the national total.

[2] This column shows the impact of updating the wage index used to calculate payment using the final FY 2002 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient final rule for FY 2002 was published in the **Federal Register** on September 1, 2001.

[3] This column shows the impact of recalibrating the APC weights based on the 1999–2000 hospital claims data and on the reassignment of some HCPCs to APCs as well as the incorporation of the device costs discussed in this rule.

[4] This column shows the difference in calculating outliers on an APC-specific rather than bill basis and with the final thresholds.

[5] This column shows changes in total payment from CY2001 to CY 2002. It incorporates all of the changes reflected in columns 2, 3, and 4. In addition, it shows the impact of the CY 2002 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare &

Medicaid Services amends 42 CFR chapter IV as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

A. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart B—Accounting Records and Reports

2. In § 413.24, the heading to paragraph (d) is republished, paragraph (d)(6) is revised, and a new paragraph (d)(7) is added, to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Provider-based entities and departments: Preventing duplication of cost.* In some situations, the main provider in a provider-based complex may purchase services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center which duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Where a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the main provider cannot be separately identified, the costs of the services purchased through a contract must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

Example: A provider-based complex is composed of a hospital and a hospital-based rural health clinic (RHC). The hospital furnishes the entirety of its own administrative and general costs internally. The RHC, however, is managed by an independent contractor through a management contract. The management contract provides a full array of administrative and general services, with the exception of patient billing. The hospital directly assigns the costs of the RHC's management contract to the RHC cost center (for example, Form HCFA 2552–96, Worksheet A, Line 71). A full allocation of the hospital's administrative and general costs to the RHC cost center would duplicate most of the RHC's administrative and general costs. However, an allocation of the hospital's cost (included in hospital administrative and general costs) of its patient billing function to the RHC would be appropriate. Therefore, the hospital must include the costs of the patient billing function in a separate cost center to be allocated to the benefiting cost centers, including the RHC cost center. The remaining hospital administrative and general costs would be allocated to all cost centers, excluding the RHC cost center. If the hospital is unable to isolate the costs of the patient billing function, the costs of the RHC's management contract must be reclassified to the hospital administrative and general cost center to be allocated among all cost centers, as appropriate.

(7) *Costs of services furnished to free-standing entities.* The costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

* * * * *

Subpart E—Payments to Providers

3. Section 413.65 is amended as follows:

A. Revising paragraph (a)(1).

B. Revising the definition of ''Provider-based entity'' in paragraph (a)(2).

C. Revising paragraph (b).

D. Revising paragraph (c).

E. Revising the introductory text to paragraph (d).

F. Revising paragraph (d)(7).

G. Revising paragraph (g)(7).

H. Revising the introductory text to paragraph (i)(1).

I. Revising paragraph (i)(1)(ii).

J. Revising paragraph (i)(2).

The revisions read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* (i) This section applies to all facilities for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter, other than facilities described in paragraph (a)(1)(ii) of this section.

(ii) This section does not apply to the following facilities:

(A) Ambulatory surgical centers (ASCs).

(B) Comprehensive outpatient rehabilitation facilities (CORFs).

(C) Home health agencies (HHAs).

(D) Skilled nursing facilities (SNFs).

(E) Hospices.

(F) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services.

(G) Independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests.

(H) Facilities furnishing only physical, occupational, or speech therapy to ambulatory patients, for as long as the $1,500 annual cap on coverage of physical, occupational, and speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation.

(I) ESRD facilities (determinations for ESRD facilities are made under § 413.174 of this chapter).

(2) *Definitions.* * * *

* * * * *

Provider-based entity means a provider of health care services, or an RHC 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 of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

* * * * *

(b) *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) If a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002. The requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of this section will not apply to that hospital or CAH for that facility until October 1, 2002. For purposes of this paragraph, a facility is considered as provider-based on October 1, 2000, if on that date it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital.

(3) Except as specified in paragraphs (b)(2) and (b)(5) of this section, a main provider or a facility must contact CMS, and the facility must be determined by CMS to be provider-based, before the main provider bills for services of the facility as if the facility were provider based, or before it includes costs of those services on its cost report.

(4) A facility that is not located on the campus of a hospital and that is used as a site where physician services of the kind ordinarily furnished in physician offices are furnished is presumed as a free-standing facility, unless CMS determines the facility has provider-based status.

(5) A facility that has requested provider-based status in relation to a hospital or CAH on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS determines that the facility does not qualify for provider-based status.

(c) *Reporting.* A main provider that has had one or more facilities considered provider-based also must report to CMS any material change in the relationship between it and any provider-based facility, such as a change in ownership of the facility or entry into a new or different management contract that would affect the provider-based status of the facility.

(d) *Requirements.* An entity must meet all of the following requirements to be determined by CMS to have provider-based status.

* * * * *

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except when the requirements in paragraphs (d)(7)(i), (d)(7)(ii), or (d)(7)(iii) of this section are met:

(i) The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider;

(ii) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act and is—

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(iii) 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, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (d)(7)(i)(A) or (d)(7)(i)(B) of this section because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

(iv) A facility or organization is not considered in the ''immediate vicinity'' of the main provider unless the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, or adjacent States.

(v) An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criteria in paragraphs (d)(7)(i) through (d)(7)(iv) of this section.

* * * * *

(g) *Obligations of hospital outpatient departments and hospital-based entities.* * * *

* * * * *

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand. If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based. The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital. If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

* * * * *

(i) *Inappropriate treatment of a facility or organization as provider-based*—(1) *Determination and review.* If CMS learns that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, CMS will—

* * * * *

(ii) Investigate and determine whether the requirements in paragraph (d) of this section (or, for periods before the beginning of the hospital's first cost reporting period beginning or or after January 10, 2001, the requirements in applicable program instructions) were met; and

* * * * *

(2) *Recovery of overpayments.* If CMS finds that payments for services at the facility or organization were made as if the facility or organization were provider-based, even though CMS had not previously determined that the facility or organization qualified for provider-based status—

(i) CMS will recover the difference between the amount of payments that actually were made and the amount of payments that CMS estimates would have been made in the absence of a determination of provider-based status.

(ii) CMS will not make recovery payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001 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 (h)(3) of this section.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

B. Part 419 is amended as set forth below:

1. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

Subpart A—General Provisions

2. In § 419.2, paragraph (c) is revised to read as follows:

§ 419.2 Basis of payment.

* * * * *

(c) *Determination of hospital outpatient prospective payment rates: Excluded costs.* The following costs are excluded from the hospital outpatient prospective payment system.

(1) The costs of direct graduate medical education activities as described in § 413.86 of this chapter.

(2) The costs of nursing and allied health programs as described in § 413.85 of this chapter.

(3) The costs associated with interns and residents not in approved teaching programs as described in § 415.202 of this chapter.

(4) The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under § 415.160.

(5) The reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under § 412.113(c) of this chapter.

(6) Bad debts for uncollectible deductibles and coinsurances as described in § 413.80(b) of this chapter.

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition costs.

Subpart B—Categories of Hospitals and Services Subject to and Excluded from the Hospital Outpatient Prospective Payment System

3. In § 419.20, paragraph (a) is revised, and paragraphs (b)(3) and (b)(4) are added to read as follows:

§ 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 August 1, 2000.

(b) *Hospitals excluded from the outpatient prospective payment system.*

* * * * *

(3) A hospital located outside one of the 50 States, the District of Columbia, and Puerto Rico is excluded from the hospital outpatient prospective payment system.

(4) A hospital of the Indian Health Service.

4. In § 419.22, the introductory text is republished, and paragraph (r) is added to read as follows:

§ 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:

* * * * *

(r) Services defined in § 419.21(b) that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

5. In § 419.32, paragraph (b)(1) is revised to read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) *Conversion factor for calendar year 2000 and subsequent years.* (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar year 2001—

(A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point; and

(B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

(iii) For calendar year 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in § 419.32(b)(ii)(B).

(iv) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

* * * * *

Subpart D—Payments to Hospitals

6. In § 419.40, the word ''coinsurance'' is removed and the word ''copayment'' is added in its place as follows. As revised, § 419.40 reads as follows:

§ 419.40 Payment concepts.

(a) 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 program payment amount for each APC group is calculated by applying the

program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

(1) Coinsurance percentage is calculated as the difference between the program payment percentage and 100 percent. The coinsurance 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.

(2) 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.

(3) 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.

(c) *Limitation of copayment amount to inpatient hospital deductible amount.* The copayment amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

7. Amend § 419.41 as follows:

A. The section heading is revised.

B. The word ''coinsurance'' is removed each time it appears, and the word ''copayment'' is added in its place.

C. Paragraph (c)(4)(ii) is redesignated as paragraph (c)(4)(iv).

D. Paragraphs (c)(4)(ii) and (c)(4)(iii) are added as follows:

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

* * * * *

(c) * * *

(4) * * *

(ii) Effective for services furnished from April 1, 2001 through December 31, 2001, the national unadjusted coinsurance rate for an APC cannot exceed 57 percent of the prospective payment rate for that APC.

(iii) The national unadjusted coinsurance rate for an APC cannot exceed 55 percent in calendar years 2002 and 2003; 50 percent in calendar year 2004; 45 percent in calendar year 2005; and 40 percent in calendar year 2006 and thereafter.

* * * * *

8. In § 419.42 paragraph (a), (c), and (e) are revised to read as follows:

§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may not elect to reduce copayment amounts for some, but not all, services within the same group.

* * * * *

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment amount (within the limits identified below) that the hospital has selected for each group.

* * * * *

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined in § 419.32.

* * * * *

§ 419.43 [Amended]

9. Section 419.43 is amended by removing the word ''coinsurance'' from the section heading and from paragraph (a), and adding the word ''copayment'' in its place.

Subpart H—Transitional Corridors

10. In § 419.70, paragraph (d)(2) is revised to read as follows:

§ 419.70 Transitional adjustment to limit decline in payment.

* * * * *

(d) *Hold harmless provisions* * * *

* * * * *

(2) *Permanent treatment for cancer hospitals and children's hospitals.* In the case of a hospital described in § 412.23(d) or § 412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under this part is increased by the amount of this difference.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

C. 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 § 489.24, paragraphs (i)(2) introductory text and (i)(2)(ii) are revised to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(i) *Off-campus departments.* * * *

(2) *Protocols for off-campus departments.* The hospital must establish protocols for the handling of individuals with potential emergency conditions at off-campus departments. These protocols must provide for direct contact between personnel at the off-campus department and emergency personnel at the main hospital campus and may provide for dispatch of practitioners, when appropriate, from the main hospital campus to the off-campus department to provide screening or stabilization services. Any contact with emergency personnel at the main hospital campus should either be made after or concurrently with the actions needed to arrange an appropriate transfer under paragraph (i)(3)(ii) of this section if contacting the main hospital campus prior to transfer would significantly jeopardize the life or health of the individual.

* * * * *

(ii) If the off-campus department is a physical therapy, radiology, or other facility not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus for direction. Under this direction, and in accordance with protocols established in advance by the hospital, the personnel at the off-campus department must describe patient appearance and report symptoms and, if appropriate, either arrange transportation of the individual to the main hospital campus in accordance with paragraph (i)(3)(i) of this section or assist in an appropriate transfer as described in paragraphs (i)(3)(ii) and (d)(2) of this section.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 20, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 23, 2001.

Tommy G. Thompson,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Photochemotherapy	S	0.43	$21.89	$7.88	$4.38
0002	Fine needle Biopsy/Aspiration	T	0.42	$21.38	$11.76	$4.28
0003	Bone Marrow Biopsy/Aspiration	T	1.03	$52.43	$27.99	$10.49
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	2.47	$125.73	$32.57	$25.15
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow	T	4.03	$205.14	$90.26	$41.03
0006	Level I Incision & Drainage	T	2.18	$110.97	$33.95	$22.19
0007	Level II Incision & Drainage	T	6.75	$343.60	$72.03	$68.72
0008	Level III Incision and Drainage	T	10.93	$556.38	$113.67	$111.28
0009	Nail Procedures	T	0.63	$32.07	$8.34	$6.41
0010	Level I Destruction of Lesion	T	0.66	$33.60	$9.86	$6.72
0011	Level II Destruction of Lesion	T	1.47	$74.83	$27.69	$14.97
0012	Level I Debridement & Destruction	T	0.66	$33.60	$9.18	$6.72
0013	Level II Debridement & Destruction	T	1.36	$69.23	$17.66	$13.85
0015	Level IV Debridement & Destruction	T	2.07	$105.37	$31.20	$21.07
0016	Level V Debridement & Destruction	T	3.02	$153.73	$64.57	$30.75
0017	Level VI Debridement & Destruction	T	9.68	$492.75	$226.67	$98.55
0018	Biopsy of Skin/Puncture of Lesion	T	1.05	$53.45	$17.66	$10.69
0019	Level I Excision/ Biopsy	T	4.22	$214.81	$78.91	$42.96
0020	Level II Excision/ Biopsy	T	8.44	$429.63	$130.53	$85.93
0021	Level IV Excision/ Biopsy	T	11.82	$601.69	$236.51	$120.34
0022	Level V Excision/ Biopsy	T	13.91	$708.07	$292.94	$141.61
0023	Exploration Penetrating Wound	T	2.08	$105.88	$40.37	$21.18
0024	Level I Skin Repair	T	2.28	$116.06	$41.78	$23.21
0025	Level II Skin Repair	T	3.39	$172.56	$65.57	$34.51
0026	Level III Skin Repair	T	12.62	$642.41	$277.92	$128.48
0027	Level IV Skin Repair	T	18.02	$917.29	$383.10	$183.46
0028	Level I Breast Surgery	T	14.00	$712.66	$303.74	$142.53
0029	Level II Breast Surgery	T	23.76	$1,209.48	$628.93	$241.90
0030	Level III Breast Surgery	T	34.20	$1,740.92	$763.55	$348.18
0032	Insertion of Central Venous/Arterial Catheter	T	12.64	$643.43	.....	$128.69
0033	Partial Hospitalization	P	4.17	$212.27	$48.17	$42.45
0035	Placement of Arterial or Central Venous Catheter	T	0.12	$6.11	$2.69	$1.22
0041	Level I Arthroscopy	T	23.61	$1,201.84	$576.88	$240.37
0042	Level II Arthroscopy	T	35.76	$1,820.33	$804.74	$364.07
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	4.05	$206.16	.....	$41.23
0044	Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk	T	2.52	$128.28	$38.08	$25.66
0045	Bone/Joint Manipulation Under Anesthesia	T	11.67	$594.05	$277.12	$118.81
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	27.69	$1,409.53	$535.76	$281.91
0047	Arthroplasty without Prosthesis	T	26.36	$1,341.83	$537.03	$268.37
0048	Arthroplasty with Prosthesis	T	43.19	$2,198.54	$725.94	$439.71
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	15.84	$806.32	$356.95	$161.26
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	20.63	$1,050.15	$504.07	$210.03
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	28.56	$1,453.82	$675.24	$290.76
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	35.94	$1,829.49	$930.91	$365.90
0053	Level I Hand Musculoskeletal Procedures	T	11.69	$595.07	$253.49	$119.01
0054	Level II Hand Musculoskeletal Procedures	T	19.83	$1,009.43	$472.33	$201.89
0055	Level I Foot Musculoskeletal Procedures	T	15.44	$785.96	$355.34	$157.19
0056	Level II Foot Musculoskeletal Procedures	T	18.85	$959.54	$405.81	$191.91
0057	Bunion Procedures	T	24.35	$1,239.51	$496.65	$247.90
0058	Level I Strapping and Cast Application	S	1.28	$65.16	$19.27	$13.03
0059	Level II Strapping and Cast Application	S	2.22	$113.01	$29.59	$22.60
0060	Manipulation Therapy	S	0.23	$11.71	.....	$2.34
0068	CPAP Initiation	S	3.02	$153.73	$84.55	$30.75
0069	Thoracoscopy	T	23.57	$1,199.81	.....	$239.96
0070	Thoracentesis/Lavage Procedures	T	4.58	$233.14	$79.60	$46.63
0071	Level I Endoscopy Upper Airway	T	1.03	$52.43	$14.22	$10.49
0072	Level II Endoscopy Upper Airway	T	1.21	$61.59	$33.87	$12.32
0073	Level III Endoscopy Upper Airway	T	3.29	$167.47	$73.69	$33.49
0074	Level IV Endoscopy Upper Airway	T	11.32	$576.23	$293.88	$115.25
0075	Level V Endoscopy Upper Airway	T	17.42	$886.75	$443.38	$177.35
0076	Endoscopy Lower Airway	T	7.56	$384.83	$188.57	$76.97
0077	Level I Pulmonary Treatment	S	0.39	$19.85	$10.92	$3.97
0078	Level II Pulmonary Treatment	S	0.86	$43.78	$18.83	$8.76
0079	Ventilation Initiation and Management	S	0.60	$30.54	$16.80	$6.11
0080	Diagnostic Cardiac Catheterization	T	34.73	$1,767.90	$838.92	$353.58
0081	Non-Coronary Angioplasty or Atherectomy	T	29.24	$1,488.43	$710.91	$297.69
0082	Coronary Atherectomy	T	92.00	$4,683.17	$1,351.74	$936.63

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0083	Coronary Angioplasty	T	59.49	$3,028.28	$794.30	$605.66
0084	Level I Electrophysiologic Evaluation	S	199.65	$10,162.98	.....	$2,032.60
0085	Level II Electrophysiologic Evaluation	T	38.69	$1,969.48	$654.48	$393.90
0086	Ablate Heart Dysrhythm Focus	T	72.72	$3,701.74	$1,265.37	$740.35
0087	Cardiac Electrophysiologic Recording/Mapping	T	52.46	$2,670.42	.....	$534.08
0088	Thrombectomy	T	34.38	$1,750.08	$678.68	$350.02
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	149.52	$7,611.17	$2,246.59	$1,522.23
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	117.54	$5,983.26	$2,133.88	$1,196.65
0091	Level I Vascular Ligation	T	20.34	$1,035.39	$348.23	$207.08
0092	Level II Vascular Ligation	T	19.91	$1,013.50	$503.71	$202.70
0093	Vascular Repair/Fistula Construction	T	14.16	$720.80	$277.34	$144.16
0094	Resuscitation and Cardioversion	S	6.08	$309.50	$105.29	$61.90
0095	Cardiac Rehabilitation	S	0.61	$31.05	$16.46	$6.21
0096	Non-Invasive Vascular Studies	S	1.71	$87.05	$47.88	$17.41
0097	Cardiac Monitoring for 30 days	X	0.84	$42.76	$23.52	$8.55
0098	Injection of Sclerosing Solution	T	1.24	$63.12	$20.88	$12.62
0099	Electrocardiograms	S	0.35	$17.82	$9.80	$3.56
0100	Stress Tests and Continuous ECG	X	1.47	$74.83	$41.16	$14.97
0101	Tilt Table Evaluation	S	3.74	$190.38	$104.71	$38.08
0103	Miscellaneous Vascular Procedures	T	15.95	$811.92	$295.70	$162.38
0104	Transcatheter Placement of Intracoronary Stents	T	87.98	$4,478.53	.....	$895.71
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	14.76	$751.34	$368.16	$150.27
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	36.64	$1,865.12	$503.07	$373.02
0107	Insertion of Cardioverter-Defibrillator	T	379.46	$19,316.03	$4,224.27	$3,863.21
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	573.46	$29,191.41	.....	$5,838.28
0109	Removal of Implanted Devices	T	6.27	$319.17	$130.86	$63.83
0110	Transfusion	S	5.30	$269.79	$113.31	$53.96
0111	Blood Product Exchange	S	21.08	$1,073.06	$300.74	$214.61
0112	Apheresis, Photopheresis, and Plasmapheresis	S	36.25	$1,845.27	$608.94	$369.05
0113	Excision Lymphatic System	T	15.53	$790.54	$326.55	$158.11
0114	Thyroid/Lymphadenectomy Procedures	T	29.28	$1,490.47	$493.78	$298.09
0115	Cannula/Access Device Procedures	T	21.35	$1,086.80	$506.74	$217.36
0116	Chemotherapy Administration by Other Technique Except Infusion	S	0.91	$46.32	.....	$9.26
0117	Chemotherapy Administration by Infusion Only	S	4.01	$204.13	$52.69	$40.83
0118	Chemotherapy Administration by Both Infusion and Other Technique	S	4.20	$213.80	$72.03	$42.76
0119	Implantation of Devices	T	79.67	$4,055.52	.....	$811.10
0120	Infusion Therapy Except Chemotherapy	T	3.08	$156.78	$42.67	$31.36
0121	Level I Tube changes and Repositioning	T	2.54	$129.30	$52.53	$25.86
0122	Level II Tube changes and Repositioning	T	9.89	$503.44	$114.93	$100.69
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	8.56	$435.74	.....	$87.15
0124	Revision of Implanted Infusion Pump	T	89.07	$4,534.02	.....	$906.80
0125	Refilling of Infusion Pump	T	3.00	$152.71	.....	$30.54
0130	Level I Laparoscopy	T	25.91	$1,318.92	$659.53	$263.78
0131	Level II Laparoscopy	T	37.63	$1,915.52	$996.07	$383.10
0132	Level III Laparoscopy	T	56.06	$2,853.68	$1,239.22	$570.74
0140	Esophageal Dilation without Endoscopy	T	5.65	$287.61	$107.24	$57.52
0141	Upper GI Procedures	T	7.21	$367.02	$184.67	$73.40
0142	Small Intestine Endoscopy	T	6.94	$353.27	$151.91	$70.65
0143	Lower GI Endoscopy	T	7.27	$370.07	$185.04	$74.01
0144	Diagnostic Anoscopy	T	4.43	$225.50	$49.32	$45.10
0145	Therapeutic Anoscopy	T	10.81	$550.27	$179.39	$110.05
0146	Level I Sigmoidoscopy	T	2.73	$138.97	$63.93	$27.79
0147	Level II Sigmoidoscopy	T	5.71	$290.66	$136.61	$58.13
0148	Level I Anal/Rectal Procedure	T	2.40	$122.17	$43.59	$24.43
0149	Level III Anal/Rectal Procedure	T	13.53	$688.73	$293.06	$137.75
0150	Level IV Anal/Rectal Procedure	T	18.08	$920.34	$437.12	$184.07
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	15.29	$778.32	$245.46	$155.66
0152	Percutaneous Biliary Endoscopic Procedures	T	16.13	$821.08	$207.38	$164.22
0153	Peritoneal and Abdominal Procedures	T	23.55	$1,198.79	$496.31	$239.76
0154	Hernia/Hydrocele Procedures	T	31.40	$1,598.39	$556.98	$319.68
0155	Level II Anal/Rectal Procedure	T	5.26	$267.76	.....	$53.55
0156	Level II Urinary and Anal Procedures	T	2.45	$124.71	$37.41	$24.94
0157	Colorectal Cancer Screening: Barium Enema	S	1.98	$100.79	$22.19	$20.16
0158	Colorectal Cancer Screening: Colonoscopy	T	6.55	$333.42	$83.36	$66.68
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.33	$118.61	$29.65	$23.72
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.13	$261.14	$104.46	$52.23
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	13.72	$698.40	$249.36	$139.68
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	25.09	$1,277.18	$427.49	$255.44
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	40.40	$2,056.52	$792.58	$411.30
0164	Level I Urinary and Anal Procedures	T	1.01	$51.41	$15.42	$10.28
0165	Level III Urinary and Anal Procedures	T	5.22	$265.72	$91.76	$53.14
0166	Level I Urethral Procedures	T	12.20	$621.03	$218.73	$124.21
0167	Level II Urethral Procedures	T	22.28	$1,134.14	$555.84	$226.83
0168	Level III Urethral Procedures	T	18.42	$937.65	$403.19	$187.53
0169	Lithotripsy	T	39.62	$2,016.82	$1,109.25	$403.36
0170	Dialysis for Other Than ESRD Patients	S	0.28	$14.25	$3.14	$2.85
0179	Urinary Incontinence Procedures	T	139.33	$7,092.45	$2,340.51	$1,418.49

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0180	Circumcision	T	15.02	$764.58	$304.87	$152.92
0181	Penile Procedures	T	22.09	$1,124.47	$618.46	$224.89
0182	Insertion of Penile Prosthesis	T	87.54	$4,456.14	$1,492.28	$891.23
0183	Testes/Epididymis Procedures	T	18.87	$960.56	$448.94	$192.11
0184	Prostate Biopsy	T	4.83	$245.87	$122.94	$49.17
0187	Miscellaneous Placement/Repositioning	X	4.22	$214.81	.....	$42.96
0188	Level II Female Reproductive Proc	T	0.80	$40.72	$11.81	$8.14
0189	Level III Female Reproductive Proc	T	1.26	$64.14	$17.96	$12.83
0190	Surgical Hysteroscopy	T	16.91	$860.79	$421.79	$172.16
0191	Level I Female Reproductive Proc	T	0.23	$11.71	$3.40	$2.34
0192	Level IV Female Reproductive Proc	T	2.50	$127.26	$35.33	$25.45
0193	Level V Female Reproductive Proc	T	11.16	$568.09	$171.13	$113.62
0194	Level VI Female Reproductive Proc	T	15.86	$807.34	$395.60	$161.47
0195	Level VII Female Reproductive Proc	T	20.62	$1,049.64	$483.80	$209.93
0196	Dilation and Curettage	T	13.48	$686.19	$336.23	$137.24
0197	Infertility Procedures	T	2.40	$122.17	$49.55	$24.43
0198	Pregnancy and Neonatal Care Procedures	T	1.31	$66.68	$32.67	$13.34
0199	Vaginal Delivery	T	5.09	$259.10	$72.55	$51.82
0200	Therapeutic Abortion	T	11.34	$577.25	$305.94	$115.45
0201	Spontaneous Abortion	T	14.33	$729.45	$329.65	$145.89
0202	Level VIII Female Reproductive Proc	T	63.54	$3,234.44	$1,487.84	$646.89
0203	Level V Nerve Injections	T	15.79	$803.77	$369.73	$160.75
0204	Level VI Nerve Injections	T	2.24	$114.02	$43.33	$22.80
0206	Level III Nerve Injections	T	3.59	$182.75	$74.93	$36.55
0207	Level IV Nerve Injections	T	5.36	$272.85	$122.78	$54.57
0208	Laminotomies and Laminectomies	T	29.12	$1,482.32	.....	$296.46
0209	Extended EEG Studies and Sleep Studies, Level II	S	10.54	$536.53	$279.00	$107.31
0212	Level II Nervous System Injections	T	3.77	$191.91	$88.78	$38.38
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.65	$134.90	$70.15	$26.98
0214	Electroencephalogram	S	2.10	$106.90	$53.45	$21.38
0215	Level I Nerve and Muscle Tests	S	0.66	$33.60	$17.47	$6.72
0216	Level III Nerve and Muscle Tests	S	2.61	$132.86	$59.79	$26.57
0218	Level II Nerve and Muscle Tests	S	1.03	$52.43	$23.59	$10.49
0220	Level I Nerve Procedures	T	13.60	$692.29	$325.38	$138.46
0221	Level II Nerve Procedures	T	21.43	$1,090.87	$463.62	$218.17
0222	Implantation of Neurological Device	T	302.53	$15,399.99	.....	$3,080.00
0223	Implantation of Pain Management Device	T	75.39	$3,837.65	.....	$767.53
0224	Implantation of Reservoir/Pump/Shunt	T	28.48	$1,449.75	$453.41	$289.95
0225	Implantation of Neurostimulator Electrodes	T	267.56	$13,619.87	.....	$2,723.97
0226	Implantation of Drug Infusion Reservoir	T	75.81	$3,859.03	.....	$771.81
0227	Implantation of Drug Infusion Device	T	139.55	$7,103.65	.....	$1,420.73
0228	Creation of Lumbar Subarachnoid Shunt	T	53.77	$2,737.11	$696.46	$547.42
0229	Transcatherter Placement of Intravascular Shunts	T	67.22	$3,421.77	$996.86	$684.35
0230	Level I Eye Tests & Treatments	S	0.61	$31.05	$14.28	$6.21
0231	Level III Eye Tests & Treatments	S	2.03	$103.34	$46.50	$20.67
0232	Level I Anterior Segment Eye Procedures	T	3.50	$178.16	$78.39	$35.63
0233	Level II Anterior Segment Eye Procedures	T	10.83	$551.29	$264.62	$110.26
0234	Level III Anterior Segment Eye Procedures	T	19.08	$971.25	$466.20	$194.25
0235	Level I Posterior Segment Eye Procedures	T	5.57	$283.54	$78.91	$56.71
0236	Level II Posterior Segment Eye Procedures	T	16.21	$825.15	.....	$165.03
0237	Level III Posterior Segment Eye Procedures	T	36.32	$1,848.83	.....	$369.77
0238	Level I Repair and Plastic Eye Procedures	T	3.01	$153.22	$58.96	$30.64
0239	Level II Repair and Plastic Eye Procedures	T	5.80	$295.24	$115.14	$59.05
0240	Level III Repair and Plastic Eye Procedures	T	13.83	$704.00	$315.34	$140.80
0241	Level IV Repair and Plastic Eye Procedures	T	18.12	$922.38	$384.47	$184.48
0242	Level V Repair and Plastic Eye Procedures	T	23.72	$1,207.44	$597.36	$241.49
0243	Strabismus/Muscle Procedures	T	17.70	$901.00	$429.78	$180.20
0244	Corneal Transplant	T	38.46	$1,957.77	$851.42	$391.55
0245	Level I Cataract Procedures without IOL Insert	T	10.44	$531.44	$249.78	$106.29
0246	Cataract Procedures with IOL Insert	T	21.20	$1,079.16	$507.21	$215.83
0247	Laser Eye Procedures Except Retinal	T	4.03	$205.14	$94.36	$41.03
0248	Laser Retinal Procedures	T	29.51	$1,502.18	.....	$300.44
0249	Level II Cataract Procedures without IOL Insert	T	21.80	$1,109.71	$521.56	$221.94
0250	Nasal Cauterization/Packing	T	2.10	$106.90	$37.42	$21.38
0251	Level I ENT Procedures	T	2.43	$123.70	$27.99	$24.74
0252	Level II ENT Procedures	T	5.95	$302.88	$114.24	$60.58
0253	Level III ENT Procedures	T	12.33	$627.65	$284.00	$125.53
0254	Level IV ENT Procedures	T	17.37	$884.20	$272.41	$176.84
0256	Level V ENT Procedures	T	26.61	$1,354.56	$623.05	$270.91
0258	Tonsil and Adenoid Procedures	T	17.43	$887.26	$434.76	$177.45
0259	Level VI ENT Procedures	T	376.56	$19,168.41	$8,798.30	$3,833.68
0260	Level I Plain Film Except Teeth	X	0.70	$35.63	$19.60	$7.13
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.21	$61.59	$33.87	$12.32
0262	Plain Film of Teeth	X	0.65	$33.09	$10.90	$6.62
0263	Level I Miscellaneous Radiology Procedures	X	1.61	$81.96	$44.26	$16.39
0264	Level II Miscellaneous Radiology Procedures	X	3.71	$188.85	$103.87	$37.77
0265	Level I Diagnostic Ultrasound Except Vascular	S	0.95	$48.36	$26.60	$9.67

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.54	$78.39	$43.11	$15.68
0267	Vascular Ultrasound	S	2.33	$118.61	$65.24	$23.72
0269	Level I Echocardiogram Except Transesophageal	S	3.85	$195.98	$101.91	$39.20
0270	Transesophageal Echocardiogram	S	5.30	$269.79	$145.69	$53.96
0271	Mammography	S	0.60	$30.54	$16.80	$6.11
0272	Level I Fluoroscopy	X	1.38	$70.25	$38.64	$14.05
0274	Myelography	S	5.24	$266.74	$128.12	$53.35
0275	Arthrography	S	2.59	$131.84	$68.56	$26.37
0276	Level I Digestive Radiology	S	1.48	$75.34	$41.44	$15.07
0277	Level II Digestive Radiology	S	2.16	$109.95	$60.47	$21.99
0278	Diagnostic Urography	S	2.34	$119.12	$65.52	$23.82
0279	Level I Angiography and Venography except Extremity	S	7.72	$392.98	$174.57	$78.60
0280	Level II Angiography and Venography except Extremity	S	13.54	$689.24	$351.51	$137.85
0281	Venography of Extremity	S	4.32	$219.91	$114.35	$43.98
0282	Miscellaneous Computerized Axial Tomography	S	1.58	$80.43	$44.24	$16.09
0283	Computerized Axial Tomography with Contrast Material	S	4.48	$228.05	$125.43	$45.61
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material.	S	7.15	$363.96	$200.18	$72.79
0285	Positron Emission Tomography (PET)	S	18.72	$952.92	$415.21	$190.58
0286	Myocardial Scans	S	5.41	$275.39	$151.46	$55.08
0287	Complex Venography	S	4.06	$206.67	$90.93	$41.33
0288	CT, Bone Density	S	1.17	$59.56	$32.76	$11.91
0289	Needle Localization for Breast Biopsy	X	1.63	$82.97	$44.80	$16.59
0290	Standard Non-Imaging Nuclear Medicine	S	1.75	$89.08	$48.99	$17.82
0291	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.50	$178.16	$90.20	$35.63
0292	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.20	$213.80	$117.59	$42.76
0294	Level I Therapeutic Nuclear Medicine	S	5.01	$255.03	$140.27	$51.01
0295	Level II Therapeutic Nuclear Medicine	S	12.10	$615.94	$338.77	$123.19
0296	Level I Therapeutic Radiologic Procedures	S	3.39	$172.56	$94.91	$34.51
0297	Level II Therapeutic Radiologic Procedures	S	7.07	$359.89	$172.51	$71.98
0299	Miscellaneous Radiation Treatment	S	0.21	$10.69	$4.06	$2.14
0300	Level I Radiation Therapy	S	2.07	$105.37	$47.72	$21.07
0301	Level II Radiation Therapy	S	5.15	$262.16	$52.53	$52.43
0302	Level III Radiation Therapy	S	11.16	$568.09	$216.55	$113.62
0303	Treatment Device Construction	X	3.00	$152.71	$69.28	$30.54
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.63	$82.97	$41.52	$16.59
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.71	$188.85	$90.65	$37.77
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.51	$738.62	$339.05	$147.72
0312	Radioelement Applications	S	32.40	$1,649.29	.....	$329.86
0313	Brachytherapy	S	14.84	$755.42	$164.02	$151.08
0314	Hyperthermic Therapies	S	3.90	$198.53	$101.25	$39.71
0320	Electroconvulsive Therapy	S	3.88	$197.51	$80.06	$39.50
0321	Biofeedback and Other Training	S	0.93	$47.34	$21.78	$9.47
0322	Brief Individual Psychotherapy	S	1.15	$58.54	$12.29	$11.71
0323	Extended Individual Psychotherapy	S	1.73	$88.06	$21.13	$17.61
0324	Family Psychotherapy	S	2.69	$136.93	$20.19	$27.39
0325	Group Psychotherapy	S	1.38	$70.25	$18.27	$14.05
0330	Dental Procedures	S	10.97	$558.42	.....	$111.68
0332	Computerized Axial Tomography and Computerized Angiography without Contrast Material.	S	3.24	$164.93	$90.71	$32.99
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast.	S	5.22	$265.72	$146.15	$53.14
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.39	$274.37	$150.90	$54.87
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	6.29	$320.19	$176.10	$64.04
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material.	S	8.54	$434.72	$239.10	$86.94
0339	Observation	X	6.85	$348.69	.....	$69.74
0340	Minor Ancillary Procedures	X	0.84	$42.76	$10.69	$8.55
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X	0.10	$5.09	$2.80	$1.02
0342	Level I Pathology	X	0.21	$10.69	$5.88	$2.14
0343	Level II Pathology	X	0.39	$19.85	$10.72	$3.97
0344	Level III Pathology	X	0.56	$28.51	$15.68	$5.70
0345	Level I Transfusion Laboratory Procedures	X	0.26	$13.24	$5.37	$2.65
0346	Level II Transfusion Laboratory Procedures	X	0.77	$39.20	$12.03	$7.84
0347	Level III Transfusion Laboratory Procedures	X	1.56	$79.41	$20.13	$15.88
0348	Fertility Laboratory Procedures	X	0.77	$39.20	.....	$7.84
0352	Level II Injections	X	0.41	$20.87	.....	$4.17
0353	Level II Allergy Injections	X	0.25	$12.73	.....	$2.55
0354	Administration of Influenza/Pneumonia Vaccine	K	0.10	$5.09	.....	.....
0355	Level I Immunizations	K	0.19	$9.67	.....	$1.93
0356	Level II Immunizations	K	1.11	$56.50	.....	$11.30
0359	Level II Injections	X	1.79	$91.12	.....	$18.22
0360	Level I Alimentary Tests	X	1.35	$68.72	$34.36	$13.74
0361	Level II Alimentary Tests	X	3.25	$165.44	$82.72	$33.09
0362	Fitting of Vision Aids	X	0.86	$43.78	$9.63	$8.76
0363	Otorhinolaryngologic Function Tests	X	1.73	$88.06	$32.58	$17.61

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0364	Level I Audiometry	X	0.58	$29.52	$11.51	$5.90
0365	Level II Audiometry	X	1.31	$66.68	$20.00	$13.34
0367	Level I Pulmonary Test	X	0.70	$35.63	$17.82	$7.13
0368	Level II Pulmonary Tests	X	1.47	$74.83	$38.16	$14.97
0369	Level III Pulmonary Tests	X	3.49	$177.65	$58.50	$35.53
0370	Allergy Tests	X	0.80	$40.72	$11.81	$8.14
0371	Level I Allergy Injections	X	0.70	$35.63	.....	$7.13
0372	Therapeutic Phlebotomy	X	0.53	$26.98	$10.09	$5.40
0373	Neuropsychological Testing	X	1.00	$50.90	$14.25	$10.18
0374	Monitoring Psychiatric Drugs	X	0.89	$45.30	$9.97	$9.06
0600	Low Level Clinic Visits	V	0.86	$43.78	.....	$8.76
0601	Mid Level Clinic Visits	V	0.95	$48.36	.....	$9.67
0602	High Level Clinic Visits	V	1.38	$70.25	.....	$14.05
0610	Low Level Emergency Visits	V	1.23	$62.61	$19.41	$12.52
0611	Mid Level Emergency Visits	V	2.16	$109.95	$36.47	$21.99
0612	High Level Emergency Visits	V	3.49	$177.65	$54.14	$35.53
0620	Critical Care	S	8.40	$427.59	$149.66	$85.52
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.16	$466.28	$205.16	$93.26
0686	Level V Skin Repair	T	24.01	$1,222.21	$277.92	$244.44
0687	Revision/Removal of Neurostimulator Electrodes	T	42.34	$2,155.28	.....	$431.06
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	145.27	$7,394.82	.....	$1,478.96
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.43	$21.89	$12.04	$4.38
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.37	$18.83	$10.36	$3.77
0691	Electronic Analysis of Programmable Shunts/Pumps	S	3.17	$161.37	$88.75	$32.27
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	14.34	$729.96	$401.48	$145.99
0693	Level II Breast Reconstruction	T	31.81	$1,619.26	$712.47	$323.85
0694	Level III Excision/Biopsy	T	3.99	$203.11	$60.93	$40.62
0695	Level VII Debridement & Destruction	T	15.78	$803.27	$369.50	$160.65
0697	Level II Echocardiogram Except Transesophageal	S	2.08	$105.88	$55.06	$21.18
0698	Level II Eye Tests & Treatments	S	1.03	$52.43	$19.92	$10.49
0699	Level IV Eye Tests & Treatment	T	6.46	$328.84	$147.98	$65.77
0701	SR 89 chloride, per mCi	G	.....	$963.42	.....	$137.92
0702	SM 153 lexidronam, 50 mCi	G	.....	$1,020.00	.....	$146.02
0704	IN 111 Satumomab pendetide per dose	G	.....	$1,591.25	.....	$227.80
0705	TC 99M tetrofosmin, per dose	G	.....	$114.00	.....	$16.32
0706	New Technology—Level I ($0–$50)	S	.....	$25.00	.....	$5.00
0707	New Technology—Level II ($50–$100)	S	.....	$75.00	.....	$15.00
0708	New Technology—Level III ($100–$200)	S	.....	$150.00	.....	$30.00
0709	New Technology—Level IV ($200–$300)	S	.....	$250.00	.....	$50.00
0710	New Technology—Level V ($300–$500)	S	.....	$400.00	.....	$80.00
0711	New Technology—Level VI ($500–$750)	S	.....	$625.00	.....	$125.00
0712	New Technology—Level VII ($750–$1000)	S	.....	$875.00	.....	$175.00
0713	New Technology—Level VIII ($1000–$1250)	S	.....	$1,125.00	.....	$225.00
0714	New Technology—Level IX ($1250–$1500)	S	.....	$1,375.00	.....	$275.00
0715	New Technology—Level X ($1500–$1750)	S	.....	$1,625.00	.....	$325.00
0716	New Technology—Level XI ($1750–$2000)	S	.....	$1,875.00	.....	$375.00
0717	New Technology—Level XII ($2000–$2500)	S	.....	$2,250.00	.....	$450.00
0718	New Technology—Level XIII ($2500–$3000)	S	.....	$2,750.00	.....	$550.00
0719	New Technology—Level XIV ($3000–$3500)	S	.....	$3,250.00	.....	$650.00
0720	New Technology—Level XV ($3500–$5000)	S	.....	$4,250.00	.....	$850.00
0721	New Technology—Level XVI ($5000–$6000)	S	.....	$5,500.00	.....	$1,100.00
0725	Leucovorin calcium inj, 50 mg	G	.....	$4.15	.....	$.38
0726	Dexrazoxane hcl injection, 250 mg	G	.....	$194.52	.....	$24.98
0727	Etidronate disodium inj 300 mg	G	.....	$63.65	.....	$9.11
0728	Filgrastim 300 mcg injection	G	.....	$179.08	.....	$23.00
0730	Pamidronate disodium , 30 mg	G	.....	$265.87	.....	$38.06
0731	Sargramostim injection 50 mcg	G	.....	$29.06	.....	$4.16
0732	Mesna injection 200 mg	G	.....	$36.48	.....	$3.30
0733	Non esrd epoetin alpha inj, 1000 u	G	.....	$12.26	.....	$1.57
0750	Dolasetron mesylate, 10 mg	G	.....	$16.45	.....	$2.11
0754	Metoclopramide hcl injection up to 10 mg	G	.....	$1.17	.....	$.11
0755	Thiethylperazine maleate inj up to 10 mg	G	.....	$4.60	.....	$.66
0762	Dronabinol 2.5mg oral	G	.....	$3.28	.....	$.42
0763	Dolasetron mesylate oral, 100 mg	G	.....	$69.64	.....	$8.94
0764	Granisetron hcl injection 10 mcg	G	.....	$18.54	.....	$2.65
0765	Granisetron hcl 1 mg oral	G	.....	$44.69	.....	$6.40
0768	Ondansetron hcl injection 1 mg	G	.....	$6.09	.....	$.78
0769	Ondansetron hcl 8mg oral	G	.....	$26.41	.....	$3.39
0800	Leuprolide acetate, 3.75 mg	G	.....	$93.47	.....	$12.00
0801	Cyclophosphamide oral 25 mg	G	.....	$2.03	.....	$.18
0802	Etoposide oral 50 mg	G	.....	$52.43	.....	$6.73
0803	Melphalan oral 2 mg	G	.....	$2.29	.....	$.33
0807	Aldesleukin/single use vial	G	.....	$672.60	.....	$96.29
0809	Bcg live intravesical vac	G	.....	$166.49	.....	$21.38
0810	Goserelin acetate implant 3.6 mg	G	.....	$446.49	.....	$63.92
0811	Carboplatin injection 50 mg	G	.....	$114.46	.....	$16.39
0812	Carmus bischl nitro inj 100 mg	G	.....	$117.84	.....	$16.87

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0813	Cisplatin 10 mg injection	G		$42.18		$3.82
0814	Asparaginase injection 10,000 u	G		$62.61		$8.96
0815	Cyclophosphamide 100 mg inj	G		$5.82		$.75
0816	Cyclophosphamide lyophilized 100 mg	G		$4.89		$.63
0817	Cytarabine hcl 100 mg inj	G		$6.10		$.55
0818	Dactinomycin 0.5 mg	G		$13.87		$1.99
0819	Dacarbazine 100 mg inj	G		$12.68		$1.15
0820	Daunorubicin 10 mg	G		$76.62		$6.94
0821	Daunorubicin citrate liposom 10 mg	G		$64.60		$9.25
0822	Diethylstilbestrol injection 250 mg	G		$14.41		$1.30
0823	Docetaxel, 20 mg	G		$297.83		$42.64
0824	Etoposide 10 mg inj	G		$10.45		$.95
0826	Methotrexate Oral 2.5 mg	G		$3.45		$.31
0827	Floxuridine injection 500 mg	G		$129.56		$16.64
0828	Gemcitabine HCL 200 mg	G		$106.72		$15.28
0830	Irinotecan injection 20 mg	G		$134.25		$19.22
0831	Ifosfomide injection 1 gm	G		$156.64		$22.42
0832	Idarubicin hcl injection 5 mg	G		$412.21		$59.01
0833	Interferon alfacon-1, 1 mcg	G		$4.10		$.59
0834	Interferon alfa-2a inj recombinant 3 million u	G		$34.86		$4.99
0836	Interferon alfa-2b inj recombinant, 1 million	G		$11.28		$1.45
0838	Interferon gamma 1–b inj, 3 million u	G		$285.65		$40.89
0839	Mechlorethamine hcl inj 10 mg	G		$12.01		$1.72
0840	Melphalan hydrochl 50 mg	G		$400.74		$57.37
0841	Methotrexate sodium inj 5 mg	G		$.45		$.04
0842	Fludarabine phosphate inj 50 mg	G		$271.82		$38.91
0844	Pentostatin injection, 10 mg	G		$1,654.14		$236.80
0847	Doxorubicin hcl 10 mg vl chemo	G		$37.46		$4.81
0849	Rituximab, 100 mg	G		$454.55		$65.07
0850	Streptozocin injection, 1 gm	G		$117.64		$16.84
0851	Thiotepa injection, 15 mg	G		$116.97		$10.59
0852	Topotecan, 4 mg	G		$664.19		$95.08
0853	Vinblastine sulfate inj, 1 mg	G		$4.11		$.37
0854	Vincristine sulfate 1 mg inj	G		$30.16		$3.87
0855	Vinorelbine tartrate, 10 mg	G		$88.83		$12.72
0856	Porfimer sodium, 75 mg	G		$2,603.67		$372.74
0857	Bleomycin sulfate injection 15 u	G		$289.37		$37.16
0858	Cladribine, 1mg	G		$53.39		$4.83
0859	Fluorouracil injection 500 mg	G		$2.73		$.25
0860	Plicamycin (mithramycin) inj 2.5 mg	G		$93.80		$13.43
0861	Leuprolide acetate injection 1 mg	G		$69.79		$6.32
0862	Mitomycin 5 mg inj	G		$121.65		$11.01
0863	Paclitaxel injection, 30 mg	G		$173.50		$22.28
0864	Mitoxantrone hcl, 5 mg	G		$244.21		$34.96
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	G		$7.86		$1.12
0884	Rho d immune globulin inj, 1 dose pkg	G		$34.11		$4.38
0886	Azathioprine oral 50mg	G		$1.25		$.11
0887	Azathioprine parenteral 100 mg	G		$1.06		$.10
0888	Cyclosporine oral 100 mg	G		$5.22		$.67
0889	Cyclosporin parenteral 250mg	G		$25.08		$3.22
0890	Lymphocyte immune globulin 250 mg	G		$269.06		$38.52
0891	Tacrolimus oral per 1 mg	G		$2.91		$.42
0900	Alglucerase injection, per 10 u	G		$37.53		$5.37
0901	Alpha 1 proteinase inhibitor, 10 mg	G		$2.09		$.30
0902	Botulinum toxin a, per unit	G		$4.39		$.63
0903	Cytomegalovirus imm IV/vial	G		$370.50		$47.58
0905	Immune globulin 500 mg	G		$35.63		$3.23
0906	RSV-ivig, 50 mg	G		$15.51		$1.99
0907	Ganciclovir Sodium 500 mg injection	K	0.42	$21.38		$4.28
0908	Tetanus immune globulin inj up to 250 u	G		$102.60		$13.18
0909	Interferon beta-1a, 33 mcg	G		$225.22		$32.24
0910	Interferon beta-1b /0.25 mg	G		$68.40		$9.79
0911	Streptokinase per 250,000 iu	K	1.66	$84.50		$16.90
0913	Ganciclovir long act implant 4.5 mg	G		$4,750.00		$680.00
0916	Injection imiglucerase /unit	G		$3.75		$.54
0917	Pharmacologic stressors	K	0.34	$17.31		$3.46
0925	Factor viii per iu	G		$.87		$.08
0926	Factor VIII (porcine) per iu	G		$2.09		$.30
0927	Factor viii recombinant per iu	G		$1.12		$.14
0928	Factor ix complex per iu	G		$.48		$.04
0929	Anti-inhibitor per iu	G		$1.43		$.18
0930	Antithrombin iii injection per iu	G		$1.05		$.15
0931	Factor IX non-recombinant, per iu	G		$26.13		$3.74
0932	Factor IX recombinant, per iu	G		$1.12		$.16
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	2.78	$141.51		$28.30
0950	Blood (Whole) For Transfusion	K	1.97	$100.28		$20.06
0952	Cryoprecipitate	K	0.66	$33.60		$6.72

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0954	RBC leukocytes reduced	K	2.67	$135.91	.....	$27.18
0955	Plasma, Fresh Frozen	K	2.13	$108.43	.....	$21.69
0956	Plasma Protein Fraction	K	1.19	$60.58	.....	$12.12
0957	Platelet Concentrate	K	0.93	$47.34	.....	$9.47
0958	Platelet Rich Plasma	K	1.10	$55.99	.....	$11.20
0959	Red Blood Cells	K	1.93	$98.24	.....	$19.65
0960	Washed Red Blood Cells	K	3.60	$183.25	.....	$36.65
0961	Infusion, Albumin (Human) 5%, 50 ml	K	2.07	$105.37	.....	$21.07
0962	Infusion, Albumin (Human) 25%, 50 ml	K	1.04	$52.94	.....	$10.59
0963	Albumin (human), 5%, 250 ml	K	10.35	$526.86	.....	$105.37
0964	Albumin (human), 25%, 20 ml	K	2.08	$105.88	.....	$21.18
0965	Albumin (human), 25%, 50ml	K	5.20	$264.70	.....	$52.94
0966	Plasmaprotein fract,5%,250ml	K	5.95	$302.88	.....	$60.58
0970	New Technology—Level I ($0–$50)	T	.....	$25.00	.....	$5.00
0971	New Technology—Level II ($50–$100)	T	.....	$75.00	.....	$15.00
0972	New Technology—Level III ($100–$200)	T	.....	$150.00	.....	$30.00
0973	New Technology—Level IV ($200–$300)	T	.....	$250.00	.....	$50.00
0974	New Technology—Level V ($300–$500)	T	.....	$400.00	.....	$80.00
0975	New Technology—Level VI ($500–$750)	T	.....	$625.00	.....	$125.00
0976	New Technology—Level VII ($750–$1000)	T	.....	$875.00	.....	$175.00
0977	New Technology—Level VIII ($1000–$1250)	T	.....	$1,125.00	.....	$225.00
0978	New Technology—Level IX ($1250–$1500)	T	.....	$1,375.00	.....	$275.00
0979	New Technology—Level X ($1500–$1750)	T	.....	$1,625.00	.....	$325.00
0980	New Technology—Level XI ($1750–$2000)	T	.....	$1,875.00	.....	$375.00
0981	New Technology—Level XII ($2000–$2500)	T	.....	$2,250.00	.....	$450.00
0982	New Technology—Level XIII ($2500–$3000)	T	.....	$2,750.00	.....	$550.00
0983	New Technology—Level XIV ($3000– $3500)	T	.....	$3,250.00	.....	$650.00
0984	New Technology—Level XV ($3500–$5000)	T	.....	$4,250.00	.....	$850.00
0985	New Technology—Level XVI ($5000–$6000)	T	.....	$5,500.00	.....	$1,100.00
1009	Cryoprecip reduced plasma	K	0.82	$41.74	.....	$8.35
1010	Blood, L/R, CMV-neg	K	2.72	$138.46	.....	$27.69
1011	Platelets, HLA-m, L/R, unit	K	11.21	$570.63	.....	$114.13
1012	Platelet concentrate, L/R, irradiated, unit	K	1.81	$92.14	.....	$18.43
1013	Platelet concentrate, L/R, unit	K	1.11	$56.50	.....	$11.30
1014	Platelets, aph/pher, L/R, unit	K	8.45	$430.14	.....	$86.03
1016	Blood, L/R, froz/deglycerol/washed	K	6.76	$344.11	.....	$68.82
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.82	$448.97	.....	$89.79
1018	Blood, L/R, irradiated	K	2.96	$150.68	.....	$30.14
1019	Platelets, aph/pher, L/R, irradiated, unit	K	9.11	$463.74	.....	$92.75
1024	Quinupristin/dalfopristin 500 mg (150/350)	G	.....	$102.05	.....	$13.11
1045	Iobenguane sulfate I–131	G	.....	$495.65	.....	$70.96
1058	TC 99M oxidronate, per vial	G	.....	$36.74	.....	$5.26
1059	Cultured chondrocytes implnt	G	.....	$14,250.00	.....	$2,040.00
1064	I–131 cap, each add mCi	G	.....	$5.86	.....	$.75
1065	I–131 sol, each add mCi	G	.....	$15.81	.....	$2.03
1066	IN 111 satumomab pendetide	G	.....	$1,591.25	.....	$227.80
1079	CO 57/58 0.5 mCi	G	.....	$253.84	.....	$36.34
1084	Denileukin diftitox, 300 MCG	G	.....	$999.88	.....	$143.14
1086	Temozolomide,oral 5 mg	G	.....	$6.05	.....	$.87
1087	I–123 per 100 uci	G	.....	$.65	.....	$.06
1089	Coo 57, 0.5 Mci	G	.....	$81.10	.....	$10.41
1091	IN 111 Oxyquinoline, per .5 mCi	G	.....	$427.50	.....	$61.20
1092	IN 111 Pentetate, per 0.5 mCi	G	.....	$256.50	.....	$23.22
1094	TC 99M Albumin aggr,1.0 cmCi	G	.....	$33.09	.....	$4.25
1095	Technetium TC 99M Depreotide	G	.....	$38.00	.....	$5.44
1096	TC 99M Exametazime, per dose	G	.....	$445.31	.....	$63.75
1097	TC 99M Mebrofenin, per vial	G	.....	$51.44	.....	$7.36
1098	TC 99M Pentetate, per vial	G	.....	$22.43	.....	$2.88
1099	TC 99M Pyrophosphate, per vial	G	.....	$39.11	.....	$5.60
1122	TC 99M arcitumomab, per vial	G	.....	$1,235.00	.....	$176.80
1166	Cytarabine liposomal, 10 mg	G	.....	$371.45	.....	$53.18
1167	Epirubicin hcl, 2 mg	G	.....	$24.94	.....	$3.57
1178	Busulfan IV, 6 mg	G	.....	$26.48	.....	$3.79
1188	I–131 cap, per 1–5 mCi	G	.....	$117.25	.....	$15.06
1200	TC 99M Sodium Glucoheptonate	G	.....	$22.61	.....	$3.24
1201	TC 99M succimer, per vial	G	.....	$135.66	.....	$19.42
1202	TC 99M Sulfur Colloid, per dose	G	.....	$76.00	.....	$9.76
1203	Verteporfin for injection	G	.....	$1,458.25	.....	$208.76
1205	Technetium Tc 99m disofenin	G	.....	$79.17	.....	$11.33
1207	Octreotide acetate depot 1mg	G	.....	$138.08	.....	$19.77
1305	Apligraf	G	.....	$1,157.81	.....	$165.75
1348	I–131 sol, per 1–6 mCi	G	.....	$146.57	.....	$18.82
1400	Diphenhydramine hcl 50mg	G	.....	$.23	.....	$.02
1401	Prochlorperazine maleate 5mg	G	.....	$.65	.....	$.06
1402	Promethazine hcl 12.5mg oral	G	.....	$.01	.....	$.00
1403	Chlorpromazine hcl 10mg oral	G	.....	$.27	.....	$.02
1404	Trimethobenzamide hcl 250mg	G	.....	$.38	.....	$.03

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1405	Thiethylperazine maleate10mg	G		$.56		$.08
1406	Perphenazine 4mg oral	G		$.62		$.06
1407	Hydroxyzine pamoate 25mg	G		$.28		$.03
1409	Factor viia recombinant, per 1.2 mg	G		$1,596.00		$228.48
1600	Technetium TC 99M sestamibi	G		$121.70		$17.42
1601	Technetium TC 99M medronate	G		$42.18		$5.42
1602	Technetium TC 99M apcitide	G		$475.00		$68.00
1603	Thallous chloride TL 201, per mCi	G		$78.16		$7.08
1604	IN 111 capromab pendetide, per dose	G		$2,192.13		$313.82
1605	Abciximab injection, 10 mg	G		$513.02		$73.44
1606	Anistreplase, 30 u	G		$2,693.80		$385.64
1607	Eptifibatide injection, 5 mg	G		$11.31		$1.45
1608	Etanercept injection, 25 mg	G		$141.01		$20.19
1609	Rho(D) immune globulin h, sd, 100 iu	G		$20.55		$2.64
1611	Hylan G–F 20 injection, 16 mg	G		$213.87		$27.47
1612	Daclizumab, parenteral, 25 mg	G		$397.29		$56.88
1613	Trastuzumab, 10 mg	G		$52.83		$7.56
1614	Valrubicin, 200 mg	G		$423.23		$60.59
1615	Basiliximab, 20 mg	G		$1,437.78		$205.83
1617	Lepirudin	G		$131.96		$18.89
1618	Vonwillebrandfactrcmplx, per iu	G		$.95		$.14
1619	Ga 67, per mCi	G		$25.62		$2.32
1620	Technetium tc99m bicisate	G		$403.99		$57.83
1621	Xenin xe 133	G		$29.93		$2.71
1622	Technetium tc99m mertiatide	G		$137.75		$19.72
1623	Technetium tc99m glucepatate	G		$22.61		$3.24
1624	Sodium phosphate p32	G		$54.34		$7.78
1625	Indium 111-in pentetreotide	G		$935.75		$133.96
1626	Technetium tc99m oxidronate	G		$1.47		$.21
1627	Technetium tc99mlabeled rbcs	G		$40.90		$5.85
1628	Chromic phosphate p32	G		$150.86		$21.60
1713	Anchor/screw bn/bn,tis/bn	H				
1714	Cath, trans atherectomy, dir	H				
1715	Brachytherapy needle	H				
1716	Brachytx seed, Gold 198	H				
1717	Brachytx seed, HDR Ir-192	H				
1718	Brachytx seed, Iodine 125	H				
1719	Brachytxseed, Non-HDR Ir-192	H				
1720	Brachytx seed, Palladium 103	H				
1721	AICD, dual chamber	H				
1722	AICD, single chamber	H				
1724	Cath, trans atherec,rotation	H				
1725	Cath, translumin non-laser	H				
1726	Cath, bal dil, non-vascular	H				
1727	Cath, bal tis dis, non-vas	H				
1728	Cath, brachytx seed adm	H				
1729	Cath, drainage	H				
1730	Cath, EP, 19 or fewer elect	H				
1731	Cath, EP, 20 or more elec	H				
1732	Cath, EP, diag/abl, 3D/vect	H				
1733	Cath, EP, othr than cool-tip	H				
1750	Cath, hemodialysis,long-term	H				
1751	Cath, inf, per/cent/midline	H				
1752	Cath, hemodialysis,short-term	H				
1753	Cath, intravas ultrasound	H				
1754	Catheter, intradiscal	H				
1755	Catheter, intraspinal	H				
1756	Cath, pacing, transesoph	H				
1757	Cath, thrombectomy/embolect	H				
1758	Cath, ureteral	H				
1759	Cath, intra echocardiography	H				
1760	Closure dev, vasc, imp/insert	H				
1762	Conn tiss, human (inc fascia)	H				
1763	Conn tiss, non-human	H				
1764	Event recorder, cardiac	H				
1765	Adhesion barrier	H				
1766	Intro/sheath,strble,non-peel	H				
1767	Generator, neurostim, imp	H				
1768	Graft, vascular	H				
1769	Guide wire	H				
1770	Imaging coil, MR, insertable	H				
1771	Rep dev, urinary, w/sling	H				
1772	Infusion pump, programmable	H				
1773	Retrieval dev, insert	H				
1776	Joint device (implantable)	H				
1777	Lead, AICD, endo single coil	H				
1778	Lead, neurostimulator	H				

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1779	Lead, pmkr, transvenous VDD	H				
1780	Lens, intraocular	H				
1781	Mesh (implantable)	H				
1782	Morcellator	H				
1784	Ocular dev, intraop, det ret	H				
1785	Pmkr, dual, rate-resp	H				
1786	Pmkr, single, rate-resp	H				
1787	Patient progr, neurostim	H				
1788	Port, indwelling, imp	H				
1789	Prosthesis, breast, imp	H				
1813	Prosthesis, penile, inflatab	H				
1815	Pros, urinary sph, imp	H				
1816	Receiver/transmitter, neuro	H				
1817	Septal defect imp sys	H				
1874	Stent, coated/cov w/del sys	H				
1875	Stent, coated/cov w/o del sy	H				
1876	Stent, non-coa/no-cov w/del	H				
1877	Stent, non-coat/cov w/o del	H				
1878	Matrl for vocal cord	H				
1879	Tissue marker, imp	H				
1880	Vena cava filter	H				
1881	Dialysis access system	H				
1882	AICD, other than sing/dual	H				
1883	Adapt/ext, pacing/neuro lead	H				
1885	Cath, translumin angio laser	H				
1887	Catheter, guiding	H				
1891	Infusion pump,non-prog,perm	H				
1892	Intro/sheath,fixed,peel-away	H				
1893	Intro/sheath,fixed,non-peel	H				
1894	Intro/sheath, non-laser	H				
1895	Lead, AICD, endo dual coil	H				
1896	Lead, AICD, non sing/dual	H				
1897	Lead, neurostim test kit	H				
1898	Lead, pmkr, other than trans	H				
1899	Lead, pmkr/AICD combination	H				
2615	Sealant, pulmonary, liquid	H				
2616	Brachytx seed, Yttrium-90	H				
2617	Stent, non-cor, tem w/o del	H				
2618	Probe, cryoablation	H				
2619	Pmkr, dual, non rate-resp	H				
2620	Pmkr, single, non rate-resp	H				
2621	Pmkr, other than sing/dual	H				
2622	Prosthesis, penile, non-inf	H				
2625	Stent, non-cor, tem w/del sys	H				
2626	Infusion pump, non-prog,temp	H				
2627	Cath, suprapubic/cystoscopic	H				
2628	Catheter, occlusion	H				
2629	Intro/sheath, laser	H				
2630	Cath, EP, cool-tip	H				
2631	Rep dev, urinary, w/o sling	H				
7000	Amifostine, 500 mg	G		$392.06		$56.13
7001	Amphotericin B lipid complex, 50 mg	G		$109.25		$15.64
7003	Epoprostenol injection 0.5 mg	G		$12.04		$1.72
7005	Gonadorelin hydroch, 100 mcg	G		$192.37		$27.54
7007	Milrinone lactate, per 5 ml, inj	K	0.44	$22.40		$4.48
7010	Morphine sulfate (preservative free) 10 mg	G		$1.02		$.09
7011	Oprelvekin injection, 5 mg	G		$245.81		$35.19
7014	Fentanyl citrate injection	G		$1.23		$.11
7015	Busulfan, oral, 2 mg	G		$1.91		$.27
7019	Aprotinin, 10,000 kiu	G		$2.16		$.31
7022	Elliot's B solution, per ml	G		$1.43		$.20
7023	Bladder calculi irrig sol	G		$24.70		$3.54
7024	Corticorelin ovine triflutat	G		$368.03		$52.69
7025	Digoxin immune FAB (ovine)	G		$551.66		$78.97
7026	Ethanolamine oleate, 100 mg	G		$39.73		$5.69
7027	Fomepizole, 15 mg	G		$10.93		$1.56
7028	Fosphenytoin, 50 mg	G		$5.73		$.82
7029	Glatiramer acetate, per dose	G		$30.07		$4.30
7030	Hemin, per 1 mg	G		$.99		$.14
7031	Octreotide acetate injection	G		$138.08		$19.77
7032	Sermorelin acetate, 0.5 mg	G		$13.60		$1.95
7033	Somatrem, 5mg	G		$209.48		$29.99
7034	Somatropin injection	G		$39.90		$5.12
7035	Teniposide, 50 mg	G		$222.80		$31.90
7036	Urokinase 250,000 iu inj	K	6.41	$326.29		$65.26
7037	Urofollitropin, 75 iu	G		$73.29		$10.49
7038	Muromonab-CD3, 5 mg	G		$269.06		$38.52

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
7039	Pegademase bovine inj 25 I.U	G		$139.33		$19.95
7040	Pentastarch 10% solution	G		$15.11		$2.16
7041	Tirofiban hydrochloride 12.5 mg	G		$436.41		$62.48
7042	Capecitabine, oral, 150 mg	G		$2.43		$.35
7043	Infliximab injection 10 mg	G		$63.24		$9.05
7045	Trimetrexate glucoronate	G		$118.75		$17.00
7046	Doxorubicin hcl liposome inj 10 mg	G		$358.95		$51.39
7048	Alteplase recombinant	K	0.36	$18.33		$3.67
7049	Filgrastim 480 mcg injection	G		$285.38		$36.65
7050	Prednisone oral	G		$.07		$.01
7051	Leuprolide acetate implant, 65 mg	G		$5,399.80		$773.02
7315	Sodium hyaluronate injection, 5mg	G		$26.13		$3.74
9000	Na chromate Cr51, per 0.25mCi	G		$.52		$.07
9001	Linezolid inj, 200mg	G		$24.13		$3.45
9002	Tenecteplase, 50mg/vial	G		$2,612.50		$374.00
9003	Palivizumab, per 50mg	G		$664.49		$95.13
9004	Gemtuzumab ozogamicin inj,5mg	G		$1,929.69		$276.25
9005	Reteplase injection	G		$1,306.25		$187.00
9006	Tacrolimus inj	G		$113.15		$16.20
9007	Baclofen Intrathecal kit-1amp	G		$79.80		$11.42
9008	Baclofen refill kit—per 500 mcg	G		$11.69		$1.67
9009	Baclofen refill kit—per 2000 mcg	G		$49.12		$7.03
9010	Baclofen refill kit—per 4000 mcg	G		$43.08		$6.17
9011	Caffeine Citrate, inj,	G		$3.05		$.44
9012	Arsenic Trioxide	G		$23.75		$3.40
9013	Co 57 Cobaltous Cl	G		$81.10		$10.41
9015	Mycophenolate mofetil oral 250 mg	G		$2.40		$.34
9016	Echocardiography contrast	G		$118.75		$17.00
9018	Botulinum tox B, per 100 u	G		$8.79		$1.26
9019	Caspofungin acetate, 5 mg	G		$34.20		$4.90
9020	Sirolimus tablet, 1 mg	G		$6.51		$.93
9100	Iodinated I–131 albumin	G		$10.34		$1.48
9102	51 na chromate, per 50mCi	G		$64.84		$9.28
9103	Na iothalamate I–125, per 10 uci	G		$17.18		$2.46
9104	Anti-thymocyte globulin rabbit	G		$325.09		$46.54
9105	Hep B imm glob, per 1 ml	G		$133.00		$17.08
9106	Sirolimus, 1 mg	G		$6.51		$.93
9108	Thyrotropin alfa, per 1.1 mg	G		$531.05		$76.02
9109	Tirofliban hcl, per 6.25 mg	G		$207.81		$29.75
9110	Alemtuzumab, per ml	G		$486.88		$69.70
9111	Inj, bivalirudin, per 250mg vial	G		$397.81		$56.95
9112	Perflutren lipid micro, per 2ml	G		$148.20		$21.22
9113	Inj pantoprazole sodium, vial	G		$22.80		$3.26
9114	Nesiritide, per 1.5 mg vial	G		$433.20		$62.02
9115	Inj, zoledronic acid, per 2 mg	G		$406.78		$58.23
9200	Orcel, per 36 cm2	G		$1,135.25		$162.52
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$82.69
9217	Leuprolide acetate suspnsion, 7.5 mg	G		$592.60		$84.84
9500	Platelets, irradiated	K	1.68	$85.52		$17.10
9501	Platelets, pheresis	K	9.16	$466.28		$93.26
9502	Platelet pheresis irradiated	K	9.94	$505.99		$101.20
9503	Fresh frozen plasma, ea unit	K	1.56	$79.41		$15.88
9504	RBC deglycerolized	K	4.11	$209.22		$41.84
9505	RBC irradiated	K	2.44	$124.21		$24.84
9506	Granulocytes, pheresis	K	27.75	$1,412.59		$282.52

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*0001T	C	Endovas repr abdo ao aneurys					
*0002T	C	Endovas repr abdo ao aneurys					
*0003T	N	Cervicography					
*0005T	C	Perc cath stent/brain cv art					
*0006T	C	Perc cath stent/brain cv art					
*0007T	C	Perc cath stent/brain cv art					
*0008T	E	Upper gi endoscopy w/suture					
*0009T	T	Endometrial cryoablation	0193	11.16	$568.09	$171.13	$113.62

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00100	N	Anesth, salivary gland					
00102	N	Anesth, repair of cleft lip					
00103	N	Anesth, blepharoplasty					
00104	N	Anesth, electroshock					
*0010T	A	Tb test, gamma interferon					
00120	N	Anesth, ear surgery					
00124	N	Anesth, ear exam					
00126	N	Anesth, tympanotomy					
*0012T	T	Osteochondral knee autograft	0041	23.61	$1,201.84	$576.88	$240.37
*0013T	T	Osteochondral knee allograft	0041	23.61	$1,201.84	$576.88	$240.37
00140	N	Anesth, procedures on eye					
00142	N	Anesth, lens surgery					
00144	N	Anesth, corneal transplant					
00145	N	Anesth, vitreoretinal surg					
00147	N	Anesth, iridectomy					
00148	N	Anesth, eye exam					
*0014T	T	Meniscal transplant, knee	0041	23.61	$1,201.84	$576.88	$240.37
00160	N	Anesth, nose/sinus surgery					
00162	N	Anesth, nose/sinus surgery					
00164	N	Anesth, biopsy of nose					
*0016T	E	Thermotx choroid vasc lesion					
00170	N	Anesth, procedure on mouth					
00172	N	Anesth, cleft palate repair					
00174	C	Anesth, pharyngeal surgery					
00176	C	Anesth, pharyngeal surgery					
*0017T	E	Photocoagulat macular drusen					
*0018T	S	Transcranial magnetic stimul	0215	0.66	$33.60	$17.47	$6.72
00190	N	Anesth, face/skull bone surg					
00192	C	Anesth, facial bone surgery					
*0019T	A	Extracorp shock wave tx, ms					
*0020T	A	Extracorp shock wave tx, ft					
00210	N	Anesth, open head surgery					
00212	N	Anesth, skull drainage					
00214	C	Anesth, skull drainage					
00215	C	Anesth, skull repair/fract					
00216	N	Anesth, head vessel surgery					
00218	N	Anesth, special head surgery					
*0021T	C	Fetal oximetry, trnsvag/cerv					
00220	N	Anesth, spinal fluid shunt					
00222	N	Anesth, head nerve surgery					
*0023T	A	Phenotype drug test, hiv 1					
*0024T	C	Transcath cardiac reduction					
*0025T	S	Ultrasonic pachymetry	0230	0.61	$31.05	$14.28	$6.21
*0026T	A	Measure remnant lipoproteins					
00300	N	Anesth, head/neck/ptrunk					
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, skin, ext/per/atrunk					
00402	N	Anesth, surgery of breast					
00404	C	Anesth, surgery of breast					
00406	C	Anesth, surgery of breast					
00410	N	Anesth, correct heart rhythm					
00450	N	Anesth, surgery of shoulder					
00452	C	Anesth, surgery of shoulder					
00454	N	Anesth, collar bone 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	N	Anesth, pacemaker insertion					
00532	N	Anesth, vascular access					
00534	N	Anesth, cardioverter/defib					
00537	N	Anesth, cardiac electrophys					
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					
00550	N	Anesth, sternal debridement					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00560	C	Anesth, open heart surgery					
00562	C	Anesth, open heart surgery					
00563	N	Anesth, heart proc w/pump					
00566	N	Anesth, cabg w/o pump					
00580	C	Anesth heart/lung transplant					
00600	N	Anesth, spine, cord surgery					
00604	C	Anesth, sitting procedure					
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					
00635	N	Anesth, lumbar puncture					
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, upper gi visualize					
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, hemorr/excise liver					
00794	C	Anesth, pancreas removal					
00796	C	Anesth, for liver transplant					
*00797	N	Anesth, surgery for obesity					
00800	N	Anesth, abdominal wall surg					
00802	C	Anesth, fat layer removal					
00810	N	Anesth, low intestine scope					
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	D	Anesth, cesarean section					
*00851	N	Anesth, tubal ligation					
00855	D	Anesth, hysterectomy					
00857	D	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					
*00869	N	Anesth, vasectomy					
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	D	Anesth, major vein revision					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00940	N	Anesth, vaginal procedures					
00942	N	Anesth, surg on vag/urethal					
00944	C	Anesth, vaginal hysterectomy					
00946	D	Anesth, vaginal delivery					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, hysteroscope/graph					
00955	D	Analgesia, vaginal delivery					
01112	N	Anesth, bone aspirate/bx					
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					
01210	N	Anesth, hip joint surgery					
01212	C	Anesth, hip disarticulation					
01214	C	Anesth, replacement of hip					
01215	N	Anesth, revise hip repair					
01220	N	Anesth, procedure on femur					
01230	N	Anesth, surgery of femur					
01232	C	Anesth, amputation of femur					
01234	C	Anesth, radical femur 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					
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					
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, lwr leg embolectomy					
01520	N	Anesth, lower leg vein surg					
01522	N	Anesth, lower leg vein 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					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01680	N	Anesth, shoulder casting					
01682	N	Anesth, airplane cast					
01710	N	Anesth, elbow area surgery					
01712	N	Anesth, uppr arm tendon surg					
01714	N	Anesth, uppr arm tendon surg					
01716	N	Anesth, biceps tendon repair					
01730	N	Anesth, uppr arm 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, uppr arm artery surg					
01772	N	Anesth, uppr arm embolectomy					
01780	N	Anesth, upper arm vein surg					
01782	N	Anesth, uppr arm vein repair					
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, lwr arm artery surg					
01842	N	Anesth, lwr arm embolectomy					
01844	N	Anesth, vascular shunt surg					
01850	N	Anesth, lower arm vein surg					
01852	N	Anesth, lwr arm vein repair					
01860	N	Anesth, lower arm casting					
01904	D	Anesth, skull x-ray inject					
*01905	N	Anes, spine inject, x-ray/re					
01906	D	Anesth, lumbar myelography					
01908	D	Anesth, cervical myelography					
01910	D	Anesth, skull myelography					
01912	D	Anesth, lumbar diskography					
01914	D	Anesth, cervical diskography					
01916	N	Anesth, head arteriogram					
01918	D	Anesth, limb arteriogram					
01920	N	Anesth, catheterize heart					
01921	D	Anesth, vessel surgery					
01922	N	Anesth, cat or MRI scan					
*01924	N	Anes, ther interven rad, art					
*01925	N	Anes, ther interven rad, car					
*01926	N	Anes, tx interv rad hrt/cran					
*01930	N	Anes, ther interven rad, vei					
*01931	N	Anes, ther interven rad, tip					
*01932	N	Anes, tx interv rad, th vein					
*01933	N	Anes, tx interv rad, cran v					
01951	N	Anesth, burn, less 1 percent					
01952	N	Anesth, burn, 1–9 percent					
01953	N	Anesth, burn, each 9 percent					
*01960	N	Anesth, vaginal delivery					
*01961	N	Anesth, cs delivery					
*01962	N	Anesth, emer hysterectomy					
*01963	N	Anesth, cs hysterectomy					
*01964	N	Anesth, abortion procedures					
*01967	N	Anesth/analg, vag delivery					
*01968	N	Anes/analg cs deliver add-on					
*01969	N	Anesth/analg cs hyst add-on					
01990	C	Support for organ donor					
01995	N	Regional anesthesia, limb					
01996	N	Manage daily drug therapy					
01999	N	Unlisted anesth procedure					
*10021	T	Fna w/o image	0002	0.42	$21.38	$11.75	$4.28
*10022	T	Fna w/image	0002	0.42	$21.38	$11.75	$4.28
10040	T	Acne surgery of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10060	T	Drainage of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10061	T	Drainage of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10080	T	Drainage of pilonidal cyst	0006	2.18	$110.97	$33.95	$22.19
10081	T	Drainage of pilonidal cyst	0007	6.75	$343.60	$72.03	$68.72
10120	T	Remove foreign body	0006	2.18	$110.97	$33.95	$22.19
10121	T	Remove foreign body	0020	8.44	$429.63	$130.53	$85.93
10140	T	Drainage of hematoma/fluid	0007	6.75	$343.60	$72.03	$68.72
10160	T	Puncture drainage of lesion	0018	1.05	$53.45	$17.66	$10.69
10180	T	Complex drainage, wound	0007	6.75	$343.60	$72.03	$68.72
11000	T	Debride infected skin	0015	2.07	$105.37	$31.20	$21.07

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11001	T	Debride infected skin add-on	0013	1.36	$69.23	$17.66	$13.85
11010	T	Debride skin, fx	0022	13.91	$708.07	$292.94	$141.61
11011	T	Debride skin/muscle, fx	0022	13.91	$708.07	$292.94	$141.61
11012	T	Debride skin/muscle/bone, fx	0022	13.91	$708.07	$292.94	$141.61
11040	T	Debride skin, partial	0015	2.07	$105.37	$31.20	$21.07
11041	T	Debride skin, full	0015	2.07	$105.37	$31.20	$21.07
11042	T	Debride skin/tissue	0016	3.02	$153.73	$64.57	$30.75
11043	T	Debride tissue/muscle	0016	3.02	$153.73	$64.57	$30.75
11044	T	Debride tissue/muscle/bone	0017	9.68	$492.75	$226.67	$98.55
11055	T	Trim skin lesion	0012	0.66	$33.60	$9.18	$6.72
11056	T	Trim skin lesions, 2 to 4	0012	0.66	$33.60	$9.18	$6.72
11057	T	Trim skin lesions, over 4	0012	0.66	$33.60	$9.18	$6.72
11100	T	Biopsy of skin lesion	0018	1.05	$53.45	$17.66	$10.69
11101	T	Biopsy, skin add-on	0018	1.05	$53.45	$17.66	$10.69
11200	T	Removal of skin tags	0013	1.36	$69.23	$17.66	$13.85
11201	T	Remove skin tags add-on	0015	2.07	$105.37	$31.20	$21.07
11300	T	Shave skin lesion	0012	0.66	$33.60	$9.18	$6.72
11301	T	Shave skin lesion	0012	0.66	$33.60	$9.18	$6.72
11302	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11303	T	Shave skin lesion	0015	2.07	$105.37	$31.20	$21.07
11305	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11306	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11307	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11308	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11310	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11311	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11312	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11313	T	Shave skin lesion	0016	3.02	$153.73	$64.57	$30.75
11400	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11401	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11402	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11403	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11404	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11406	T	Removal of skin lesion	0021	11.82	$601.69	$236.51	$120.34
11420	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11421	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11422	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11423	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11424	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11426	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11440	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11441	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11442	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11443	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11444	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11446	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11450	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11451	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11462	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11463	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11470	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11471	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11600	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11601	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11602	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11603	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11604	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11606	T	Removal of skin lesion	0021	11.82	$601.69	$236.51	$120.34
11620	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11621	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11622	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11623	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11624	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11626	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11640	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11641	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11642	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11643	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11644	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11646	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11719	T	Trim nail(s)	0009	0.63	$32.07	$8.34	$6.41
11720	T	Debride nail, 1–5	0009	0.63	$32.07	$8.34	$6.41
11721	T	Debride nail, 6 or more	0009	0.63	$32.07	$8.34	$6.41
11730	T	Removal of nail plate	0013	1.36	$69.23	$17.66	$13.85
11732	T	Remove nail plate, add-on	0012	0.66	$33.60	$9.18	$6.72

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11740	T	Drain blood from under nail	0009	0.63	$32.07	$8.34	$6.41
11750	T	Removal of nail bed	0019	4.22	$214.81	$78.91	$42.96
11752	T	Remove nail bed/finger tip	0022	13.91	$708.07	$292.94	$141.61
11755	T	Biopsy, nail unit	0019	4.22	$214.81	$78.91	$42.96
11760	T	Repair of nail bed	0024	2.28	$116.06	$41.78	$23.21
11762	T	Reconstruction of nail bed	0024	2.28	$116.06	$41.78	$23.21
11765	T	Excision of nail fold, toe	0015	2.07	$105.37	$31.20	$21.07
11770	T	Removal of pilonidal lesion	0021	11.82	$601.69	$236.51	$120.34
11771	T	Removal of pilonidal lesion	0022	13.91	$708.07	$292.94	$141.61
11772	T	Removal of pilonidal lesion	0022	13.91	$708.07	$292.94	$141.61
11900	T	Injection into skin lesions	0012	0.66	$33.60	$9.18	$6.72
11901	T	Added skin lesions injection	0012	0.66	$33.60	$9.18	$6.72
11920	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11921	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11922	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11950	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11951	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11952	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11954	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11960	T	Insert tissue expander(s)	0026	12.62	$642.41	$277.92	$128.48
11970	T	Replace tissue expander	0026	12.62	$642.41	$277.92	$128.48
11971	T	Remove tissue expander(s)	0022	13.91	$708.07	$292.94	$141.61
11975	E	Insert contraceptive cap	.....	.....	.....	.....	.....
11976	T	Removal of contraceptive cap	0019	4.22	$214.81	$78.91	$42.96
11977	E	Removal/reinsert contra cap	.....	.....	.....	.....	.....
11980	X	Implant hormone pellet(s)	0340	0.84	$42.76	$10.69	$8.55
*11981	X	Insert drug implant device	0340	0.84	$42.76	$10.69	$8.55
*11982	X	Remove drug implant device	0340	0.84	$42.76	$10.69	$8.55
*11983	X	Remove/insert drug implant	0340	0.84	$42.76	$10.69	$8.55
12001	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12002	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12004	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12005	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12006	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12007	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12011	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12013	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12014	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12015	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12016	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12017	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12018	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12020	T	Closure of split wound	0024	2.28	$116.06	$41.78	$23.21
12021	T	Closure of split wound	0024	2.28	$116.06	$41.78	$23.21
12031	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12032	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12034	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12035	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12036	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12037	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
12041	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12042	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12044	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12045	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12046	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12047	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
12051	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12052	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12053	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12054	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12055	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12056	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12057	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
13100	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13101	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13102	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13120	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13121	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13122	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13131	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13132	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13133	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13150	T	Repair of wound or lesion	0026	12.62	$642.41	$277.92	$128.48
13151	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13152	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
13153	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13160	T	Late closure of wound	0026	12.62	$642.41	$277.92	$128.48
14000	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14001	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14020	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14021	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14040	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14041	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14060	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14061	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14300	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14350	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
15000	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15001	T	Skin graft add-on	0026	12.62	$642.41	$277.92	$128.48
15050	T	Skin pinch graft	0026	12.62	$642.41	$277.92	$128.48
15100	T	Skin split graft	0026	12.62	$642.41	$277.92	$128.48
15101	T	Skin split graft add-on	0026	12.62	$642.41	$277.92	$128.48
15120	T	Skin split graft	0026	12.62	$642.41	$277.92	$128.48
15121	T	Skin split graft add-on	0026	12.62	$642.41	$277.92	$128.48
15200	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15201	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15220	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15221	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15240	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15241	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15260	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15261	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15342	T	Cultured skin graft, 25 cm	0025	3.39	$172.56	$65.57	$34.51
15343	T	Culture skn graft addl 25 cm	0025	3.39	$172.56	$65.57	$34.51
15350	T	Skin homograft	0686	24.01	$1,222.21	$277.92	$244.44
15351	T	Skin homograft add-on	0026	12.62	$642.41	$277.92	$128.48
15400	T	Skin heterograft	0026	12.62	$642.41	$277.92	$128.48
15401	T	Skin heterograft add-on	0026	12.62	$642.41	$277.92	$128.48
15570	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15572	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15574	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15576	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15600	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15610	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15620	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15630	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15650	T	Transfer skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15732	T	Muscle-skin graft, head/neck	0027	18.02	$917.29	$383.10	$183.46
15734	T	Muscle-skin graft, trunk	0027	18.02	$917.29	$383.10	$183.46
15736	T	Muscle-skin graft, arm	0027	18.02	$917.29	$383.10	$183.46
15738	T	Muscle-skin graft, leg	0027	18.02	$917.29	$383.10	$183.46
15740	T	Island pedicle flap graft	0027	18.02	$917.29	$383.10	$183.46
15750	T	Neurovascular pedicle graft	0027	18.02	$917.29	$383.10	$183.46
15756	C	Free muscle flap, microvasc					
15757	C	Free skin flap, microvasc					
15758	C	Free fascial flap, microvasc					
15760	T	Composite skin graft	0027	18.02	$917.29	$383.10	$183.46
15770	T	Derma-fat-fascia graft	0027	18.02	$917.29	$383.10	$183.46
15775	T	Hair transplant punch grafts	0026	12.62	$642.41	$277.92	$128.48
15776	T	Hair transplant punch grafts	0026	12.62	$642.41	$277.92	$128.48
15780	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15781	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15782	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15783	T	Abrasion treatment of skin	0016	3.02	$153.73	$64.57	$30.75
15786	T	Abrasion, lesion, single	0013	1.36	$69.23	$17.66	$13.85
15787	T	Abrasion, lesions, add-on	0013	1.36	$69.23	$17.66	$13.85
15788	T	Chemical peel, face, epiderm	0012	0.66	$33.60	$9.18	$6.72
15789	T	Chemical peel, face, dermal	0015	2.07	$105.37	$31.20	$21.07
15792	T	Chemical peel, nonfacial	0012	0.66	$33.60	$9.18	$6.72
15793	T	Chemical peel, nonfacial	0013	1.36	$69.23	$17.66	$13.85
15810	T	Salabrasion	0016	3.02	$153.73	$64.57	$30.75
15811	T	Salabrasion	0016	3.02	$153.73	$64.57	$30.75
15819	T	Plastic surgery, neck	0026	12.62	$642.41	$277.92	$128.48
15820	T	Revision of lower eyelid	0026	12.62	$642.41	$277.92	$128.48
15821	T	Revision of lower eyelid	0026	12.62	$642.41	$277.92	$128.48
15822	T	Revision of upper eyelid	0026	12.62	$642.41	$277.92	$128.48
15823	T	Revision of upper eyelid	0026	12.62	$642.41	$277.92	$128.48
15824	T	Removal of forehead wrinkles	0027	18.02	$917.29	$383.10	$183.46
15825	T	Removal of neck wrinkles	0026	12.62	$642.41	$277.92	$128.48
15826	T	Removal of brow wrinkles	0026	12.62	$642.41	$277.92	$128.48

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15828	T	Removal of face wrinkles	0027	18.02	$917.29	$383.10	$183.46
15829	T	Removal of skin wrinkles	0026	12.62	$642.41	$277.92	$128.48
15831	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15832	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15833	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15834	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15835	T	Excise excessive skin tissue	0026	12.62	$642.41	$277.92	$128.48
15836	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15837	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15838	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15839	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15840	T	Graft for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15841	T	Graft for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15842	T	Flap for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15845	T	Skin and muscle repair, face	0027	18.02	$917.29	$383.10	$183.46
15850	T	Removal of sutures	0016	3.02	$153.73	$64.57	$30.75
15851	T	Removal of sutures	0013	1.36	$69.23	$17.66	$13.85
15852	T	Dressing change, not for burn	0013	1.36	$69.23	$17.66	$13.85
15860	N	Test for blood flow in graft	.....	.....	.....	.....	.....
15876	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15877	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15878	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15879	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15920	T	Removal of tail bone ulcer	0022	13.91	$708.07	$292.94	$141.61
15922	T	Removal of tail bone ulcer	0027	18.02	$917.29	$383.10	$183.46
15931	T	Remove sacrum pressure sore	0022	13.91	$708.07	$292.94	$141.61
15933	T	Remove sacrum pressure sore	0022	13.91	$708.07	$292.94	$141.61
15934	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15935	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15936	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15937	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15940	T	Remove hip pressure sore	0022	13.91	$708.07	$292.94	$141.61
15941	T	Remove hip pressure sore	0022	13.91	$708.07	$292.94	$141.61
15944	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15945	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15946	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15950	T	Remove thigh pressure sore	0022	13.91	$708.07	$292.94	$141.61
15951	T	Remove thigh pressure sore	0022	13.91	$708.07	$292.94	$141.61
15952	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15953	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15956	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15958	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15999	T	Removal of pressure sore	0022	13.91	$708.07	$292.94	$141.61
16000	T	Initial treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16010	T	Treatment of burn(s)	0016	3.02	$153.73	$64.57	$30.75
16015	T	Treatment of burn(s)	0017	9.68	$492.75	$226.67	$98.55
16020	T	Treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16025	T	Treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16030	T	Treatment of burn(s)	0015	2.07	$105.37	$31.20	$21.07
16035	C	Incision of burn scab, initi	.....	.....	.....	.....	.....
16036	C	Incise burn scab, addl incis	.....	.....	.....	.....	.....
17000	T	Destroy benign/premal lesion	0010	0.66	$33.60	$9.86	$6.72
17003	T	Destroy lesions, 2–14	0010	0.66	$33.60	$9.86	$6.72
17004	T	Destroy lesions, 15 or more	0011	1.47	$74.83	$27.69	$14.97
17106	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17107	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17108	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17110	T	Destruct lesion, 1–14	0010	0.66	$33.60	$9.86	$6.72
17111	T	Destruct lesion, 15 or more	0011	1.47	$74.83	$27.69	$14.97
17250	T	Chemical cautery, tissue	0013	1.36	$69.23	$17.66	$13.85
17260	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17261	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17262	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17263	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17264	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17266	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17270	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17271	T	Destruction of skin lesions	0012	0.66	$33.60	$9.18	$6.72
17272	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17273	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07
17274	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17276	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17280	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17281	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17282	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17283	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07
17284	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17286	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17304	T	Chemosurgery of skin lesion	0694	3.99	$203.11	$60.93	$40.62
17305	T	2nd stage chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17306	T	3rd stage chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17307	T	Followup skin lesion therapy	0694	3.99	$203.11	$60.93	$40.62
17310	T	Extensive skin chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17340	T	Cryotherapy of skin	0012	0.66	$33.60	$9.18	$6.72
17360	T	Skin peel therapy	0012	0.66	$33.60	$9.18	$6.72
17380	T	Hair removal by electrolysis	0017	9.68	$492.75	$226.67	$98.55
17999	T	Skin tissue procedure	0004	2.47	$125.73	$32.57	$25.15
19000	T	Drainage of breast lesion	0004	2.47	$125.73	$32.57	$25.15
19001	T	Drain breast lesion add-on	0004	2.47	$125.73	$32.57	$25.15
19020	T	Incision of breast lesion	0008	10.93	$556.38	$113.67	$111.28
19030	N	Injection for breast x-ray					
19100	T	Bx breast percut w/o image	0005	4.03	$205.14	$90.26	$41.03
19101	T	Biopsy of breast, open	0028	14.00	$712.66	$303.74	$142.53
19102	T	Bx breast percut w/image	0005	4.03	$205.14	$90.26	$41.03
19103	S	Bx breast percut w/device	0710		$400.00		$80.00
19110	T	Nipple exploration	0028	14.00	$712.66	$303.74	$142.53
19112	T	Excise breast duct fistula	0028	14.00	$712.66	$303.74	$142.53
19120	T	Removal of breast lesion	0028	14.00	$712.66	$303.74	$142.53
19125	T	Excision, breast lesion	0028	14.00	$712.66	$303.74	$142.53
19126	T	Excision, addl breast lesion	0028	14.00	$712.66	$303.74	$142.53
19140	T	Removal of breast tissue	0028	14.00	$712.66	$303.74	$142.53
19160	T	Removal of breast tissue	0028	14.00	$712.66	$303.74	$142.53
19162	T	Remove breast tissue, nodes	0693	31.81	$1,619.26	$712.47	$323.85
19180	T	Removal of breast	0029	23.76	$1,209.48	$628.93	$241.90
19182	T	Removal of breast	0029	23.76	$1,209.48	$628.93	$241.90
19200	C	Removal of breast					
19220	C	Removal of breast					
19240	T	Removal of breast	0030	34.20	$1,740.92	$763.55	$348.18
19260	T	Removal of chest wall lesion	0021	11.82	$601.69	$236.51	$120.34
19271	C	Revision of chest wall					
19272	C	Extensive chest wall surgery					
19290	N	Place needle wire, breast					
19291	N	Place needle wire, breast					
19295	N	Place breast clip, percut					
19316	T	Suspension of breast	0029	23.76	$1,209.48	$628.93	$241.90
19318	T	Reduction of large breast	0693	31.81	$1,619.26	$712.47	$323.85
19324	T	Enlarge breast	0693	31.81	$1,619.26	$712.47	$323.85
19325	T	Enlarge breast with implant	0693	31.81	$1,619.26	$712.47	$323.85
19328	T	Removal of breast implant	0029	23.76	$1,209.48	$628.93	$241.90
19330	T	Removal of implant material	0029	23.76	$1,209.48	$628.93	$241.90
19340	T	Immediate breast prosthesis	0030	34.20	$1,740.92	$763.55	$348.18
19342	T	Delayed breast prosthesis	0693	31.81	$1,619.26	$712.47	$323.85
19350	T	Breast reconstruction	0029	23.76	$1,209.48	$628.93	$241.90
19355	T	Correct inverted nipple(s)	0029	23.76	$1,209.48	$628.93	$241.90
19357	T	Breast reconstruction	0693	31.81	$1,619.26	$712.47	$323.85
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	0029	23.76	$1,209.48	$628.93	$241.90
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	0029	23.76	$1,209.48	$628.93	$241.90
19371	T	Removal of breast capsule	0029	23.76	$1,209.48	$628.93	$241.90
19380	T	Revise breast reconstruction	0030	34.20	$1,740.92	$763.55	$348.18
19396	T	Design custom breast implant	0029	23.76	$1,209.48	$628.93	$241.90
19499	T	Breast surgery procedure	0028	14.00	$712.66	$303.74	$142.53
20000	T	Incision of abscess	0006	2.18	$110.97	$33.95	$22.19
20005	T	Incision of deep abscess	0049	15.84	$806.32	$356.95	$161.26
20100	T	Explore wound, neck	0023	2.08	$105.88	$40.37	$21.18
20101	T	Explore wound, chest	0026	12.62	$642.41	$277.92	$128.48
20102	T	Explore wound, abdomen	0026	12.62	$642.41	$277.92	$128.48
20103	T	Explore wound, extremity	0023	2.08	$105.88	$40.37	$21.18
20150	T	Excise epiphyseal bar	0051	28.56	$1,453.82	$675.24	$290.76
20200	T	Muscle biopsy	0020	8.44	$429.63	$130.53	$85.93
20205	T	Deep muscle biopsy	0021	11.82	$601.69	$236.51	$120.34
20206	T	Needle biopsy, muscle	0005	4.03	$205.14	$90.26	$41.03
20220	T	Bone biopsy, trocar/needle	0019	4.22	$214.81	$78.91	$42.96
20225	T	Bone biopsy, trocar/needle	0019	4.22	$214.81	$78.91	$42.96
20240	T	Bone biopsy, excisional	0022	13.91	$708.07	$292.94	$141.61
20245	T	Bone biopsy, excisional	0022	13.91	$708.07	$292.94	$141.61

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20250	T	Open bone biopsy	0049	15.84	$806.32	$356.95	$161.26
20251	T	Open bone biopsy	0049	15.84	$806.32	$356.95	$161.26
20500	T	Injection of sinus tract	0251	2.43	$123.70	$27.99	$24.74
20501	N	Inject sinus tract for x-ray					
20520	T	Removal of foreign body	0019	4.22	$214.81	$78.91	$42.96
20525	T	Removal of foreign body	0022	13.91	$708.07	$292.94	$141.61
*20526	T	Ther injection carpal tunnel	0204	2.24	$114.02	$43.33	$22.80
20550	T	Inject tendon/ligament/cyst	0204	2.24	$114.02	$43.33	$22.80
*20551	T	Inject tendon origin/insert	0204	2.24	$114.02	$43.33	$22.80
*20552	T	Inject trigger point, 1 or 2	0204	2.24	$114.02	$43.33	$22.80
*20553	T	Inject trigger points, > 3	0204	2.24	$114.02	$43.33	$22.80
20600	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20605	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20610	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20615	T	Treatment of bone cyst	0004	2.47	$125.73	$32.57	$25.15
20650	T	Insert and remove bone pin	0049	15.84	$806.32	$356.95	$161.26
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	0021	11.82	$601.69	$236.51	$120.34
20680	T	Removal of support implant	0022	13.91	$708.07	$292.94	$141.61
20690	T	Apply bone fixation device	0050	20.63	$1,050.15	$504.07	$210.03
20692	T	Apply bone fixation device	0050	20.63	$1,050.15	$504.07	$210.03
20693	T	Adjust bone fixation device	0049	15.84	$806.32	$356.95	$161.26
20694	T	Remove bone fixation device	0049	15.84	$806.32	$356.95	$161.26
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	0050	20.63	$1,050.15	$504.07	$210.03
20902	T	Removal of bone for graft	0050	20.63	$1,050.15	$504.07	$210.03
20910	T	Remove cartilage for graft	0026	12.62	$642.41	$277.92	$128.48
20912	T	Remove cartilage for graft	0026	12.62	$642.41	$277.92	$128.48
20920	T	Removal of fascia for graft	0026	12.62	$642.41	$277.92	$128.48
20922	T	Removal of fascia for graft	0026	12.62	$642.41	$277.92	$128.48
20924	T	Removal of tendon for graft	0050	20.63	$1,050.15	$504.07	$210.03
20926	T	Removal of tissue for graft	0026	12.62	$642.41	$277.92	$128.48
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					
20950	T	Fluid pressure, muscle	0006	2.18	$110.97	$33.95	$22.19
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	0049	15.84	$806.32	$356.95	$161.26
20979	A	Us bone stimulation					
20999	N	Musculoskeletal surgery					
21010	T	Incision of jaw joint	0254	17.37	$884.20	$272.41	$176.84
21015	T	Resection of facial tumor	0252	5.95	$302.88	$114.24	$60.58
21025	T	Excision of bone, lower jaw	0256	26.61	$1,354.56	$623.05	$270.91
21026	T	Excision of facial bone(s)	0256	26.61	$1,354.56	$623.05	$270.91
21029	T	Contour of face bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21030	T	Removal of face bone lesion	0254	17.37	$884.20	$272.41	$176.84
21031	T	Remove exostosis, mandible	0254	17.37	$884.20	$272.41	$176.84
21032	T	Remove exostosis, maxilla	0254	17.37	$884.20	$272.41	$176.84
21034	T	Removal of face bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21040	T	Removal of jaw bone lesion	0254	17.37	$884.20	$272.41	$176.84
21041	T	Removal of jaw bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21044	T	Removal of jaw bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21045	C	Extensive jaw surgery					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21050	T	Removal of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21060	T	Remove jaw joint cartilage	0256	26.61	$1,354.56	$623.05	$270.91
21070	T	Remove coronoid process	0256	26.61	$1,354.56	$623.05	$270.91
21076	T	Prepare face/oral prosthesis	0254	17.37	$884.20	$272.41	$176.84
21077	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21079	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21080	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21081	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21082	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21083	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21084	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21085	T	Prepare face/oral prosthesis	0253	12.33	$627.65	$284.00	$125.53
21086	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21087	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21088	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21089	T	Prepare face/oral prosthesis	0253	12.33	$627.65	$284.00	$125.53
21100	T	Maxillofacial fixation	0256	26.61	$1,354.56	$623.05	$270.91
21110	T	Interdental fixation	0252	5.95	$302.88	$114.24	$60.58
21116	N	Injection, jaw joint x-ray					
21120	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21121	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21122	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21123	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21125	T	Augmentation, lower jaw bone	0254	17.37	$884.20	$272.41	$176.84
21127	T	Augmentation, lower jaw bone	0256	26.61	$1,354.56	$623.05	$270.91
21137	T	Reduction of forehead	0254	17.37	$884.20	$272.41	$176.84
21138	T	Reduction of forehead	0256	26.61	$1,354.56	$623.05	$270.91
21139	T	Reduction of forehead	0256	26.61	$1,354.56	$623.05	$270.91
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					
21181	T	Contour cranial bone lesion	0254	17.37	$884.20	$272.41	$176.84
21182	C	Reconstruct cranial bone					
21183	C	Reconstruct cranial bone					
21184	C	Reconstruct cranial bone					
21188	C	Reconstruction of midface					
21193	C	Reconst lwr jaw w/o graft					
21194	C	Reconst lwr jaw w/graft					
21195	C	Reconst lwr jaw w/o fixation					
21196	C	Reconst lwr jaw w/fixation					
21198	T	Reconstr lwr jaw segment	0256	26.61	$1,354.56	$623.05	$270.91
21199	T	Reconstr lwr jaw w/advance	0256	26.61	$1,354.56	$623.05	$270.91
21206	T	Reconstruct upper jaw bone	0256	26.61	$1,354.56	$623.05	$270.91
21208	T	Augmentation of facial bones	0256	26.61	$1,354.56	$623.05	$270.91
21209	T	Reduction of facial bones	0256	26.61	$1,354.56	$623.05	$270.91
21210	T	Face bone graft	0256	26.61	$1,354.56	$623.05	$270.91
21215	T	Lower jaw bone graft	0256	26.61	$1,354.56	$623.05	$270.91
21230	T	Rib cartilage graft	0256	26.61	$1,354.56	$623.05	$270.91
21235	T	Ear cartilage graft	0254	17.37	$884.20	$272.41	$176.84
21240	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21242	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21243	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21244	T	Reconstruction of lower jaw	0256	26.61	$1,354.56	$623.05	$270.91
21245	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21246	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21249	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21261	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21263	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21267	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21268	C	Revise eye sockets					
21270	T	Augmentation, cheek bone	0256	26.61	$1,354.56	$623.05	$270.91
21275	T	Revision, orbitofacial bones	0256	26.61	$1,354.56	$623.05	$270.91
21280	T	Revision of eyelid	0256	26.61	$1,354.56	$623.05	$270.91
21282	T	Revision of eyelid	0253	12.33	$627.65	$284.00	$125.53
21295	T	Revision of jaw muscle/bone	0252	5.95	$302.88	$114.24	$60.58
21296	T	Revision of jaw muscle/bone	0254	17.37	$884.20	$272.41	$176.84
21299	T	Cranio/maxillofacial surgery	0253	12.33	$627.65	$284.00	$125.53
21300	T	Treatment of skull fracture	0253	12.33	$627.65	$284.00	$125.53
21310	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21315	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21320	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21325	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21330	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21335	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21336	T	Treat nasal septal fracture	0046	27.69	$1,409.53	$535.76	$281.91
21337	T	Treat nasal septal fracture	0253	12.33	$627.65	$284.00	$125.53
21338	T	Treat nasoethmoid fracture	0254	17.37	$884.20	$272.41	$176.84
21339	T	Treat nasoethmoid fracture	0254	17.37	$884.20	$272.41	$176.84
21340	T	Treatment of nose fracture	0256	26.61	$1,354.56	$623.05	$270.91
21343	C	Treatment of sinus fracture					
21344	C	Treatment of sinus fracture					
21345	T	Treat nose/jaw fracture	0254	17.37	$884.20	$272.41	$176.84
21346	C	Treat nose/jaw fracture					
21347	C	Treat nose/jaw fracture					
21348	C	Treat nose/jaw fracture					
21355	T	Treat cheek bone fracture	0256	26.61	$1,354.56	$623.05	$270.91
21356	C	Treat cheek bone fracture					
21360	C	Treat cheek bone fracture					
21365	C	Treat cheek bone fracture					
21366	C	Treat cheek bone fracture					
21385	C	Treat eye socket fracture					
21386	C	Treat eye socket fracture					
21387	C	Treat eye socket fracture					
21390	C	Treat eye socket fracture					
21395	C	Treat eye socket fracture					
21400	T	Treat eye socket fracture	0252	5.95	$302.88	$114.24	$60.58
21401	T	Treat eye socket fracture	0253	12.33	$627.65	$284.00	$125.53
21406	T	Treat eye socket fracture	0256	26.61	$1,354.56	$623.05	$270.91
21407	T	Treat eye socket fracture	0256	26.61	$1,354.56	$623.05	$270.91
21408	C	Treat eye socket fracture					
21421	T	Treat mouth roof fracture	0254	17.37	$884.20	$272.41	$176.84
21422	C	Treat mouth roof fracture					
21423	C	Treat mouth roof fracture					
21431	C	Treat craniofacial fracture					
21432	C	Treat craniofacial fracture					
21433	C	Treat craniofacial fracture					
21435	C	Treat craniofacial fracture					
21436	C	Treat craniofacial fracture					
21440	T	Treat dental ridge fracture	0254	17.37	$884.20	$272.41	$176.84
21445	T	Treat dental ridge fracture	0254	17.37	$884.20	$272.41	$176.84
21450	T	Treat lower jaw fracture	0251	2.43	$123.70	$27.99	$24.74
21451	T	Treat lower jaw fracture	0252	5.95	$302.88	$114.24	$60.58
21452	T	Treat lower jaw fracture	0253	12.33	$627.65	$284.00	$125.53
21453	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21454	T	Treat lower jaw fracture	0254	17.37	$884.20	$272.41	$176.84
21461	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21462	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21465	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21470	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21480	T	Reset dislocated jaw	0251	2.43	$123.70	$27.99	$24.74
21485	T	Reset dislocated jaw	0253	12.33	$627.65	$284.00	$125.53
21490	T	Repair dislocated jaw	0256	26.61	$1,354.56	$623.05	$270.91
21493	T	Treat hyoid bone fracture	0252	5.95	$302.88	$114.24	$60.58
21494	T	Treat hyoid bone fracture	0252	5.95	$302.88	$114.24	$60.58
21495	C	Treat hyoid bone fracture					
21497	T	Interdental wiring	0253	12.33	$627.65	$284.00	$125.53
21499	T	Head surgery procedure	0253	12.33	$627.65	$284.00	$125.53
21501	T	Drain neck/chest lesion	0008	10.93	$556.38	$113.67	$111.28
21502	T	Drain chest lesion	0049	15.84	$806.32	$356.95	$161.26
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	0019	4.22	$214.81	$78.91	$42.96
21555	T	Remove lesion, neck/chest	0022	13.91	$708.07	$292.94	$141.61

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21556	T	Remove lesion, neck/chest	0022	13.91	$708.07	$292.94	$141.61
21557	C	Remove tumor, neck/chest					
21600	T	Partial removal of rib	0050	20.63	$1,050.15	$504.07	$210.03
21610	T	Partial removal of rib	0050	20.63	$1,050.15	$504.07	$210.03
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	0006	2.18	$110.97	$33.95	$22.19
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	0008	10.93	$556.38	$113.67	$111.28
21725	T	Revision of neck muscle	0006	2.18	$110.97	$33.95	$22.19
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	0043	4.05	$206.16		$41.23
21805	T	Treatment of rib fracture	0046	27.69	$1,409.53	$535.76	$281.91
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	0044	2.52	$128.28	$38.08	$25.66
21825	C	Treat sternum fracture					
21899	T	Neck/chest surgery procedure	0252	5.95	$302.88	$114.24	$60.58
21920	T	Biopsy soft tissue of back	0019	4.22	$214.81	$78.91	$42.96
21925	T	Biopsy soft tissue of back	0022	13.91	$708.07	$292.94	$141.61
21930	T	Remove lesion, back or flank	0022	13.91	$708.07	$292.94	$141.61
21935	T	Remove tumor, back	0022	13.91	$708.07	$292.94	$141.61
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	0043	4.05	$206.16		$41.23
22310	T	Treat spine fracture	0043	4.05	$206.16		$41.23
22315	T	Treat spine fracture	0043	4.05	$206.16		$41.23
22318	C	Treat odontoid fx w/o graft					
22319	C	Treat odontoid fx w/graft					
22325	C	Treat spine fracture					
22326	C	Treat neck spine fracture					
22327	C	Treat thorax spine fracture					
22328	C	Treat each add spine fx					
22505	T	Manipulation of spine	0045	11.67	$594.05	$277.12	$118.81
22520	T	Percut vertebroplasty thor	0050	20.63	$1,050.15	$504.07	$210.03
22521	T	Percut vertebroplasty lumb	0050	20.63	$1,050.15	$504.07	$210.03
22522	T	Percut vertebroplasty addl	0050	20.63	$1,050.15	$504.07	$210.03
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22819	C	Kyphectomy, 3 or more					
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 pelv 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	0043	4.05	$206.16		$41.23
22900	T	Remove abdominal wall lesion	0022	13.91	$708.07	$292.94	$141.61
22999	T	Abdomen surgery procedure	0022	13.91	$708.07	$292.94	$141.61
23000	T	Removal of calcium deposits	0021	11.82	$601.69	$236.51	$120.34
23020	T	Release shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23030	T	Drain shoulder lesion	0008	10.93	$556.38	$113.67	$111.28
23031	T	Drain shoulder bursa	0008	10.93	$556.38	$113.67	$111.28
23035	C	Drain shoulder bone lesion					
23040	T	Exploratory shoulder surgery	0050	20.63	$1,050.15	$504.07	$210.03
23044	T	Exploratory shoulder surgery	0050	20.63	$1,050.15	$504.07	$210.03
23065	T	Biopsy shoulder tissues	0021	11.82	$601.69	$236.51	$120.34
23066	T	Biopsy shoulder tissues	0022	13.91	$708.07	$292.94	$141.61
23075	T	Removal of shoulder lesion	0021	11.82	$601.69	$236.51	$120.34
23076	T	Removal of shoulder lesion	0022	13.91	$708.07	$292.94	$141.61
23077	T	Remove tumor of shoulder	0022	13.91	$708.07	$292.94	$141.61
23100	T	Biopsy of shoulder joint	0049	15.84	$806.32	$356.95	$161.26
23101	T	Shoulder joint surgery	0050	20.63	$1,050.15	$504.07	$210.03
23105	T	Remove shoulder joint lining	0050	20.63	$1,050.15	$504.07	$210.03
23106	T	Incision of collarbone joint	0050	20.63	$1,050.15	$504.07	$210.03
23107	T	Explore treat shoulder joint	0050	20.63	$1,050.15	$504.07	$210.03
23120	T	Partial removal, collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23125	C	Removal of collar bone					
23130	T	Remove shoulder bone, part	0051	28.56	$1,453.82	$675.24	$290.76
23140	T	Removal of bone lesion	0049	15.84	$806.32	$356.95	$161.26
23145	T	Removal of bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23146	T	Removal of bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23150	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23155	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23156	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23170	T	Remove collar bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23172	T	Remove shoulder blade lesion	0050	20.63	$1,050.15	$504.07	$210.03
23174	T	Remove humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23180	T	Remove collar bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23182	T	Remove shoulder blade lesion	0050	20.63	$1,050.15	$504.07	$210.03
23184	T	Remove humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23190	T	Partial removal of scapula	0050	20.63	$1,050.15	$504.07	$210.03
23195	C	Removal of head of humerus					
23200	C	Removal of collar bone					
23210	C	Removal of shoulder blade					
23220	C	Partial removal of humerus					
23221	C	Partial removal of humerus					
23222	C	Partial removal of humerus					
23330	T	Remove shoulder foreign body	0019	4.22	$214.81	$78.91	$42.96
23331	T	Remove shoulder foreign body	0022	13.91	$708.07	$292.94	$141.61
23332	C	Remove shoulder foreign body					
23350	N	Injection for shoulder x-ray					
23395	C	Muscle transfer,shoulder/arm					
23397	C	Muscle transfers					
23400	C	Fixation of shoulder blade					
23405	T	Incision of tendon & muscle	0050	20.63	$1,050.15	$504.07	$210.03
23406	T	Incise tendon(s) & muscle(s)	0050	20.63	$1,050.15	$504.07	$210.03
23410	T	Repair of tendon(s)	0052	35.94	$1,829.49	$930.91	$365.90
23412	T	Repair of tendon(s)	0052	35.94	$1,829.49	$930.91	$365.90
23415	T	Release of shoulder ligament	0051	28.56	$1,453.82	$675.24	$290.76
23420	T	Repair of shoulder	0052	35.94	$1,829.49	$930.91	$365.90
23430	T	Repair biceps tendon	0052	35.94	$1,829.49	$930.91	$365.90
23440	T	Remove/transplant tendon	0052	35.94	$1,829.49	$930.91	$365.90
23450	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23455	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23460	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23462	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23465	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23466	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23470	T	Reconstruct shoulder joint	0048	43.19	$2,198.54	$725.94	$439.71
23472	C	Reconstruct shoulder joint					
23480	T	Revision of collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23485	T	Revision of collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23490	T	Reinforce clavicle	0051	28.56	$1,453.82	$675.24	$290.76
23491	T	Reinforce shoulder bones	0051	28.56	$1,453.82	$675.24	$290.76
23500	T	Treat clavicle fracture	0043	4.05	$206.16		$41.23
23505	T	Treat clavicle fracture	0043	4.05	$206.16		$41.23
23515	T	Treat clavicle fracture	0046	27.69	$1,409.53	$535.76	$281.91
23520	T	Treat clavicle dislocation	0044	2.52	$128.28	$38.08	$25.66
23525	T	Treat clavicle dislocation	0043	4.05	$206.16		$41.23
23530	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23532	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23540	T	Treat clavicle dislocation	0044	2.52	$128.28	$38.08	$25.66
23545	T	Treat clavicle dislocation	0043	4.05	$206.16		$41.23
23550	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23552	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23570	T	Treat shoulder blade fx	0043	4.05	$206.16		$41.23
23575	T	Treat shoulder blade fx	0044	2.52	$128.28	$38.08	$25.66
23585	T	Treat scapula fracture	0046	27.69	$1,409.53	$535.76	$281.91
23600	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23605	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23615	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23616	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23620	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23625	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23630	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23650	T	Treat shoulder dislocation	0043	4.05	$206.16		$41.23
23655	T	Treat shoulder dislocation	0045	11.67	$594.05	$277.12	$118.81
23660	T	Treat shoulder dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23665	T	Treat dislocation/fracture	0044	2.52	$128.28	$38.08	$25.66
23670	T	Treat dislocation/fracture	0046	27.69	$1,409.53	$535.76	$281.91
23675	T	Treat dislocation/fracture	0044	2.52	$128.28	$38.08	$25.66
23680	T	Treat dislocation/fracture	0046	27.69	$1,409.53	$535.76	$281.91
23700	T	Fixation of shoulder	0045	11.67	$594.05	$277.12	$118.81
23800	T	Fusion of shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23802	T	Fusion of shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23900	C	Amputation of arm & girdle					
23920	C	Amputation at shoulder joint					
23921	T	Amputation follow-up surgery	0026	12.62	$642.41	$277.92	$128.48
23929	T	Shoulder surgery procedure	0043	4.05	$206.16		$41.23
23930	T	Drainage of arm lesion	0008	10.93	$556.38	$113.67	$111.28
23931	T	Drainage of arm bursa	0006	2.18	$110.97	$33.95	$22.19
23935	T	Drain arm/elbow bone lesion	0049	15.84	$806.32	$356.95	$161.26
24000	T	Exploratory elbow surgery	0050	20.63	$1,050.15	$504.07	$210.03
24006	T	Release elbow joint	0050	20.63	$1,050.15	$504.07	$210.03
24065	T	Biopsy arm/elbow soft tissue	0020	8.44	$429.63	$130.53	$85.93
24066	T	Biopsy arm/elbow soft tissue	0021	11.82	$601.69	$236.51	$120.34
24075	T	Remove arm/elbow lesion	0021	11.82	$601.69	$236.51	$120.34
24076	T	Remove arm/elbow lesion	0022	13.91	$708.07	$292.94	$141.61
24077	T	Remove tumor of arm/elbow	0022	13.91	$708.07	$292.94	$141.61
24100	T	Biopsy elbow joint lining	0049	15.84	$806.32	$356.95	$161.26
24101	T	Explore/treat elbow joint	0050	20.63	$1,050.15	$504.07	$210.03
24102	T	Remove elbow joint lining	0050	20.63	$1,050.15	$504.07	$210.03
24105	T	Removal of elbow bursa	0049	15.84	$806.32	$356.95	$161.26
24110	T	Remove humerus lesion	0049	15.84	$806.32	$356.95	$161.26
24115	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24116	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24120	T	Remove elbow lesion	0049	15.84	$806.32	$356.95	$161.26
24125	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24126	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24130	T	Removal of head of radius	0050	20.63	$1,050.15	$504.07	$210.03
24134	T	Removal of arm bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24136	T	Remove radius bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24138	T	Remove elbow bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24140	T	Partial removal of arm bone	0050	20.63	$1,050.15	$504.07	$210.03
24145	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
24147	T	Partial removal of elbow	0050	20.63	$1,050.15	$504.07	$210.03
24149	C	Radical resection of elbow					
24150	C	Extensive humerus surgery					
24151	C	Extensive humerus surgery					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24152	C	Extensive radius surgery	.....	.....	.....	.....	.....
24153	C	Extensive radius surgery	.....	.....	.....	.....	.....
24155	T	Removal of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24160	T	Remove elbow joint implant	0050	20.63	$1,050.15	$504.07	$210.03
24164	T	Remove radius head implant	0050	20.63	$1,050.15	$504.07	$210.03
24200	T	Removal of arm foreign body	0019	4.22	$214.81	$78.91	$42.96
24201	T	Removal of arm foreign body	0021	11.82	$601.69	$236.51	$120.34
24220	N	Injection for elbow x-ray	.....	.....	.....	.....	.....
*24300	T	Manipulate elbow w/anesth	0045	11.67	$594.05	$277.12	$118.81
24301	T	Muscle/tendon transfer	0050	20.63	$1,050.15	$504.07	$210.03
24305	T	Arm tendon lengthening	0050	20.63	$1,050.15	$504.07	$210.03
24310	T	Revision of arm tendon	0049	15.84	$806.32	$356.95	$161.26
24320	T	Repair of arm tendon	0051	28.56	$1,453.82	$675.24	$290.76
24330	T	Revision of arm muscles	0051	28.56	$1,453.82	$675.24	$290.76
24331	T	Revision of arm muscles	0051	28.56	$1,453.82	$675.24	$290.76
*24332	T	Tenolysis, triceps	0049	15.84	$806.32	$356.95	$161.26
24340	T	Repair of biceps tendon	0051	28.56	$1,453.82	$675.24	$290.76
24341	T	Repair arm tendon/muscle	0051	28.56	$1,453.82	$675.24	$290.76
24342	T	Repair of ruptured tendon	0051	28.56	$1,453.82	$675.24	$290.76
*24343	T	Repr elbow lat ligmnt w/tiss	0050	20.63	$1,050.15	$504.07	$210.03
*24344	T	Reconstruct elbow lat ligmnt	0051	28.56	$1,453.82	$675.24	$290.76
*24345	T	Repr elbw med ligmnt w/tiss	0050	20.63	$1,050.15	$504.07	$210.03
*24346	T	Reconstruct elbow med ligmnt	0051	28.56	$1,453.82	$675.24	$290.76
24350	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24351	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24352	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24354	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24356	T	Revision of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24360	T	Reconstruct elbow joint	0047	26.36	$1,341.83	$537.03	$268.37
24361	T	Reconstruct elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24362	T	Reconstruct elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24363	T	Replace elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24365	T	Reconstruct head of radius	0047	26.36	$1,341.83	$537.03	$268.37
24366	T	Reconstruct head of radius	0048	43.19	$2,198.54	$725.94	$439.71
24400	T	Revision of humerus	0050	20.63	$1,050.15	$504.07	$210.03
24410	T	Revision of humerus	0050	20.63	$1,050.15	$504.07	$210.03
24420	T	Revision of humerus	0051	28.56	$1,453.82	$675.24	$290.76
24430	T	Repair of humerus	0051	28.56	$1,453.82	$675.24	$290.76
24435	T	Repair humerus with graft	0051	28.56	$1,453.82	$675.24	$290.76
24470	T	Revision of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24495	T	Decompression of forearm	0050	20.63	$1,050.15	$504.07	$210.03
24498	T	Reinforce humerus	0051	28.56	$1,453.82	$675.24	$290.76
24500	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24505	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24515	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24516	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24530	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24535	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24538	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24545	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24546	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24560	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24565	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24566	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24575	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24576	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24577	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24579	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24582	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24586	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24587	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24600	T	Treat elbow dislocation	0044	2.52	$128.28	$38.08	$25.66
24605	T	Treat elbow dislocation	0045	11.67	$594.05	$277.12	$118.81
24615	T	Treat elbow dislocation	0046	27.69	$1,409.53	$535.76	$281.91
24620	T	Treat elbow fracture	0044	2.52	$128.28	$38.08	$25.66
24635	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24640	T	Treat elbow dislocation	0044	2.52	$128.28	$38.08	$25.66
24650	T	Treat radius fracture	0044	2.52	$128.28	$38.08	$25.66
24655	T	Treat radius fracture	0044	2.52	$128.28	$38.08	$25.66
24665	T	Treat radius fracture	0046	27.69	$1,409.53	$535.76	$281.91
24666	T	Treat radius fracture	0046	27.69	$1,409.53	$535.76	$281.91
24670	T	Treat ulnar fracture	0044	2.52	$128.28	$38.08	$25.66
24675	T	Treat ulnar fracture	0044	2.52	$128.28	$38.08	$25.66
24685	T	Treat ulnar fracture	0046	27.69	$1,409.53	$535.76	$281.91
24800	T	Fusion of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24802	T	Fusion/graft of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24900	C	Amputation of upper arm	.....	.....	.....	.....	.....
24920	C	Amputation of upper arm	.....	.....	.....	.....	.....
24925	T	Amputation follow-up surgery	0049	15.84	$806.32	$356.95	$161.26
24930	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
24931	C	Amputate upper arm & implant	.....	.....	.....	.....	.....
24935	T	Revision of amputation	0052	35.94	$1,829.49	$930.91	$365.90
24940	C	Revision of upper arm	.....	.....	.....	.....	.....
24999	T	Upper arm/elbow surgery	0044	2.52	$128.28	$38.08	$25.66
25000	T	Incision of tendon sheath	0049	15.84	$806.32	$356.95	$161.26
*25001	T	Incise flexor carpi radialis	0049	15.84	$806.32	$356.95	$161.26
25020	T	Decompression of forearm	0049	15.84	$806.32	$356.95	$161.26
25023	T	Decompression of forearm	0050	20.63	$1,050.15	$504.07	$210.03
*25024	T	Decompress forearm 2 spaces	0050	20.63	$1,050.15	$504.07	$210.03
*25025	T	Decompress forarm 2 spaces	0050	20.63	$1,050.15	$504.07	$210.03
25028	T	Drainage of forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25031	T	Drainage of forearm bursa	0049	15.84	$806.32	$356.95	$161.26
25035	T	Treat forearm bone lesion	0049	15.84	$806.32	$356.95	$161.26
25040	T	Explore/treat wrist joint	0050	20.63	$1,050.15	$504.07	$210.03
25065	T	Biopsy forearm soft tissues	0021	11.82	$601.69	$236.51	$120.34
25066	T	Biopsy forearm soft tissues	0022	13.91	$708.07	$292.94	$141.61
25075	T	Removal of forearm lesion	0020	8.44	$429.63	$130.53	$85.93
25076	T	Removal of forearm lesion	0022	13.91	$708.07	$292.94	$141.61
25077	T	Remove tumor, forearm/wrist	0022	13.91	$708.07	$292.94	$141.61
25085	T	Incision of wrist capsule	0049	15.84	$806.32	$356.95	$161.26
25100	T	Biopsy of wrist joint	0049	15.84	$806.32	$356.95	$161.26
25101	T	Explore/treat wrist joint	0050	20.63	$1,050.15	$504.07	$210.03
25105	T	Remove wrist joint lining	0050	20.63	$1,050.15	$504.07	$210.03
25107	T	Remove wrist joint cartilage	0050	20.63	$1,050.15	$504.07	$210.03
25110	T	Remove wrist tendon lesion	0049	15.84	$806.32	$356.95	$161.26
25111	T	Remove wrist tendon lesion	0053	11.69	$595.07	$253.49	$119.01
25112	T	Reremove wrist tendon lesion	0053	11.69	$595.07	$253.49	$119.01
25115	T	Remove wrist/forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25116	T	Remove wrist/forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25118	T	Excise wrist tendon sheath	0050	20.63	$1,050.15	$504.07	$210.03
25119	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25120	T	Removal of forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25125	T	Remove/graft forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25126	T	Remove/graft forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25130	T	Removal of wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25135	T	Remove & graft wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25136	T	Remove & graft wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25145	T	Remove forearm bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
25150	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25151	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
25170	C	Extensive forearm surgery	.....	.....	.....	.....	.....
25210	T	Removal of wrist bone	0054	19.83	$1,009.43	$472.33	$201.89
25215	T	Removal of wrist bones	0054	19.83	$1,009.43	$472.33	$201.89
25230	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
25240	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25246	N	Injection for wrist x-ray	.....	.....	.....	.....	.....
25248	T	Remove forearm foreign body	0049	15.84	$806.32	$356.95	$161.26
25250	T	Removal of wrist prosthesis	0050	20.63	$1,050.15	$504.07	$210.03
25251	T	Removal of wrist prosthesis	0050	20.63	$1,050.15	$504.07	$210.03
*25259	T	Manipulate wrist w/anesthes	0044	2.52	$128.28	$38.08	$25.66
25260	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25263	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25265	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25270	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25272	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25274	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
*25275	T	Repair forearm tendon sheath	0050	20.63	$1,050.15	$504.07	$210.03
25280	T	Revise wrist/forearm tendon	0050	20.63	$1,050.15	$504.07	$210.03
25290	T	Incise wrist/forearm tendon	0050	20.63	$1,050.15	$504.07	$210.03
25295	T	Release wrist/forearm tendon	0049	15.84	$806.32	$356.95	$161.26
25300	T	Fusion of tendons at wrist	0050	20.63	$1,050.15	$504.07	$210.03
25301	T	Fusion of tendons at wrist	0050	20.63	$1,050.15	$504.07	$210.03
25310	T	Transplant forearm tendon	0051	28.56	$1,453.82	$675.24	$290.76
25312	T	Transplant forearm tendon	0051	28.56	$1,453.82	$675.24	$290.76
25315	T	Revise palsy hand tendon(s)	0051	28.56	$1,453.82	$675.24	$290.76
25316	T	Revise palsy hand tendon(s)	0051	28.56	$1,453.82	$675.24	$290.76
25320	T	Repair/revise wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25332	T	Revise wrist joint	0047	26.36	$1,341.83	$537.03	$268.37
25335	T	Realignment of hand	0051	28.56	$1,453.82	$675.24	$290.76
25337	T	Reconstruct ulna/radioulnar	0051	28.56	$1,453.82	$675.24	$290.76

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25350	T	Revision of radius	0051	28.56	$1,453.82	$675.24	$290.76
25355	T	Revision of radius	0051	28.56	$1,453.82	$675.24	$290.76
25360	T	Revision of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25365	T	Revise radius & ulna	0050	20.63	$1,050.15	$504.07	$210.03
25370	T	Revise radius or ulna	0051	28.56	$1,453.82	$675.24	$290.76
25375	T	Revise radius & ulna	0051	28.56	$1,453.82	$675.24	$290.76
25390	C	Shorten radius or ulna					
25391	C	Lengthen radius or ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
*25394	T	Repair carpal bone, shorten	0053	11.69	$595.07	$253.49	$119.01
25400	T	Repair radius or ulna	0050	20.63	$1,050.15	$504.07	$210.03
25405	T	Repair/graft radius or ulna	0050	20.63	$1,050.15	$504.07	$210.03
25415	T	Repair radius & ulna	0050	20.63	$1,050.15	$504.07	$210.03
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	0051	28.56	$1,453.82	$675.24	$290.76
25426	T	Repair/graft radius & ulna	0051	28.56	$1,453.82	$675.24	$290.76
*25430	T	Vasc graft into carpal bone	0054	19.83	$1,009.43	$472.33	$201.89
*25431	T	Repair nonunion carpal bone	0054	19.83	$1,009.43	$472.33	$201.89
25440	T	Repair/graft wrist bone	0051	28.56	$1,453.82	$675.24	$290.76
25441	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25442	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25443	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25444	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25445	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25446	T	Wrist replacement	0048	43.19	$2,198.54	$725.94	$439.71
25447	T	Repair wrist joint(s)	0047	26.36	$1,341.83	$537.03	$268.37
25449	T	Remove wrist joint implant	0047	26.36	$1,341.83	$537.03	$268.37
25450	T	Revision of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25455	T	Revision of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25490	T	Reinforce radius	0051	28.56	$1,453.82	$675.24	$290.76
25491	T	Reinforce ulna	0051	28.56	$1,453.82	$675.24	$290.76
25492	T	Reinforce radius and ulna	0051	28.56	$1,453.82	$675.24	$290.76
25500	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25505	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25515	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25520	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25525	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25526	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25530	T	Treat fracture of ulna	0044	2.52	$128.28	$38.08	$25.66
25535	T	Treat fracture of ulna	0044	2.52	$128.28	$38.08	$25.66
25545	T	Treat fracture of ulna	0046	27.69	$1,409.53	$535.76	$281.91
25560	T	Treat fracture radius & ulna	0044	2.52	$128.28	$38.08	$25.66
25565	T	Treat fracture radius & ulna	0044	2.52	$128.28	$38.08	$25.66
25574	T	Treat fracture radius & ulna	0046	27.69	$1,409.53	$535.76	$281.91
25575	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25600	T	Treat fracture radius/ulna	0044	2.52	$128.28	$38.08	$25.66
25605	T	Treat fracture radius/ulna	0044	2.52	$128.28	$38.08	$25.66
25611	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25620	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25622	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25624	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25628	T	Treat wrist bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
25630	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25635	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25645	T	Treat wrist bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
25650	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
*25651	T	Pin ulnar styloid fracture	0046	27.69	$1,409.53	$535.76	$281.91
*25652	T	Treat fracture ulnar styloid	0046	27.69	$1,409.53	$535.76	$281.91
25660	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25670	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
*25671	T	Pin radioulnar dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25675	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25676	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25680	T	Treat wrist fracture	0044	2.52	$128.28	$38.08	$25.66
25685	T	Treat wrist fracture	0046	27.69	$1,409.53	$535.76	$281.91
25690	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25695	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25800	T	Fusion of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25805	T	Fusion/graft of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25810	T	Fusion/graft of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25820	T	Fusion of hand bones	0053	11.69	$595.07	$253.49	$119.01
25825	T	Fuse hand bones with graft	0054	19.83	$1,009.43	$472.33	$201.89
25830	T	Fusion, radioulnar jnt/ulna	0051	28.56	$1,453.82	$675.24	$290.76
25900	C	Amputation of forearm					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25905	C	Amputation of forearm	.....	.....	.....	.....	.....
25907	T	Amputation follow-up surgery	0049	15.84	$806.32	$356.95	$161.26
25909	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25915	C	Amputation of forearm	.....	.....	.....	.....	.....
25920	C	Amputate hand at wrist	.....	.....	.....	.....	.....
25922	T	Amputate hand at wrist	0049	15.84	$806.32	$356.95	$161.26
25924	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25927	C	Amputation of hand	.....	.....	.....	.....	.....
25929	T	Amputation follow-up surgery	0026	12.62	$642.41	$277.92	$128.48
25931	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25999	T	Forearm or wrist surgery	0044	2.52	$128.28	$38.08	$25.66
26010	T	Drainage of finger abscess	0006	2.18	$110.97	$33.95	$22.19
26011	T	Drainage of finger abscess	0007	6.75	$343.60	$72.03	$68.72
26020	T	Drain hand tendon sheath	0053	11.69	$595.07	$253.49	$119.01
26025	T	Drainage of palm bursa	0053	11.69	$595.07	$253.49	$119.01
26030	T	Drainage of palm bursa(s)	0053	11.69	$595.07	$253.49	$119.01
26034	T	Treat hand bone lesion	0053	11.69	$595.07	$253.49	$119.01
26035	T	Decompress fingers/hand	0053	11.69	$595.07	$253.49	$119.01
26037	T	Decompress fingers/hand	0053	11.69	$595.07	$253.49	$119.01
26040	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26045	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26055	T	Incise finger tendon sheath	0053	11.69	$595.07	$253.49	$119.01
26060	T	Incision of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26070	T	Explore/treat hand joint	0053	11.69	$595.07	$253.49	$119.01
26075	T	Explore/treat finger joint	0053	11.69	$595.07	$253.49	$119.01
26080	T	Explore/treat finger joint	0053	11.69	$595.07	$253.49	$119.01
26100	T	Biopsy hand joint lining	0053	11.69	$595.07	$253.49	$119.01
26105	T	Biopsy finger joint lining	0053	11.69	$595.07	$253.49	$119.01
26110	T	Biopsy finger joint lining	0053	11.69	$595.07	$253.49	$119.01
26115	T	Removal of hand lesion	0022	13.91	$708.07	$292.94	$141.61
26116	T	Removal of hand lesion	0022	13.91	$708.07	$292.94	$141.61
26117	T	Remove tumor, hand/finger	0022	13.91	$708.07	$292.94	$141.61
26121	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26123	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26125	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26130	T	Remove wrist joint lining	0053	11.69	$595.07	$253.49	$119.01
26135	T	Revise finger joint, each	0054	19.83	$1,009.43	$472.33	$201.89
26140	T	Revise finger joint, each	0053	11.69	$595.07	$253.49	$119.01
26145	T	Tendon excision, palm/finger	0053	11.69	$595.07	$253.49	$119.01
26160	T	Remove tendon sheath lesion	0053	11.69	$595.07	$253.49	$119.01
26170	T	Removal of palm tendon, each	0053	11.69	$595.07	$253.49	$119.01
26180	T	Removal of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26185	T	Remove finger bone	0053	11.69	$595.07	$253.49	$119.01
26200	T	Remove hand bone lesion	0053	11.69	$595.07	$253.49	$119.01
26205	T	Remove/graft bone lesion	0054	19.83	$1,009.43	$472.33	$201.89
26210	T	Removal of finger lesion	0053	11.69	$595.07	$253.49	$119.01
26215	T	Remove/graft finger lesion	0053	11.69	$595.07	$253.49	$119.01
26230	T	Partial removal of hand bone	0053	11.69	$595.07	$253.49	$119.01
26235	T	Partial removal, finger bone	0053	11.69	$595.07	$253.49	$119.01
26236	T	Partial removal, finger bone	0053	11.69	$595.07	$253.49	$119.01
26250	T	Extensive hand surgery	0053	11.69	$595.07	$253.49	$119.01
26255	T	Extensive hand surgery	0054	19.83	$1,009.43	$472.33	$201.89
26260	T	Extensive finger surgery	0053	11.69	$595.07	$253.49	$119.01
26261	T	Extensive finger surgery	0053	11.69	$595.07	$253.49	$119.01
26262	T	Partial removal of finger	0053	11.69	$595.07	$253.49	$119.01
26320	T	Removal of implant from hand	0020	8.44	$429.63	$130.53	$85.93
*26340	T	Manipulate finger w/anesth	0043	4.05	$206.16	.....	$41.23
26350	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26352	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26356	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26357	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26358	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26370	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26372	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26373	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26390	T	Revise hand/finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26392	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26410	T	Repair hand tendon	0053	11.69	$595.07	$253.49	$119.01
26412	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26415	T	Excision, hand/finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26416	T	Graft hand or finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26418	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26420	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26426	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26428	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26432	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26433	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26434	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26437	T	Realignment of tendons	0053	11.69	$595.07	$253.49	$119.01
26440	T	Release palm/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26442	T	Release palm & finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26445	T	Release hand/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26449	T	Release forearm/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26450	T	Incision of palm tendon	0053	11.69	$595.07	$253.49	$119.01
26455	T	Incision of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26460	T	Incise hand/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26471	T	Fusion of finger tendons	0053	11.69	$595.07	$253.49	$119.01
26474	T	Fusion of finger tendons	0053	11.69	$595.07	$253.49	$119.01
26476	T	Tendon lengthening	0053	11.69	$595.07	$253.49	$119.01
26477	T	Tendon shortening	0053	11.69	$595.07	$253.49	$119.01
26478	T	Lengthening of hand tendon	0053	11.69	$595.07	$253.49	$119.01
26479	T	Shortening of hand tendon	0053	11.69	$595.07	$253.49	$119.01
26480	T	Transplant hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26483	T	Transplant/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26485	T	Transplant palm tendon	0054	19.83	$1,009.43	$472.33	$201.89
26489	T	Transplant/graft palm tendon	0054	19.83	$1,009.43	$472.33	$201.89
26490	T	Revise thumb tendon	0054	19.83	$1,009.43	$472.33	$201.89
26492	T	Tendon transfer with graft	0054	19.83	$1,009.43	$472.33	$201.89
26494	T	Hand tendon/muscle transfer	0054	19.83	$1,009.43	$472.33	$201.89
26496	T	Revise thumb tendon	0054	19.83	$1,009.43	$472.33	$201.89
26497	T	Finger tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26498	T	Finger tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26499	T	Revision of finger	0054	19.83	$1,009.43	$472.33	$201.89
26500	T	Hand tendon reconstruction	0053	11.69	$595.07	$253.49	$119.01
26502	T	Hand tendon reconstruction	0054	19.83	$1,009.43	$472.33	$201.89
26504	T	Hand tendon reconstruction	0054	19.83	$1,009.43	$472.33	$201.89
26508	T	Release thumb contracture	0053	11.69	$595.07	$253.49	$119.01
26510	T	Thumb tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26516	T	Fusion of knuckle joint	0054	19.83	$1,009.43	$472.33	$201.89
26517	T	Fusion of knuckle joints	0054	19.83	$1,009.43	$472.33	$201.89
26518	T	Fusion of knuckle joints	0054	19.83	$1,009.43	$472.33	$201.89
26520	T	Release knuckle contracture	0053	11.69	$595.07	$253.49	$119.01
26525	T	Release finger contracture	0053	11.69	$595.07	$253.49	$119.01
26530	T	Revise knuckle joint	0047	26.36	$1,341.83	$537.03	$268.37
26531	T	Revise knuckle with implant	0048	43.19	$2,198.54	$725.94	$439.71
26535	T	Revise finger joint	0047	26.36	$1,341.83	$537.03	$268.37
26536	T	Revise/implant finger joint	0048	43.19	$2,198.54	$725.94	$439.71
26540	T	Repair hand joint	0053	11.69	$595.07	$253.49	$119.01
26541	T	Repair hand joint with graft	0054	19.83	$1,009.43	$472.33	$201.89
26542	T	Repair hand joint with graft	0053	11.69	$595.07	$253.49	$119.01
26545	T	Reconstruct finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26546	T	Repair nonunion hand	0054	19.83	$1,009.43	$472.33	$201.89
26548	T	Reconstruct finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26550	T	Construct thumb replacement	0054	19.83	$1,009.43	$472.33	$201.89
26551	C	Great toe-hand transfer	.....	.....	.....	.....	.....
26553	C	Single transfer, toe-hand	.....	.....	.....	.....	.....
26554	C	Double transfer, toe-hand	.....	.....	.....	.....	.....
26555	T	Positional change of finger	0054	19.83	$1,009.43	$472.33	$201.89
26556	C	Toe joint transfer	.....	.....	.....	.....	.....
26560	T	Repair of web finger	0053	11.69	$595.07	$253.49	$119.01
26561	T	Repair of web finger	0054	19.83	$1,009.43	$472.33	$201.89
26562	T	Repair of web finger	0054	19.83	$1,009.43	$472.33	$201.89
26565	T	Correct metacarpal flaw	0054	19.83	$1,009.43	$472.33	$201.89
26567	T	Correct finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26568	T	Lengthen metacarpal/finger	0054	19.83	$1,009.43	$472.33	$201.89
26580	T	Repair hand deformity	0054	19.83	$1,009.43	$472.33	$201.89
26585	D	Repair finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26587	T	Reconstruct extra finger	0053	11.69	$595.07	$253.49	$119.01
26590	T	Repair finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26591	T	Repair muscles of hand	0054	19.83	$1,009.43	$472.33	$201.89
26593	T	Release muscles of hand	0053	11.69	$595.07	$253.49	$119.01
26596	T	Excision constricting tissue	0054	19.83	$1,009.43	$472.33	$201.89
26597	D	Release of scar contracture	0054	19.83	$1,009.43	$472.33	$201.89
26600	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26605	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26607	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26608	T	Treat metacarpal fracture	0046	27.69	$1,409.53	$535.76	$281.91
26615	T	Treat metacarpal fracture	0046	27.69	$1,409.53	$535.76	$281.91
26641	T	Treat thumb dislocation	0044	2.52	$128.28	$38.08	$25.66
26645	T	Treat thumb fracture	0044	2.52	$128.28	$38.08	$25.66

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26650	T	Treat thumb fracture	0046	27.69	$1,409.53	$535.76	$281.91
26665	T	Treat thumb fracture	0046	27.69	$1,409.53	$535.76	$281.91
26670	T	Treat hand dislocation	0044	2.52	$128.28	$38.08	$25.66
26675	T	Treat hand dislocation	0044	2.52	$128.28	$38.08	$25.66
26676	T	Pin hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26685	T	Treat hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26686	T	Treat hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26700	T	Treat knuckle dislocation	0043	4.05	$206.16	.....	$41.23
26705	T	Treat knuckle dislocation	0044	2.52	$128.28	$38.08	$25.66
26706	T	Pin knuckle dislocation	0044	2.52	$128.28	$38.08	$25.66
26715	T	Treat knuckle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26720	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26725	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26727	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26735	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26740	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26742	T	Treat finger fracture, each	0044	2.52	$128.28	$38.08	$25.66
26746	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26750	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26755	T	Treat finger fracture, each	0043	4.05	$206.16	.....	$41.23
26756	T	Pin finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26765	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26770	T	Treat finger dislocation	0043	4.05	$206.16	.....	$41.23
26775	T	Treat finger dislocation	0045	11.67	$594.05	$277.12	$118.81
26776	T	Pin finger dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26785	T	Treat finger dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26820	T	Thumb fusion with graft	0054	19.83	$1,009.43	$472.33	$201.89
26841	T	Fusion of thumb	0054	19.83	$1,009.43	$472.33	$201.89
26842	T	Thumb fusion with graft	0054	19.83	$1,009.43	$472.33	$201.89
26843	T	Fusion of hand joint	0054	19.83	$1,009.43	$472.33	$201.89
26844	T	Fusion/graft of hand joint	0054	19.83	$1,009.43	$472.33	$201.89
26850	T	Fusion of knuckle	0054	19.83	$1,009.43	$472.33	$201.89
26852	T	Fusion of knuckle with graft	0054	19.83	$1,009.43	$472.33	$201.89
26860	T	Fusion of finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26861	T	Fusion of finger jnt, add-on	0054	19.83	$1,009.43	$472.33	$201.89
26862	T	Fusion/graft of finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26863	T	Fuse/graft added joint	0054	19.83	$1,009.43	$472.33	$201.89
26910	T	Amputate metacarpal bone	0054	19.83	$1,009.43	$472.33	$201.89
26951	T	Amputation of finger/thumb	0053	11.69	$595.07	$253.49	$119.01
26952	T	Amputation of finger/thumb	0053	11.69	$595.07	$253.49	$119.01
26989	T	Hand/finger surgery	0043	4.05	$206.16	.....	$41.23
26990	T	Drainage of pelvis lesion	0049	15.84	$806.32	$356.95	$161.26
26991	T	Drainage of pelvis bursa	0049	15.84	$806.32	$356.95	$161.26
26992	C	Drainage of bone lesion	.....	.....	.....	.....	.....
27000	T	Incision of hip tendon	0049	15.84	$806.32	$356.95	$161.26
27001	T	Incision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
27003	T	Incision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
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	0051	28.56	$1,453.82	$675.24	$290.76
27035	C	Denervation of hip joint	.....	.....	.....	.....	.....
27036	C	Excision of hip joint/muscle	.....	.....	.....	.....	.....
27040	T	Biopsy of soft tissues	0021	11.82	$601.69	$236.51	$120.34
27041	T	Biopsy of soft tissues	0022	13.91	$708.07	$292.94	$141.61
27047	T	Remove hip/pelvis lesion	0022	13.91	$708.07	$292.94	$141.61
27048	T	Remove hip/pelvis lesion	0022	13.91	$708.07	$292.94	$141.61
27049	T	Remove tumor, hip/pelvis	0022	13.91	$708.07	$292.94	$141.61
27050	T	Biopsy of sacroiliac joint	0049	15.84	$806.32	$356.95	$161.26
27052	T	Biopsy of hip joint	0049	15.84	$806.32	$356.95	$161.26
27054	C	Removal of hip joint lining	.....	.....	.....	.....	.....
27060	T	Removal of ischial bursa	0049	15.84	$806.32	$356.95	$161.26
27062	T	Remove femur lesion/bursa	0049	15.84	$806.32	$356.95	$161.26
27065	T	Removal of hip bone lesion	0049	15.84	$806.32	$356.95	$161.26
27066	T	Removal of hip bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27067	T	Remove/graft hip bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
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	.....	.....	.....	.....	.....
27080	T	Removal of tail bone	0050	20.63	$1,050.15	$504.07	$210.03

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27086	T	Remove hip foreign body	0019	4.22	$214.81	$78.91	$42.96
27087	T	Remove hip foreign body	0049	15.84	$806.32	$356.95	$161.26
27090	C	Removal of hip prosthesis					
27091	C	Removal of hip prosthesis					
27093	N	Injection for hip x-ray					
27095	N	Injection for hip x-ray					
27096	N	Inject sacroiliac joint					
27097	T	Revision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
27098	T	Transfer tendon to pelvis	0050	20.63	$1,050.15	$504.07	$210.03
27100	T	Transfer of abdominal muscle	0051	28.56	$1,453.82	$675.24	$290.76
27105	T	Transfer of spinal muscle	0051	28.56	$1,453.82	$675.24	$290.76
27110	T	Transfer of iliopsoas muscle	0051	28.56	$1,453.82	$675.24	$290.76
27111	T	Transfer of iliopsoas muscle	0051	28.56	$1,453.82	$675.24	$290.76
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 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	Treat slipped epiphysis					
27178	C	Treat slipped epiphysis					
27179	C	Revise head/neck of femur					
27181	C	Treat slipped epiphysis					
27185	C	Revision of femur epiphysis					
27187	C	Reinforce hip bones					
27193	T	Treat pelvic ring fracture	0044	2.52	$128.28	$38.08	$25.66
27194	T	Treat pelvic ring fracture	0045	11.67	$594.05	$277.12	$118.81
27200	T	Treat tail bone fracture	0044	2.52	$128.28	$38.08	$25.66
27202	T	Treat tail bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
27215	C	Treat pelvic fracture(s)					
27216	C	Treat pelvic ring fracture					
27217	C	Treat pelvic ring fracture					
27218	C	Treat pelvic ring fracture					
27220	T	Treat hip socket fracture	0044	2.52	$128.28	$38.08	$25.66
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 thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27232	C	Treat thigh fracture					
27235	C	Treat thigh fracture					
27236	C	Treat thigh fracture					
27238	T	Treat thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27240	C	Treat thigh fracture					
27244	C	Treat thigh fracture					
27245	C	Treat thigh fracture					
27246	T	Treat thigh fracture	0043	4.05	$206.16		$41.23
27248	C	Treat thigh fracture					
27250	T	Treat hip dislocation	0044	2.52	$128.28	$38.08	$25.66
27252	T	Treat hip dislocation	0045	11.67	$594.05	$277.12	$118.81
27253	C	Treat hip dislocation					
27254	C	Treat hip dislocation					
27256	T	Treat hip dislocation	0043	4.05	$206.16		$41.23
27257	T	Treat hip dislocation	0045	11.67	$594.05	$277.12	$118.81
27258	C	Treat hip dislocation					
27259	C	Treat hip dislocation					
27265	T	Treat hip dislocation	0044	2.52	$128.28	$38.08	$25.66
27266	T	Treat hip dislocation	0047	26.36	$1,341.83	$537.03	$268.37
27275	T	Manipulation of hip joint	0045	11.67	$594.05	$277.12	$118.81
27280	C	Fusion of sacroiliac joint					
27282	C	Fusion of pubic bones					
27284	C	Fusion of hip joint					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0043	4.05	$206.16		$41.23
27301	T	Drain thigh/knee lesion	0008	10.93	$556.38	$113.67	$111.28
27303	C	Drainage of bone lesion					
27305	T	Incise thigh tendon & fascia	0049	15.84	$806.32	$356.95	$161.26
27306	T	Incision of thigh tendon	0049	15.84	$806.32	$356.95	$161.26
27307	T	Incision of thigh tendons	0049	15.84	$806.32	$356.95	$161.26
27310	T	Exploration of knee joint	0050	20.63	$1,050.15	$504.07	$210.03
27315	T	Partial removal, thigh nerve	0220	13.60	$692.29	$325.38	$138.46
27320	T	Partial removal, thigh nerve	0220	13.60	$692.29	$325.38	$138.46
27323	T	Biopsy, thigh soft tissues	0021	11.82	$601.69	$236.51	$120.34
27324	T	Biopsy, thigh soft tissues	0022	13.91	$708.07	$292.94	$141.61
27327	T	Removal of thigh lesion	0022	13.91	$708.07	$292.94	$141.61
27328	T	Removal of thigh lesion	0022	13.91	$708.07	$292.94	$141.61
27329	T	Remove tumor, thigh/knee	0022	13.91	$708.07	$292.94	$141.61
27330	T	Biopsy, knee joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27331	T	Explore/treat knee joint	0050	20.63	$1,050.15	$504.07	$210.03
27332	T	Removal of knee cartilage	0050	20.63	$1,050.15	$504.07	$210.03
27333	T	Removal of knee cartilage	0050	20.63	$1,050.15	$504.07	$210.03
27334	T	Remove knee joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27335	T	Remove knee joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27340	T	Removal of kneecap bursa	0049	15.84	$806.32	$356.95	$161.26
27345	T	Removal of knee cyst	0049	15.84	$806.32	$356.95	$161.26
27347	T	Remove knee cyst	0049	15.84	$806.32	$356.95	$161.26
27350	T	Removal of kneecap	0050	20.63	$1,050.15	$504.07	$210.03
27355	T	Remove femur lesion	0050	20.63	$1,050.15	$504.07	$210.03
27356	T	Remove femur lesion/graft	0050	20.63	$1,050.15	$504.07	$210.03
27357	T	Remove femur lesion/graft	0050	20.63	$1,050.15	$504.07	$210.03
27358	T	Remove femur lesion/fixation	0050	20.63	$1,050.15	$504.07	$210.03
27360	T	Partial removal, leg bone(s)	0050	20.63	$1,050.15	$504.07	$210.03
27365	C	Extensive leg surgery					
27370	N	Injection for knee x-ray					
27372	T	Removal of foreign body	0022	13.91	$708.07	$292.94	$141.61
27380	T	Repair of kneecap tendon	0049	15.84	$806.32	$356.95	$161.26
27381	T	Repair/graft kneecap tendon	0049	15.84	$806.32	$356.95	$161.26
27385	T	Repair of thigh muscle	0049	15.84	$806.32	$356.95	$161.26
27386	T	Repair/graft of thigh muscle	0049	15.84	$806.32	$356.95	$161.26
27390	T	Incision of thigh tendon	0049	15.84	$806.32	$356.95	$161.26
27391	T	Incision of thigh tendons	0049	15.84	$806.32	$356.95	$161.26
27392	T	Incision of thigh tendons	0049	15.84	$806.32	$356.95	$161.26
27393	T	Lengthening of thigh tendon	0050	20.63	$1,050.15	$504.07	$210.03
27394	T	Lengthening of thigh tendons	0050	20.63	$1,050.15	$504.07	$210.03
27395	T	Lengthening of thigh tendons	0051	28.56	$1,453.82	$675.24	$290.76
27396	T	Transplant of thigh tendon	0050	20.63	$1,050.15	$504.07	$210.03
27397	T	Transplants of thigh tendons	0051	28.56	$1,453.82	$675.24	$290.76
27400	T	Revise thigh muscles/tendons	0051	28.56	$1,453.82	$675.24	$290.76
27403	T	Repair of knee cartilage	0050	20.63	$1,050.15	$504.07	$210.03
27405	T	Repair of knee ligament	0051	28.56	$1,453.82	$675.24	$290.76
27407	T	Repair of knee ligament	0051	28.56	$1,453.82	$675.24	$290.76
27409	T	Repair of knee ligaments	0051	28.56	$1,453.82	$675.24	$290.76
27418	T	Repair degenerated kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27420	T	Revision of unstable kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27422	T	Revision of unstable kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27424	T	Revision/removal of kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27425	T	Lateral retinacular release	0050	20.63	$1,050.15	$504.07	$210.03
27427	T	Reconstruction, knee	0052	35.94	$1,829.49	$930.91	$365.90
27428	T	Reconstruction, knee	0052	35.94	$1,829.49	$930.91	$365.90
27429	T	Reconstruction, knee	0052	35.94	$1,829.49	$930.91	$365.90
27430	T	Revision of thigh muscles	0051	28.56	$1,453.82	$675.24	$290.76
27435	T	Incision of knee joint	0051	28.56	$1,453.82	$675.24	$290.76
27437	T	Revise kneecap	0047	26.36	$1,341.83	$537.03	$268.37
27438	T	Revise kneecap with implant	0048	43.19	$2,198.54	$725.94	$439.71
27440	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27441	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27442	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27443	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27445	C	Revision of knee joint					
27446	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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/replace knee joint					
27487	C	Revise/replace knee joint					
27488	C	Removal of knee prosthesis					
27495	C	Reinforce thigh					
27496	T	Decompression of thigh/knee	0049	15.84	$806.32	$356.95	$161.26
27497	T	Decompression of thigh/knee	0049	15.84	$806.32	$356.95	$161.26
27498	T	Decompression of thigh/knee	0049	15.84	$806.32	$356.95	$161.26
27499	T	Decompression of thigh/knee	0049	15.84	$806.32	$356.95	$161.26
27500	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27501	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27502	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27503	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27506	C	Treatment of thigh fracture					
27507	C	Treatment of thigh fracture					
27508	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27509	T	Treatment of thigh fracture	0046	27.69	$1,409.53	$535.76	$281.91
27510	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27511	C	Treatment of thigh fracture					
27513	C	Treatment of thigh fracture					
27514	C	Treatment of thigh fracture					
27516	T	Treat thigh fx growth plate	0044	2.52	$128.28	$38.08	$25.66
27517	T	Treat thigh fx growth plate	0043	4.05	$206.16		$41.23
27519	C	Treat thigh fx growth plate					
27520	T	Treat kneecap fracture	0044	2.52	$128.28	$38.08	$25.66
27524	T	Treat kneecap fracture	0046	27.69	$1,409.53	$535.76	$281.91
27530	T	Treat knee fracture	0044	2.52	$128.28	$38.08	$25.66
27532	T	Treat knee fracture	0044	2.52	$128.28	$38.08	$25.66
27535	C	Treat knee fracture					
27536	C	Treat knee fracture					
27538	T	Treat knee fracture(s)	0043	4.05	$206.16		$41.23
27540	C	Treat knee fracture					
27550	T	Treat knee dislocation	0044	2.52	$128.28	$38.08	$25.66
27552	T	Treat knee dislocation	0045	11.67	$594.05	$277.12	$118.81
27556	C	Treat knee dislocation					
27557	C	Treat knee dislocation					
27558	C	Treat knee dislocation					
27560	T	Treat kneecap dislocation	0044	2.52	$128.28	$38.08	$25.66
27562	T	Treat kneecap dislocation	0045	11.67	$594.05	$277.12	$118.81
27566	T	Treat kneecap dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27570	T	Fixation of knee joint	0045	11.67	$594.05	$277.12	$118.81
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	0049	15.84	$806.32	$356.95	$161.26
27596	C	Amputation follow-up surgery					
27598	C	Amputate lower leg at knee					
27599	T	Leg surgery procedure	0044	2.52	$128.28	$38.08	$25.66
27600	T	Decompression of lower leg	0049	15.84	$806.32	$356.95	$161.26
27601	T	Decompression of lower leg	0049	15.84	$806.32	$356.95	$161.26
27602	T	Decompression of lower leg	0049	15.84	$806.32	$356.95	$161.26
27603	T	Drain lower leg lesion	0008	10.93	$556.38	$113.67	$111.28
27604	T	Drain lower leg bursa	0049	15.84	$806.32	$356.95	$161.26
27605	T	Incision of achilles tendon	0055	15.44	$785.96	$355.34	$157.19
27606	T	Incision of achilles tendon	0049	15.84	$806.32	$356.95	$161.26
27607	T	Treat lower leg bone lesion	0049	15.84	$806.32	$356.95	$161.26
27610	T	Explore/treat ankle joint	0050	20.63	$1,050.15	$504.07	$210.03
27612	T	Exploration of ankle joint	0050	20.63	$1,050.15	$504.07	$210.03
27613	T	Biopsy lower leg soft tissue	0019	4.22	$214.81	$78.91	$42.96
27614	T	Biopsy lower leg soft tissue	0022	13.91	$708.07	$292.94	$141.61
27615	T	Remove tumor, lower leg	0046	27.69	$1,409.53	$535.76	$281.91
27618	T	Remove lower leg lesion	0021	11.82	$601.69	$236.51	$120.34
27619	T	Remove lower leg lesion	0022	13.91	$708.07	$292.94	$141.61
27620	T	Explore/treat ankle joint	0050	20.63	$1,050.15	$504.07	$210.03
27625	T	Remove ankle joint lining	0050	20.63	$1,050.15	$504.07	$210.03

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27626	T	Remove ankle joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27630	T	Removal of tendon lesion	0049	15.84	$806.32	$356.95	$161.26
27635	T	Remove lower leg bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27637	T	Remove/graft leg bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27638	T	Remove/graft leg bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27640	T	Partial removal of tibia	0051	28.56	$1,453.82	$675.24	$290.76
27641	T	Partial removal of fibula	0050	20.63	$1,050.15	$504.07	$210.03
27645	C	Extensive lower leg surgery					
27646	C	Extensive lower leg surgery					
27647	T	Extensive ankle/heel surgery	0051	28.56	$1,453.82	$675.24	$290.76
27648	N	Injection for ankle x-ray					
27650	T	Repair achilles tendon	0051	28.56	$1,453.82	$675.24	$290.76
27652	T	Repair/graft achilles tendon	0051	28.56	$1,453.82	$675.24	$290.76
27654	T	Repair of achilles tendon	0051	28.56	$1,453.82	$675.24	$290.76
27656	T	Repair leg fascia defect	0049	15.84	$806.32	$356.95	$161.26
27658	T	Repair of leg tendon, each	0049	15.84	$806.32	$356.95	$161.26
27659	T	Repair of leg tendon, each	0049	15.84	$806.32	$356.95	$161.26
27664	T	Repair of leg tendon, each	0049	15.84	$806.32	$356.95	$161.26
27665	T	Repair of leg tendon, each	0050	20.63	$1,050.15	$504.07	$210.03
27675	T	Repair lower leg tendons	0049	15.84	$806.32	$356.95	$161.26
27676	T	Repair lower leg tendons	0050	20.63	$1,050.15	$504.07	$210.03
27680	T	Release of lower leg tendon	0050	20.63	$1,050.15	$504.07	$210.03
27681	T	Release of lower leg tendons	0050	20.63	$1,050.15	$504.07	$210.03
27685	T	Revision of lower leg tendon	0050	20.63	$1,050.15	$504.07	$210.03
27686	T	Revise lower leg tendons	0050	20.63	$1,050.15	$504.07	$210.03
27687	T	Revision of calf tendon	0050	20.63	$1,050.15	$504.07	$210.03
27690	T	Revise lower leg tendon	0051	28.56	$1,453.82	$675.24	$290.76
27691	T	Revise lower leg tendon	0051	28.56	$1,453.82	$675.24	$290.76
27692	T	Revise additional leg tendon	0051	28.56	$1,453.82	$675.24	$290.76
27695	T	Repair of ankle ligament	0050	20.63	$1,050.15	$504.07	$210.03
27696	T	Repair of ankle ligaments	0050	20.63	$1,050.15	$504.07	$210.03
27698	T	Repair of ankle ligament	0050	20.63	$1,050.15	$504.07	$210.03
27700	T	Revision of ankle joint	0047	26.36	$1,341.83	$537.03	$268.37
27702	C	Reconstruct ankle joint					
27703	C	Reconstruction, ankle joint					
27704	T	Removal of ankle implant	0049	15.84	$806.32	$356.95	$161.26
27705	T	Incision of tibia	0051	28.56	$1,453.82	$675.24	$290.76
27707	T	Incision of fibula	0049	15.84	$806.32	$356.95	$161.26
27709	T	Incision of tibia & fibula	0050	20.63	$1,050.15	$504.07	$210.03
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	0050	20.63	$1,050.15	$504.07	$210.03
27732	T	Repair of fibula epiphysis	0050	20.63	$1,050.15	$504.07	$210.03
27734	T	Repair lower leg epiphyses	0050	20.63	$1,050.15	$504.07	$210.03
27740	T	Repair of leg epiphyses	0050	20.63	$1,050.15	$504.07	$210.03
27742	T	Repair of leg epiphyses	0051	28.56	$1,453.82	$675.24	$290.76
27745	T	Reinforce tibia	0051	28.56	$1,453.82	$675.24	$290.76
27750	T	Treatment of tibia fracture	0044	2.52	$128.28	$38.08	$25.66
27752	T	Treatment of tibia fracture	0044	2.52	$128.28	$38.08	$25.66
27756	T	Treatment of tibia fracture	0046	27.69	$1,409.53	$535.76	$281.91
27758	T	Treatment of tibia fracture	0046	27.69	$1,409.53	$535.76	$281.91
27759	T	Treatment of tibia fracture	0046	27.69	$1,409.53	$535.76	$281.91
27760	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27762	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27766	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27780	T	Treatment of fibula fracture	0044	2.52	$128.28	$38.08	$25.66
27781	T	Treatment of fibula fracture	0044	2.52	$128.28	$38.08	$25.66
27784	T	Treatment of fibula fracture	0046	27.69	$1,409.53	$535.76	$281.91
27786	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27788	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27792	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27808	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27810	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27814	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27816	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27818	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27822	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27823	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27824	T	Treat lower leg fracture	0044	2.52	$128.28	$38.08	$25.66
27825	T	Treat lower leg fracture	0044	2.52	$128.28	$38.08	$25.66

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27826	T	Treat lower leg fracture	0046	27.69	$1,409.53	$535.76	$281.91
27827	T	Treat lower leg fracture	0046	27.69	$1,409.53	$535.76	$281.91
27828	T	Treat lower leg fracture	0046	27.69	$1,409.53	$535.76	$281.91
27829	T	Treat lower leg joint	0046	27.69	$1,409.53	$535.76	$281.91
27830	T	Treat lower leg dislocation	0044	2.52	$128.28	$38.08	$25.66
27831	T	Treat lower leg dislocation	0044	2.52	$128.28	$38.08	$25.66
27832	T	Treat lower leg dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27840	T	Treat ankle dislocation	0044	2.52	$128.28	$38.08	$25.66
27842	T	Treat ankle dislocation	0045	11.67	$594.05	$277.12	$118.81
27846	T	Treat ankle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27848	T	Treat ankle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27860	T	Fixation of ankle joint	0045	11.67	$594.05	$277.12	$118.81
27870	T	Fusion of ankle joint	0051	28.56	$1,453.82	$675.24	$290.76
27871	T	Fusion of tibiofibular joint	0051	28.56	$1,453.82	$675.24	$290.76
27880	C	Amputation of lower leg	.....	.....	.....	.....	.....
27881	C	Amputation of lower leg	.....	.....	.....	.....	.....
27882	C	Amputation of lower leg	.....	.....	.....	.....	.....
27884	T	Amputation follow-up surgery	0049	15.84	$806.32	$356.95	$161.26
27886	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
27888	C	Amputation of foot at ankle	.....	.....	.....	.....	.....
27889	T	Amputation of foot at ankle	0050	20.63	$1,050.15	$504.07	$210.03
27892	T	Decompression of leg	0049	15.84	$806.32	$356.95	$161.26
27893	T	Decompression of leg	0049	15.84	$806.32	$356.95	$161.26
27894	T	Decompression of leg	0049	15.84	$806.32	$356.95	$161.26
27899	T	Leg/ankle surgery procedure	0044	2.52	$128.28	$38.08	$25.66
28001	T	Drainage of bursa of foot	0008	10.93	$556.38	$113.67	$111.28
28002	T	Treatment of foot infection	0049	15.84	$806.32	$356.95	$161.26
28003	T	Treatment of foot infection	0049	15.84	$806.32	$356.95	$161.26
28005	T	Treat foot bone lesion	0055	15.44	$785.96	$355.34	$157.19
28008	T	Incision of foot fascia	0055	15.44	$785.96	$355.34	$157.19
28010	T	Incision of toe tendon	0055	15.44	$785.96	$355.34	$157.19
28011	T	Incision of toe tendons	0055	15.44	$785.96	$355.34	$157.19
28020	T	Exploration of foot joint	0055	15.44	$785.96	$355.34	$157.19
28022	T	Exploration of foot joint	0055	15.44	$785.96	$355.34	$157.19
28024	T	Exploration of toe joint	0055	15.44	$785.96	$355.34	$157.19
28030	T	Removal of foot nerve	0220	13.60	$692.29	$325.38	$138.46
28035	T	Decompression of tibia nerve	0220	13.60	$692.29	$325.38	$138.46
28043	T	Excision of foot lesion	0021	11.82	$601.69	$236.51	$120.34
28045	T	Excision of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28046	T	Resection of tumor, foot	0055	15.44	$785.96	$355.34	$157.19
28050	T	Biopsy of foot joint lining	0055	15.44	$785.96	$355.34	$157.19
28052	T	Biopsy of foot joint lining	0055	15.44	$785.96	$355.34	$157.19
28054	T	Biopsy of toe joint lining	0055	15.44	$785.96	$355.34	$157.19
28060	T	Partial removal, foot fascia	0056	18.85	$959.54	$405.81	$191.91
28062	T	Removal of foot fascia	0056	18.85	$959.54	$405.81	$191.91
28070	T	Removal of foot joint lining	0056	18.85	$959.54	$405.81	$191.91
28072	T	Removal of foot joint lining	0056	18.85	$959.54	$405.81	$191.91
28080	T	Removal of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28086	T	Excise foot tendon sheath	0055	15.44	$785.96	$355.34	$157.19
28088	T	Excise foot tendon sheath	0055	15.44	$785.96	$355.34	$157.19
28090	T	Removal of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28092	T	Removal of toe lesions	0055	15.44	$785.96	$355.34	$157.19
28100	T	Removal of ankle/heel lesion	0055	15.44	$785.96	$355.34	$157.19
28102	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28103	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28104	T	Removal of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28106	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28107	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28108	T	Removal of toe lesions	0055	15.44	$785.96	$355.34	$157.19
28110	T	Part removal of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28111	T	Part removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28112	T	Part removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28113	T	Part removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28114	T	Removal of metatarsal heads	0055	15.44	$785.96	$355.34	$157.19
28116	T	Revision of foot	0055	15.44	$785.96	$355.34	$157.19
28118	T	Removal of heel bone	0055	15.44	$785.96	$355.34	$157.19
28119	T	Removal of heel spur	0055	15.44	$785.96	$355.34	$157.19
28120	T	Part removal of ankle/heel	0055	15.44	$785.96	$355.34	$157.19
28122	T	Partial removal of foot bone	0055	15.44	$785.96	$355.34	$157.19
28124	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19
28126	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19
28130	T	Removal of ankle bone	0055	15.44	$785.96	$355.34	$157.19
28140	T	Removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28150	T	Removal of toe	0055	15.44	$785.96	$355.34	$157.19
28153	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28160	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19
28171	T	Extensive foot surgery	0055	15.44	$785.96	$355.34	$157.19
28173	T	Extensive foot surgery	0055	15.44	$785.96	$355.34	$157.19
28175	T	Extensive foot surgery	0055	15.44	$785.96	$355.34	$157.19
28190	T	Removal of foot foreign body	0019	4.22	$214.81	$78.91	$42.96
28192	T	Removal of foot foreign body	0021	11.82	$601.69	$236.51	$120.34
28193	T	Removal of foot foreign body	0021	11.82	$601.69	$236.51	$120.34
28200	T	Repair of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28202	T	Repair/graft of foot tendon	0056	18.85	$959.54	$405.81	$191.91
28208	T	Repair of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28210	T	Repair/graft of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28220	T	Release of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28222	T	Release of foot tendons	0055	15.44	$785.96	$355.34	$157.19
28225	T	Release of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28226	T	Release of foot tendons	0055	15.44	$785.96	$355.34	$157.19
28230	T	Incision of foot tendon(s)	0055	15.44	$785.96	$355.34	$157.19
28232	T	Incision of toe tendon	0055	15.44	$785.96	$355.34	$157.19
28234	T	Incision of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28238	T	Revision of foot tendon	0056	18.85	$959.54	$405.81	$191.91
28240	T	Release of big toe	0055	15.44	$785.96	$355.34	$157.19
28250	T	Revision of foot fascia	0056	18.85	$959.54	$405.81	$191.91
28260	T	Release of midfoot joint	0056	18.85	$959.54	$405.81	$191.91
28261	T	Revision of foot tendon	0056	18.85	$959.54	$405.81	$191.91
28262	T	Revision of foot and ankle	0056	18.85	$959.54	$405.81	$191.91
28264	T	Release of midfoot joint	0056	18.85	$959.54	$405.81	$191.91
28270	T	Release of foot contracture	0055	15.44	$785.96	$355.34	$157.19
28272	T	Release of toe joint, each	0055	15.44	$785.96	$355.34	$157.19
28280	T	Fusion of toes	0055	15.44	$785.96	$355.34	$157.19
28285	T	Repair of hammertoe	0055	15.44	$785.96	$355.34	$157.19
28286	T	Repair of hammertoe	0055	15.44	$785.96	$355.34	$157.19
28288	T	Partial removal of foot bone	0056	18.85	$959.54	$405.81	$191.91
28289	T	Repair hallux rigidus	0056	18.85	$959.54	$405.81	$191.91
28290	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28292	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28293	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28294	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28296	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28297	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28298	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28299	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28300	T	Incision of heel bone	0056	18.85	$959.54	$405.81	$191.91
28302	T	Incision of ankle bone	0056	18.85	$959.54	$405.81	$191.91
28304	T	Incision of midfoot bones	0056	18.85	$959.54	$405.81	$191.91
28305	T	Incise/graft midfoot bones	0056	18.85	$959.54	$405.81	$191.91
28306	T	Incision of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28307	T	Incision of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28308	T	Incision of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28309	T	Incision of metatarsals	0056	18.85	$959.54	$405.81	$191.91
28310	T	Revision of big toe	0055	15.44	$785.96	$355.34	$157.19
28312	T	Revision of toe	0055	15.44	$785.96	$355.34	$157.19
28313	T	Repair deformity of toe	0055	15.44	$785.96	$355.34	$157.19
28315	T	Removal of sesamoid bone	0055	15.44	$785.96	$355.34	$157.19
28320	T	Repair of foot bones	0056	18.85	$959.54	$405.81	$191.91
28322	T	Repair of metatarsals	0056	18.85	$959.54	$405.81	$191.91
28340	T	Resect enlarged toe tissue	0055	15.44	$785.96	$355.34	$157.19
28341	T	Resect enlarged toe	0055	15.44	$785.96	$355.34	$157.19
28344	T	Repair extra toe(s)	0056	18.85	$959.54	$405.81	$191.91
28345	T	Repair webbed toe(s)	0056	18.85	$959.54	$405.81	$191.91
28360	T	Reconstruct cleft foot	0056	18.85	$959.54	$405.81	$191.91
28400	T	Treatment of heel fracture	0044	2.52	$128.28	$38.08	$25.66
28405	T	Treatment of heel fracture	0044	2.52	$128.28	$38.08	$25.66
28406	T	Treatment of heel fracture	0046	27.69	$1,409.53	$535.76	$281.91
28415	T	Treat heel fracture	0046	27.69	$1,409.53	$535.76	$281.91
28420	T	Treat/graft heel fracture	0046	27.69	$1,409.53	$535.76	$281.91
28430	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
28435	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
28436	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
28445	T	Treat ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
28450	T	Treat midfoot fracture, each	0044	2.52	$128.28	$38.08	$25.66
28455	T	Treat midfoot fracture, each	0044	2.52	$128.28	$38.08	$25.66
28456	T	Treat midfoot fracture	0046	27.69	$1,409.53	$535.76	$281.91
28465	T	Treat midfoot fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
28470	T	Treat metatarsal fracture	0044	2.52	$128.28	$38.08	$25.66
28475	T	Treat metatarsal fracture	0044	2.52	$128.28	$38.08	$25.66
28476	T	Treat metatarsal fracture	0046	27.69	$1,409.53	$535.76	$281.91

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28485	T	Treat metatarsal fracture	0046	27.69	$1,409.53	$535.76	$281.91
28490	T	Treat big toe fracture	0044	2.52	$128.28	$38.08	$25.66
28495	T	Treat big toe fracture	0044	2.52	$128.28	$38.08	$25.66
28496	T	Treat big toe fracture	0046	27.69	$1,409.53	$535.76	$281.91
28505	T	Treat big toe fracture	0046	27.69	$1,409.53	$535.76	$281.91
28510	T	Treatment of toe fracture	0043	4.05	$206.16	.....	$41.23
28515	T	Treatment of toe fracture	0043	4.05	$206.16	.....	$41.23
28525	T	Treat toe fracture	0046	27.69	$1,409.53	$535.76	$281.91
28530	T	Treat sesamoid bone fracture	0044	2.52	$128.28	$38.08	$25.66
28531	T	Treat sesamoid bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
28540	T	Treat foot dislocation	0044	2.52	$128.28	$38.08	$25.66
28545	T	Treat foot dislocation	0045	11.67	$594.05	$277.12	$118.81
28546	T	Treat foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28555	T	Repair foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28570	T	Treat foot dislocation	0044	2.52	$128.28	$38.08	$25.66
28575	T	Treat foot dislocation	0043	4.05	$206.16	.....	$41.23
28576	T	Treat foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28585	T	Repair foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28600	T	Treat foot dislocation	0044	2.52	$128.28	$38.08	$25.66
28605	T	Treat foot dislocation	0043	4.05	$206.16	.....	$41.23
28606	T	Treat foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28615	T	Repair foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28630	T	Treat toe dislocation	0044	2.52	$128.28	$38.08	$25.66
28635	T	Treat toe dislocation	0045	11.67	$594.05	$277.12	$118.81
28636	T	Treat toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28645	T	Repair toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28660	T	Treat toe dislocation	0043	4.05	$206.16	.....	$41.23
28665	T	Treat toe dislocation	0045	11.67	$594.05	$277.12	$118.81
28666	T	Treat toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28675	T	Repair of toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28705	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28715	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28725	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28730	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28735	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28737	T	Revision of foot bones	0055	15.44	$785.96	$355.34	$157.19
28740	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28750	T	Fusion of big toe joint	0055	15.44	$785.96	$355.34	$157.19
28755	T	Fusion of big toe joint	0055	15.44	$785.96	$355.34	$157.19
28760	T	Fusion of big toe joint	0056	18.85	$959.54	$405.81	$191.91
28800	C	Amputation of midfoot	.....	.....	.....	.....	.....
28805	C	Amputation thru metatarsal	.....	.....	.....	.....	.....
28810	T	Amputation toe & metatarsal	0055	15.44	$785.96	$355.34	$157.19
28820	T	Amputation of toe	0055	15.44	$785.96	$355.34	$157.19
28825	T	Partial amputation of toe	0055	15.44	$785.96	$355.34	$157.19
28899	T	Foot/toes surgery procedure	0043	4.05	$206.16	.....	$41.23
29000	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29010	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29015	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29020	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29025	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29035	S	Application of body cast	0058	1.28	$65.16	$19.27	$13.03
29040	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29044	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29046	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29049	S	Application of figure eight	0059	2.22	$113.01	$29.59	$22.60
29055	S	Application of shoulder cast	0059	2.22	$113.01	$29.59	$22.60
29058	S	Application of shoulder cast	0059	2.22	$113.01	$29.59	$22.60
29065	S	Application of long arm cast	0059	2.22	$113.01	$29.59	$22.60
29075	S	Application of forearm cast	0058	1.28	$65.16	$19.27	$13.03
29085	S	Apply hand/wrist cast	0058	1.28	$65.16	$19.27	$13.03
*29086	S	Apply finger cast	0058	1.28	$65.16	$19.27	$13.03
29105	S	Apply long arm splint	0058	1.28	$65.16	$19.27	$13.03
29125	S	Apply forearm splint	0058	1.28	$65.16	$19.27	$13.03
29126	S	Apply forearm splint	0058	1.28	$65.16	$19.27	$13.03
29130	S	Application of finger splint	0058	1.28	$65.16	$19.27	$13.03
29131	S	Application of finger splint	0058	1.28	$65.16	$19.27	$13.03
29200	S	Strapping of chest	0058	1.28	$65.16	$19.27	$13.03
29220	S	Strapping of low back	0059	2.22	$113.01	$29.59	$22.60
29240	S	Strapping of shoulder	0058	1.28	$65.16	$19.27	$13.03
29260	S	Strapping of elbow or wrist	0058	1.28	$65.16	$19.27	$13.03
29280	S	Strapping of hand or finger	0058	1.28	$65.16	$19.27	$13.03
29305	S	Application of hip cast	0058	1.28	$65.16	$19.27	$13.03
29325	S	Application of hip casts	0059	2.22	$113.01	$29.59	$22.60
29345	S	Application of long leg cast	0059	2.22	$113.01	$29.59	$22.60

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29355	S	Application of long leg cast	0059	2.22	$113.01	$29.59	$22.60
29358	S	Apply long leg cast brace	0059	2.22	$113.01	$29.59	$22.60
29365	S	Application of long leg cast	0059	2.22	$113.01	$29.59	$22.60
29405	S	Apply short leg cast	0058	1.28	$65.16	$19.27	$13.03
29425	S	Apply short leg cast	0059	2.22	$113.01	$29.59	$22.60
29435	S	Apply short leg cast	0058	1.28	$65.16	$19.27	$13.03
29440	S	Addition of walker to cast	0059	2.22	$113.01	$29.59	$22.60
29445	S	Apply rigid leg cast	0059	2.22	$113.01	$29.59	$22.60
29450	S	Application of leg cast	0059	2.22	$113.01	$29.59	$22.60
29505	S	Application, long leg splint	0059	2.22	$113.01	$29.59	$22.60
29515	S	Application lower leg splint	0059	2.22	$113.01	$29.59	$22.60
29520	S	Strapping of hip	0058	1.28	$65.16	$19.27	$13.03
29530	S	Strapping of knee	0058	1.28	$65.16	$19.27	$13.03
29540	S	Strapping of ankle	0058	1.28	$65.16	$19.27	$13.03
29550	S	Strapping of toes	0058	1.28	$65.16	$19.27	$13.03
29580	S	Application of paste boot	0058	1.28	$65.16	$19.27	$13.03
29590	S	Application of foot splint	0058	1.28	$65.16	$19.27	$13.03
29700	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29705	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29710	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29715	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29720	S	Repair of body cast	0058	1.28	$65.16	$19.27	$13.03
29730	S	Windowing of cast	0058	1.28	$65.16	$19.27	$13.03
29740	S	Wedging of cast	0058	1.28	$65.16	$19.27	$13.03
29750	S	Wedging of clubfoot cast	0058	1.28	$65.16	$19.27	$13.03
29799	N	Casting/strapping procedure	.....	.....	.....	.....	.....
29800	T	Jaw arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29804	T	Jaw arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29805	T	Shoulder arthroscopy, dx	0041	23.61	$1,201.84	$576.88	$240.37
*29806	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29807	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29815	D	Shoulder arthroscopy	0041	23.61	$1,201.84	$576.88	$240.37
29819	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29820	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29821	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29822	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29823	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29824	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29825	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29826	T	Shoulder arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29830	T	Elbow arthroscopy	0041	23.61	$1,201.84	$576.88	$240.37
29834	T	Elbow arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29835	T	Elbow arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29836	T	Elbow arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29837	T	Elbow arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29838	T	Elbow arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29840	T	Wrist arthroscopy	0041	23.61	$1,201.84	$576.88	$240.37
29843	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29844	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29845	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29846	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29847	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29848	T	Wrist endoscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29850	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29851	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29855	T	Tibial arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29856	T	Tibial arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29860	T	Hip arthroscopy, dx	0041	23.61	$1,201.84	$576.88	$240.37
29861	T	Hip arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29862	T	Hip arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29863	T	Hip arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29870	T	Knee arthroscopy, dx	0041	23.61	$1,201.84	$576.88	$240.37
29871	T	Knee arthroscopy/drainage	0041	23.61	$1,201.84	$576.88	$240.37
29874	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29875	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29876	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29877	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29879	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29880	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29881	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29882	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29883	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29884	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29885	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29886	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29887	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29888	T	Knee arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29889	T	Knee arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29891	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29892	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29893	T	Scope, plantar fasciotomy	0055	15.44	$785.96	$355.34	$157.19
29894	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29895	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29897	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29898	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29900	T	Mcp joint arthroscopy, dx	0053	11.69	$595.07	$253.49	$119.01
*29901	T	Mcp joint arthroscopy, surg	0053	11.69	$595.07	$253.49	$119.01
*29902	T	Mcp joint arthroscopy, surg	0053	11.69	$595.07	$253.49	$119.01
29909	D	Arthroscopy of joint	0041	23.61	$1,201.84	$576.88	$240.37
*29999	T	Arthroscopy of joint	0041	23.61	$1,201.84	$576.88	$240.37
30000	T	Drainage of nose lesion	0251	2.43	$123.70	$27.99	$24.74
30020	T	Drainage of nose lesion	0251	2.43	$123.70	$27.99	$24.74
30100	T	Intranasal biopsy	0252	5.95	$302.88	$114.24	$60.58
30110	T	Removal of nose polyp(s)	0253	12.33	$627.65	$284.00	$125.53
30115	T	Removal of nose polyp(s)	0253	12.33	$627.65	$284.00	$125.53
30117	T	Removal of intranasal lesion	0253	12.33	$627.65	$284.00	$125.53
30118	T	Removal of intranasal lesion	0254	17.37	$884.20	$272.41	$176.84
30120	T	Revision of nose	0253	12.33	$627.65	$284.00	$125.53
30124	T	Removal of nose lesion	0252	5.95	$302.88	$114.24	$60.58
30125	T	Removal of nose lesion	0256	26.61	$1,354.56	$623.05	$270.91
30130	T	Removal of turbinate bones	0253	12.33	$627.65	$284.00	$125.53
30140	T	Removal of turbinate bones	0254	17.37	$884.20	$272.41	$176.84
30150	T	Partial removal of nose	0256	26.61	$1,354.56	$623.05	$270.91
30160	T	Removal of nose	0256	26.61	$1,354.56	$623.05	$270.91
30200	T	Injection treatment of nose	0253	12.33	$627.65	$284.00	$125.53
30210	T	Nasal sinus therapy	0252	5.95	$302.88	$114.24	$60.58
30220	T	Insert nasal septal button	0252	5.95	$302.88	$114.24	$60.58
30300	X	Remove nasal foreign body	0340	0.84	$42.76	$10.69	$8.55
30310	T	Remove nasal foreign body	0253	12.33	$627.65	$284.00	$125.53
30320	T	Remove nasal foreign body	0253	12.33	$627.65	$284.00	$125.53
30400	T	Reconstruction of nose	0256	26.61	$1,354.56	$623.05	$270.91
30410	T	Reconstruction of nose	0256	26.61	$1,354.56	$623.05	$270.91
30420	T	Reconstruction of nose	0256	26.61	$1,354.56	$623.05	$270.91
30430	T	Revision of nose	0254	17.37	$884.20	$272.41	$176.84
30435	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30450	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30460	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30462	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30465	T	Repair nasal stenosis	0256	26.61	$1,354.56	$623.05	$270.91
30520	T	Repair of nasal septum	0256	26.61	$1,354.56	$623.05	$270.91
30540	T	Repair nasal defect	0256	26.61	$1,354.56	$623.05	$270.91
30545	T	Repair nasal defect	0256	26.61	$1,354.56	$623.05	$270.91
30560	T	Release of nasal adhesions	0251	2.43	$123.70	$27.99	$24.74
30580	T	Repair upper jaw fistula	0256	26.61	$1,354.56	$623.05	$270.91
30600	T	Repair mouth/nose fistula	0256	26.61	$1,354.56	$623.05	$270.91
30620	T	Intranasal reconstruction	0256	26.61	$1,354.56	$623.05	$270.91
30630	T	Repair nasal septum defect	0254	17.37	$884.20	$272.41	$176.84
30801	T	Cauterization, inner nose	0252	5.95	$302.88	$114.24	$60.58
30802	T	Cauterization, inner nose	0253	12.33	$627.65	$284.00	$125.53
30901	T	Control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30903	T	Control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30905	T	Control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30906	T	Repeat control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30915	T	Ligation, nasal sinus artery	0091	20.34	$1,035.39	$348.23	$207.08
30920	T	Ligation, upper jaw artery	0092	19.91	$1,013.50	$503.71	$202.70
30930	T	Therapy, fracture of nose	0253	12.33	$627.65	$284.00	$125.53
30999	T	Nasal surgery procedure	0251	2.43	$123.70	$27.99	$24.74
31000	T	Irrigation, maxillary sinus	0251	2.43	$123.70	$27.99	$24.74
31002	T	Irrigation, sphenoid sinus	0252	5.95	$302.88	$114.24	$60.58
31020	T	Exploration, maxillary sinus	0254	17.37	$884.20	$272.41	$176.84
31030	T	Exploration, maxillary sinus	0256	26.61	$1,354.56	$623.05	$270.91
31032	T	Explore sinus,remove polyps	0256	26.61	$1,354.56	$623.05	$270.91
31040	T	Exploration behind upper jaw	0254	17.37	$884.20	$272.41	$176.84
31050	T	Exploration, sphenoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31051	T	Sphenoid sinus surgery	0256	26.61	$1,354.56	$623.05	$270.91
31070	T	Exploration of frontal sinus	0254	17.37	$884.20	$272.41	$176.84
31075	T	Exploration of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31080	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31081	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31084	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31085	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31086	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31087	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31090	T	Exploration of sinuses	0256	26.61	$1,354.56	$623.05	$270.91
31200	T	Removal of ethmoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31201	T	Removal of ethmoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31205	T	Removal of ethmoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31225	C	Removal of upper jaw					
31230	C	Removal of upper jaw					
31231	T	Nasal endoscopy, dx	0071	1.03	$52.43	$14.22	$10.49
31233	T	Nasal/sinus endoscopy, dx	0072	1.21	$61.59	$33.87	$12.32
31235	T	Nasal/sinus endoscopy, dx	0074	11.32	$576.23	$293.88	$115.25
31237	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
31238	T	Nasal/sinus endoscopy, surg	0074	11.32	$576.23	$293.88	$115.25
31239	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
31240	T	Nasal/sinus endoscopy, surg	0074	11.32	$576.23	$293.88	$115.25
31254	T	Revision of ethmoid sinus	0075	17.42	$886.75	$443.38	$177.35
31255	T	Removal of ethmoid sinus	0075	17.42	$886.75	$443.38	$177.35
31256	T	Exploration maxillary sinus	0075	17.42	$886.75	$443.38	$177.35
31267	T	Endoscopy, maxillary sinus	0075	17.42	$886.75	$443.38	$177.35
31276	T	Sinus endoscopy, surgical	0075	17.42	$886.75	$443.38	$177.35
31287	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
31288	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
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	0252	5.95	$302.88	$114.24	$60.58
31300	T	Removal of larynx lesion	0256	26.61	$1,354.56	$623.05	$270.91
31320	T	Diagnostic incision, larynx	0256	26.61	$1,354.56	$623.05	$270.91
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	0256	26.61	$1,354.56	$623.05	$270.91
31420	T	Removal of epiglottis	0256	26.61	$1,354.56	$623.05	$270.91
31500	S	Insert emergency airway	0094	6.08	$309.50	$105.29	$61.90
31502	T	Change of windpipe airway	0121	2.54	$129.30	$52.53	$25.86
31505	T	Diagnostic laryngoscopy	0072	1.21	$61.59	$33.87	$12.32
31510	T	Laryngoscopy with biopsy	0074	11.32	$576.23	$293.88	$115.25
31511	T	Remove foreign body, larynx	0072	1.21	$61.59	$33.87	$12.32
31512	T	Removal of larynx lesion	0074	11.32	$576.23	$293.88	$115.25
31513	T	Injection into vocal cord	0073	3.29	$167.47	$73.69	$33.49
31515	T	Laryngoscopy for aspiration	0074	11.32	$576.23	$293.88	$115.25
31520	T	Diagnostic laryngoscopy	0072	1.21	$61.59	$33.87	$12.32
31525	T	Diagnostic laryngoscopy	0074	11.32	$576.23	$293.88	$115.25
31526	T	Diagnostic laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31527	T	Laryngoscopy for treatment	0075	17.42	$886.75	$443.38	$177.35
31528	T	Laryngoscopy and dilatation	0074	11.32	$576.23	$293.88	$115.25
31529	T	Laryngoscopy and dilatation	0074	11.32	$576.23	$293.88	$115.25
31530	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31531	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31535	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31536	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31540	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31541	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31560	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31561	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31570	T	Laryngoscopy with injection	0074	11.32	$576.23	$293.88	$115.25
31571	T	Laryngoscopy with injection	0075	17.42	$886.75	$443.38	$177.35
31575	T	Diagnostic laryngoscopy	0071	1.03	$52.43	$14.22	$10.49
31576	T	Laryngoscopy with biopsy	0075	17.42	$886.75	$443.38	$177.35
31577	T	Remove foreign body, larynx	0073	3.29	$167.47	$73.69	$33.49
31578	T	Removal of larynx lesion	0075	17.42	$886.75	$443.38	$177.35
31579	T	Diagnostic laryngoscopy	0073	3.29	$167.47	$73.69	$33.49
31580	T	Revision of larynx	0256	26.61	$1,354.56	$623.05	$270.91
31582	C	Revision of larynx					
31584	C	Treat larynx fracture					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31585	T	Treat larynx fracture	0253	12.33	$627.65	$284.00	$125.53
31586	T	Treat larynx fracture	0256	26.61	$1,354.56	$623.05	$270.91
31587	C	Revision of larynx					
31588	T	Revision of larynx	0256	26.61	$1,354.56	$623.05	$270.91
31590	T	Reinnervate larynx	0256	26.61	$1,354.56	$623.05	$270.91
31595	T	Larynx nerve surgery	0256	26.61	$1,354.56	$623.05	$270.91
31599	T	Larynx surgery procedure	0254	17.37	$884.20	$272.41	$176.84
31600	T	Incision of windpipe	0254	17.37	$884.20	$272.41	$176.84
31601	T	Incision of windpipe	0254	17.37	$884.20	$272.41	$176.84
31603	T	Incision of windpipe	0252	5.95	$302.88	$114.24	$60.58
31605	T	Incision of windpipe	0253	12.33	$627.65	$284.00	$125.53
31610	T	Incision of windpipe	0254	17.37	$884.20	$272.41	$176.84
31611	T	Surgery/speech prosthesis	0254	17.37	$884.20	$272.41	$176.84
31612	T	Puncture/clear windpipe	0254	17.37	$884.20	$272.41	$176.84
31613	T	Repair windpipe opening	0254	17.37	$884.20	$272.41	$176.84
31614	T	Repair windpipe opening	0256	26.61	$1,354.56	$623.05	$270.91
31615	T	Visualization of windpipe	0076	7.56	$384.83	$188.57	$76.97
31622	T	Dx bronchoscope/wash	0076	7.56	$384.83	$188.57	$76.97
31623	T	Dx bronchoscope/brush	0076	7.56	$384.83	$188.57	$76.97
31624	T	Dx bronchoscope/lavage	0076	7.56	$384.83	$188.57	$76.97
31625	T	Bronchoscopy with biopsy	0076	7.56	$384.83	$188.57	$76.97
31628	T	Bronchoscopy with biopsy	0076	7.56	$384.83	$188.57	$76.97
31629	T	Bronchoscopy with biopsy	0076	7.56	$384.83	$188.57	$76.97
31630	T	Bronchoscopy with repair	0076	7.56	$384.83	$188.57	$76.97
31631	T	Bronchoscopy with dilation	0076	7.56	$384.83	$188.57	$76.97
31635	T	Remove foreign body, airway	0076	7.56	$384.83	$188.57	$76.97
31640	T	Bronchoscopy & remove lesion	0076	7.56	$384.83	$188.57	$76.97
31641	T	Bronchoscopy, treat blockage	0076	7.56	$384.83	$188.57	$76.97
31643	T	Diag bronchoscope/catheter	0076	7.56	$384.83	$188.57	$76.97
31645	T	Bronchoscopy, clear airways	0076	7.56	$384.83	$188.57	$76.97
31646	T	Bronchoscopy, reclear airway	0076	7.56	$384.83	$188.57	$76.97
31656	T	Bronchoscopy, inj for xray	0076	7.56	$384.83	$188.57	$76.97
31700	T	Insertion of airway catheter	0072	1.21	$61.59	$33.87	$12.32
31708	N	Instill airway contrast dye					
31710	N	Insertion of airway catheter					
31715	N	Injection for bronchus x-ray					
31717	T	Bronchial brush biopsy	0073	3.29	$167.47	$73.69	$33.49
31720	T	Clearance of airways	0072	1.21	$61.59	$33.87	$12.32
31725	C	Clearance of airways					
31730	T	Intro, windpipe wire/tube	0073	3.29	$167.47	$73.69	$33.49
31750	T	Repair of windpipe	0256	26.61	$1,354.56	$623.05	$270.91
31755	T	Repair of windpipe	0256	26.61	$1,354.56	$623.05	$270.91
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	0253	12.33	$627.65	$284.00	$125.53
31825	T	Repair of windpipe defect	0254	17.37	$884.20	$272.41	$176.84
31830	T	Revise windpipe scar	0254	17.37	$884.20	$272.41	$176.84
31899	T	Airways surgical procedure	0076	7.56	$384.83	$188.57	$76.97
32000	T	Drainage of chest	0070	4.58	$233.14	$79.60	$46.63
32002	T	Treatment of collapsed lung	0070	4.58	$233.14	$79.60	$46.63
32005	T	Treat lung lining chemically	0070	4.58	$233.14	$79.60	$46.63
32020	T	Insertion of chest tube	0070	4.58	$233.14	$79.60	$46.63
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	Drain, open, lung lesion					
32201	C	Drain, percut, lung lesion					
32215	C	Treat chest lining					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0005	4.03	$205.14	$90.26	$41.03
32402	C	Open biopsy chest lining					
32405	T	Biopsy, lung or mediastinum	0685	9.16	$466.28	$205.16	$93.26
32420	T	Puncture/clear lung	0070	4.58	$233.14	$79.60	$46.63
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	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32602	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32603	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32604	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32605	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32606	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
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 with bypass					
32853	C	Lung transplant, double					
32854	C	Lung transplant with 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	0070	4.58	$233.14	$79.60	$46.63
32997	C	Total lung lavage					
32999	T	Chest surgery procedure	0070	4.58	$233.14	$79.60	$46.63
33010	T	Drainage of heart sac	0070	4.58	$233.14	$79.60	$46.63
33011	T	Repeat drainage of heart sac	0070	4.58	$233.14	$79.60	$46.63
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					
33140	C	Heart revascularize (tmr)					
33141	C	Heart tmr w/other procedure					
33200	C	Insertion of heart pacemaker					
33201	C	Insertion of heart pacemaker					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33206	T	Insertion of heart pacemaker	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33207	T	Insertion of heart pacemaker	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33208	T	Insertion of heart pacemaker	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33210	T	Insertion of heart electrode	0106	36.64	$1,865.12	$503.07	$373.02
33211	T	Insertion of heart electrode	0106	36.64	$1,865.12	$503.07	$373.02
33212	T	Insertion of pulse generator	0090	117.54	$5,983.26	$2,133.88	$1,196.65
33213	T	Insertion of pulse generator	0090	117.54	$5,983.26	$2,133.88	$1,196.65
33214	T	Upgrade of pacemaker system	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33216	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33217	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33218	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33220	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33222	T	Revise pocket, pacemaker	0026	12.62	$642.41	$277.92	$128.48
33223	T	Revise pocket, pacing-defib	0026	12.62	$642.41	$277.92	$128.48
33233	T	Removal of pacemaker system	0105	14.76	$751.34	$368.16	$150.27
33234	T	Removal of pacemaker system	0105	14.76	$751.34	$368.16	$150.27
33235	T	Removal pacemaker electrode	0105	14.76	$751.34	$368.16	$150.27
33236	C	Remove electrode/thoracotomy					
33237	C	Remove electrode/thoracotomy					
33238	C	Remove electrode/thoracotomy					
33240	T	Insert pulse generator	0107	379.46	$19,316.03	$4,224.27	$3,863.21
33241	T	Remove pulse generator	0105	14.76	$751.34	$368.16	$150.27
33243	C	Remove eltrd/thoracotomy					
33244	T	Remove eltrd, transven	0105	14.76	$751.34	$368.16	$150.27
33245	C	Insert epic eltrd pace-defib					
33246	C	Insert epic eltrd/generator					
33249	T	Eltrd/insert pace-defib	0108	573.46	$29,191.41		$5,838.28
33250	C	Ablate heart dysrhythm focus					
33251	C	Ablate heart dysrhythm focus					
33253	C	Reconstruct atria					
33261	C	Ablate heart dysrhythm focus					
33282	S	Implant pat-active ht record	0710		$400.00		$80.00
33284	T	Remove pat-active ht record	0109	6.27	$319.17	$130.86	$63.83
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 of aortic valve					
33410	C	Replacement of aortic valve					
33411	C	Replacement of aortic valve					
33412	C	Replacement of aortic valve					
33413	C	Replacement of aortic valve					
33414	C	Repair of 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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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 or more					
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, art-vein, six or more					
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 or more					
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, modified fontan					
33617	C	Repair single ventricle					
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	Major vessel shunt					
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					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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 aortic graft					
33861	C	Ascending aortic graft					
33863	C	Ascending aortic graft					
33870	C	Transverse aortic arch graft					
33875	C	Thoracic aortic 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					
*33967	C	Insert ia percut device					
33968	C	Remove aortic assist device					
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					
*33979	C	Insert intracorporeal device					
*33980	C	Remove intracorporeal device					
33999	T	Cardiac surgery procedure	0070	4.58	$233.14	$79.60	$46.63
34001	C	Removal of artery clot					
34051	C	Removal of artery clot					
34101	T	Removal of artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34111	T	Removal of arm artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34151	C	Removal of artery clot					
34201	T	Removal of artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34203	T	Removal of leg artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34401	C	Removal of vein clot					
34421	T	Removal of vein clot	0088	34.38	$1,750.08	$678.68	$350.02
34451	C	Removal of vein clot					
34471	T	Removal of vein clot	0088	34.38	$1,750.08	$678.68	$350.02
34490	T	Removal of vein clot	0088	34.38	$1,750.08	$678.68	$350.02
34501	T	Repair valve, femoral vein	0088	34.38	$1,750.08	$678.68	$350.02
34502	C	Reconstruct vena cava					
34510	T	Transposition of vein valve	0088	34.38	$1,750.08	$678.68	$350.02
34520	T	Cross-over vein graft	0088	34.38	$1,750.08	$678.68	$350.02
34530	T	Leg vein fusion	0088	34.38	$1,750.08	$678.68	$350.02
34800	C	Endovasc abdo repair w/tube					
34802	C	Endovasc abdo repr w/device					
34804	C	Endovasc abdo repr w/device					
34808	C	Endovasc abdo occlud device					
34812	C	Xpose for endoprosth, aortic					
34813	C	Xpose for endoprosth, femorl					
34820	C	Xpose for endoprosth, iliac					
34825	C	Endovasc extend prosth, init					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
34826	C	Endovasc exten prosth, addl					
34830	C	Open aortic tube prosth repr					
34831	C	Open aortoiliac prosth repr					
34832	C	Open aortofemor prosth repr					
35001	C	Repair defect of artery					
35002	C	Repair artery rupture, neck					
35005	C	Repair defect of artery					
35011	T	Repair defect of artery	0093	14.16	$720.80	$277.34	$144.16
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	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35182	C	Repair blood vessel lesion					
35184	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35188	T	Repair blood vessel lesion	0088	34.38	$1,750.08	$678.68	$350.02
35189	C	Repair blood vessel lesion					
35190	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35201	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35206	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35207	T	Repair blood vessel lesion	0088	34.38	$1,750.08	$678.68	$350.02
35211	C	Repair blood vessel lesion					
35216	C	Repair blood vessel lesion					
35221	C	Repair blood vessel lesion					
35226	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35231	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35236	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35241	C	Repair blood vessel lesion					
35246	C	Repair blood vessel lesion					
35251	C	Repair blood vessel lesion					
35256	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35261	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35266	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35271	C	Repair blood vessel lesion					
35276	C	Repair blood vessel lesion					
35281	C	Repair blood vessel lesion					
35286	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35301	C	Rechanneling of artery					
35311	C	Rechanneling of artery					
35321	T	Rechanneling of artery	0093	14.16	$720.80	$277.34	$144.16
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 add-on					
35400	C	Angioscopy					
35450	C	Repair arterial blockage					
35452	C	Repair arterial blockage					
35454	C	Repair arterial blockage					
35456	C	Repair arterial blockage					
35458	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35459	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35460	T	Repair venous blockage	0081	29.24	$1,488.43	$710.91	$297.69
35470	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35471	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35472	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35473	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35474	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35475	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35476	T	Repair venous blockage	0081	29.24	$1,488.43	$710.91	$297.69
35480	C	Atherectomy, open					
35481	C	Atherectomy, open					
35482	C	Atherectomy, open					
35483	C	Atherectomy, open					
35484	T	Atherectomy, open	0081	29.24	$1,488.43	$710.91	$297.69
35485	T	Atherectomy, open	0081	29.24	$1,488.43	$710.91	$297.69
35490	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35491	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35492	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35493	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35494	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35495	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35500	T	Harvest vein for bypass	0081	29.24	$1,488.43	$710.91	$297.69
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					
35600	C	Harvest artery for cabg					
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					
*35647	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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35681	C	Composite bypass graft					
35682	C	Composite bypass graft					
35683	C	Composite bypass graft					
*35685	T	Bypass graft patency/patch	0093	14.16	$720.80	$277.34	$144.16
*35686	T	Bypass graft/av fist patency	0093	14.16	$720.80	$277.34	$144.16
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	T	Exploration of artery/vein	0115	21.35	$1,086.80	$506.74	$217.36
35800	C	Explore neck vessels					
35820	C	Explore chest vessels					
35840	C	Explore abdominal vessels					
35860	T	Explore limb vessels	0093	14.16	$720.80	$277.34	$144.16
35870	C	Repair vessel graft defect					
35875	T	Removal of clot in graft	0088	34.38	$1,750.08	$678.68	$350.02
35876	T	Removal of clot in graft	0088	34.38	$1,750.08	$678.68	$350.02
35879	T	Revise graft w/vein	0088	34.38	$1,750.08	$678.68	$350.02
35881	T	Revise graft w/vein	0088	34.38	$1,750.08	$678.68	$350.02
35901	C	Excision, graft, neck					
35903	T	Excision, graft, extremity	0115	21.35	$1,086.80	$506.74	$217.36
35905	C	Excision, graft, thorax					
35907	C	Excision, graft, abdomen					
36000	N	Place needle in vein					
*36002	S	Pseudoaneurysm injection trt	0267	2.33	$118.61	$65.23	$23.72
36005	N	Injection, venography					
36010	N	Place catheter in vein					
36011	N	Place catheter in vein					
36012	N	Place catheter in vein					
36013	N	Place catheter in artery					
36014	N	Place catheter in artery					
36015	N	Place catheter in artery					
36100	N	Establish access to artery					
36120	N	Establish access to artery					
36140	N	Establish access to artery					
36145	N	Artery to vein shunt					
36160	N	Establish access to aorta					
36200	N	Place catheter in aorta					
36215	N	Place catheter in artery					
36216	N	Place catheter in artery					
36217	N	Place catheter in artery					
36218	N	Place catheter in artery					
36245	N	Place catheter in artery					
36246	N	Place catheter in artery					
36247	N	Place catheter in artery					
36248	N	Place catheter in artery					
36260	T	Insertion of infusion pump	0119	79.67	$4,055.52		$811.10
36261	T	Revision of infusion pump	0124	89.07	$4,534.02		$906.80
36262	T	Removal of infusion pump	0109	6.27	$319.17	$130.86	$63.83
36299	N	Vessel injection procedure					
36400	N	Drawing blood					
36405	N	Drawing blood					
36406	N	Drawing blood					
36410	N	Drawing blood					
36415	E	Drawing blood					
36420	T	Establish access to vein	0035	0.12	$6.11	$2.69	$1.22
36425	T	Establish access to vein	0035	0.12	$6.11	$2.69	$1.22
36430	S	Blood transfusion service	0110	5.30	$269.79	$113.31	$53.96
36440	S	Blood transfusion service	0110	5.30	$269.79	$113.31	$53.96
36450	S	Exchange transfusion service	0110	5.30	$269.79	$113.31	$53.96
36455	S	Exchange transfusion service	0110	5.30	$269.79	$113.31	$53.96
36460	S	Transfusion service, fetal	0110	5.30	$269.79	$113.31	$53.96
36468	T	Injection(s), spider veins	0098	1.24	$63.12	$20.88	$12.62
36469	T	Injection(s), spider veins	0098	1.24	$63.12	$20.88	$12.62
36470	T	Injection therapy of vein	0098	1.24	$63.12	$20.88	$12.62
36471	T	Injection therapy of veins	0098	1.24	$63.12	$20.88	$12.62
36481	N	Insertion of catheter, vein					
36488	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69
36489	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69
36490	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69
36491	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36493	X	Repositioning of cvc	0187	4.22	$214.81	.....	$42.96
36500	N	Insertion of catheter, vein	.....	.....	.....	.....	.....
36510	C	Insertion of catheter, vein	.....	.....	.....	.....	.....
36520	S	Plasma and/or cell exchange	0111	21.08	$1,073.06	$300.74	$214.61
36521	S	Apheresis w/ adsorp/reinfuse	0112	36.25	$1,845.27	$608.94	$369.05
36522	S	Photopheresis	0112	36.25	$1,845.27	$608.94	$369.05
36530	T	Insertion of infusion pump	0119	79.67	$4,055.52	.....	$811.10
36531	T	Revision of infusion pump	0124	89.07	$4,534.02	.....	$906.80
36532	T	Removal of infusion pump	0109	6.27	$319.17	$130.86	$63.83
36533	T	Insertion of access device	0115	21.35	$1,086.80	$506.74	$217.36
36534	T	Revision of access device	0109	6.27	$319.17	$130.86	$63.83
36535	T	Removal of access device	0109	6.27	$319.17	$130.86	$63.83
36540	N	Collect blood venous device	.....	.....	.....	.....	.....
36550	T	Declot vascular device	0972	.....	$150.00	.....	$30.00
36600	N	Withdrawal of arterial blood	.....	.....	.....	.....	.....
36620	N	Insertion catheter, artery	.....	.....	.....	.....	.....
36625	N	Insertion catheter, artery	.....	.....	.....	.....	.....
36640	T	Insertion catheter, artery	0032	12.64	$643.43	.....	$128.69
36660	C	Insertion catheter, artery	.....	.....	.....	.....	.....
36680	T	Insert needle, bone cavity	0120	3.08	$156.78	$42.67	$31.36
36800	T	Insertion of cannula	0115	21.35	$1,086.80	$506.74	$217.36
36810	T	Insertion of cannula	0115	21.35	$1,086.80	$506.74	$217.36
36815	T	Insertion of cannula	0115	21.35	$1,086.80	$506.74	$217.36
36819	T	Av fusion by basilic vein	0088	34.38	$1,750.08	$678.68	$350.02
*36820	T	Av fusion/forearm vein	0088	34.38	$1,750.08	$678.68	$350.02
36821	T	Av fusion direct any site	0088	34.38	$1,750.08	$678.68	$350.02
36822	C	Insertion of cannula(s)	.....	.....	.....	.....	.....
36823	C	Insertion of cannula(s)	.....	.....	.....	.....	.....
36825	T	Artery-vein graft	0088	34.38	$1,750.08	$678.68	$350.02
36830	T	Artery-vein graft	0088	34.38	$1,750.08	$678.68	$350.02
36831	T	Av fistula excision, open	0088	34.38	$1,750.08	$678.68	$350.02
36832	T	Av fistula revision, open	0088	34.38	$1,750.08	$678.68	$350.02
36833	T	Av fistula revision	0088	34.38	$1,750.08	$678.68	$350.02
36834	T	Repair A-V aneurysm	0088	34.38	$1,750.08	$678.68	$350.02
36835	T	Artery to vein shunt	0115	21.35	$1,086.80	$506.74	$217.36
36860	T	External cannula declotting	0115	21.35	$1,086.80	$506.74	$217.36
36861	T	Cannula declotting	0115	21.35	$1,086.80	$506.74	$217.36
36870	T	Av fistula revision, open	0093	14.16	$720.80	$277.34	$144.16
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	T	Transcatheter biopsy	0685	9.16	$466.28	$205.16	$93.26
37201	T	Transcatheter therapy infuse	0120	3.08	$156.78	$42.67	$31.36
37202	T	Transcatheter therapy infuse	0120	3.08	$156.78	$42.67	$31.36
37203	T	Transcatheter retrieval	0103	15.95	$811.92	$295.70	$162.38
37204	T	Transcatheter occlusion	0103	15.95	$811.92	$295.70	$162.38
37205	T	Transcatheter stent	0229	67.22	$3,421.77	$996.86	$684.35
37206	T	Transcatheter stent add-on	0229	67.22	$3,421.77	$996.86	$684.35
37207	T	Transcatheter stent	0229	67.22	$3,421.77	$996.86	$684.35
37208	T	Transcatheter stent add-on	0229	67.22	$3,421.77	$996.86	$684.35
37209	T	Exchange arterial catheter	0103	15.95	$811.92	$295.70	$162.38
37250	T	Iv us first vessel add-on	0103	15.95	$811.92	$295.70	$162.38
37251	T	Iv us each add vessel add-on	0103	15.95	$811.92	$295.70	$162.38
37565	T	Ligation of neck vein	0093	14.16	$720.80	$277.34	$144.16
37600	T	Ligation of neck artery	0093	14.16	$720.80	$277.34	$144.16
37605	T	Ligation of neck artery	0091	20.34	$1,035.39	$348.23	$207.08
37606	T	Ligation of neck artery	0091	20.34	$1,035.39	$348.23	$207.08
37607	T	Ligation of a-v fistula	0092	19.91	$1,013.50	$503.71	$202.70
37609	T	Temporal artery procedure	0020	8.44	$429.63	$130.53	$85.93
37615	T	Ligation of neck artery	0091	20.34	$1,035.39	$348.23	$207.08
37616	C	Ligation of chest artery	.....	.....	.....	.....	.....
37617	C	Ligation of abdomen artery	.....	.....	.....	.....	.....
37618	C	Ligation of extremity artery	.....	.....	.....	.....	.....
37620	T	Revision of major vein	0091	20.34	$1,035.39	$348.23	$207.08
37650	T	Revision of major vein	0091	20.34	$1,035.39	$348.23	$207.08
37660	C	Revision of major vein	.....	.....	.....	.....	.....
37700	T	Revise leg vein	0091	20.34	$1,035.39	$348.23	$207.08
37720	T	Removal of leg vein	0092	19.91	$1,013.50	$503.71	$202.70
37730	T	Removal of leg veins	0092	19.91	$1,013.50	$503.71	$202.70
37735	T	Removal of leg veins/lesion	0092	19.91	$1,013.50	$503.71	$202.70
37760	T	Revision of leg veins	0091	20.34	$1,035.39	$348.23	$207.08
37780	T	Revision of leg vein	0091	20.34	$1,035.39	$348.23	$207.08

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37785	T	Revise secondary varicosity	0091	20.34	$1,035.39	$348.23	$207.08
37788	C	Revascularization, penis					
37790	T	Penile venous occlusion	0181	22.09	$1,124.47	$618.45	$224.89
37799	T	Vascular surgery procedure	0020	8.44	$429.63	$130.53	$85.93
38100	C	Removal of spleen, total					
38101	C	Removal of spleen, partial					
38102	C	Removal of spleen, total					
38115	C	Repair of ruptured spleen					
38120	T	Laparoscopy, splenectomy	0131	37.63	$1,915.52	$996.07	$383.10
38129	T	Laparoscope proc, spleen	0130	25.91	$1,318.92	$659.53	$263.78
38200	N	Injection for spleen x-ray					
*38220	T	Bone marrow aspiration	0003	1.03	$52.43	$27.99	$10.49
*38221	T	Bone marrow biopsy	0003	1.03	$52.43	$27.99	$10.49
38230	S	Bone marrow collection	0123	8.56	$435.74		$87.15
38231	S	Stem cell collection	0111	21.08	$1,073.06	$300.74	$214.61
38240	S	Bone marrow/stem transplant	0123	8.56	$435.74		$87.15
38241	S	Bone marrow/stem transplant	0123	8.56	$435.74		$87.15
38300	T	Drainage, lymph node lesion	0008	10.93	$556.38	$113.67	$111.28
38305	T	Drainage, lymph node lesion	0008	10.93	$556.38	$113.67	$111.28
38308	T	Incision of lymph channels	0113	15.53	$790.54	$326.55	$158.11
38380	C	Thoracic duct procedure					
38381	C	Thoracic duct procedure					
38382	C	Thoracic duct procedure					
38500	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38505	T	Needle biopsy, lymph nodes	0005	4.03	$205.14	$90.26	$41.03
38510	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38520	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38525	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38530	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38542	T	Explore deep node(s), neck	0114	29.28	$1,490.47	$493.78	$298.09
38550	T	Removal, neck/armpit lesion	0113	15.53	$790.54	$326.55	$158.11
38555	T	Removal, neck/armpit lesion	0113	15.53	$790.54	$326.55	$158.11
38562	C	Removal, pelvic lymph nodes					
38564	C	Removal, abdomen lymph nodes					
38570	T	Laparoscopy, lymph node biop	0131	37.63	$1,915.52	$996.07	$383.10
38571	T	Laparoscopy, lymphadenectomy	0132	56.06	$2,853.68	$1,239.22	$570.74
38572	T	Laparoscopy, lymphadenectomy	0131	37.63	$1,915.52	$996.07	$383.10
38589	T	Laparoscope proc, lymphatic	0130	25.91	$1,318.92	$659.53	$263.78
38700	C	Removal of lymph nodes, neck					
38720	T	Removal of lymph nodes, neck	0113	15.53	$790.54	$326.55	$158.11
38724	C	Removal of lymph nodes, neck					
38740	T	Remove armpit lymph nodes	0114	29.28	$1,490.47	$493.78	$298.09
38745	T	Remove armpit lymph nodes	0114	29.28	$1,490.47	$493.78	$298.09
38746	C	Remove thoracic lymph nodes					
38747	C	Remove abdominal lymph nodes					
38760	T	Remove groin lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38765	C	Remove groin lymph nodes					
38770	C	Remove pelvis lymph nodes					
38780	C	Remove abdomen lymph nodes					
38790	N	Inject for lymphatic x-ray					
38792	N	Identify sentinel node					
38794	N	Access thoracic lymph duct					
38999	T	Blood/lymph system procedure	0008	10.93	$556.38	$113.67	$111.28
39000	C	Exploration of chest					
39010	C	Exploration of chest					
39200	C	Removal chest lesion					
39220	C	Removal chest lesion					
39400	T	Visualization of chest	0069	23.57	$1,199.81		$239.96
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					
39560	C	Resect diaphragm, simple					
39561	C	Resect diaphragm, complex					
39599	C	Diaphragm surgery procedure					
40490	T	Biopsy of lip	0251	2.43	$123.70	$27.99	$24.74
40500	T	Partial excision of lip	0253	12.33	$627.65	$284.00	$125.53
40510	T	Partial excision of lip	0254	17.37	$884.20	$272.41	$176.84
40520	T	Partial excision of lip	0253	12.33	$627.65	$284.00	$125.53

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40525	T	Reconstruct lip with flap	0254	17.37	$884.20	$272.41	$176.84
40527	T	Reconstruct lip with flap	0254	17.37	$884.20	$272.41	$176.84
40530	T	Partial removal of lip	0254	17.37	$884.20	$272.41	$176.84
40650	T	Repair lip	0252	5.95	$302.88	$114.24	$60.58
40652	T	Repair lip	0252	5.95	$302.88	$114.24	$60.58
40654	T	Repair lip	0252	5.95	$302.88	$114.24	$60.58
40700	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40701	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40702	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40720	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40761	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40799	T	Lip surgery procedure	0253	12.33	$627.65	$284.00	$125.53
40800	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
40801	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
40804	X	Removal, foreign body, mouth	0340	0.84	$42.76	$10.69	$8.55
40805	T	Removal, foreign body, mouth	0252	5.95	$302.88	$114.24	$60.58
40806	T	Incision of lip fold	0251	2.43	$123.70	$27.99	$24.74
40808	T	Biopsy of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
40810	T	Excision of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
40812	T	Excise/repair mouth lesion	0252	5.95	$302.88	$114.24	$60.58
40814	T	Excise/repair mouth lesion	0253	12.33	$627.65	$284.00	$125.53
40816	T	Excision of mouth lesion	0254	17.37	$884.20	$272.41	$176.84
40818	T	Excise oral mucosa for graft	0251	2.43	$123.70	$27.99	$24.74
40819	T	Excise lip or cheek fold	0252	5.95	$302.88	$114.24	$60.58
40820	T	Treatment of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
40830	T	Repair mouth laceration	0251	2.43	$123.70	$27.99	$24.74
40831	T	Repair mouth laceration	0252	5.95	$302.88	$114.24	$60.58
40840	T	Reconstruction of mouth	0254	17.37	$884.20	$272.41	$176.84
40842	T	Reconstruction of mouth	0254	17.37	$884.20	$272.41	$176.84
40843	T	Reconstruction of mouth	0254	17.37	$884.20	$272.41	$176.84
40844	T	Reconstruction of mouth	0256	26.61	$1,354.56	$623.05	$270.91
40845	T	Reconstruction of mouth	0256	26.61	$1,354.56	$623.05	$270.91
40899	T	Mouth surgery procedure	0252	5.95	$302.88	$114.24	$60.58
41000	T	Drainage of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41005	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
41006	T	Drainage of mouth lesion	0254	17.37	$884.20	$272.41	$176.84
41007	T	Drainage of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41008	T	Drainage of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41009	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
41010	T	Incision of tongue fold	0253	12.33	$627.65	$284.00	$125.53
41015	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
41016	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
41017	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
41018	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
41100	T	Biopsy of tongue	0252	5.95	$302.88	$114.24	$60.58
41105	T	Biopsy of tongue	0253	12.33	$627.65	$284.00	$125.53
41108	T	Biopsy of floor of mouth	0252	5.95	$302.88	$114.24	$60.58
41110	T	Excision of tongue lesion	0253	12.33	$627.65	$284.00	$125.53
41112	T	Excision of tongue lesion	0253	12.33	$627.65	$284.00	$125.53
41113	T	Excision of tongue lesion	0253	12.33	$627.65	$284.00	$125.53
41114	T	Excision of tongue lesion	0254	17.37	$884.20	$272.41	$176.84
41115	T	Excision of tongue fold	0252	5.95	$302.88	$114.24	$60.58
41116	T	Excision of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41120	T	Partial removal of tongue	0256	26.61	$1,354.56	$623.05	$270.91
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	0251	2.43	$123.70	$27.99	$24.74
41251	T	Repair tongue laceration	0252	5.95	$302.88	$114.24	$60.58
41252	T	Repair tongue laceration	0252	5.95	$302.88	$114.24	$60.58
41500	T	Fixation of tongue	0254	17.37	$884.20	$272.41	$176.84
41510	T	Tongue to lip surgery	0253	12.33	$627.65	$284.00	$125.53
41520	T	Reconstruction, tongue fold	0252	5.95	$302.88	$114.24	$60.58
41599	T	Tongue and mouth surgery	0251	2.43	$123.70	$27.99	$24.74
41800	T	Drainage of gum lesion	0251	2.43	$123.70	$27.99	$24.74
41805	T	Removal foreign body, gum	0254	17.37	$884.20	$272.41	$176.84
41806	T	Removal foreign body, jawbone	0253	12.33	$627.65	$284.00	$125.53
41820	T	Excision, gum, each quadrant	0252	5.95	$302.88	$114.24	$60.58
41821	T	Excision of gum flap	0252	5.95	$302.88	$114.24	$60.58
41822	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41823	T	Excision of gum lesion	0254	17.37	$884.20	$272.41	$176.84

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41825	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41826	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41827	T	Excision of gum lesion	0254	17.37	$884.20	$272.41	$176.84
41828	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41830	T	Removal of gum tissue	0253	12.33	$627.65	$284.00	$125.53
41850	T	Treatment of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41870	T	Gum graft	0254	17.37	$884.20	$272.41	$176.84
41872	T	Repair gum	0253	12.33	$627.65	$284.00	$125.53
41874	T	Repair tooth socket	0254	17.37	$884.20	$272.41	$176.84
41899	T	Dental surgery procedure	0253	12.33	$627.65	$284.00	$125.53
42000	T	Drainage mouth roof lesion	0251	2.43	$123.70	$27.99	$24.74
42100	T	Biopsy roof of mouth	0252	5.95	$302.88	$114.24	$60.58
42104	T	Excision lesion, mouth roof	0253	12.33	$627.65	$284.00	$125.53
42106	T	Excision lesion, mouth roof	0253	12.33	$627.65	$284.00	$125.53
42107	T	Excision lesion, mouth roof	0254	17.37	$884.20	$272.41	$176.84
42120	T	Remove palate/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42140	T	Excision of uvula	0252	5.95	$302.88	$114.24	$60.58
42145	T	Repair palate, pharynx/uvula	0254	17.37	$884.20	$272.41	$176.84
42160	T	Treatment mouth roof lesion	0253	12.33	$627.65	$284.00	$125.53
42180	T	Repair palate	0251	2.43	$123.70	$27.99	$24.74
42182	T	Repair palate	0256	26.61	$1,354.56	$623.05	$270.91
42200	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42205	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42210	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42215	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42220	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42225	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42226	T	Lengthening of palate	0256	26.61	$1,354.56	$623.05	$270.91
42227	T	Lengthening of palate	0256	26.61	$1,354.56	$623.05	$270.91
42235	T	Repair palate	0253	12.33	$627.65	$284.00	$125.53
42260	T	Repair nose to lip fistula	0254	17.37	$884.20	$272.41	$176.84
42280	T	Preparation, palate mold	0251	2.43	$123.70	$27.99	$24.74
42281	T	Insertion, palate prosthesis	0253	12.33	$627.65	$284.00	$125.53
42299	T	Palate/uvula surgery	0251	2.43	$123.70	$27.99	$24.74
42300	T	Drainage of salivary gland	0253	12.33	$627.65	$284.00	$125.53
42305	T	Drainage of salivary gland	0253	12.33	$627.65	$284.00	$125.53
42310	T	Drainage of salivary gland	0251	2.43	$123.70	$27.99	$24.74
42320	T	Drainage of salivary gland	0251	2.43	$123.70	$27.99	$24.74
42325	T	Create salivary cyst drain	0251	2.43	$123.70	$27.99	$24.74
42326	T	Create salivary cyst drain	0252	5.95	$302.88	$114.24	$60.58
42330	T	Removal of salivary stone	0252	5.95	$302.88	$114.24	$60.58
42335	T	Removal of salivary stone	0253	12.33	$627.65	$284.00	$125.53
42340	T	Removal of salivary stone	0253	12.33	$627.65	$284.00	$125.53
42400	T	Biopsy of salivary gland	0004	2.47	$125.73	$32.57	$25.15
42405	T	Biopsy of salivary gland	0253	12.33	$627.65	$284.00	$125.53
42408	T	Excision of salivary cyst	0253	12.33	$627.65	$284.00	$125.53
42409	T	Drainage of salivary cyst	0253	12.33	$627.65	$284.00	$125.53
42410	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42415	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42420	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42425	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42426	C	Excise parotid gland/lesion	.....	.....	.....	.....	.....
42440	T	Excise submaxillary gland	0256	26.61	$1,354.56	$623.05	$270.91
42450	T	Excise sublingual gland	0254	17.37	$884.20	$272.41	$176.84
42500	T	Repair salivary duct	0254	17.37	$884.20	$272.41	$176.84
42505	T	Repair salivary duct	0256	26.61	$1,354.56	$623.05	$270.91
42507	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42508	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42509	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42510	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42550	N	Injection for salivary x-ray	.....	.....	.....	.....	.....
42600	T	Closure of salivary fistula	0253	12.33	$627.65	$284.00	$125.53
42650	T	Dilation of salivary duct	0252	5.95	$302.88	$114.24	$60.58
42660	T	Dilation of salivary duct	0252	5.95	$302.88	$114.24	$60.58
42665	T	Ligation of salivary duct	0254	17.37	$884.20	$272.41	$176.84
42699	T	Salivary surgery procedure	0253	12.33	$627.65	$284.00	$125.53
42700	T	Drainage of tonsil abscess	0251	2.43	$123.70	$27.99	$24.74
42720	T	Drainage of throat abscess	0253	12.33	$627.65	$284.00	$125.53
42725	T	Drainage of throat abscess	0256	26.61	$1,354.56	$623.05	$270.91
42800	T	Biopsy of throat	0252	5.95	$302.88	$114.24	$60.58
42802	T	Biopsy of throat	0253	12.33	$627.65	$284.00	$125.53
42804	T	Biopsy of upper nose/throat	0253	12.33	$627.65	$284.00	$125.53
42806	T	Biopsy of upper nose/throat	0254	17.37	$884.20	$272.41	$176.84
42808	T	Excise pharynx lesion	0253	12.33	$627.65	$284.00	$125.53
42809	X	Remove pharynx foreign body	0340	0.84	$42.76	$10.69	$8.55

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42810	T	Excision of neck cyst	0254	17.37	$884.20	$272.41	$176.84
42815	T	Excision of neck cyst	0256	26.61	$1,354.56	$623.05	$270.91
42820	T	Remove tonsils and adenoids	0258	17.43	$887.26	$434.76	$177.45
42821	T	Remove tonsils and adenoids	0258	17.43	$887.26	$434.76	$177.45
42825	T	Removal of tonsils	0258	17.43	$887.26	$434.76	$177.45
42826	T	Removal of tonsils	0258	17.43	$887.26	$434.76	$177.45
42830	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42831	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42835	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42836	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42842	C	Extensive surgery of throat					
42844	T	Extensive surgery of throat	0256	26.61	$1,354.56	$623.05	$270.91
42845	C	Extensive surgery of throat					
42860	T	Excision of tonsil tags	0258	17.43	$887.26	$434.76	$177.45
42870	T	Excision of lingual tonsil	0258	17.43	$887.26	$434.76	$177.45
42890	T	Partial removal of pharynx	0256	26.61	$1,354.56	$623.05	$270.91
42892	T	Revision of pharyngeal walls	0256	26.61	$1,354.56	$623.05	$270.91
42894	C	Revision of pharyngeal walls					
42900	T	Repair throat wound	0252	5.95	$302.88	$114.24	$60.58
42950	T	Reconstruction of throat	0254	17.37	$884.20	$272.41	$176.84
42953	C	Repair throat, esophagus					
42955	T	Surgical opening of throat	0254	17.37	$884.20	$272.41	$176.84
42960	T	Control throat bleeding	0250	2.10	$106.90	$37.42	$21.38
42961	C	Control throat bleeding					
42962	T	Control throat bleeding	0256	26.61	$1,354.56	$623.05	$270.91
42970	T	Control nose/throat bleeding	0250	2.10	$106.90	$37.42	$21.38
42971	C	Control nose/throat bleeding					
42972	T	Control nose/throat bleeding	0253	12.33	$627.65	$284.00	$125.53
42999	T	Throat surgery procedure	0252	5.95	$302.88	$114.24	$60.58
43020	T	Incision of esophagus	0252	5.95	$302.88	$114.24	$60.58
43030	C	Throat muscle surgery					
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	Parital removal of esophagus					
43123	C	Partial removal of esophagus					
43124	C	Removal of esophagus					
43130	T	Removal of esophagus pouch	0254	17.37	$884.20	$272.41	$176.84
43135	C	Removal of esophagus pouch					
43200	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43202	T	Esophagus endoscopy, biopsy	0141	7.21	$367.02	$184.67	$73.40
43204	T	Esophagus endoscopy & inject	0141	7.21	$367.02	$184.67	$73.40
43205	T	Esophagus endoscopy/ligation	0141	7.21	$367.02	$184.67	$73.40
43215	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43216	T	Esophagus endoscopy/lesion	0141	7.21	$367.02	$184.67	$73.40
43217	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43219	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43220	T	Esoph endoscopy, dilation	0141	7.21	$367.02	$184.67	$73.40
43226	T	Esoph endoscopy, dilation	0141	7.21	$367.02	$184.67	$73.40
43227	T	Esoph endoscopy, repair	0141	7.21	$367.02	$184.67	$73.40
43228	T	Esoph endoscopy, ablation	0141	7.21	$367.02	$184.67	$73.40
43231	T	Esoph endoscopy w/us exam	0141	7.21	$367.02	$184.67	$73.40
43232	T	Esoph endoscopy w/us fn bx	0141	7.21	$367.02	$184.67	$73.40
43234	T	Upper GI endoscopy, exam	0141	7.21	$367.02	$184.67	$73.40
43235	T	Uppr gi endoscopy, diagnosis	0141	7.21	$367.02	$184.67	$73.40
43239	T	Upper GI endoscopy, biopsy	0141	7.21	$367.02	$184.67	$73.40
43240	T	Esoph endoscope w/drain cyst	0141	7.21	$367.02	$184.67	$73.40
43241	T	Upper GI endoscopy with tube	0141	7.21	$367.02	$184.67	$73.40
43242	T	Uppr gi endoscopy w/us fn bx	0141	7.21	$367.02	$184.67	$73.40
43243	T	Upper gi endoscopy & inject	0141	7.21	$367.02	$184.67	$73.40
43244	T	Upper GI endoscopy/ligation	0141	7.21	$367.02	$184.67	$73.40
43245	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43246	T	Place gastrostomy tube	0141	7.21	$367.02	$184.67	$73.40
43247	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43248	T	Uppr gi endoscopy/guide wire	0141	7.21	$367.02	$184.67	$73.40
43249	T	Esoph endoscopy, dilation	0141	7.21	$367.02	$184.67	$73.40
43250	T	Upper GI endoscopy/tumor	0141	7.21	$367.02	$184.67	$73.40

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43251	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43255	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43256	T	Uppr gi endoscopy w stent	0141	7.21	$367.02	$184.67	$73.40
43258	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43259	T	Endoscopic ultrasound exam	0141	7.21	$367.02	$184.67	$73.40
43260	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43261	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43262	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43263	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43264	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43265	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43267	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43268	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43269	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43271	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43272	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43280	T	Laparoscopy, fundoplasty	0132	56.06	$2,853.68	$1,239.22	$570.74
43289	T	Laparoscope proc, esoph	0130	25.91	$1,318.92	$659.53	$263.78
43300	C	Repair of esophagus					
43305	C	Repair esophagus and fistula					
43310	C	Repair of esophagus					
43312	C	Repair esophagus and fistula					
*43313	C	Esophagoplasty congential					
*43314	C	Tracheo-esophagoplasty cong					
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	0140	5.65	$287.61	$107.24	$57.52
43453	T	Dilate esophagus	0140	5.65	$287.61	$107.24	$57.52
43456	T	Dilate esophagus	0140	5.65	$287.61	$107.24	$57.52
43458	T	Dilate esophagus	0140	5.65	$287.61	$107.24	$57.52
43460	C	Pressure treatment esophagus					
43496	C	Free jejunum flap, microvasc					
43499	T	Esophagus surgery procedure	0140	5.65	$287.61	$107.24	$57.52
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	0141	7.21	$367.02	$184.67	$73.40
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 of stomach, partial					
43633	C	Removal of stomach, partial					
43634	C	Removal of stomach, partial					
43635	C	Removal of stomach, partial					
43638	C	Removal of stomach, partial					
43639	C	Removal of stomach, partial					
43640	C	Vagotomy & pylorus repair					
43641	C	Vagotomy & pylorus repair					
43651	T	Laparoscopy, vagus nerve	0132	56.06	$2,853.68	$1,239.22	$570.74
43652	T	Laparoscopy, vagus nerve	0132	56.06	$2,853.68	$1,239.22	$570.74
43653	T	Laparoscopy, gastrostomy	0131	37.63	$1,915.52	$996.07	$383.10

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43659	T	Laparoscope proc, stom	0130	25.91	$1,318.92	$659.53	$263.78
43750	T	Place gastrostomy tube	0141	7.21	$367.02	$184.67	$73.40
43752	E	Nasal/orogastric w/stent					
43760	T	Change gastrostomy tube	0121	2.54	$129.30	$52.53	$25.86
43761	T	Reposition gastrostomy tube	0121	2.54	$129.30	$52.53	$25.86
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	T	Place gastrostomy tube	0141	7.21	$367.02	$184.67	$73.40
43831	T	Place gastrostomy tube	0141	7.21	$367.02	$184.67	$73.40
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	0025	3.39	$172.56	$65.57	$34.51
43880	C	Repair stomach-bowel fistula					
43999	T	Stomach surgery procedure	0121	2.54	$129.30	$52.53	$25.86
44005	C	Freeing of bowel adhesion					
44010	C	Incision of small bowel					
44015	C	Insert needle cath 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	0141	7.21	$367.02	$184.67	$73.40
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					
*44126	C	Enterectomy w/taper, cong					
*44127	C	Enterectomy w/o taper, cong					
*44128	C	Enterectomy cong, add-on					
44130	C	Bowel to bowel fusion					
44132	C	Enterectomy, cadaver donor					
44133	C	Enterectomy, live donor					
44135	C	Intestine transplnt, cadaver					
44136	C	Intestine transplant, live					
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/ileostomy					
44156	C	Removal of colon/ileostomy					
44160	C	Removal of colon					
44200	T	Laparoscopy, enterolysis	0131	37.63	$1,915.52	$996.07	$383.10
44201	T	Laparoscopy, jejunostomy	0131	37.63	$1,915.52	$996.07	$383.10
44202	C	Laparo, resect intestine					
*44203	C	Lap resect s/intestine, addl					
*44204	C	Laparo partial colectomy					
*44205	C	Lap colectomy part w/ileum					
44209	T	Laparoscope proc, intestine	0130	25.91	$1,318.92	$659.53	$263.78
44300	C	Open bowel to skin					
44310	C	Ileostomy/jejunostomy					
44312	T	Revision of ileostomy	0026	12.62	$642.41	$277.92	$128.48
44314	C	Revision of ileostomy					
44316	C	Devise bowel pouch					
44320	C	Colostomy					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44322	C	Colostomy with biopsies					
44340	T	Revision of colostomy	0026	12.62	$642.41	$277.92	$128.48
44345	C	Revision of colostomy					
44346	C	Revision of colostomy					
44360	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44361	T	Small bowel endoscopy/biopsy	0142	6.94	$353.27	$151.91	$70.65
44363	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44364	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44365	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44366	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44369	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44370	T	Small bowel endoscopy/stent	0142	6.94	$353.27	$151.91	$70.65
44372	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44373	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44376	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44377	T	Small bowel endoscopy/biopsy	0142	6.94	$353.27	$151.91	$70.65
44378	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44379	T	S bowel endoscope w/stent	0142	6.94	$353.27	$151.91	$70.65
44380	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44382	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44383	T	Ileoscopy w/stent	0142	6.94	$353.27	$151.91	$70.65
44385	T	Endoscopy of bowel pouch	0143	7.27	$370.07	$185.04	$74.01
44386	T	Endoscopy, bowel pouch/biop	0143	7.27	$370.07	$185.04	$74.01
44388	T	Colon endoscopy	0143	7.27	$370.07	$185.04	$74.01
44389	T	Colonoscopy with biopsy	0143	7.27	$370.07	$185.04	$74.01
44390	T	Colonoscopy for foreign body	0143	7.27	$370.07	$185.04	$74.01
44391	T	Colonoscopy for bleeding	0143	7.27	$370.07	$185.04	$74.01
44392	T	Colonoscopy & polypectomy	0143	7.27	$370.07	$185.04	$74.01
44393	T	Colonoscopy, lesion removal	0143	7.27	$370.07	$185.04	$74.01
44394	T	Colonoscopy w/snare	0143	7.27	$370.07	$185.04	$74.01
44397	T	Colonoscopy w stent	0143	7.27	$370.07	$185.04	$74.01
44500	T	Intro, gastrointestinal tube	0121	2.54	$129.30	$52.53	$25.86
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	0142	6.94	$353.27	$151.91	$70.65
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, percut					
44950	C	Appendectomy					
44955	C	Appendectomy add-on					
44960	C	Appendectomy					
44970	T	Laparoscopy, appendectomy	0130	25.91	$1,318.92	$659.53	$263.78
44979	T	Laparoscope proc, app	0130	25.91	$1,318.92	$659.53	$263.78
45000	T	Drainage of pelvic abscess	0149	13.53	$688.73	$293.06	$137.75
45005	T	Drainage of rectal abscess	0148	2.40	$122.17	$43.59	$24.43
45020	T	Drainage of rectal abscess	0149	13.53	$688.73	$293.06	$137.75
45100	T	Biopsy of rectum	0149	13.53	$688.73	$293.06	$137.75
45108	T	Removal of anorectal lesion	0150	18.08	$920.34	$437.12	$184.07
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					
45126	C	Pelvic exenteration					
45130	C	Excision of rectal prolapse					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45135	C	Excision of rectal prolapse					
*45136	C	Excise ileoanal reservoir					
45150	T	Excision of rectal stricture	0150	18.08	$920.34	$437.12	$184.07
45160	T	Excision of rectal lesion	0150	18.08	$920.34	$437.12	$184.07
45170	T	Excision of rectal lesion	0150	18.08	$920.34	$437.12	$184.07
45190	T	Destruction, rectal tumor	0150	18.08	$920.34	$437.12	$184.07
45300	T	Proctosigmoidoscopy dx	0146	2.73	$138.97	$63.93	$27.79
45303	T	Proctosigmoidoscopy dilate	0146	2.73	$138.97	$63.93	$27.79
45305	T	Protosigmoidoscopy w/bx	0146	2.73	$138.97	$63.93	$27.79
45307	T	Protosigmoidoscopy fb	0146	2.73	$138.97	$63.93	$27.79
45308	T	Protosigmoidoscopy removal	0147	5.71	$290.66	$136.61	$58.13
45309	T	Protosigmoidoscopy removal	0147	5.71	$290.66	$136.61	$58.13
45315	T	Protosigmoidoscopy removal	0147	5.71	$290.66	$136.61	$58.13
45317	T	Protosigmoidoscopy bleed	0146	2.73	$138.97	$63.93	$27.79
45320	T	Protosigmoidoscopy ablate	0147	5.71	$290.66	$136.61	$58.13
45321	T	Protosigmoidoscopy volvul	0147	5.71	$290.66	$136.61	$58.13
45327	T	Proctosigmoidoscopy w/stent	0147	5.71	$290.66	$136.61	$58.13
45330	T	Diagnostic sigmoidoscopy	0146	2.73	$138.97	$63.93	$27.79
45331	T	Sigmoidoscopy and biopsy	0146	2.73	$138.97	$63.93	$27.79
45332	T	Sigmoidoscopy w/fb removal	0146	2.73	$138.97	$63.93	$27.79
45333	T	Sigmoidoscopy & polypectomy	0147	5.71	$290.66	$136.61	$58.13
45334	T	Sigmoidoscopy for bleeding	0147	5.71	$290.66	$136.61	$58.13
45337	T	Sigmoidoscopy & decompress	0147	5.71	$290.66	$136.61	$58.13
45338	T	Sigmoidoscpy w/tumr remove	0147	5.71	$290.66	$136.61	$58.13
45339	T	Sigmoidoscopy w/ablate tumr	0147	5.71	$290.66	$136.61	$58.13
45341	T	Sigmoidoscopy w/ultrasound	0147	5.71	$290.66	$136.61	$58.13
45342	T	Sigmoidoscopy w/us guide bx	0147	5.71	$290.66	$136.61	$58.13
45345	T	Sigmodoscopy w/stent	0147	5.71	$290.66	$136.61	$58.13
45355	T	Surgical colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45378	T	Diagnostic colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45379	T	Colonoscopy w/fb removal	0143	7.27	$370.07	$185.04	$74.01
45380	T	Colonoscopy and biopsy	0143	7.27	$370.07	$185.04	$74.01
45382	T	Colonoscopy/control bleeding	0143	7.27	$370.07	$185.04	$74.01
45383	T	Lesion removal colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45384	T	Lesion remove colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45385	T	Lesion removal colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45387	T	Colonoscopy w/stent	0143	7.27	$370.07	$185.04	$74.01
45500	T	Repair of rectum	0150	18.08	$920.34	$437.12	$184.07
45505	T	Repair of rectum	0150	18.08	$920.34	$437.12	$184.07
45520	T	Treatment of rectal prolapse	0098	1.24	$63.12	$20.88	$12.62
45540	C	Correct rectal prolapse					
45541	C	Correct rectal prolapse					
45550	C	Repair rectum/remove sigmoid					
45560	T	Repair of rectocele	0150	18.08	$920.34	$437.12	$184.07
45562	C	Exploration/repair of rectum					
45563	C	Exploration/repair of rectum					
45800	C	Repair rect/bladder fistula					
45805	C	Repair fistula w/colostomy					
45820	C	Repair rectourethral fistula					
45825	C	Repair fistula w/colostomy					
45900	T	Reduction of rectal prolapse	0148	2.40	$122.17	$43.59	$24.43
45905	T	Dilation of anal sphincter	0149	13.53	$688.73	$293.06	$137.75
45910	T	Dilation of rectal narrowing	0149	13.53	$688.73	$293.06	$137.75
45915	T	Remove rectal obstruction	0148	2.40	$122.17	$43.59	$24.43
45999	T	Rectum surgery procedure	0148	2.40	$122.17	$43.59	$24.43
*46020	T	Placement of seton	0148	2.40	$122.17	$43.59	$24.43
46030	N	Removal of rectal marker					
46040	T	Incision of rectal abscess	0155	5.26	$267.76		$53.55
46045	T	Incision of rectal abscess	0150	18.08	$920.34	$437.12	$184.07
46050	T	Incision of anal abscess	0148	2.40	$122.17	$43.59	$24.43
46060	T	Incision of rectal abscess	0150	18.08	$920.34	$437.12	$184.07
46070	T	Incision of anal septum	0155	5.26	$267.76		$53.55
46080	T	Incision of anal sphincter	0149	13.53	$688.73	$293.06	$137.75
46083	T	Incise external hemorrhoid	0148	2.40	$122.17	$43.59	$24.43
46200	T	Removal of anal fissure	0150	18.08	$920.34	$437.12	$184.07
46210	T	Removal of anal crypt	0149	13.53	$688.73	$293.06	$137.75
46211	T	Removal of anal crypts	0150	18.08	$920.34	$437.12	$184.07
46220	T	Removal of anal tab	0149	13.53	$688.73	$293.06	$137.75
46221	T	Ligation of hemorrhoid(s)	0155	5.26	$267.76		$53.55
46230	T	Removal of anal tabs	0149	13.53	$688.73	$293.06	$137.75
46250	T	Hemorrhoidectomy	0150	18.08	$920.34	$437.12	$184.07
46255	T	Hemorrhoidectomy	0150	18.08	$920.34	$437.12	$184.07
46257	T	Remove hemorrhoids & fissure	0150	18.08	$920.34	$437.12	$184.07
46258	T	Remove hemorrhoids & fistula	0150	18.08	$920.34	$437.12	$184.07
46260	T	Hemorrhoidectomy	0150	18.08	$920.34	$437.12	$184.07

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46261	T	Remove hemorrhoids & fissure	0150	18.08	$920.34	$437.12	$184.07
46262	T	Remove hemorrhoids & fistula	0150	18.08	$920.34	$437.12	$184.07
46270	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46275	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46280	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46285	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46288	T	Repair anal fistula	0150	18.08	$920.34	$437.12	$184.07
46320	T	Removal of hemorrhoid clot	0155	5.26	$267.76	.....	$53.55
46500	T	Injection into hemorrhoids	0155	5.26	$267.76	.....	$53.55
46600	N	Diagnostic anoscopy	.....	.....	.....	.....	.....
46604	T	Anoscopy and dilation	0144	4.43	$225.50	$49.32	$45.10
46606	T	Anoscopy and biopsy	0145	10.81	$550.27	$179.39	$110.05
46608	T	Anoscopy/ remove for body	0144	4.43	$225.50	$49.32	$45.10
46610	T	Anoscopy/remove lesion	0145	10.81	$550.27	$179.39	$110.05
46611	T	Anoscopy	0145	10.81	$550.27	$179.39	$110.05
46612	T	Anoscopy/ remove lesions	0145	10.81	$550.27	$179.39	$110.05
46614	T	Anoscopy/control bleeding	0145	10.81	$550.27	$179.39	$110.05
46615	T	Anoscopy	0145	10.81	$550.27	$179.39	$110.05
46700	T	Repair of anal stricture	0150	18.08	$920.34	$437.12	$184.07
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 of imperforated anus	.....	.....	.....	.....	.....
46744	C	Repair of cloacal anomaly	.....	.....	.....	.....	.....
46746	C	Repair of cloacal anomaly	.....	.....	.....	.....	.....
46748	C	Repair of cloacal anomaly	.....	.....	.....	.....	.....
46750	T	Repair of anal sphincter	0150	18.08	$920.34	$437.12	$184.07
46751	C	Repair of anal sphincter	.....	.....	.....	.....	.....
46753	T	Reconstruction of anus	0150	18.08	$920.34	$437.12	$184.07
46754	T	Removal of suture from anus	0149	13.53	$688.73	$293.06	$137.75
46760	T	Repair of anal sphincter	0150	18.08	$920.34	$437.12	$184.07
46761	T	Repair of anal sphincter	0150	18.08	$920.34	$437.12	$184.07
46762	T	Implant artificial sphincter	0150	18.08	$920.34	$437.12	$184.07
46900	T	Destruction, anal lesion(s)	0016	3.02	$153.73	$64.57	$30.75
46910	T	Destruction, anal lesion(s)	0017	9.68	$492.75	$226.67	$98.55
46916	T	Cryosurgery, anal lesion(s)	0013	1.36	$69.23	$17.66	$13.85
46917	T	Laser surgery, anal lesions	0695	15.78	$803.27	$369.50	$160.65
46922	T	Excision of anal lesion(s)	0695	15.78	$803.27	$369.50	$160.65
46924	T	Destruction, anal lesion(s)	0695	15.78	$803.27	$369.50	$160.65
46934	T	Destruction of hemorrhoids	0155	5.26	$267.76	.....	$53.55
46935	T	Destruction of hemorrhoids	0155	5.26	$267.76	.....	$53.55
46936	T	Destruction of hemorrhoids	0149	13.53	$688.73	$293.06	$137.75
46937	T	Cryotherapy of rectal lesion	0149	13.53	$688.73	$293.06	$137.75
46938	T	Cryotherapy of rectal lesion	0150	18.08	$920.34	$437.12	$184.07
46940	T	Treatment of anal fissure	0149	13.53	$688.73	$293.06	$137.75
46942	T	Treatment of anal fissure	0149	13.53	$688.73	$293.06	$137.75
46945	T	Ligation of hemorrhoids	0155	5.26	$267.76	.....	$53.55
46946	T	Ligation of hemorrhoids	0155	5.26	$267.76	.....	$53.55
46999	T	Anus surgery procedure	0149	13.53	$688.73	$293.06	$137.75
47000	T	Needle biopsy of liver	0685	9.16	$466.28	$205.16	$93.26
47001	C	Needle biopsy, liver add-on	.....	.....	.....	.....	.....
47010	C	Open drainage, liver lesion	.....	.....	.....	.....	.....
47011	T	Percut drain, liver lesion	0005	4.03	$205.14	$90.26	$41.03
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	.....	.....	.....	.....	.....
*47370	T	Laparo ablate liver tumor rf	0130	25.91	$1,318.92	$659.53	$263.78
*47371	T	Laparo ablate liver cryosug	0130	25.91	$1,318.92	$659.53	$263.78
47379	T	Laparoscope procedure, liver	0130	25.91	$1,318.92	$659.53	$263.78
*47380	C	Open ablate liver tumor rf	.....	.....	.....	.....	.....

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*47381	C	Open ablate liver tumor cryo					
*47382	T	Percut ablate liver rf	0152	16.13	$821.08	$207.38	$164.22
47399	T	Liver surgery procedure	0005	4.03	$205.14	$90.26	$41.03
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	N	Injection for liver x-rays					
47505	N	Injection for liver x-rays					
47510	T	Insert catheter, bile duct	0152	16.13	$821.08	$207.38	$164.22
47511	T	Insert bile duct drain	0152	16.13	$821.08	$207.38	$164.22
47525	T	Change bile duct catheter	0122	9.89	$503.44	$114.93	$100.69
47530	T	Revise/reinsert bile tube	0121	2.54	$129.30	$52.53	$25.86
47550	C	Bile duct endoscopy add-on					
47552	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47553	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47554	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47555	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47556	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47560	T	Laparoscopy w/cholangio	0130	25.91	$1,318.92	$659.53	$263.78
47561	T	Laparo w/cholangio/biopsy	0130	25.91	$1,318.92	$659.53	$263.78
47562	T	Laparoscopic cholecystectomy	0131	37.63	$1,915.52	$996.07	$383.10
47563	T	Laparo cholecystectomy/graph	0131	37.63	$1,915.52	$996.07	$383.10
47564	T	Laparo cholecystectomy/explr	0131	37.63	$1,915.52	$996.07	$383.10
47570	C	Laparo cholecystoenterostomy					
47579	T	Laparoscope proc, biliary	0130	25.91	$1,318.92	$659.53	$263.78
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	0152	16.13	$821.08	$207.38	$164.22
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					
47999	T	Bile tract surgery procedure	0121	2.54	$129.30	$52.53	$25.86
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	0685	9.16	$466.28	$205.16	$93.26
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, intraop add-on					
48500	C	Surgery of pancreas cyst					
48510	C	Drain pancreatic pseudocyst					
48511	S	Drain pancreatic pseudocyst	0005	4.03	$205.14	$90.26	$41.03

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	Transpl allograft pancreas					
48556	C	Removal, allograft pancreas					
48999	T	Pancreas surgery procedure	0005	4.03	$205.14	$90.26	$41.03
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	Drain, open, abdom abscess					
49041	C	Drain, percut, abdom abscess					
49060	C	Drain, open, retrop abscess					
49061	C	Drain, percut, retroper absc					
49062	C	Drain to peritoneal cavity					
49080	T	Puncture, peritoneal cavity	0070	4.58	$233.14	$79.60	$46.63
49081	T	Removal of abdominal fluid	0070	4.58	$233.14	$79.60	$46.63
49085	T	Remove abdomen foreign body	0153	23.55	$1,198.79	$496.31	$239.76
49180	T	Biopsy, abdominal mass	0685	9.16	$466.28	$205.16	$93.26
49200	T	Removal of abdominal lesion	0130	25.91	$1,318.92	$659.53	$263.78
49201	C	Removal of abdominal lesion					
49215	C	Excise sacral spine tumor					
49220	C	Multiple surgery, abdomen					
49250	T	Excision of umbilicus	0153	23.55	$1,198.79	$496.31	$239.76
49255	C	Removal of omentum					
49320	T	Diag laparo separate proc	0130	25.91	$1,318.92	$659.53	$263.78
49321	T	Laparoscopy, biopsy	0130	25.91	$1,318.92	$659.53	$263.78
49322	T	Laparoscopy, aspiration	0130	25.91	$1,318.92	$659.53	$263.78
49323	T	Laparo drain lymphocele	0130	25.91	$1,318.92	$659.53	$263.78
49329	T	Laparo proc, abdm/per/oment	0130	25.91	$1,318.92	$659.53	$263.78
49400	N	Air injection into abdomen					
49420	T	Insert abdominal drain	0153	23.55	$1,198.79	$496.31	$239.76
49421	T	Insert abdominal drain	0153	23.55	$1,198.79	$496.31	$239.76
49422	T	Remove perm cannula/catheter	0105	14.76	$751.34	$368.16	$150.27
49423	T	Exchange drainage catheter	0153	23.55	$1,198.79	$496.31	$239.76
49424	N	Assess cyst, contrast inject					
49425	C	Insert abdomen-venous drain					
49426	T	Revise abdomen-venous shunt	0153	23.55	$1,198.79	$496.31	$239.76
49427	N	Injection, abdominal shunt					
49428	C	Ligation of shunt					
49429	T	Removal of shunt	0105	14.76	$751.34	$368.16	$150.27
*49491	T	Repairing hern premie reduc	0154	31.40	$1,598.39	$556.98	$319.68
*49492	T	Rpr ing hern premie, blocked	0154	31.40	$1,598.39	$556.98	$319.68
49495	T	Repair inguinal hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49496	T	Repair inguinal hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49500	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49501	T	Repair inguinal hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49505	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49507	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49520	T	Rerepair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49521	T	Repair inguinal hernia, rec	0154	31.40	$1,598.39	$556.98	$319.68
49525	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49540	T	Repair lumbar hernia	0154	31.40	$1,598.39	$556.98	$319.68
49550	T	Repair femoral hernia	0154	31.40	$1,598.39	$556.98	$319.68
49553	T	Repair femoral hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49555	T	Repair femoral hernia	0154	31.40	$1,598.39	$556.98	$319.68
49557	T	Repair femoral hernia, recur	0154	31.40	$1,598.39	$556.98	$319.68
49560	T	Repair abdominal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49561	T	Repair incisional hernia	0154	31.40	$1,598.39	$556.98	$319.68
49565	T	Rerepair abdominal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49566	T	Repair incisional hernia	0154	31.40	$1,598.39	$556.98	$319.68
49568	T	Hernia repair w/mesh	0154	31.40	$1,598.39	$556.98	$319.68
49570	T	Repair epigastric hernia	0154	31.40	$1,598.39	$556.98	$319.68
49572	T	Repair epigastric hernia	0154	31.40	$1,598.39	$556.98	$319.68
49580	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49582	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49585	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49587	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49590	T	Repair abdominal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49600	T	Repair umbilical lesion	0154	31.40	$1,598.39	$556.98	$319.68
49605	C	Repair umbilical lesion					
49606	C	Repair umbilical lesion					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49610	C	Repair umbilical lesion					
49611	C	Repair umbilical lesion					
49650	T	Laparo hernia repair initial	0131	37.63	$1,915.52	$996.07	$383.10
49651	T	Laparo hernia repair recur	0131	37.63	$1,915.52	$996.07	$383.10
49659	T	Laparo proc, hernia repair	0131	37.63	$1,915.52	$996.07	$383.10
49900	C	Repair of abdominal wall					
49905	C	Omental flap					
49906	C	Free omental flap, microvasc					
49999	T	Abdomen surgery procedure	0121	2.54	$129.30	$52.53	$25.86
50010	C	Exploration of kidney					
50020	C	Renal abscess, open drain					
50021	S	Renal abscess, percut drain	0005	4.03	$205.14	$90.26	$41.03
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	T	Removal of kidney stone	0163	40.40	$2,056.52	$792.58	$411.30
50081	T	Removal of kidney stone	0163	40.40	$2,056.52	$792.58	$411.30
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	0685	9.16	$466.28	$205.16	$93.26
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	0685	9.16	$466.28	$205.16	$93.26
50392	T	Insert kidney drain	0161	13.72	$698.40	$249.36	$139.68
50393	T	Insert ureteral tube	0161	13.72	$698.40	$249.36	$139.68
50394	N	Injection for kidney x-ray					
50395	T	Create passage to kidney	0161	13.72	$698.40	$249.36	$139.68
50396	T	Measure kidney pressure	0164	1.01	$51.41	$15.42	$10.28
50398	T	Change kidney tube	0122	9.89	$503.44	$114.93	$100.69
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					
50541	T	Laparo ablate renal cyst	0130	25.91	$1,318.92	$659.53	$263.78
50544	T	Laparoscopy, pyeloplasty	0130	25.91	$1,318.92	$659.53	$263.78
50545	C	Laparo radical nephrectomy					
50546	C	Laparoscopic nephrectomy					
50547	C	Laparo removal donor kidney					
50548	C	Laparo remove k/ureter					
50549	T	Laparoscope proc, renal	0130	25.91	$1,318.92	$659.53	$263.78
50551	T	Kidney endoscopy	0160	5.13	$261.14	$104.46	$52.23
50553	T	Kidney endoscopy	0161	13.72	$698.40	$249.36	$139.68
50555	T	Kidney endoscopy & biopsy	0160	5.13	$261.14	$104.46	$52.23
50557	T	Kidney endoscopy & treatment	0162	25.09	$1,277.18	$427.49	$255.44
50559	T	Renal endoscopy/radiotracer	0160	5.13	$261.14	$104.46	$52.23
50561	T	Kidney endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
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					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50580	C	Kidney endoscopy & treatment					
50590	T	Fragmenting of kidney stone	0169	39.62	$2,016.82	$1,109.25	$403.36
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	N	Injection for ureter x-ray					
50686	T	Measure ureter pressure	0164	1.01	$51.41	$15.42	$10.28
50688	T	Change of ureter tube	0121	2.54	$129.30	$52.53	$25.86
50690	N	Injection for ureter x-ray					
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					
50945	T	Laparoscopy ureterolithotomy	0131	37.63	$1,915.52	$996.07	$383.10
50947	T	Laparo new ureter/bladder	0131	37.63	$1,915.52	$996.07	$383.10
50948	T	Laparo new ureter/bladder	0131	37.63	$1,915.52	$996.07	$383.10
50949	T	Laparoscope proc, ureter	0130	25.91	$1,318.92	$659.53	$263.78
50951	T	Endoscopy of ureter	0160	5.13	$261.14	$104.46	$52.23
50953	T	Endoscopy of ureter	0160	5.13	$261.14	$104.46	$52.23
50955	T	Ureter endoscopy & biopsy	0161	13.72	$698.40	$249.36	$139.68
50957	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
50959	T	Ureter endoscopy & tracer	0161	13.72	$698.40	$249.36	$139.68
50961	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
50970	T	Ureter endoscopy	0160	5.13	$261.14	$104.46	$52.23
50972	T	Ureter endoscopy & catheter	0160	5.13	$261.14	$104.46	$52.23
50974	T	Ureter endoscopy & biopsy	0161	13.72	$698.40	$249.36	$139.68
50976	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
50978	T	Ureter endoscopy & tracer	0161	13.72	$698.40	$249.36	$139.68
50980	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
51000	T	Drainage of bladder	0165	5.22	$265.72	$91.76	$53.14
51005	T	Drainage of bladder	0156	2.45	$124.71	$37.41	$24.94
51010	T	Drainage of bladder	0165	5.22	$265.72	$91.76	$53.14
51020	T	Incise & treat bladder	0162	25.09	$1,277.18	$427.49	$255.44
51030	T	Incise & treat bladder	0162	25.09	$1,277.18	$427.49	$255.44
51040	T	Incise & drain bladder	0162	25.09	$1,277.18	$427.49	$255.44
51045	T	Incise bladder/drain ureter	0160	5.13	$261.14	$104.46	$52.23
51050	T	Removal of bladder stone	0162	25.09	$1,277.18	$427.49	$255.44
51060	C	Removal of ureter stone					
51065	T	Removal of ureter stone	0162	25.09	$1,277.18	$427.49	$255.44
51080	T	Drainage of bladder abscess	0007	6.75	$343.60	$72.03	$68.72
51500	T	Removal of bladder cyst	0154	31.40	$1,598.39	$556.98	$319.68
51520	T	Removal of bladder lesion	0162	25.09	$1,277.18	$427.49	$255.44
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)					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	N	Injection for bladder x-ray					
51605	N	Preparation for bladder xray					
51610	N	Injection for bladder x-ray					
51700	T	Irrigation of bladder	0156	2.45	$124.71	$37.41	$24.94
51705	T	Change of bladder tube	0121	2.54	$129.30	$52.53	$25.86
51710	T	Change of bladder tube	0121	2.54	$129.30	$52.53	$25.86
51715	T	Endoscopic injection/implant	0167	22.28	$1,134.14	$555.84	$226.83
51720	T	Treatment of bladder lesion	0156	2.45	$124.71	$37.41	$24.94
51725	T	Simple cystometrogram	0165	5.22	$265.72	$91.76	$53.14
51726	T	Complex cystometrogram	0165	5.22	$265.72	$91.76	$53.14
51736	T	Urine flow measurement	0164	1.01	$51.41	$15.42	$10.28
51741	T	Electro-uroflowmetry, first	0164	1.01	$51.41	$15.42	$10.28
51772	T	Urethra pressure profile	0165	5.22	$265.72	$91.76	$53.14
51784	T	Anal/urinary muscle study	0164	1.01	$51.41	$15.42	$10.28
51785	T	Anal/urinary muscle study	0156	2.45	$124.71	$37.41	$24.94
51792	T	Urinary reflex study	0156	2.45	$124.71	$37.41	$24.94
51795	T	Urine voiding pressure study	0165	5.22	$265.72	$91.76	$53.14
51797	T	Intraabdominal pressure test	0165	5.22	$265.72	$91.76	$53.14
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	0162	25.09	$1,277.18	$427.49	$255.44
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					
51990	T	Laparo urethral suspension	0131	37.63	$1,915.52	$996.07	$383.10
51992	T	Laparo sling operation	0132	56.06	$2,853.68	$1,239.22	$570.74
52000	T	Cystoscopy	0160	5.13	$261.14	$104.46	$52.23
*52001	T	Cystoscopy, removal of clots	0160	5.13	$261.14	$104.46	$52.23
52005	T	Cystoscopy & ureter catheter	0161	13.72	$698.40	$249.36	$139.68
52007	T	Cystoscopy and biopsy	0161	13.72	$698.40	$249.36	$139.68
52010	T	Cystoscopy & duct catheter	0160	5.13	$261.14	$104.46	$52.23
52204	T	Cystoscopy	0161	13.72	$698.40	$249.36	$139.68
52214	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52224	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52234	T	Cystoscopy and treatment	0163	40.40	$2,056.52	$792.58	$411.30
52235	T	Cystoscopy and treatment	0163	40.40	$2,056.52	$792.58	$411.30
52240	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52250	T	Cystoscopy and radiotracer	0162	25.09	$1,277.18	$427.49	$255.44
52260	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52265	T	Cystoscopy and treatment	0160	5.13	$261.14	$104.46	$52.23
52270	T	Cystoscopy & revise urethra	0161	13.72	$698.40	$249.36	$139.68
52275	T	Cystoscopy & revise urethra	0161	13.72	$698.40	$249.36	$139.68
52276	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52277	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52281	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52282	T	Cystoscopy, implant stent	0163	40.40	$2,056.52	$792.58	$411.30
52283	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52285	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52290	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52300	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52301	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52305	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52310	T	Cystoscopy and treatment	0160	5.13	$261.14	$104.46	$52.23
52315	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52317	T	Remove bladder stone	0162	25.09	$1,277.18	$427.49	$255.44
52318	T	Remove bladder stone	0162	25.09	$1,277.18	$427.49	$255.44
52320	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52325	T	Cystoscopy, stone removal	0162	25.09	$1,277.18	$427.49	$255.44
52327	T	Cystoscopy, inject material	0162	25.09	$1,277.18	$427.49	$255.44

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52330	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52332	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52334	T	Create passage to kidney	0162	25.09	$1,277.18	$427.49	$255.44
52341	T	Cysto w/ureter stricture tx	0162	25.09	$1,277.18	$427.49	$255.44
52342	T	Cysto w/up stricture tx	0162	25.09	$1,277.18	$427.49	$255.44
52343	T	Cysto w/renal stricture tx	0162	25.09	$1,277.18	$427.49	$255.44
52344	T	Cysto/uretero, stone remove	0162	25.09	$1,277.18	$427.49	$255.44
52345	T	Cysto/uretero w/up stricture	0162	25.09	$1,277.18	$427.49	$255.44
52346	T	Cystouretero w/renal strict	0162	25.09	$1,277.18	$427.49	$255.44
*52347	T	Cystoscopy, resect ducts	0160	5.13	$261.14	$104.46	$52.23
52351	T	Cystouretro & or pyeloscope	0160	5.13	$261.14	$104.46	$52.23
52352	T	Cystouretro w/stone remove	0162	25.09	$1,277.18	$427.49	$255.44
52353	T	Cystouretero w/lithotripsy	0163	40.40	$2,056.52	$792.58	$411.30
52354	T	Cystouretero w/biopsy	0162	25.09	$1,277.18	$427.49	$255.44
52355	T	Cystouretero w/excise tumor	0162	25.09	$1,277.18	$427.49	$255.44
52400	T	Cystouretero w/congen repr	0162	25.09	$1,277.18	$427.49	$255.44
52450	T	Incision of prostate	0162	25.09	$1,277.18	$427.49	$255.44
52500	T	Revision of bladder neck	0162	25.09	$1,277.18	$427.49	$255.44
52510	T	Dilation prostatic urethra	0161	13.72	$698.40	$249.36	$139.68
52601	T	Prostatectomy (TURP)	0163	40.40	$2,056.52	$792.58	$411.30
52606	T	Control postop bleeding	0162	25.09	$1,277.18	$427.49	$255.44
52612	T	Prostatectomy, first stage	0163	40.40	$2,056.52	$792.58	$411.30
52614	T	Prostatectomy, second stage	0163	40.40	$2,056.52	$792.58	$411.30
52620	T	Remove residual prostate	0163	40.40	$2,056.52	$792.58	$411.30
52630	T	Remove prostate regrowth	0163	40.40	$2,056.52	$792.58	$411.30
52640	T	Relieve bladder contracture	0162	25.09	$1,277.18	$427.49	$255.44
52647	T	Laser surgery of prostate	0163	40.40	$2,056.52	$792.58	$411.30
52648	T	Laser surgery of prostate	0163	40.40	$2,056.52	$792.58	$411.30
52700	T	Drainage of prostate abscess	0162	25.09	$1,277.18	$427.49	$255.44
53000	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53010	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53020	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53025	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53040	T	Drainage of urethra abscess	0166	12.20	$621.03	$218.73	$124.21
53060	T	Drainage of urethra abscess	0166	12.20	$621.03	$218.73	$124.21
53080	T	Drainage of urinary leakage	0166	12.20	$621.03	$218.73	$124.21
53085	C	Drainage of urinary leakage					
53200	T	Biopsy of urethra	0166	12.20	$621.03	$218.73	$124.21
53210	T	Removal of urethra	0168	18.42	$937.65	$403.19	$187.53
53215	T	Removal of urethra	0168	18.42	$937.65	$403.19	$187.53
53220	T	Treatment of urethra lesion	0168	18.42	$937.65	$403.19	$187.53
53230	T	Removal of urethra lesion	0168	18.42	$937.65	$403.19	$187.53
53235	T	Removal of urethra lesion	0168	18.42	$937.65	$403.19	$187.53
53240	T	Surgery for urethra pouch	0168	18.42	$937.65	$403.19	$187.53
53250	T	Removal of urethra gland	0166	12.20	$621.03	$218.73	$124.21
53260	T	Treatment of urethra lesion	0166	12.20	$621.03	$218.73	$124.21
53265	T	Treatment of urethra lesion	0166	12.20	$621.03	$218.73	$124.21
53270	T	Removal of urethra gland	0167	22.28	$1,134.14	$555.84	$226.83
53275	T	Repair of urethra defect	0166	12.20	$621.03	$218.73	$124.21
53400	T	Revise urethra, stage 1	0168	18.42	$937.65	$403.19	$187.53
53405	T	Revise urethra, stage 2	0168	18.42	$937.65	$403.19	$187.53
53410	T	Reconstruction of urethra	0168	18.42	$937.65	$403.19	$187.53
53415	C	Reconstruction of urethra					
53420	T	Reconstruct urethra, stage 1	0168	18.42	$937.65	$403.19	$187.53
53425	T	Reconstruct urethra, stage 2	0168	18.42	$937.65	$403.19	$187.53
53430	T	Reconstruction of urethra	0168	18.42	$937.65	$403.19	$187.53
*53431	T	Reconstruct urethra/bladder	0168	18.42	$937.65	$403.19	$187.53
53440	T	Correct bladder function	0179	139.33	$7,092.45	$2,340.51	$1,418.49
53442	T	Remove perineal prosthesis	0166	12.20	$621.03	$218.73	$124.21
53443	D	Reconstruction of urethra					
*53444	T	Insert tandem cuff	0179	139.33	$7,092.45	$2,340.51	$1,418.49
53445	T	Correct urine flow control	0179	139.33	$7,092.45	$2,340.51	$1,418.49
*53446	T	Remove uro sphincter	0168	18.42	$937.65	$403.19	$187.53
53447	T	Remove artificial sphincter	0179	139.33	$7,092.45	$2,340.51	$1,418.49
*53448	C	Remov/replc ur sphinctr comp					
53449	T	Correct artificial sphincter	0168	18.42	$937.65	$403.19	$187.53
53450	T	Revision of urethra	0168	18.42	$937.65	$403.19	$187.53
53460	T	Revision of urethra	0168	18.42	$937.65	$403.19	$187.53
53502	T	Repair of urethra injury	0166	12.20	$621.03	$218.73	$124.21
53505	T	Repair of urethra injury	0167	22.28	$1,134.14	$555.84	$226.83
53510	T	Repair of urethra injury	0166	12.20	$621.03	$218.73	$124.21
53515	T	Repair of urethra injury	0168	18.42	$937.65	$403.19	$187.53
53520	T	Repair of urethra defect	0168	18.42	$937.65	$403.19	$187.53
53600	T	Dilate urethra stricture	0156	2.45	$124.71	$37.41	$24.94
53601	T	Dilate urethra stricture	0164	1.01	$51.41	$15.42	$10.28

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53605	T	Dilate urethra stricture	0161	13.72	$698.40	$249.36	$139.68
53620	T	Dilate urethra stricture	0165	5.22	$265.72	$91.76	$53.14
53621	T	Dilate urethra stricture	0164	1.01	$51.41	$15.42	$10.28
53660	T	Dilation of urethra	0164	1.01	$51.41	$15.42	$10.28
53661	T	Dilation of urethra	0164	1.01	$51.41	$15.42	$10.28
53665	T	Dilation of urethra	0166	12.20	$621.03	$218.73	$124.21
53670	N	Insert urinary catheter					
53675	T	Insert urinary catheter	0156	2.45	$124.71	$37.41	$24.94
53850	T	Prostatic microwave thermotx	0982		$2,750.00		$550.00
53852	T	Prostatic rf thermotx	0982		$2,750.00		$550.00
*53853	T	Prostatic water thermother	0977		$1,125.00		$225.00
53899	T	Urology surgery procedure	0165	5.22	$265.72	$91.76	$53.14
54000	T	Slitting of prepuce	0166	12.20	$621.03	$218.73	$124.21
54001	T	Slitting of prepuce	0166	12.20	$621.03	$218.73	$124.21
54015	T	Drain penis lesion	0006	2.18	$110.97	$33.95	$22.19
54050	T	Destruction, penis lesion(s)	0013	1.36	$69.23	$17.66	$13.85
54055	T	Destruction, penis lesion(s)	0017	9.68	$492.75	$226.67	$98.55
54056	T	Cryosurgery, penis lesion(s)	0012	0.66	$33.60	$9.18	$6.72
54057	T	Laser surg, penis lesion(s)	0017	9.68	$492.75	$226.67	$98.55
54060	T	Excision of penis lesion(s)	0017	9.68	$492.75	$226.67	$98.55
54065	T	Destruction, penis lesion(s)	0695	15.78	$803.27	$369.50	$160.65
54100	T	Biopsy of penis	0020	8.44	$429.63	$130.53	$85.93
54105	T	Biopsy of penis	0021	11.82	$601.69	$236.51	$120.34
54110	T	Treatment of penis lesion	0181	22.09	$1,124.47	$618.45	$224.89
54111	T	Treat penis lesion, graft	0181	22.09	$1,124.47	$618.45	$224.89
54112	T	Treat penis lesion, graft	0181	22.09	$1,124.47	$618.45	$224.89
54115	T	Treatment of penis lesion	0008	10.93	$556.38	$113.67	$111.28
54120	T	Partial removal of penis	0181	22.09	$1,124.47	$618.45	$224.89
54125	C	Removal of penis					
54130	C	Remove penis & nodes					
54135	C	Remove penis & nodes					
54150	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
54152	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
54160	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
54161	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
*54162	T	Lysis penil circumcis lesion	0180	15.02	$764.58	$304.87	$152.92
*54163	T	Repair of circumcision	0180	15.02	$764.58	$304.87	$152.92
*54164	T	Frenulotomy of penis	0180	15.02	$764.58	$304.87	$152.92
54200	T	Treatment of penis lesion	0156	2.45	$124.71	$37.41	$24.94
54205	T	Treatment of penis lesion	0181	22.09	$1,124.47	$618.45	$224.89
54220	T	Treatment of penis lesion	0156	2.45	$124.71	$37.41	$24.94
54230	N	Prepare penis study					
54231	T	Dynamic cavernosometry	0165	5.22	$265.72	$91.76	$53.14
54235	T	Penile injection	0164	1.01	$51.41	$15.42	$10.28
54240	T	Penis study	0164	1.01	$51.41	$15.42	$10.28
54250	T	Penis study	0165	5.22	$265.72	$91.76	$53.14
54300	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54304	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54308	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54312	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54316	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54318	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54322	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54324	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54326	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54328	T	Revise penis/urethra	0181	22.09	$1,124.47	$618.45	$224.89
54332	C	Revise penis/urethra					
54336	C	Revise penis/urethra					
54340	T	Secondary urethral surgery	0181	22.09	$1,124.47	$618.45	$224.89
54344	T	Secondary urethral surgery	0181	22.09	$1,124.47	$618.45	$224.89
54348	T	Secondary urethral surgery	0181	22.09	$1,124.47	$618.45	$224.89
54352	T	Reconstruct urethra/penis	0181	22.09	$1,124.47	$618.45	$224.89
54360	T	Penis plastic surgery	0181	22.09	$1,124.47	$618.45	$224.89
54380	T	Repair penis	0181	22.09	$1,124.47	$618.45	$224.89
54385	T	Repair penis	0181	22.09	$1,124.47	$618.45	$224.89
54390	C	Repair penis and bladder					
54400	T	Insert semi-rigid prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
54401	T	Insert self-contd prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
54402	D	Remove penis prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
54405	T	Insert multi-comp prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
*54406	T	Remove multi-comp penis pros	0181	22.09	$1,124.47	$618.45	$224.89
54407	D	Remove multi-comp prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
*54408	T	Repair multi-comp penis pros	0181	22.09	$1,124.47	$618.45	$224.89
54409	D	Revise penis prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
*54410	T	Remove/replace penis prosth	0182	87.54	$4,456.14	$1,492.28	$891.23

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*54411	C	Remv/replc penis pros, comp					
*54415	T	Remove self-contd penis pros	0181	22.09	$1,124.47	$618.45	$224.89
*54416	T	Remv/repl penis contain pros	0182	87.54	$4,456.14	$1,492.28	$891.23
*54417	C	Remv/replc penis pros, compl					
54420	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54430	C	Revision of penis					
54435	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54440	T	Repair of penis	0181	22.09	$1,124.47	$618.45	$224.89
54450	T	Preputial stretching	0156	2.45	$124.71	$37.41	$24.94
54500	T	Biopsy of testis	0005	4.03	$205.14	$90.26	$41.03
54505	T	Biopsy of testis	0183	18.87	$960.56	$448.94	$192.11
54510	D	Removal of testis lesion	0183	18.87	$960.56	$448.94	$192.11
54512	T	Excise lesion testis	0183	18.87	$960.56	$448.94	$192.11
54520	T	Removal of testis	0183	18.87	$960.56	$448.94	$192.11
54522	T	Orchiectomy, partial	0183	18.87	$960.56	$448.94	$192.11
54530	T	Removal of testis	0154	31.40	$1,598.39	$556.98	$319.68
54535	C	Extensive testis surgery					
54550	T	Exploration for testis	0154	31.40	$1,598.39	$556.98	$319.68
54560	C	Exploration for testis					
54600	T	Reduce testis torsion	0183	18.87	$960.56	$448.94	$192.11
54620	T	Suspension of testis	0183	18.87	$960.56	$448.94	$192.11
54640	T	Suspension of testis	0154	31.40	$1,598.39	$556.98	$319.68
54650	C	Orchiopexy (Fowler-Stephens)					
54660	T	Revision of testis	0183	18.87	$960.56	$448.94	$192.11
54670	T	Repair testis injury	0183	18.87	$960.56	$448.94	$192.11
54680	T	Relocation of testis(es)	0183	18.87	$960.56	$448.94	$192.11
54690	T	Laparoscopy, orchiectomy	0131	37.63	$1,915.52	$996.07	$383.10
54692	T	Laparoscopy, orchiopexy	0132	56.06	$2,853.68	$1,239.22	$570.74
54699	T	Laparoscope proc, testis	0130	25.91	$1,318.92	$659.53	$263.78
54700	T	Drainage of scrotum	0183	18.87	$960.56	$448.94	$192.11
54800	T	Biopsy of epididymis	0004	2.47	$125.73	$32.57	$25.15
54820	T	Exploration of epididymis	0183	18.87	$960.56	$448.94	$192.11
54830	T	Remove epididymis lesion	0183	18.87	$960.56	$448.94	$192.11
54840	T	Remove epididymis lesion	0183	18.87	$960.56	$448.94	$192.11
54860	T	Removal of epididymis	0183	18.87	$960.56	$448.94	$192.11
54861	T	Removal of epididymis	0183	18.87	$960.56	$448.94	$192.11
54900	T	Fusion of spermatic ducts	0183	18.87	$960.56	$448.94	$192.11
54901	T	Fusion of spermatic ducts	0183	18.87	$960.56	$448.94	$192.11
55000	T	Drainage of hydrocele	0004	2.47	$125.73	$32.57	$25.15
55040	T	Removal of hydrocele	0154	31.40	$1,598.39	$556.98	$319.68
55041	T	Removal of hydroceles	0154	31.40	$1,598.39	$556.98	$319.68
55060	T	Repair of hydrocele	0183	18.87	$960.56	$448.94	$192.11
55100	T	Drainage of scrotum abscess	0007	6.75	$343.60	$72.03	$68.72
55110	T	Explore scrotum	0183	18.87	$960.56	$448.94	$192.11
55120	T	Removal of scrotum lesion	0183	18.87	$960.56	$448.94	$192.11
55150	T	Removal of scrotum	0183	18.87	$960.56	$448.94	$192.11
55175	T	Revision of scrotum	0183	18.87	$960.56	$448.94	$192.11
55180	T	Revision of scrotum	0183	18.87	$960.56	$448.94	$192.11
55200	T	Incision of sperm duct	0183	18.87	$960.56	$448.94	$192.11
55250	T	Removal of sperm duct(s)	0183	18.87	$960.56	$448.94	$192.11
55300	N	Prepare, sperm duct x-ray					
55400	T	Repair of sperm duct	0183	18.87	$960.56	$448.94	$192.11
55450	T	Ligation of sperm duct	0183	18.87	$960.56	$448.94	$192.11
55500	T	Removal of hydrocele	0183	18.87	$960.56	$448.94	$192.11
55520	T	Removal of sperm cord lesion	0183	18.87	$960.56	$448.94	$192.11
55530	T	Revise spermatic cord veins	0183	18.87	$960.56	$448.94	$192.11
55535	T	Revise spermatic cord veins	0154	31.40	$1,598.39	$556.98	$319.68
55540	T	Revise hernia & sperm veins	0154	31.40	$1,598.39	$556.98	$319.68
55550	T	Laparo ligate spermatic vein	0131	37.63	$1,915.52	$996.07	$383.10
55559	T	Laparo proc, spermatic cord	0130	25.91	$1,318.92	$659.53	$263.78
55600	C	Incise sperm duct pouch					
55605	C	Incise sperm duct pouch					
55650	C	Remove sperm duct pouch					
55680	T	Remove sperm pouch lesion	0183	18.87	$960.56	$448.94	$192.11
55700	T	Biopsy of prostate	0184	4.83	$245.87	$122.94	$49.17
55705	T	Biopsy of prostate	0184	4.83	$245.87	$122.94	$49.17
55720	T	Drainage of prostate abscess	0162	25.09	$1,277.18	$427.49	$255.44
55725	T	Drainage of prostate abscess	0162	25.09	$1,277.18	$427.49	$255.44
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55842	C	Extensive prostate surgery					
55845	C	Extensive prostate surgery					
55859	T	Percut/needle insert, pros	0163	40.40	$2,056.52	$792.58	$411.30
55860	T	Surgical exposure, prostate	0165	5.22	$265.72	$91.76	$53.14
55862	C	Extensive prostate surgery					
55865	C	Extensive prostate surgery					
55870	T	Electroejaculation	0197	2.40	$122.17	$49.55	$24.43
55873	T	Cryoablate prostate	0982		$2,750.00		$550.00
55899	T	Genital surgery procedure	0164	1.01	$51.41	$15.42	$10.28
55970	E	Sex transformation, M to F					
55980	E	Sex transformation, F to M					
56405	T	I & D of vulva/perineum	0192	2.50	$127.26	$35.33	$25.45
56420	T	Drainage of gland abscess	0192	2.50	$127.26	$35.33	$25.45
56440	T	Surgery for vulva lesion	0194	15.86	$807.34	$395.60	$161.47
56441	T	Lysis of labial lesion(s)	0193	11.16	$568.09	$171.13	$113.62
56501	T	Destruction, vulva lesion(s)	0017	9.68	$492.75	$226.67	$98.55
56515	T	Destruction, vulva lesion(s)	0695	15.78	$803.27	$369.50	$160.65
56605	T	Biopsy of vulva/perineum	0019	4.22	$214.81	$78.91	$42.96
56606	T	Biopsy of vulva/perineum	0019	4.22	$214.81	$78.91	$42.96
56620	T	Partial removal of vulva	0195	20.62	$1,049.64	$483.80	$209.93
56625	T	Complete removal of vulva	0195	20.62	$1,049.64	$483.80	$209.93
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	0194	15.86	$807.34	$395.60	$161.47
56720	T	Incision of hymen	0193	11.16	$568.09	$171.13	$113.62
56740	T	Remove vagina gland lesion	0194	15.86	$807.34	$395.60	$161.47
56800	T	Repair of vagina	0194	15.86	$807.34	$395.60	$161.47
56805	T	Repair clitoris	0194	15.86	$807.34	$395.60	$161.47
56810	T	Repair of perineum	0194	15.86	$807.34	$395.60	$161.47
57000	T	Exploration of vagina	0194	15.86	$807.34	$395.60	$161.47
57010	T	Drainage of pelvic abscess	0194	15.86	$807.34	$395.60	$161.47
57020	T	Drainage of pelvic fluid	0193	11.16	$568.09	$171.13	$113.62
57022	T	I &d vaginal hematoma, ob	0007	6.75	$343.60	$72.03	$68.72
57023	T	I &d vag hematoma, trauma	0007	6.75	$343.60	$72.03	$68.72
57061	T	Destruction vagina lesion(s)	0194	15.86	$807.34	$395.60	$161.47
57065	T	Destruction vagina lesion(s)	0194	15.86	$807.34	$395.60	$161.47
57100	T	Biopsy of vagina	0193	11.16	$568.09	$171.13	$113.62
57105	T	Biopsy of vagina	0194	15.86	$807.34	$395.60	$161.47
57106	T	Remove vagina wall, partial	0194	15.86	$807.34	$395.60	$161.47
57107	T	Remove vagina tissue, part	0195	20.62	$1,049.64	$483.80	$209.93
57109	T	Vaginectomy partial w/nodes	0202	63.54	$3,234.44	$1,487.84	$646.89
57110	C	Remove vagina wall, complete					
57111	C	Remove vagina tissue, compl					
57112	C	Vaginectomy w/nodes, compl					
57120	T	Closure of vagina	0194	15.86	$807.34	$395.60	$161.47
57130	T	Remove vagina lesion	0194	15.86	$807.34	$395.60	$161.47
57135	T	Remove vagina lesion	0194	15.86	$807.34	$395.60	$161.47
57150	T	Treat vagina infection	0191	0.23	$11.71	$3.40	$2.34
*57155	T	Insert uteri tandems/ovoids	0192	2.50	$127.26	$35.33	$25.45
57160	T	Insert pessary/other device	0188	0.80	$40.72	$11.81	$8.14
57170	T	Fitting of diaphragm/cap	0191	0.23	$11.71	$3.40	$2.34
57180	T	Treat vaginal bleeding	0192	2.50	$127.26	$35.33	$25.45
57200	T	Repair of vagina	0194	15.86	$807.34	$395.60	$161.47
57210	T	Repair vagina/perineum	0194	15.86	$807.34	$395.60	$161.47
57220	T	Revision of urethra	0195	20.62	$1,049.64	$483.80	$209.93
57230	T	Repair of urethral lesion	0194	15.86	$807.34	$395.60	$161.47
57240	T	Repair bladder & vagina	0195	20.62	$1,049.64	$483.80	$209.93
57250	T	Repair rectum & vagina	0195	20.62	$1,049.64	$483.80	$209.93
57260	T	Repair of vagina	0195	20.62	$1,049.64	$483.80	$209.93
57265	T	Extensive repair of vagina	0195	20.62	$1,049.64	$483.80	$209.93
57268	T	Repair of bowel bulge	0195	20.62	$1,049.64	$483.80	$209.93
57270	C	Repair of bowel pouch					
57280	C	Suspension of vagina					
57282	C	Repair of vaginal prolapse					
57284	T	Repair paravaginal defect	0195	20.62	$1,049.64	$483.80	$209.93
57287	T	Revise/remove sling repair	0202	63.54	$3,234.44	$1,487.84	$646.89
57288	T	Repair bladder defect	0202	63.54	$3,234.44	$1,487.84	$646.89
57289	T	Repair bladder & vagina	0195	20.62	$1,049.64	$483.80	$209.93
57291	T	Construction of vagina	0195	20.62	$1,049.64	$483.80	$209.93
57292	C	Construct vagina with graft					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57300	T	Repair rectum-vagina fistula	0195	20.62	$1,049.64	$483.80	$209.93
57305	C	Repair rectum-vagina fistula					
57307	C	Fistula repair & colostomy					
57308	C	Fistula repair, transperine					
57310	T	Repair urethrovaginal lesion	0195	20.62	$1,049.64	$483.80	$209.93
57311	C	Repair urethrovaginal lesion					
57320	T	Repair bladder-vagina lesion	0195	20.62	$1,049.64	$483.80	$209.93
57330	T	Repair bladder-vagina lesion	0195	20.62	$1,049.64	$483.80	$209.93
57335	C	Repair vagina					
57400	T	Dilation of vagina	0194	15.86	$807.34	$395.60	$161.47
57410	T	Pelvic examination	0194	15.86	$807.34	$395.60	$161.47
57415	T	Remove vaginal foreign body	0194	15.86	$807.34	$395.60	$161.47
57452	T	Examination of vagina	0189	1.26	$64.14	$17.96	$12.83
57454	T	Vagina examination & biopsy	0192	2.50	$127.26	$35.33	$25.45
57460	T	Cervix excision	0193	11.16	$568.09	$171.13	$113.62
57500	T	Biopsy of cervix	0192	2.50	$127.26	$35.33	$25.45
57505	T	Endocervical curettage	0192	2.50	$127.26	$35.33	$25.45
57510	T	Cauterization of cervix	0193	11.16	$568.09	$171.13	$113.62
57511	T	Cryocautery of cervix	0189	1.26	$64.14	$17.96	$12.83
57513	T	Laser surgery of cervix	0193	11.16	$568.09	$171.13	$113.62
57520	T	Conization of cervix	0194	15.86	$807.34	$395.60	$161.47
57522	T	Conization of cervix	0195	20.62	$1,049.64	$483.80	$209.93
57530	T	Removal of cervix	0195	20.62	$1,049.64	$483.80	$209.93
57531	C	Removal of cervix, radical					
57540	C	Removal of residual cervix					
57545	C	Remove cervix/repair pelvis					
57550	T	Removal of residual cervix	0195	20.62	$1,049.64	$483.80	$209.93
57555	T	Remove cervix/repair vagina	0195	20.62	$1,049.64	$483.80	$209.93
57556	T	Remove cervix, repair bowel	0195	20.62	$1,049.64	$483.80	$209.93
57700	T	Revision of cervix	0194	15.86	$807.34	$395.60	$161.47
57720	T	Revision of cervix	0194	15.86	$807.34	$395.60	$161.47
57800	T	Dilation of cervical canal	0192	2.50	$127.26	$35.33	$25.45
57820	T	D & c of residual cervix	0196	13.48	$686.19	$336.23	$137.24
58100	T	Biopsy of uterus lining	0188	0.80	$40.72	$11.81	$8.14
58120	T	Dilation and curettage	0196	13.48	$686.19	$336.23	$137.24
58140	C	Removal of uterus lesion					
58145	T	Removal of uterus lesion	0195	20.62	$1,049.64	$483.80	$209.93
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	0189	1.26	$64.14	$17.96	$12.83
58321	T	Artificial insemination	0197	2.40	$122.17	$49.55	$24.43
58322	T	Artificial insemination	0197	2.40	$122.17	$49.55	$24.43
58323	T	Sperm washing	0197	2.40	$122.17	$49.55	$24.43
58340	N	Catheter for hysterography					
58345	T	Reopen fallopian tube	0194	15.86	$807.34	$395.60	$161.47
*58346	T	Insert heyman uteri capsule	0192	2.50	$127.26	$35.33	$25.45
58350	T	Reopen fallopian tube	0194	15.86	$807.34	$395.60	$161.47
58353	T	Endometr ablate, thermal	0193	11.16	$568.09	$171.13	$113.62
58400	C	Suspension of uterus					
58410	C	Suspension of uterus					
58520	C	Repair of ruptured uterus					
58540	C	Revision of uterus					
58550	T	Laparo-asst vag hysterectomy	0132	56.06	$2,853.68	$1,239.22	$570.74
58551	T	Laparoscopy, remove myoma	0131	37.63	$1,915.52	$996.07	$383.10
58555	T	Hysteroscopy, dx, sep proc	0194	15.86	$807.34	$395.60	$161.47
58558	T	Hysteroscopy, biopsy	0190	16.91	$860.79	$421.79	$172.16
58559	T	Hysteroscopy, lysis	0190	16.91	$860.79	$421.79	$172.16
58560	T	Hysteroscopy, resect septum	0190	16.91	$860.79	$421.79	$172.16
58561	T	Hysteroscopy, remove myoma	0190	16.91	$860.79	$421.79	$172.16
58562	T	Hysteroscopy, remove fb	0190	16.91	$860.79	$421.79	$172.16
58563	T	Hysteroscopy, ablation	0190	16.91	$860.79	$421.79	$172.16
58578	T	Laparo proc, uterus	0190	16.91	$860.79	$421.79	$172.16

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58579	T	Hysteroscope procedure	0190	16.91	$860.79	$421.79	$172.16
58600	T	Division of fallopian tube	0194	15.86	$807.34	$395.60	$161.47
58605	C	Division of fallopian tube					
58611	C	Ligate oviduct(s) add-on					
58615	T	Occlude fallopian tube(s)	0194	15.86	$807.34	$395.60	$161.47
58660	T	Laparoscopy, lysis	0131	37.63	$1,915.52	$996.07	$383.10
58661	T	Laparoscopy, remove adnexa	0131	37.63	$1,915.52	$996.07	$383.10
58662	T	Laparoscopy, excise lesions	0131	37.63	$1,915.52	$996.07	$383.10
58670	T	Laparoscopy, tubal cautery	0131	37.63	$1,915.52	$996.07	$383.10
58671	T	Laparoscopy, tubal block	0131	37.63	$1,915.52	$996.07	$383.10
58672	T	Laparoscopy, fimbrioplasty	0131	37.63	$1,915.52	$996.07	$383.10
58673	T	Laparoscopy, salpingostomy	0131	37.63	$1,915.52	$996.07	$383.10
58679	T	Laparo proc, oviduct-ovary	0130	25.91	$1,318.92	$659.53	$263.78
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)	0195	20.62	$1,049.64	$483.80	$209.93
58805	C	Drainage of ovarian cyst(s)					
58820	T	Drain ovary abscess, open	0195	20.62	$1,049.64	$483.80	$209.93
58822	C	Drain ovary abscess, percut					
58823	T	Drain pelvic abscess, percut	0193	11.16	$568.09	$171.13	$113.62
58825	C	Transposition, ovary(s)					
58900	T	Biopsy of ovary(s)	0195	20.62	$1,049.64	$483.80	$209.93
58920	T	Partial removal of ovary(s)	0202	63.54	$3,234.44	$1,487.84	$646.89
58925	T	Removal of ovarian cyst(s)	0202	63.54	$3,234.44	$1,487.84	$646.89
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					
*58953	C	Tah, rad dissect for debulk					
*58954	C	Tah rad debulk/lymph remove					
58960	C	Exploration of abdomen					
58970	T	Retrieval of oocyte	0194	15.86	$807.34	$395.60	$161.47
58974	T	Transfer of embryo	0197	2.40	$122.17	$49.55	$24.43
58976	T	Transfer of embryo	0197	2.40	$122.17	$49.55	$24.43
58999	T	Genital surgery procedure	0019	4.22	$214.81	$78.91	$42.96
59000	T	Amniocentesis	0198	1.31	$66.68	$32.67	$13.34
*59001	T	Amniocentesis, therapeutic	0198	1.31	$66.68	$32.67	$13.34
59012	T	Fetal cord puncture,prenatal	0198	1.31	$66.68	$32.67	$13.34
59015	T	Chorion biopsy	0198	1.31	$66.68	$32.67	$13.34
59020	T	Fetal contract stress test	0198	1.31	$66.68	$32.67	$13.34
59025	T	Fetal non-stress test	0198	1.31	$66.68	$32.67	$13.34
59030	T	Fetal scalp blood sample	0198	1.31	$66.68	$32.67	$13.34
59050	T	Fetal monitor w/report	0198	1.31	$66.68	$32.67	$13.34
59051	E	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	T	Treat ectopic pregnancy	0131	37.63	$1,915.52	$996.07	$383.10
59151	T	Treat ectopic pregnancy	0131	37.63	$1,915.52	$996.07	$383.10
59160	T	D & c after delivery	0196	13.48	$686.19	$336.23	$137.24
59200	T	Insert cervical dilator	0189	1.26	$64.14	$17.96	$12.83
59300	T	Episiotomy or vaginal repair	0193	11.16	$568.09	$171.13	$113.62
59320	T	Revision of cervix	0194	15.86	$807.34	$395.60	$161.47
59325	C	Revision of cervix					
59350	C	Repair of uterus					
59400	E	Obstetrical care					
59409	T	Obstetrical care	0199	5.09	$259.10	$72.55	$51.82
59410	E	Obstetrical care					
59412	T	Antepartum manipulation	0199	5.09	$259.10	$72.55	$51.82
59414	T	Deliver placenta	0199	5.09	$259.10	$72.55	$51.82
59425	E	Antepartum care only					
59426	E	Antepartum care only					
59430	E	Care after delivery					
59510	E	Cesarean delivery					
59514	C	Cesarean delivery only					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59515	E	Cesarean delivery					
59525	C	Remove uterus after cesarean					
59610	E	Vbac delivery					
59612	T	Vbac delivery only	0199	5.09	$259.10	$72.55	$51.82
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	0201	14.33	$729.45	$329.65	$145.89
59820	T	Care of miscarriage	0201	14.33	$729.45	$329.65	$145.89
59821	T	Treatment of miscarriage	0201	14.33	$729.45	$329.65	$145.89
59830	C	Treat uterus infection					
59840	T	Abortion	0200	11.34	$577.25	$305.94	$115.45
59841	T	Abortion	0200	11.34	$577.25	$305.94	$115.45
59850	C	Abortion					
59851	C	Abortion					
59852	C	Abortion					
59855	C	Abortion					
59856	C	Abortion					
59857	C	Abortion					
59866	T	Abortion (mpr)	0198	1.31	$66.68	$32.67	$13.34
59870	T	Evacuate mole of uterus	0201	14.33	$729.45	$329.65	$145.89
59871	T	Remove cerclage suture	0194	15.86	$807.34	$395.60	$161.47
59898	T	Laparo proc, ob care/deliver	0130	25.91	$1,318.92	$659.53	$263.78
59899	T	Maternity care procedure	0198	1.31	$66.68	$32.67	$13.34
60000	T	Drain thyroid/tongue cyst	0252	5.95	$302.88	$114.24	$60.58
60001	T	Aspirate/inject thyriod cyst	0004	2.47	$125.73	$32.57	$25.15
60100	T	Biopsy of thyroid	0004	2.47	$125.73	$32.57	$25.15
60200	T	Remove thyroid lesion	0114	29.28	$1,490.47	$493.78	$298.09
60210	T	Partial thyroid excision	0114	29.28	$1,490.47	$493.78	$298.09
60212	T	Parital thyroid excision	0114	29.28	$1,490.47	$493.78	$298.09
60220	T	Partial removal of thyroid	0114	29.28	$1,490.47	$493.78	$298.09
60225	T	Partial removal of thyroid	0114	29.28	$1,490.47	$493.78	$298.09
60240	T	Removal of thyroid	0114	29.28	$1,490.47	$493.78	$298.09
60252	T	Removal of thyroid	0256	26.61	$1,354.56	$623.05	$270.91
60254	C	Extensive thyroid surgery					
60260	T	Repeat thyroid surgery	0256	26.61	$1,354.56	$623.05	$270.91
60270	C	Removal of thyroid					
60271	C	Removal of thyroid					
60280	T	Remove thyroid duct lesion	0114	29.28	$1,490.47	$493.78	$298.09
60281	T	Remove thyroid duct lesion	0114	29.28	$1,490.47	$493.78	$298.09
60500	T	Explore parathyroid glands	0256	26.61	$1,354.56	$623.05	$270.91
60502	C	Re-explore parathyroids					
60505	C	Explore parathyroid glands					
60512	T	Autotransplant parathyroid	0021	11.82	$601.69	$236.51	$120.34
60520	C	Removal of thymus gland					
60521	C	Removal of 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					
60650	C	Laparoscopy adrenalectomy					
60659	T	Laparo proc, endocrine	0130	25.91	$1,318.92	$659.53	$263.78
60699	T	Endocrine surgery procedure	0004	2.47	$125.73	$32.57	$25.15
61000	T	Remove cranial cavity fluid	0212	3.77	$191.91	$88.78	$38.38
61001	T	Remove cranial cavity fluid	0212	3.77	$191.91	$88.78	$38.38
61020	T	Remove brain cavity fluid	0212	3.77	$191.91	$88.78	$38.38
61026	T	Injection into brain canal	0212	3.77	$191.91	$88.78	$38.38
61050	T	Remove brain canal fluid	0212	3.77	$191.91	$88.78	$38.38
61055	T	Injection into brain canal	0212	3.77	$191.91	$88.78	$38.38
61070	T	Brain canal shunt procedure	0212	3.77	$191.91	$88.78	$38.38
61105	C	Twist drill hole					
61107	C	Drill skull for implantation					
61108	C	Drill skull for drainage					
61120	C	Burr hole for puncture					
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	0224	28.48	$1,449.75	$453.41	$289.95
61250	C	Pierce skull & explore					
61253	C	Pierce skull & explore					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	T	Decompress eye socket	0256	26.61	$1,354.56	$623.05	$270.91
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 (press 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 foreign body, brain					
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	Transtemporal approach/skull					
61596	C	Transcochlear approach/skull					
61597	C	Transcondylar approach/skull					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	T	Occlusion/embolization cath	0081	29.24	$1,488.43	$710.91	$297.69
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					
61697	C	Brain aneurysm repr, complx					
61698	C	Brain aneurysm repr, complx					
61700	C	Brain aneurysm repr , simple					
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					
61720	C	Incise skull/brain surgery					
61735	C	Incise skull/brain surgery					
61750	C	Incise skull/brain biopsy					
61751	C	Brain biopsy w/ ct/mr guide					
61760	C	Implant brain electrodes					
61770	C	Incise skull for treatment					
61790	T	Treat trigeminal nerve	0220	13.60	$692.29	$325.38	$138.46
61791	T	Treat trigeminal tract	0204	2.24	$114.02	$43.33	$22.80
61793	S	Focus radiation beam	0302	11.16	$568.09	$216.55	$113.62
61795	S	Brain surgery using computer	0302	11.16	$568.09	$216.55	$113.62
61850	C	Implant neuroelectrodes					
61860	C	Implant neuroelectrodes					
61862	C	Implant neurostimul, subcort					
61870	C	Implant neuroelectrodes					
61875	C	Implant neuroelectrodes					
61880	T	Revise/remove neuroelectrode	0687	42.34	$2,155.28		$431.06
61885	T	Implant neurostim one array	0222	302.53	$15,399.99		$3,080.00
61886	T	Implant neurostim arrays	0222	302.53	$15,399.99		$3,080.00
61888	T	Revise/remove neuroreceiver	0688	145.27	$7,394.82		$1,478.96
62000	C	Treat skull fracture					
62005	C	Treat 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 & 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	0121	2.54	$129.30	$52.53	$25.86
62200	C	Establish brain cavity shunt					
62201	C	Establish brain cavity shunt					
62220	C	Establish brain cavity shunt					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62223	C	Establish brain cavity shunt					
62225	T	Replace/irrigate catheter	0121	2.54	$129.30	$52.53	$25.86
62230	T	Replace/revise brain shunt	0224	28.48	$1,449.75	$453.41	$289.95
62252	S	Csf shunt reprogram	0691	3.17	$161.37	$88.75	$32.27
62256	C	Remove brain cavity shunt					
62258	C	Replace brain cavity shunt					
62263	T	Lysis epidural adhesions	0203	15.79	$803.77	$369.73	$160.75
62268	T	Drain spinal cord cyst	0212	3.77	$191.91	$88.78	$38.38
62269	T	Needle biopsy, spinal cord	0005	4.03	$205.14	$90.26	$41.03
62270	T	Spinal fluid tap, diagnostic	0206	3.59	$182.75	$74.93	$36.55
62272	T	Drain spinal fluid	0206	3.59	$182.75	$74.93	$36.55
62273	T	Treat epidural spine lesion	0206	3.59	$182.75	$74.93	$36.55
62280	T	Treat spinal cord lesion	0207	5.36	$272.85	$122.78	$54.57
62281	T	Treat spinal cord lesion	0207	5.36	$272.85	$122.78	$54.57
62282	T	Treat spinal canal lesion	0207	5.36	$272.85	$122.78	$54.57
62284	N	Injection for myelogram					
62287	T	Percutaneous diskectomy	0220	13.60	$692.29	$325.38	$138.46
62290	N	Inject for spine disk x-ray					
62291	N	Inject for spine disk x-ray					
62292	T	Injection into disk lesion	0212	3.77	$191.91	$88.78	$38.38
62294	T	Injection into spinal artery	0212	3.77	$191.91	$88.78	$38.38
62310	T	Inject spine c/t	0206	3.59	$182.75	$74.93	$36.55
62311	T	Inject spine l/s (cd)	0206	3.59	$182.75	$74.93	$36.55
62318	T	Inject spine w/cath, c/t	0206	3.59	$182.75	$74.93	$36.55
62319	T	Inject spine w/cath l/s (cd)	0206	3.59	$182.75	$74.93	$36.55
62350	T	Implant spinal canal cath	0223	75.39	$3,837.65		$767.53
62351	C	Implant spinal canal cath					
62355	T	Remove spinal canal catheter	0105	14.76	$751.34	$368.16	$150.27
62360	T	Insert spine infusion device	0226	75.81	$3,859.03		$771.81
62361	T	Implant spine infusion pump	0227	139.55	$7,103.65		$1,420.73
62362	T	Implant spine infusion pump	0227	139.55	$7,103.65		$1,420.73
62365	T	Remove spine infusion device	0105	14.76	$751.34	$368.16	$150.27
62367	S	Analyze spine infusion pump	0691	3.17	$161.37	$88.75	$32.27
62368	S	Analyze spine infusion pump	0691	3.17	$161.37	$88.75	$32.27
63001	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63003	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63005	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63011	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63012	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63015	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63016	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63017	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63020	T	Neck spine disk surgery	0208	29.12	$1,482.32		$296.46
63030	T	Low back disk surgery	0208	29.12	$1,482.32		$296.46
63035	T	Spinal disk surgery add-on	0208	29.12	$1,482.32		$296.46
63040	T	Laminotomy, single cervical	0208	29.12	$1,482.32		$296.46
63042	T	Laminotomy, single lumbar	0208	29.12	$1,482.32		$296.46
63043	C	Laminotomy, addl cervical					
63044	C	Laminotomy, addl lumbar					
63045	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63046	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63047	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63048	T	Remove spinal lamina add-on	0208	29.12	$1,482.32		$296.46
63055	T	Decompress spinal cord	0208	29.12	$1,482.32		$296.46
63056	T	Decompress spinal cord	0208	29.12	$1,482.32		$296.46
63057	T	Decompress spine cord add-on	0208	29.12	$1,482.32		$296.46
63064	T	Decompress spinal cord	0208	29.12	$1,482.32		$296.46
63066	T	Decompress spine cord add-on	0208	29.12	$1,482.32		$296.46
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	Remove vertebral body add-on					
63085	C	Removal of vertebral body					
63086	C	Remove vertebral body add-on					
63087	C	Removal of vertebral body					
63088	C	Remove vertebral body add-on					
63090	C	Removal of vertebral body					
63091	C	Remove vertebral body add-on					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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	Remove vertebral body add-on					
63600	T	Remove spinal cord lesion	0220	13.60	$692.29	$325.38	$138.46
63610	T	Stimulation of spinal cord	0220	13.60	$692.29	$325.38	$138.46
63615	T	Remove lesion of spinal cord	0220	13.60	$692.29	$325.38	$138.46
63650	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
63655	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
63660	T	Revise/remove neuroelectrode	0687	42.34	$2,155.28		$431.06
63685	T	Implant neuroreceiver	0222	302.53	$15,399.99		$3,080.00
63688	T	Revise/remove neuroreceiver	0688	145.27	$7,394.82		$1,478.96
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	T	Install spinal shunt	0228	53.77	$2,737.11	$696.46	$547.42
63744	T	Revision of spinal shunt	0228	53.77	$2,737.11	$696.46	$547.42
63746	T	Removal of spinal shunt	0109	6.27	$319.17	$130.86	$63.83
64400	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64402	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64405	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64408	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64410	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64412	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64413	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64415	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64417	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64418	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64420	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64421	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64425	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64430	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64435	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64445	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64450	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64470	T	Inj paravertebral c/t	0207	5.36	$272.85	$122.78	$54.57
64472	T	Inj paravertebral c/t add-on	0207	5.36	$272.85	$122.78	$54.57
64475	T	Inj paravertebral l/s	0207	5.36	$272.85	$122.78	$54.57
64476	T	Inj paravertebral l/s add-on	0207	5.36	$272.85	$122.78	$54.57
64479	T	Inj foramen epidural c/t	0207	5.36	$272.85	$122.78	$54.57
64480	T	Inj foramen epidural add-on	0207	5.36	$272.85	$122.78	$54.57
64483	T	Inj foramen epidural l/s	0207	5.36	$272.85	$122.78	$54.57
64484	T	Inj foramen epidural add-on	0207	5.36	$272.85	$122.78	$54.57
64505	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64508	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64510	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64520	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64530	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64550	A	Apply neurostimulator					
64553	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64555	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64560	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
*64561	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64565	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64573	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64575	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64577	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64580	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
*64581	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64585	T	Revise/remove neuroelectrode	0687	42.34	$2,155.28		$431.06
64590	T	Implant neuroreceiver	0222	302.53	$15,399.99		$3,080.00
64595	T	Revise/remove neuroreceiver	0688	145.27	$7,394.82		$1,478.96
64600	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64605	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64610	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64612	T	Destroy nerve, face muscle	0204	2.24	$114.02	$43.33	$22.80
64613	T	Destroy nerve, spine muscle	0204	2.24	$114.02	$43.33	$22.80
64614	T	Destroy nerve, extrem musc	0206	3.59	$182.75	$74.93	$36.55
64620	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64622	T	Destr paravertebrl nerve l/s	0203	15.79	$803.77	$369.73	$160.75
64623	T	Destr paravertebral n add-on	0203	15.79	$803.77	$369.73	$160.75
64626	T	Destr paravertebrl nerve c/t	0203	15.79	$803.77	$369.73	$160.75
64627	T	Destr paravertebral n add-on	0203	15.79	$803.77	$369.73	$160.75
64630	T	Injection treatment of nerve	0207	5.36	$272.85	$122.78	$54.57
64640	T	Injection treatment of nerve	0207	5.36	$272.85	$122.78	$54.57
64680	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64702	T	Revise finger/toe nerve	0220	13.60	$692.29	$325.38	$138.46
64704	T	Revise hand/foot nerve	0220	13.60	$692.29	$325.38	$138.46
64708	T	Revise arm/leg nerve	0220	13.60	$692.29	$325.38	$138.46
64712	T	Revision of sciatic nerve	0220	13.60	$692.29	$325.38	$138.46
64713	T	Revision of arm nerve(s)	0220	13.60	$692.29	$325.38	$138.46
64714	T	Revise low back nerve(s)	0220	13.60	$692.29	$325.38	$138.46
64716	T	Revision of cranial nerve	0220	13.60	$692.29	$325.38	$138.46
64718	T	Revise ulnar nerve at elbow	0220	13.60	$692.29	$325.38	$138.46
64719	T	Revise ulnar nerve at wrist	0220	13.60	$692.29	$325.38	$138.46
64721	T	Carpal tunnel surgery	0220	13.60	$692.29	$325.38	$138.46
64722	T	Relieve pressure on nerve(s)	0220	13.60	$692.29	$325.38	$138.46
64726	T	Release foot/toe nerve	0220	13.60	$692.29	$325.38	$138.46
64727	T	Internal nerve revision	0220	13.60	$692.29	$325.38	$138.46
64732	T	Incision of brow nerve	0220	13.60	$692.29	$325.38	$138.46
64734	T	Incision of cheek nerve	0220	13.60	$692.29	$325.38	$138.46
64736	T	Incision of chin nerve	0220	13.60	$692.29	$325.38	$138.46
64738	T	Incision of jaw nerve	0220	13.60	$692.29	$325.38	$138.46
64740	T	Incision of tongue nerve	0220	13.60	$692.29	$325.38	$138.46
64742	T	Incision of facial nerve	0220	13.60	$692.29	$325.38	$138.46
64744	T	Incise nerve, back of head	0220	13.60	$692.29	$325.38	$138.46
64746	T	Incise diaphragm nerve	0220	13.60	$692.29	$325.38	$138.46
64752	C	Incision of vagus nerve					
64755	C	Incision of stomach nerves					
64760	C	Incision of vagus nerve					
64761	T	Incision of pelvis nerve	0220	13.60	$692.29	$325.38	$138.46
64763	C	Incise hip/thigh nerve					
64766	C	Incise hip/thigh nerve					
64771	T	Sever cranial nerve	0220	13.60	$692.29	$325.38	$138.46
64772	T	Incision of spinal nerve	0220	13.60	$692.29	$325.38	$138.46
64774	T	Remove skin nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64776	T	Remove digit nerve lesion	0220	13.60	$692.29	$325.38	$138.46

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64778	T	Digit nerve surgery add-on	0220	13.60	$692.29	$325.38	$138.46
64782	T	Remove limb nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64783	T	Limb nerve surgery add-on	0220	13.60	$692.29	$325.38	$138.46
64784	T	Remove nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64786	T	Remove sciatic nerve lesion	0221	21.43	$1,090.87	$463.62	$218.17
64787	T	Implant nerve end	0220	13.60	$692.29	$325.38	$138.46
64788	T	Remove skin nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64790	T	Removal of nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64792	T	Removal of nerve lesion	0221	21.43	$1,090.87	$463.62	$218.17
64795	T	Biopsy of nerve	0220	13.60	$692.29	$325.38	$138.46
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	.....	.....	.....	.....	.....
*64821	T	Remove sympathetic nerves	0054	19.83	$1,009.43	$472.33	$201.89
*64822	T	Remove sympathetic nerves	0054	19.83	$1,009.43	$472.33	$201.89
*64823	T	Remove sympathetic nerves	0054	19.83	$1,009.43	$472.33	$201.89
64831	T	Repair of digit nerve	0221	21.43	$1,090.87	$463.62	$218.17
64832	T	Repair nerve add-on	0221	21.43	$1,090.87	$463.62	$218.17
64834	T	Repair of hand or foot nerve	0221	21.43	$1,090.87	$463.62	$218.17
64835	T	Repair of hand or foot nerve	0221	21.43	$1,090.87	$463.62	$218.17
64836	T	Repair of hand or foot nerve	0221	21.43	$1,090.87	$463.62	$218.17
64837	T	Repair nerve add-on	0221	21.43	$1,090.87	$463.62	$218.17
64840	T	Repair of leg nerve	0221	21.43	$1,090.87	$463.62	$218.17
64856	T	Repair/transpose nerve	0221	21.43	$1,090.87	$463.62	$218.17
64857	T	Repair arm/leg nerve	0221	21.43	$1,090.87	$463.62	$218.17
64858	T	Repair sciatic nerve	0221	21.43	$1,090.87	$463.62	$218.17
64859	T	Nerve surgery	0221	21.43	$1,090.87	$463.62	$218.17
64861	T	Repair of arm nerves	0221	21.43	$1,090.87	$463.62	$218.17
64862	T	Repair of low back nerves	0221	21.43	$1,090.87	$463.62	$218.17
64864	T	Repair of facial nerve	0221	21.43	$1,090.87	$463.62	$218.17
64865	T	Repair of facial nerve	0221	21.43	$1,090.87	$463.62	$218.17
64866	C	Fusion of facial/other nerve	.....	.....	.....	.....	.....
64868	C	Fusion of facial/other nerve	.....	.....	.....	.....	.....
64870	T	Fusion of facial/other nerve	0221	21.43	$1,090.87	$463.62	$218.17
64872	T	Subsequent repair of nerve	0221	21.43	$1,090.87	$463.62	$218.17
64874	T	Repair & revise nerve add-on	0221	21.43	$1,090.87	$463.62	$218.17
64876	T	Repair nerve/shorten bone	0221	21.43	$1,090.87	$463.62	$218.17
64885	T	Nerve graft, head or neck	0221	21.43	$1,090.87	$463.62	$218.17
64886	T	Nerve graft, head or neck	0221	21.43	$1,090.87	$463.62	$218.17
64890	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64891	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64892	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64893	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64895	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64896	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64897	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64898	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64901	T	Nerve graft add-on	0221	21.43	$1,090.87	$463.62	$218.17
64902	T	Nerve graft add-on	0221	21.43	$1,090.87	$463.62	$218.17
64905	T	Nerve pedicle transfer	0221	21.43	$1,090.87	$463.62	$218.17
64907	T	Nerve pedicle transfer	0221	21.43	$1,090.87	$463.62	$218.17
64999	T	Nervous system surgery	0204	2.24	$114.02	$43.33	$22.80
65091	T	Revise eye	0242	23.72	$1,207.44	$597.36	$241.49
65093	T	Revise eye with implant	0241	18.12	$922.38	$384.47	$184.48
65101	T	Removal of eye	0242	23.72	$1,207.44	$597.36	$241.49
65103	T	Remove eye/insert implant	0242	23.72	$1,207.44	$597.36	$241.49
65105	T	Remove eye/attach implant	0242	23.72	$1,207.44	$597.36	$241.49
65110	T	Removal of eye	0242	23.72	$1,207.44	$597.36	$241.49
65112	T	Remove eye/revise socket	0242	23.72	$1,207.44	$597.36	$241.49
65114	T	Remove eye/revise socket	0242	23.72	$1,207.44	$597.36	$241.49
65125	T	Revise ocular implant	0240	13.83	$704.00	$315.34	$140.80
65130	T	Insert ocular implant	0241	18.12	$922.38	$384.47	$184.48
65135	T	Insert ocular implant	0241	18.12	$922.38	$384.47	$184.48
65140	T	Attach ocular implant	0242	23.72	$1,207.44	$597.36	$241.49
65150	T	Revise ocular implant	0241	18.12	$922.38	$384.47	$184.48
65155	T	Reinsert ocular implant	0242	23.72	$1,207.44	$597.36	$241.49
65175	T	Removal of ocular implant	0240	13.83	$704.00	$315.34	$140.80
65205	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65210	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65220	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65222	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65235	T	Remove foreign body from eye	0233	10.83	$551.29	$264.62	$110.26
65260	T	Remove foreign body from eye	0237	36.32	$1,848.83	.....	$369.77

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65265	T	Remove foreign body from eye	0236	16.21	$825.15	.....	$165.03
65270	T	Repair of eye wound	0240	13.83	$704.00	$315.34	$140.80
65272	T	Repair of eye wound	0233	10.83	$551.29	$264.62	$110.26
65273	C	Repair of eye wound	.....	.....	.....	.....	.....
65275	T	Repair of eye wound	0233	10.83	$551.29	$264.62	$110.26
65280	T	Repair of eye wound	0234	19.08	$971.25	$466.20	$194.25
65285	T	Repair of eye wound	0234	19.08	$971.25	$466.20	$194.25
65286	T	Repair of eye wound	0233	10.83	$551.29	$264.62	$110.26
65290	T	Repair of eye socket wound	0243	17.70	$901.00	$429.78	$180.20
65400	T	Removal of eye lesion	0233	10.83	$551.29	$264.62	$110.26
65410	T	Biopsy of cornea	0233	10.83	$551.29	$264.62	$110.26
65420	T	Removal of eye lesion	0233	10.83	$551.29	$264.62	$110.26
65426	T	Removal of eye lesion	0234	19.08	$971.25	$466.20	$194.25
65430	S	Corneal smear	0230	0.61	$31.05	$14.28	$6.21
65435	T	Curette/treat cornea	0239	5.80	$295.24	$115.14	$59.05
65436	T	Curette/treat cornea	0233	10.83	$551.29	$264.62	$110.26
65450	S	Treatment of corneal lesion	0231	2.03	$103.34	$46.50	$20.67
65600	T	Revision of cornea	0240	13.83	$704.00	$315.34	$140.80
65710	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65730	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65750	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65755	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65760	E	Revision of cornea	.....	.....	.....	.....	.....
65765	E	Revision of cornea	.....	.....	.....	.....	.....
65767	E	Corneal tissue transplant	.....	.....	.....	.....	.....
65770	T	Revise cornea with implant	0244	38.46	$1,957.77	$851.42	$391.55
65771	E	Radial keratotomy	.....	.....	.....	.....	.....
65772	T	Correction of astigmatism	0233	10.83	$551.29	$264.62	$110.26
65775	T	Correction of astigmatism	0233	10.83	$551.29	$264.62	$110.26
65800	T	Drainage of eye	0233	10.83	$551.29	$264.62	$110.26
65805	T	Drainage of eye	0233	10.83	$551.29	$264.62	$110.26
65810	T	Drainage of eye	0233	10.83	$551.29	$264.62	$110.26
65815	T	Drainage of eye	0234	19.08	$971.25	$466.20	$194.25
65820	T	Relieve inner eye pressure	0232	3.50	$178.16	$78.39	$35.63
65850	T	Incision of eye	0234	19.08	$971.25	$466.20	$194.25
65855	T	Laser surgery of eye	0248	29.51	$1,502.18	.....	$300.44
65860	T	Incise inner eye adhesions	0247	4.03	$205.14	$94.36	$41.03
65865	T	Incise inner eye adhesions	0233	10.83	$551.29	$264.62	$110.26
65870	T	Incise inner eye adhesions	0234	19.08	$971.25	$466.20	$194.25
65875	T	Incise inner eye adhesions	0234	19.08	$971.25	$466.20	$194.25
65880	T	Incise inner eye adhesions	0233	10.83	$551.29	$264.62	$110.26
65900	T	Remove eye lesion	0233	10.83	$551.29	$264.62	$110.26
65920	T	Remove implant from eye	0233	10.83	$551.29	$264.62	$110.26
65930	T	Remove blood clot from eye	0234	19.08	$971.25	$466.20	$194.25
66020	T	Injection treatment of eye	0233	10.83	$551.29	$264.62	$110.26
66030	T	Injection treatment of eye	0233	10.83	$551.29	$264.62	$110.26
66130	T	Remove eye lesion	0234	19.08	$971.25	$466.20	$194.25
66150	T	Glaucoma surgery	0233	10.83	$551.29	$264.62	$110.26
66155	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66160	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66165	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66170	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66172	T	Incision of eye	0234	19.08	$971.25	$466.20	$194.25
66180	T	Implant eye shunt	0234	19.08	$971.25	$466.20	$194.25
66185	T	Revise eye shunt	0234	19.08	$971.25	$466.20	$194.25
66220	T	Repair eye lesion	0236	16.21	$825.15	.....	$165.03
66225	T	Repair/graft eye lesion	0234	19.08	$971.25	$466.20	$194.25
66250	T	Follow-up surgery of eye	0233	10.83	$551.29	$264.62	$110.26
66500	T	Incision of iris	0232	3.50	$178.16	$78.39	$35.63
66505	T	Incision of iris	0232	3.50	$178.16	$78.39	$35.63
66600	T	Remove iris and lesion	0233	10.83	$551.29	$264.62	$110.26
66605	T	Removal of iris	0234	19.08	$971.25	$466.20	$194.25
66625	T	Removal of iris	0233	10.83	$551.29	$264.62	$110.26
66630	T	Removal of iris	0233	10.83	$551.29	$264.62	$110.26
66635	T	Removal of iris	0234	19.08	$971.25	$466.20	$194.25
66680	T	Repair iris & ciliary body	0234	19.08	$971.25	$466.20	$194.25
66682	T	Repair iris & ciliary body	0234	19.08	$971.25	$466.20	$194.25
66700	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66710	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66720	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66740	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66761	T	Revision of iris	0248	29.51	$1,502.18	.....	$300.44
66762	T	Revision of iris	0247	4.03	$205.14	$94.36	$41.03
66770	T	Removal of inner eye lesion	0247	4.03	$205.14	$94.36	$41.03
66820	T	Incision, secondary cataract	0232	3.50	$178.16	$78.39	$35.63

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66821	T	After cataract laser surgery	0248	29.51	$1,502.18	.....	$300.44
66825	T	Reposition intraocular lens	0234	19.08	$971.25	$466.20	$194.25
66830	T	Removal of lens lesion	0232	3.50	$178.16	$78.39	$35.63
66840	T	Removal of lens material	0245	10.44	$531.44	$249.78	$106.29
66850	T	Removal of lens material	0249	21.80	$1,109.71	$521.56	$221.94
66852	T	Removal of lens material	0249	21.80	$1,109.71	$521.56	$221.94
66920	T	Extraction of lens	0249	21.80	$1,109.71	$521.56	$221.94
66930	T	Extraction of lens	0249	21.80	$1,109.71	$521.56	$221.94
66940	T	Extraction of lens	0245	10.44	$531.44	$249.78	$106.29
66982	T	Cataract surgery, complex	0246	21.20	$1,079.16	$507.21	$215.83
66983	T	Cataract surg w/iol, 1 stage	0246	21.20	$1,079.16	$507.21	$215.83
66984	T	Cataract surg w/iol, i stage	0246	21.20	$1,079.16	$507.21	$215.83
66985	T	Insert lens prosthesis	0246	21.20	$1,079.16	$507.21	$215.83
66986	T	Exchange lens prosthesis	0246	21.20	$1,079.16	$507.21	$215.83
66999	T	Eye surgery procedure	0247	4.03	$205.14	$94.36	$41.03
67005	T	Partial removal of eye fluid	0237	36.32	$1,848.83	.....	$369.77
67010	T	Partial removal of eye fluid	0237	36.32	$1,848.83	.....	$369.77
67015	T	Release of eye fluid	0237	36.32	$1,848.83	.....	$369.77
67025	T	Replace eye fluid	0236	16.21	$825.15	.....	$165.03
67027	T	Implant eye drug system	0237	36.32	$1,848.83	.....	$369.77
67028	T	Injection eye drug	0235	5.57	$283.54	$78.91	$56.71
67030	T	Incise inner eye strands	0236	16.21	$825.15	.....	$165.03
67031	T	Laser surgery, eye strands	0247	4.03	$205.14	$94.36	$41.03
67036	T	Removal of inner eye fluid	0237	36.32	$1,848.83	.....	$369.77
67038	T	Strip retinal membrane	0237	36.32	$1,848.83	.....	$369.77
67039	T	Laser treatment of retina	0237	36.32	$1,848.83	.....	$369.77
67040	T	Laser treatment of retina	0237	36.32	$1,848.83	.....	$369.77
67101	T	Repair detached retina	0235	5.57	$283.54	$78.91	$56.71
67105	T	Repair detached retina	0247	4.03	$205.14	$94.36	$41.03
67107	T	Repair detached retina	0237	36.32	$1,848.83	.....	$369.77
67108	T	Repair detached retina	0237	36.32	$1,848.83	.....	$369.77
67110	T	Repair detached retina	0235	5.57	$283.54	$78.91	$56.71
67112	T	Rerepair detached retina	0237	36.32	$1,848.83	.....	$369.77
67115	T	Release encircling material	0236	16.21	$825.15	.....	$165.03
67120	T	Remove eye implant material	0236	16.21	$825.15	.....	$165.03
67121	T	Remove eye implant material	0237	36.32	$1,848.83	.....	$369.77
67141	T	Treatment of retina	0235	5.57	$283.54	$78.91	$56.71
67145	T	Treatment of retina	0247	4.03	$205.14	$94.36	$41.03
67208	S	Treatment of retinal lesion	0231	2.03	$103.34	$46.50	$20.67
67210	T	Treatment of retinal lesion	0247	4.03	$205.14	$94.36	$41.03
67218	T	Treatment of retinal lesion	0237	36.32	$1,848.83	.....	$369.77
67220	T	Treatment of choroid lesion	0235	5.57	$283.54	$78.91	$56.71
67221	T	Ocular photodynamic ther	0235	5.57	$283.54	$78.91	$56.71
*67225	T	Eye photodynamic ther add-on	0235	5.57	$283.54	$78.91	$56.71
67227	T	Treatment of retinal lesion	0235	5.57	$283.54	$78.91	$56.71
67228	T	Treatment of retinal lesion	0248	29.51	$1,502.18	.....	$300.44
67250	T	Reinforce eye wall	0240	13.83	$704.00	$315.34	$140.80
67255	T	Reinforce/graft eye wall	0237	36.32	$1,848.83	.....	$369.77
67299	T	Eye surgery procedure	0248	29.51	$1,502.18	.....	$300.44
67311	T	Revise eye muscle	0243	17.70	$901.00	$429.78	$180.20
67312	T	Revise two eye muscles	0243	17.70	$901.00	$429.78	$180.20
67314	T	Revise eye muscle	0243	17.70	$901.00	$429.78	$180.20
67316	T	Revise two eye muscles	0243	17.70	$901.00	$429.78	$180.20
67318	T	Revise eye muscle(s)	0243	17.70	$901.00	$429.78	$180.20
67320	T	Revise eye muscle(s) add-on	0243	17.70	$901.00	$429.78	$180.20
67331	T	Eye surgery follow-up add-on	0243	17.70	$901.00	$429.78	$180.20
67332	T	Rerevise eye muscles add-on	0243	17.70	$901.00	$429.78	$180.20
67334	T	Revise eye muscle w/suture	0243	17.70	$901.00	$429.78	$180.20
67335	T	Eye suture during surgery	0243	17.70	$901.00	$429.78	$180.20
67340	T	Revise eye muscle add-on	0243	17.70	$901.00	$429.78	$180.20
67343	T	Release eye tissue	0243	17.70	$901.00	$429.78	$180.20
67345	T	Destroy nerve of eye muscle	0238	3.01	$153.22	$58.96	$30.64
67350	T	Biopsy eye muscle	0699	6.46	$328.84	$147.98	$65.77
67399	T	Eye muscle surgery procedure	0243	17.70	$901.00	$429.78	$180.20
67400	T	Explore/biopsy eye socket	0241	18.12	$922.38	$384.47	$184.48
67405	T	Explore/drain eye socket	0241	18.12	$922.38	$384.47	$184.48
67412	T	Explore/treat eye socket	0241	18.12	$922.38	$384.47	$184.48
67413	T	Explore/treat eye socket	0241	18.12	$922.38	$384.47	$184.48
67414	T	Explr/decompress eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67415	T	Aspiration, orbital contents	0239	5.80	$295.24	$115.14	$59.05
67420	T	Explore/treat eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67430	T	Explore/treat eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67440	T	Explore/drain eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67445	T	Explr/decompress eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67450	T	Explore/biopsy eye socket	0242	23.72	$1,207.44	$597.36	$241.49

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67500	S	Inject/treat eye socket	0231	2.03	$103.34	$46.50	$20.67
67505	T	Inject/treat eye socket	0238	3.01	$153.22	$58.96	$30.64
67515	T	Inject/treat eye socket	0239	5.80	$295.24	$115.14	$59.05
67550	T	Insert eye socket implant	0242	23.72	$1,207.44	$597.36	$241.49
67560	T	Revise eye socket implant	0241	18.12	$922.38	$384.47	$184.48
67570	T	Decompress optic nerve	0242	23.72	$1,207.44	$597.36	$241.49
67599	T	Orbit surgery procedure	0239	5.80	$295.24	$115.14	$59.05
67700	T	Drainage of eyelid abscess	0238	3.01	$153.22	$58.96	$30.64
67710	T	Incision of eyelid	0239	5.80	$295.24	$115.14	$59.05
67715	T	Incision of eyelid fold	0240	13.83	$704.00	$315.34	$140.80
67800	T	Remove eyelid lesion	0238	3.01	$153.22	$58.96	$30.64
67801	T	Remove eyelid lesions	0239	5.80	$295.24	$115.14	$59.05
67805	T	Remove eyelid lesions	0238	3.01	$153.22	$58.96	$30.64
67808	T	Remove eyelid lesion(s)	0240	13.83	$704.00	$315.34	$140.80
67810	T	Biopsy of eyelid	0238	3.01	$153.22	$58.96	$30.64
67820	S	Revise eyelashes	0698	1.03	$52.43	$19.92	$10.49
67825	T	Revise eyelashes	0238	3.01	$153.22	$58.96	$30.64
67830	T	Revise eyelashes	0239	5.80	$295.24	$115.14	$59.05
67835	T	Revise eyelashes	0240	13.83	$704.00	$315.34	$140.80
67840	T	Remove eyelid lesion	0239	5.80	$295.24	$115.14	$59.05
67850	T	Treat eyelid lesion	0239	5.80	$295.24	$115.14	$59.05
67875	T	Closure of eyelid by suture	0239	5.80	$295.24	$115.14	$59.05
67880	T	Revision of eyelid	0233	10.83	$551.29	$264.62	$110.26
67882	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67900	T	Repair brow defect	0240	13.83	$704.00	$315.34	$140.80
67901	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67902	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67903	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67904	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67906	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67908	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67909	T	Revise eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67911	T	Revise eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67914	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67915	T	Repair eyelid defect	0239	5.80	$295.24	$115.14	$59.05
67916	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67917	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67921	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67922	T	Repair eyelid defect	0239	5.80	$295.24	$115.14	$59.05
67923	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67924	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67930	T	Repair eyelid wound	0240	13.83	$704.00	$315.34	$140.80
67935	T	Repair eyelid wound	0240	13.83	$704.00	$315.34	$140.80
67938	S	Remove eyelid foreign body	0698	1.03	$52.43	$19.92	$10.49
67950	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67961	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67966	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67971	T	Reconstruction of eyelid	0241	18.12	$922.38	$384.47	$184.48
67973	T	Reconstruction of eyelid	0241	18.12	$922.38	$384.47	$184.48
67974	T	Reconstruction of eyelid	0241	18.12	$922.38	$384.47	$184.48
67975	T	Reconstruction of eyelid	0240	13.83	$704.00	$315.34	$140.80
67999	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
68020	T	Incise/drain eyelid lining	0240	13.83	$704.00	$315.34	$140.80
68040	S	Treatment of eyelid lesions	0698	1.03	$52.43	$19.92	$10.49
68100	T	Biopsy of eyelid lining	0233	10.83	$551.29	$264.62	$110.26
68110	T	Remove eyelid lining lesion	0699	6.46	$328.84	$147.98	$65.77
68115	T	Remove eyelid lining lesion	0239	5.80	$295.24	$115.14	$59.05
68130	T	Remove eyelid lining lesion	0233	10.83	$551.29	$264.62	$110.26
68135	T	Remove eyelid lining lesion	0239	5.80	$295.24	$115.14	$59.05
68200	S	Treat eyelid by injection	0698	1.03	$52.43	$19.92	$10.49
68320	T	Revise/graft eyelid lining	0240	13.83	$704.00	$315.34	$140.80
68325	T	Revise/graft eyelid lining	0242	23.72	$1,207.44	$597.36	$241.49
68326	T	Revise/graft eyelid lining	0241	18.12	$922.38	$384.47	$184.48
68328	T	Revise/graft eyelid lining	0241	18.12	$922.38	$384.47	$184.48
68330	T	Revise eyelid lining	0233	10.83	$551.29	$264.62	$110.26
68335	T	Revise/graft eyelid lining	0241	18.12	$922.38	$384.47	$184.48
68340	T	Separate eyelid adhesions	0240	13.83	$704.00	$315.34	$140.80
68360	T	Revise eyelid lining	0234	19.08	$971.25	$466.20	$194.25
68362	T	Revise eyelid lining	0234	19.08	$971.25	$466.20	$194.25
68399	T	Eyelid lining surgery	0239	5.80	$295.24	$115.14	$59.05
68400	T	Incise/drain tear gland	0238	3.01	$153.22	$58.96	$30.64
68420	T	Incise/drain tear sac	0240	13.83	$704.00	$315.34	$140.80
68440	T	Incise tear duct opening	0238	3.01	$153.22	$58.96	$30.64
68500	T	Removal of tear gland	0241	18.12	$922.38	$384.47	$184.48
68505	T	Partial removal, tear gland	0241	18.12	$922.38	$384.47	$184.48

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68510	T	Biopsy of tear gland	0240	13.83	$704.00	$315.34	$140.80
68520	T	Removal of tear sac	0241	18.12	$922.38	$384.47	$184.48
68525	T	Biopsy of tear sac	0240	13.83	$704.00	$315.34	$140.80
68530	T	Clearance of tear duct	0240	13.83	$704.00	$315.34	$140.80
68540	T	Remove tear gland lesion	0241	18.12	$922.38	$384.47	$184.48
68550	T	Remove tear gland lesion	0242	23.72	$1,207.44	$597.36	$241.49
68700	T	Repair tear ducts	0241	18.12	$922.38	$384.47	$184.48
68705	T	Revise tear duct opening	0238	3.01	$153.22	$58.96	$30.64
68720	T	Create tear sac drain	0242	23.72	$1,207.44	$597.36	$241.49
68745	T	Create tear duct drain	0241	18.12	$922.38	$384.47	$184.48
68750	T	Create tear duct drain	0242	23.72	$1,207.44	$597.36	$241.49
68760	S	Close tear duct opening	0698	1.03	$52.43	$19.92	$10.49
68761	S	Close tear duct opening	0231	2.03	$103.34	$46.50	$20.67
68770	T	Close tear system fistula	0240	13.83	$704.00	$315.34	$140.80
68801	S	Dilate tear duct opening	0231	2.03	$103.34	$46.50	$20.67
68810	T	Probe nasolacrimal duct	0699	6.46	$328.84	$147.98	$65.77
68811	T	Probe nasolacrimal duct	0240	13.83	$704.00	$315.34	$140.80
68815	T	Probe nasolacrimal duct	0240	13.83	$704.00	$315.34	$140.80
68840	T	Explore/irrigate tear ducts	0699	6.46	$328.84	$147.98	$65.77
68850	N	Injection for tear sac x-ray					
68899	T	Tear duct system surgery	0699	6.46	$328.84	$147.98	$65.77
69000	T	Drain external ear lesion	0006	2.18	$110.97	$33.95	$22.19
69005	T	Drain external ear lesion	0007	6.75	$343.60	$72.03	$68.72
69020	T	Drain outer ear canal lesion	0006	2.18	$110.97	$33.95	$22.19
69090	E	Pierce earlobes					
69100	T	Biopsy of external ear	0019	4.22	$214.81	$78.91	$42.96
69105	T	Biopsy of external ear canal	0253	12.33	$627.65	$284.00	$125.53
69110	T	Remove external ear, partial	0020	8.44	$429.63	$130.53	$85.93
69120	T	Removal of external ear	0254	17.37	$884.20	$272.41	$176.84
69140	T	Remove ear canal lesion(s)	0254	17.37	$884.20	$272.41	$176.84
69145	T	Remove ear canal lesion(s)	0020	8.44	$429.63	$130.53	$85.93
69150	C	Extensive ear canal surgery					
69155	C	Extensive ear/neck surgery					
69200	X	Clear outer ear canal	0340	0.84	$42.76	$10.69	$8.55
69205	T	Clear outer ear canal	0022	13.91	$708.07	$292.94	$141.61
69210	X	Remove impacted ear wax	0340	0.84	$42.76	$10.69	$8.55
69220	T	Clean out mastoid cavity	0012	0.66	$33.60	$9.18	$6.72
69222	T	Clean out mastoid cavity	0253	12.33	$627.65	$284.00	$125.53
69300	T	Revise external ear	0254	17.37	$884.20	$272.41	$176.84
69310	T	Rebuild outer ear canal	0256	26.61	$1,354.56	$623.05	$270.91
69320	T	Rebuild outer ear canal	0256	26.61	$1,354.56	$623.05	$270.91
69399	T	Outer ear surgery procedure	0251	2.43	$123.70	$27.99	$24.74
69400	T	Inflate middle ear canal	0251	2.43	$123.70	$27.99	$24.74
69401	N	Inflate middle ear canal					
69405	T	Catheterize middle ear canal	0252	5.95	$302.88	$114.24	$60.58
69410	T	Inset middle ear (baffle)	0252	5.95	$302.88	$114.24	$60.58
69420	T	Incision of eardrum	0251	2.43	$123.70	$27.99	$24.74
69421	T	Incision of eardrum	0253	12.33	$627.65	$284.00	$125.53
69424	T	Remove ventilating tube	0252	5.95	$302.88	$114.24	$60.58
69433	T	Create eardrum opening	0252	5.95	$302.88	$114.24	$60.58
69436	T	Create eardrum opening	0253	12.33	$627.65	$284.00	$125.53
69440	T	Exploration of middle ear	0254	17.37	$884.20	$272.41	$176.84
69450	T	Eardrum revision	0256	26.61	$1,354.56	$623.05	$270.91
69501	T	Mastoidectomy	0256	26.61	$1,354.56	$623.05	$270.91
69502	C	Mastoidectomy					
69505	T	Remove mastoid structures	0256	26.61	$1,354.56	$623.05	$270.91
69511	T	Extensive mastoid surgery	0256	26.61	$1,354.56	$623.05	$270.91
69530	T	Extensive mastoid surgery	0256	26.61	$1,354.56	$623.05	$270.91
69535	C	Remove part of temporal bone					
69540	T	Remove ear lesion	0253	12.33	$627.65	$284.00	$125.53
69550	T	Remove ear lesion	0256	26.61	$1,354.56	$623.05	$270.91
69552	T	Remove ear lesion	0256	26.61	$1,354.56	$623.05	$270.91
69554	C	Remove ear lesion					
69601	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69602	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69603	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69604	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69605	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69610	T	Repair of eardrum	0254	17.37	$884.20	$272.41	$176.84
69620	T	Repair of eardrum	0254	17.37	$884.20	$272.41	$176.84
69631	T	Repair eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69632	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69633	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69635	T	Repair eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69636	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69637	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69641	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69642	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69643	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69644	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69645	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69646	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69650	T	Release middle ear bone	0254	17.37	$884.20	$272.41	$176.84
69660	T	Revise middle ear bone	0256	26.61	$1,354.56	$623.05	$270.91
69661	T	Revise middle ear bone	0256	26.61	$1,354.56	$623.05	$270.91
69662	T	Revise middle ear bone	0256	26.61	$1,354.56	$623.05	$270.91
69666	T	Repair middle ear structures	0256	26.61	$1,354.56	$623.05	$270.91
69667	T	Repair middle ear structures	0256	26.61	$1,354.56	$623.05	$270.91
69670	T	Remove mastoid air cells	0256	26.61	$1,354.56	$623.05	$270.91
69676	T	Remove middle ear nerve	0256	26.61	$1,354.56	$623.05	$270.91
69700	T	Close mastoid fistula	0256	26.61	$1,354.56	$623.05	$270.91
69710	E	Implant/replace hearing aid	.....	.....	.....	.....	.....
69711	T	Remove/repair hearing aid	0256	26.61	$1,354.56	$623.05	$270.91
69714	T	Implant temple bone w/stimul	0256	26.61	$1,354.56	$623.05	$270.91
69715	T	Temple bne implnt w/stimulat	0256	26.61	$1,354.56	$623.05	$270.91
69717	T	Temple bone implant revision	0256	26.61	$1,354.56	$623.05	$270.91
69718	T	Revise temple bone implant	0256	26.61	$1,354.56	$623.05	$270.91
69720	T	Release facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69725	T	Release facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69740	T	Repair facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69745	T	Repair facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69799	T	Middle ear surgery procedure	0253	12.33	$627.65	$284.00	$125.53
69801	T	Incise inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69802	T	Incise inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69805	T	Explore inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69806	T	Explore inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69820	T	Establish inner ear window	0256	26.61	$1,354.56	$623.05	$270.91
69840	T	Revise inner ear window	0256	26.61	$1,354.56	$623.05	$270.91
69905	T	Remove inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69910	T	Remove inner ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69915	T	Incise inner ear nerve	0256	26.61	$1,354.56	$623.05	$270.91
69930	T	Implant cochlear device	0259	376.56	$19,168.41	$8,798.30	$3,833.68
69949	T	Inner ear surgery procedure	0253	12.33	$627.65	$284.00	$125.53
69950	C	Incise inner ear nerve	.....	.....	.....	.....	.....
69955	T	Release facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69960	T	Release inner ear canal	0256	26.61	$1,354.56	$623.05	$270.91
69970	C	Remove inner ear lesion	.....	.....	.....	.....	.....
69979	T	Temporal bone surgery	0251	2.43	$123.70	$27.99	$24.74
69990	N	Microsurgery add-on	.....	.....	.....	.....	.....
70010	S	Contrast x-ray of brain	0274	5.24	$266.74	$128.12	$53.35
70015	S	Contrast x-ray of brain	0274	5.24	$266.74	$128.12	$53.35
70030	X	X-ray eye for foreign body	0260	0.70	$35.63	$19.59	$7.13
70100	X	X-ray exam of jaw	0260	0.70	$35.63	$19.59	$7.13
70110	X	X-ray exam of jaw	0260	0.70	$35.63	$19.59	$7.13
70120	X	X-ray exam of mastoids	0260	0.70	$35.63	$19.59	$7.13
70130	X	X-ray exam of mastoids	0260	0.70	$35.63	$19.59	$7.13
70134	X	X-ray exam of middle ear	0261	1.21	$61.59	$33.87	$12.32
70140	X	X-ray exam of facial bones	0260	0.70	$35.63	$19.59	$7.13
70150	X	X-ray exam of facial bones	0260	0.70	$35.63	$19.59	$7.13
70160	X	X-ray exam of nasal bones	0260	0.70	$35.63	$19.59	$7.13
70170	X	X-ray exam of tear duct	0263	1.61	$81.96	$44.26	$16.39
70190	X	X-ray exam of eye sockets	0260	0.70	$35.63	$19.59	$7.13
70200	X	X-ray exam of eye sockets	0260	0.70	$35.63	$19.59	$7.13
70210	X	X-ray exam of sinuses	0260	0.70	$35.63	$19.59	$7.13
70220	X	X-ray exam of sinuses	0260	0.70	$35.63	$19.59	$7.13
70240	X	X-ray exam, pituitary saddle	0260	0.70	$35.63	$19.59	$7.13
70250	X	X-ray exam of skull	0260	0.70	$35.63	$19.59	$7.13
70260	X	X-ray exam of skull	0261	1.21	$61.59	$33.87	$12.32
70300	X	X-ray exam of teeth	0262	0.65	$33.09	$10.90	$6.62
70310	X	X-ray exam of teeth	0262	0.65	$33.09	$10.90	$6.62
70320	X	Full mouth x-ray of teeth	0262	0.65	$33.09	$10.90	$6.62
70328	X	X-ray exam of jaw joint	0260	0.70	$35.63	$19.59	$7.13
70330	X	X-ray exam of jaw joints	0260	0.70	$35.63	$19.59	$7.13
70332	S	X-ray exam of jaw joint	0275	2.59	$131.84	$68.56	$26.37
70336	S	Magnetic image, jaw joint	0335	5.39	$274.37	$150.90	$54.87
70350	X	X-ray head for orthodontia	0260	0.70	$35.63	$19.59	$7.13
70355	X	Panoramic x-ray of jaws	0260	0.70	$35.63	$19.59	$7.13
70360	X	X-ray exam of neck	0260	0.70	$35.63	$19.59	$7.13
70370	X	Throat x-ray & fluoroscopy	0272	1.38	$70.25	$38.63	$14.05
70371	X	Speech evaluation, complex	0272	1.38	$70.25	$38.63	$14.05

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70373	X	Contrast x-ray of larynx	0263	1.61	$81.96	$44.26	$16.39
70380	X	X-ray exam of salivary gland	0260	0.70	$35.63	$19.59	$7.13
70390	X	X-ray exam of salivary duct	0263	1.61	$81.96	$44.26	$16.39
70450	S	Ct head/brain w/o dye	0332	3.24	$164.93	$90.71	$32.99
70460	S	Ct head/brain w/dye	0283	4.48	$228.05	$125.42	$45.61
70470	S	Ct head/brain w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
70480	S	Ct orbit/ear/fossa w/o dye	0332	3.24	$164.93	$90.71	$32.99
70481	S	Ct orbit/ear/fossa w/dye	0283	4.48	$228.05	$125.42	$45.61
70482	S	Ct orbit/ear/fossa w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
70486	S	Ct maxillofacial w/o dye	0332	3.24	$164.93	$90.71	$32.99
70487	S	Ct maxillofacial w/dye	0283	4.48	$228.05	$125.42	$45.61
70488	S	Ct maxillofacial w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
70490	S	Ct soft tissue neck w/o dye	0332	3.24	$164.93	$90.71	$32.99
70491	S	Ct soft tissue neck w/dye	0283	4.48	$228.05	$125.42	$45.61
70492	S	Ct sft tsue nck w/o & w/dye	0333	5.22	$265.72	$146.14	$53.14
70496	S	Ct angiography, head	0333	5.22	$265.72	$146.14	$53.14
70498	S	Ct angiography, neck	0333	5.22	$265.72	$146.14	$53.14
70540	S	Mri orbit/face/neck w/o dye	0336	6.29	$320.19	$176.10	$64.04
70542	S	Mri orbit/face/neck w/dye	0284	7.15	$363.96	$200.17	$72.79
70543	S	Mri orbt/fac/nck w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
70544	S	Mr angiography head w/o dye	0336	6.29	$320.19	$176.10	$64.04
70545	S	Mr angiography head w/dye	0284	7.15	$363.96	$200.17	$72.79
70546	S	Mr angiograph head w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
70547	S	Mr angiography neck w/o dye	0336	6.29	$320.19	$176.10	$64.04
70548	S	Mr angiography neck w/dye	0284	7.15	$363.96	$200.17	$72.79
70549	S	Mr angiograph neck w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
70551	S	Mri brain w/o dye	0336	6.29	$320.19	$176.10	$64.04
70552	S	Mri brain w/dye	0284	7.15	$363.96	$200.17	$72.79
70553	S	Mri brain w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
71010	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71015	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71020	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71021	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71022	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71023	X	Chest x-ray and fluoroscopy	0272	1.38	$70.25	$38.63	$14.05
71030	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71034	X	Chest x-ray and fluoroscopy	0272	1.38	$70.25	$38.63	$14.05
71035	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71040	X	Contrast x-ray of bronchi	0263	1.61	$81.96	$44.26	$16.39
71060	X	Contrast x-ray of bronchi	0263	1.61	$81.96	$44.26	$16.39
71090	X	X-ray & pacemaker insertion	0272	1.38	$70.25	$38.63	$14.05
71100	X	X-ray exam of ribs	0260	0.70	$35.63	$19.59	$7.13
71101	X	X-ray exam of ribs/chest	0260	0.70	$35.63	$19.59	$7.13
71110	X	X-ray exam of ribs	0260	0.70	$35.63	$19.59	$7.13
71111	X	X-ray exam of ribs/ chest	0261	1.21	$61.59	$33.87	$12.32
71120	X	X-ray exam of breastbone	0260	0.70	$35.63	$19.59	$7.13
71130	X	X-ray exam of breastbone	0260	0.70	$35.63	$19.59	$7.13
71250	S	Ct thorax w/o dye	0332	3.24	$164.93	$90.71	$32.99
71260	S	Ct thorax w/dye	0283	4.48	$228.05	$125.42	$45.61
71270	S	Ct thorax w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
71275	S	Ct angiography, chest	0333	5.22	$265.72	$146.14	$53.14
71550	S	Mri chest w/o dye	0336	6.29	$320.19	$176.10	$64.04
71551	S	Mri chest w/dye	0284	7.15	$363.96	$200.17	$72.79
71552	S	Mri chest w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
71555	E	Mri angio chest w or w/o dye					
72010	X	X-ray exam of spine	0261	1.21	$61.59	$33.87	$12.32
72020	X	X-ray exam of spine	0260	0.70	$35.63	$19.59	$7.13
72040	X	X-ray exam of neck spine	0260	0.70	$35.63	$19.59	$7.13
72050	X	X-ray exam of neck spine	0261	1.21	$61.59	$33.87	$12.32
72052	X	X-ray exam of neck spine	0261	1.21	$61.59	$33.87	$12.32
72069	X	X-ray exam of trunk spine	0260	0.70	$35.63	$19.59	$7.13
72070	X	X-ray exam of thoracic spine	0260	0.70	$35.63	$19.59	$7.13
72072	X	X-ray exam of thoracic spine	0260	0.70	$35.63	$19.59	$7.13
72074	X	X-ray exam of thoracic spine	0260	0.70	$35.63	$19.59	$7.13
72080	X	X-ray exam of trunk spine	0260	0.70	$35.63	$19.59	$7.13
72090	X	X-ray exam of trunk spine	0261	1.21	$61.59	$33.87	$12.32
72100	X	X-ray exam of lower spine	0260	0.70	$35.63	$19.59	$7.13
72110	X	X-ray exam of lower spine	0261	1.21	$61.59	$33.87	$12.32
72114	X	X-ray exam of lower spine	0261	1.21	$61.59	$33.87	$12.32
72120	X	X-ray exam of lower spine	0260	0.70	$35.63	$19.59	$7.13
72125	S	Ct neck spine w/o dye	0332	3.24	$164.93	$90.71	$32.99
72126	S	Ct neck spine w/dye	0283	4.48	$228.05	$125.42	$45.61
72127	S	Ct neck spine w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72128	S	Ct chest spine w/o dye	0332	3.24	$164.93	$90.71	$32.99
72129	S	Ct chest spine w/dye	0283	4.48	$228.05	$125.42	$45.61

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72130	S	Ct chest spine w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72131	S	Ct lumbar spine w/o dye	0332	3.24	$164.93	$90.71	$32.99
72132	S	Ct lumbar spine w/dye	0283	4.48	$228.05	$125.42	$45.61
72133	S	Ct lumbar spine w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72141	S	Mri neck spine w/o dye	0336	6.29	$320.19	$176.10	$64.04
72142	S	Mri neck spine w/dye	0284	7.15	$363.96	$200.17	$72.79
72146	S	Mri chest spine w/o dye	0336	6.29	$320.19	$176.10	$64.04
72147	S	Mri chest spine w/dye	0284	7.15	$363.96	$200.17	$72.79
72148	S	Mri lumbar spine w/o dye	0336	6.29	$320.19	$176.10	$64.04
72149	S	Mri lumbar spine w/dye	0284	7.15	$363.96	$200.17	$72.79
72156	S	Mri neck spine w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
72157	S	Mri chest spine w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
72158	S	Mri lumbar spine w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
72159	E	Mr angio spine w/o&w dye	.....	.....	.....	.....	.....
72170	X	X-ray exam of pelvis	0260	0.70	$35.63	$19.59	$7.13
72190	X	X-ray exam of pelvis	0260	0.70	$35.63	$19.59	$7.13
72191	S	Ct angiograph pelv w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72192	S	Ct pelvis w/o dye	0332	3.24	$164.93	$90.71	$32.99
72193	S	Ct pelvis w/dye	0283	4.48	$228.05	$125.42	$45.61
72194	S	Ct pelvis w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72195	S	Mri pelvis w/o dye	0336	6.29	$320.19	$176.10	$64.04
72196	S	Mri pelvis w/dye	0284	7.15	$363.96	$200.17	$72.79
72197	S	Mri pelvis w/o & w dye	0337	8.54	$434.72	$239.09	$86.94
72198	E	Mr angio pelvis w/o&w dye	.....	.....	.....	.....	.....
72200	X	X-ray exam sacroiliac joints	0260	0.70	$35.63	$19.59	$7.13
72202	X	X-ray exam sacroiliac joints	0260	0.70	$35.63	$19.59	$7.13
72220	X	X-ray exam of tailbone	0260	0.70	$35.63	$19.59	$7.13
72240	S	Contrast x-ray of neck spine	0274	5.24	$266.74	$128.12	$53.35
72255	S	Contrast x-ray, thorax spine	0274	5.24	$266.74	$128.12	$53.35
72265	S	Contrast x-ray, lower spine	0274	5.24	$266.74	$128.12	$53.35
72270	S	Contrast x-ray of spine	0274	5.24	$266.74	$128.12	$53.35
72275	S	Epidurography	0274	5.24	$266.74	$128.12	$53.35
72285	S	X-ray c/t spine disk	0274	5.24	$266.74	$128.12	$53.35
72295	S	X-ray of lower spine disk	0274	5.24	$266.74	$128.12	$53.35
73000	X	X-ray exam of collar bone	0260	0.70	$35.63	$19.59	$7.13
73010	X	X-ray exam of shoulder blade	0260	0.70	$35.63	$19.59	$7.13
73020	X	X-ray exam of shoulder	0260	0.70	$35.63	$19.59	$7.13
73030	X	X-ray exam of shoulder	0260	0.70	$35.63	$19.59	$7.13
73040	S	Contrast x-ray of shoulder	0275	2.59	$131.84	$68.56	$26.37
73050	X	X-ray exam of shoulders	0260	0.70	$35.63	$19.59	$7.13
73060	X	X-ray exam of humerus	0260	0.70	$35.63	$19.59	$7.13
73070	X	X-ray exam of elbow	0260	0.70	$35.63	$19.59	$7.13
73080	X	X-ray exam of elbow	0260	0.70	$35.63	$19.59	$7.13
73085	S	Contrast x-ray of elbow	0275	2.59	$131.84	$68.56	$26.37
73090	X	X-ray exam of forearm	0260	0.70	$35.63	$19.59	$7.13
73092	X	X-ray exam of arm, infant	0260	0.70	$35.63	$19.59	$7.13
73100	X	X-ray exam of wrist	0260	0.70	$35.63	$19.59	$7.13
73110	X	X-ray exam of wrist	0260	0.70	$35.63	$19.59	$7.13
73115	S	Contrast x-ray of wrist	0275	2.59	$131.84	$68.56	$26.37
73120	X	X-ray exam of hand	0260	0.70	$35.63	$19.59	$7.13
73130	X	X-ray exam of hand	0260	0.70	$35.63	$19.59	$7.13
73140	X	X-ray exam of finger(s)	0260	0.70	$35.63	$19.59	$7.13
73200	S	Ct upper extremity w/o dye	0332	3.24	$164.93	$90.71	$32.99
73201	S	Ct upper extremity w/dye	0283	4.48	$228.05	$125.42	$45.61
73202	S	Ct uppr extremity w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73206	S	Ct angio upr extrm w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73218	S	Mri upper extremity w/o dye	0336	6.29	$320.19	$176.10	$64.04
73219	S	Mri upper extremity w/dye	0284	7.15	$363.96	$200.17	$72.79
73220	S	Mri uppr extremity w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73221	S	Mri joint upr extrem w/o dye	0336	6.29	$320.19	$176.10	$64.04
73222	S	Mri joint upr extrem w/ dye	0284	7.15	$363.96	$200.17	$72.79
73223	S	Mri joint upr extr w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73225	E	Mr angio upr extr w/o&w dye	.....	.....	.....	.....	.....
73500	X	X-ray exam of hip	0260	0.70	$35.63	$19.59	$7.13
73510	X	X-ray exam of hip	0260	0.70	$35.63	$19.59	$7.13
73520	X	X-ray exam of hips	0260	0.70	$35.63	$19.59	$7.13
73525	S	Contrast x-ray of hip	0275	2.59	$131.84	$68.56	$26.37
73530	X	X-ray exam of hip	0261	1.21	$61.59	$33.87	$12.32
73540	X	X-ray exam of pelvis & hips	0260	0.70	$35.63	$19.59	$7.13
73542	S	X-ray exam, sacroiliac joint	0275	2.59	$131.84	$68.56	$26.37
73550	X	X-ray exam of thigh	0260	0.70	$35.63	$19.59	$7.13
73560	X	X-ray exam of knee, 1 or 2	0260	0.70	$35.63	$19.59	$7.13
73562	X	X-ray exam of knee, 3	0260	0.70	$35.63	$19.59	$7.13
73564	X	X-ray exam, knee, 4 or more	0260	0.70	$35.63	$19.59	$7.13
73565	X	X-ray exam of knees	0260	0.70	$35.63	$19.59	$7.13

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73580	S	Contrast x-ray of knee joint	0275	2.59	$131.84	$68.56	$26.37
73590	X	X-ray exam of lower leg	0260	0.70	$35.63	$19.59	$7.13
73592	X	X-ray exam of leg, infant	0261	1.21	$61.59	$33.87	$12.32
73600	X	X-ray exam of ankle	0260	0.70	$35.63	$19.59	$7.13
73610	X	X-ray exam of ankle	0260	0.70	$35.63	$19.59	$7.13
73615	S	Contrast x-ray of ankle	0275	2.59	$131.84	$68.56	$26.37
73620	X	X-ray exam of foot	0260	0.70	$35.63	$19.59	$7.13
73630	X	X-ray exam of foot	0260	0.70	$35.63	$19.59	$7.13
73650	X	X-ray exam of heel	0260	0.70	$35.63	$19.59	$7.13
73660	X	X-ray exam of toe(s)	0260	0.70	$35.63	$19.59	$7.13
73700	S	Ct lower extremity w/o dye	0332	3.24	$164.93	$90.71	$32.99
73701	S	Ct lower extremity w/dye	0283	4.48	$228.05	$125.42	$45.61
73702	S	Ct lwr extremity w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73706	S	Ct angio lwr extr w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73718	S	Mri lower extremity w/o dye	0336	6.29	$320.19	$176.10	$64.04
73719	S	Mri lower extremity w/dye	0284	7.15	$363.96	$200.17	$72.79
73720	S	Mri lwr extremity w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73721	S	Mri joint of lwr extre w/o d	0336	6.29	$320.19	$176.10	$64.04
73722	S	Mri joint of lwr extr w/dye	0284	7.15	$363.96	$200.17	$72.79
73723	S	Mri joint lwr extr w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73725	E	Mr ang lwr ext w or w/o dye					
74000	X	X-ray exam of abdomen	0260	0.70	$35.63	$19.59	$7.13
74010	X	X-ray exam of abdomen	0260	0.70	$35.63	$19.59	$7.13
74020	X	X-ray exam of abdomen	0260	0.70	$35.63	$19.59	$7.13
74022	X	X-ray exam series, abdomen	0261	1.21	$61.59	$33.87	$12.32
74150	S	Ct abdomen w/o dye	0332	3.24	$164.93	$90.71	$32.99
74160	S	Ct abdomen w/dye	0283	4.48	$228.05	$125.42	$45.61
74170	S	Ct abdomen w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
74175	S	Ct angio abdom w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
74181	S	Mri abdomen w/o dye	0336	6.29	$320.19	$176.10	$64.04
74182	S	Mri abdomen w/dye	0284	7.15	$363.96	$200.17	$72.79
74183	S	Mri abdomen w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
74185	E	Mri angio, abdom w or w/o dy					
74190	X	X-ray exam of peritoneum	0263	1.61	$81.96	$44.26	$16.39
74210	S	Contrst x-ray exam of throat	0276	1.48	$75.34	$41.43	$15.07
74220	S	Contrast x-ray, esophagus	0276	1.48	$75.34	$41.43	$15.07
74230	S	Cinema x-ray, throat/esoph	0276	1.48	$75.34	$41.43	$15.07
74235	S	Remove esophagus obstruction	0296	3.39	$172.56	$94.90	$34.51
74240	S	X-ray exam, upper gi tract	0276	1.48	$75.34	$41.43	$15.07
74241	S	X-ray exam, upper gi tract	0276	1.48	$75.34	$41.43	$15.07
74245	S	X-ray exam, upper gi tract	0277	2.16	$109.95	$60.47	$21.99
74246	S	Contrst x-ray uppr gi tract	0276	1.48	$75.34	$41.43	$15.07
74247	S	Contrst x-ray uppr gi tract	0276	1.48	$75.34	$41.43	$15.07
74249	S	Contrst x-ray uppr gi tract	0277	2.16	$109.95	$60.47	$21.99
74250	S	X-ray exam of small bowel	0276	1.48	$75.34	$41.43	$15.07
74251	S	X-ray exam of small bowel	0277	2.16	$109.95	$60.47	$21.99
74260	S	X-ray exam of small bowel	0277	2.16	$109.95	$60.47	$21.99
74270	S	Contrast x-ray exam of colon	0276	1.48	$75.34	$41.43	$15.07
74280	S	Contrast x-ray exam of colon	0277	2.16	$109.95	$60.47	$21.99
74283	S	Contrast x-ray exam of colon	0276	1.48	$75.34	$41.43	$15.07
74290	S	Contrast x-ray, gallbladder	0276	1.48	$75.34	$41.43	$15.07
74291	S	Contrast x-rays, gallbladder	0276	1.48	$75.34	$41.43	$15.07
74300	X	X-ray bile ducts/pancreas	0263	1.61	$81.96	$44.26	$16.39
74301	X	X-rays at surgery add-on	0263	1.61	$81.96	$44.26	$16.39
74305	X	X-ray bile ducts/pancreas	0263	1.61	$81.96	$44.26	$16.39
74320	X	Contrast x-ray of bile ducts	0264	3.71	$188.85	$103.86	$37.77
74327	S	X-ray bile stone removal	0296	3.39	$172.56	$94.90	$34.51
74328	N	Xray bile duct endoscopy					
74329	N	X-ray for pancreas endoscopy					
74330	N	X-ray bile/panc endoscopy					
74340	X	X-ray guide for GI tube	0272	1.38	$70.25	$38.63	$14.05
74350	X	X-ray guide, stomach tube	0187	4.22	$214.81		$42.96
74355	X	X-ray guide, intestinal tube	0187	4.22	$214.81		$42.96
74360	S	X-ray guide, GI dilation	0296	3.39	$172.56	$94.90	$34.51
74363	S	X-ray, bile duct dilation	0297	7.07	$359.89	$172.51	$71.98
74400	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74410	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74415	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74420	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74425	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74430	S	Contrast x-ray, bladder	0278	2.34	$119.12	$65.51	$23.82
74440	S	X-ray, male genital tract	0278	2.34	$119.12	$65.51	$23.82
74445	S	X-ray exam of penis	0278	2.34	$119.12	$65.51	$23.82
74450	S	X-ray, urethra/bladder	0278	2.34	$119.12	$65.51	$23.82
74455	S	X-ray, urethra/bladder	0278	2.34	$119.12	$65.51	$23.82

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74470	X	X-ray exam of kidney lesion	0264	3.71	$188.85	$103.86	$37.77
74475	S	X-ray control, cath insert	0297	7.07	$359.89	$172.51	$71.98
74480	S	X-ray control, cath insert	0297	7.07	$359.89	$172.51	$71.98
74485	S	X-ray guide, GU dilation	0296	3.39	$172.56	$94.90	$34.51
74710	X	X-ray measurement of pelvis	0260	0.70	$35.63	$19.59	$7.13
74740	X	X-ray, female genital tract	0264	3.71	$188.85	$103.86	$37.77
74742	X	X-ray, fallopian tube	0187	4.22	$214.81	.....	$42.96
74775	S	X-ray exam of perineum	0278	2.34	$119.12	$65.51	$23.82
75552	S	Heart mri for morph w/o dye	0336	6.29	$320.19	$176.10	$64.04
75553	S	Heart mri for morph w/dye	0284	7.15	$363.96	$200.17	$72.79
75554	S	Cardiac MRI/function	0335	5.39	$274.37	$150.90	$54.87
75555	S	Cardiac MRI/limited study	0335	5.39	$274.37	$150.90	$54.87
75556	E	Cardiac MRI/flow mapping	.....	.....	.....	.....	.....
75600	S	Contrast x-ray exam of aorta	0280	13.54	$689.24	$351.51	$137.85
75605	S	Contrast x-ray exam of aorta	0280	13.54	$689.24	$351.51	$137.85
75625	S	Contrast x-ray exam of aorta	0280	13.54	$689.24	$351.51	$137.85
75630	S	X-ray aorta, leg arteries	0280	13.54	$689.24	$351.51	$137.85
75635	S	Ct angio abdominal arteries	0333	5.22	$265.72	$146.14	$53.14
75650	S	Artery x-rays, head & neck	0280	13.54	$689.24	$351.51	$137.85
75658	S	Artery x-rays, arm	0280	13.54	$689.24	$351.51	$137.85
75660	S	Artery x-rays, head & neck	0279	7.72	$392.98	$174.57	$78.60
75662	S	Artery x-rays, head & neck	0279	7.72	$392.98	$174.57	$78.60
75665	S	Artery x-rays, head & neck	0280	13.54	$689.24	$351.51	$137.85
75671	S	Artery x-rays, head & neck	0280	13.54	$689.24	$351.51	$137.85
75676	S	Artery x-rays, neck	0280	13.54	$689.24	$351.51	$137.85
75680	S	Artery x-rays, neck	0280	13.54	$689.24	$351.51	$137.85
75685	S	Artery x-rays, spine	0279	7.72	$392.98	$174.57	$78.60
75705	S	Artery x-rays, spine	0279	7.72	$392.98	$174.57	$78.60
75710	S	Artery x-rays, arm/leg	0280	13.54	$689.24	$351.51	$137.85
75716	S	Artery x-rays, arms/legs	0280	13.54	$689.24	$351.51	$137.85
75722	S	Artery x-rays, kidney	0280	13.54	$689.24	$351.51	$137.85
75724	S	Artery x-rays, kidneys	0280	13.54	$689.24	$351.51	$137.85
75726	S	Artery x-rays, abdomen	0280	13.54	$689.24	$351.51	$137.85
75731	S	Artery x-rays, adrenal gland	0280	13.54	$689.24	$351.51	$137.85
75733	S	Artery x-rays, adrenals	0280	13.54	$689.24	$351.51	$137.85
75736	S	Artery x-rays, pelvis	0280	13.54	$689.24	$351.51	$137.85
75741	S	Artery x-rays, lung	0279	7.72	$392.98	$174.57	$78.60
75743	S	Artery x-rays, lungs	0280	13.54	$689.24	$351.51	$137.85
75746	S	Artery x-rays, lung	0279	7.72	$392.98	$174.57	$78.60
75756	S	Artery x-rays, chest	0279	7.72	$392.98	$174.57	$78.60
75774	S	Artery x-ray, each vessel	0279	7.72	$392.98	$174.57	$78.60
75790	S	Visualize A-V shunt	0281	4.32	$219.91	$114.35	$43.98
75801	X	Lymph vessel x-ray, arm/leg	0264	3.71	$188.85	$103.86	$37.77
75803	X	Lymph vessel x-ray,arms/legs	0264	3.71	$188.85	$103.86	$37.77
75805	X	Lymph vessel x-ray, trunk	0264	3.71	$188.85	$103.86	$37.77
75807	X	Lymph vessel x-ray, trunk	0264	3.71	$188.85	$103.86	$37.77
75809	X	Nonvascular shunt, x-ray	0263	1.61	$81.96	$44.26	$16.39
75810	S	Vein x-ray, spleen/liver	0279	7.72	$392.98	$174.57	$78.60
75820	S	Vein x-ray, arm/leg	0281	4.32	$219.91	$114.35	$43.98
75822	S	Vein x-ray, arms/legs	0281	4.32	$219.91	$114.35	$43.98
75825	S	Vein x-ray, trunk	0279	7.72	$392.98	$174.57	$78.60
75827	S	Vein x-ray, chest	0279	7.72	$392.98	$174.57	$78.60
75831	S	Vein x-ray, kidney	0287	4.06	$206.67	$90.93	$41.33
75833	S	Vein x-ray, kidneys	0279	7.72	$392.98	$174.57	$78.60
75840	S	Vein x-ray, adrenal gland	0287	4.06	$206.67	$90.93	$41.33
75842	S	Vein x-ray, adrenal glands	0287	4.06	$206.67	$90.93	$41.33
75860	S	Vein x-ray, neck	0287	4.06	$206.67	$90.93	$41.33
75870	S	Vein x-ray, skull	0287	4.06	$206.67	$90.93	$41.33
75872	S	Vein x-ray, skull	0287	4.06	$206.67	$90.93	$41.33
75880	S	Vein x-ray, eye socket	0287	4.06	$206.67	$90.93	$41.33
75885	S	Vein x-ray, liver	0279	7.72	$392.98	$174.57	$78.60
75887	S	Vein x-ray, liver	0280	13.54	$689.24	$351.51	$137.85
75889	S	Vein x-ray, liver	0279	7.72	$392.98	$174.57	$78.60
75891	S	Vein x-ray, liver	0279	7.72	$392.98	$174.57	$78.60
75893	N	Venous sampling by catheter	.....	.....	.....	.....	.....
75894	S	X-rays, transcath therapy	0297	7.07	$359.89	$172.51	$71.98
75896	S	X-rays, transcath therapy	0297	7.07	$359.89	$172.51	$71.98
75898	X	Follow-up angiogram	0264	3.71	$188.85	$103.86	$37.77
75900	C	Arterial catheter exchange	.....	.....	.....	.....	.....
75940	X	X-ray placement, vein filter	0187	4.22	$214.81	.....	$42.96
75945	S	Intravascular us	0267	2.33	$118.61	$65.23	$23.72
75946	S	Intravascular us add-on	0267	2.33	$118.61	$65.23	$23.72
75952	C	Endovasc repair abdom aorta	.....	.....	.....	.....	.....
75953	C	Abdom aneurysm endovas rpr	.....	.....	.....	.....	.....
75960	S	Transcatheter intro, stent	0280	13.54	$689.24	$351.51	$137.85

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75961	S	Retrieval, broken catheter	0280	13.54	$689.24	$351.51	$137.85
75962	S	Repair arterial blockage	0280	13.54	$689.24	$351.51	$137.85
75964	S	Repair artery blockage, each	0280	13.54	$689.24	$351.51	$137.85
75966	S	Repair arterial blockage	0280	13.54	$689.24	$351.51	$137.85
75968	S	Repair artery blockage, each	0280	13.54	$689.24	$351.51	$137.85
75970	S	Vascular biopsy	0280	13.54	$689.24	$351.51	$137.85
75978	S	Repair venous blockage	0280	13.54	$689.24	$351.51	$137.85
75980	S	Contrast xray exam bile duct	0297	7.07	$359.89	$172.51	$71.98
75982	S	Contrast xray exam bile duct	0297	7.07	$359.89	$172.51	$71.98
75984	S	Xray control catheter change	0296	3.39	$172.56	$94.90	$34.51
75989	N	Abscess drainage under x-ray					
75992	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75993	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75994	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75995	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75996	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
76000	X	Fluoroscope examination	0272	1.38	$70.25	$38.63	$14.05
76001	N	Fluoroscope exam, extensive					
76003	N	Needle localization by x-ray					
76005	N	Fluoroguide for spine inject					
76006	X	X-ray stress view	0261	1.21	$61.59	$33.87	$12.32
76010	X	X-ray, nose to rectum	0260	0.70	$35.63	$19.59	$7.13
76012	S	Percut vertebroplasty fluor	0274	5.24	$266.74	$128.12	$53.35
76013	S	Percut vertebroplasty, ct	0274	5.24	$266.74	$128.12	$53.35
76020	X	X-rays for bone age	0261	1.21	$61.59	$33.87	$12.32
76040	X	X-rays, bone evaluation	0260	0.70	$35.63	$19.59	$7.13
76061	X	X-rays, bone survey	0261	1.21	$61.59	$33.87	$12.32
76062	X	X-rays, bone survey	0261	1.21	$61.59	$33.87	$12.32
76065	X	X-rays, bone evaluation	0261	1.21	$61.59	$33.87	$12.32
76066	X	Joint(s) survey, single film	0260	0.70	$35.63	$19.59	$7.13
76070	E	CT scan, bone density study					
76075	S	Dual energy x-ray study	0707		$75.00		$15.00
76076	S	Dual energy x-ray study	0707		$75.00		$15.00
76078	X	Photodensitometry	0261	1.21	$61.59	$33.87	$12.32
76080	X	X-ray exam of fistula	0263	1.61	$81.96	$44.26	$16.39
*76085	A	Computer mammogram add-on					
76086	X	X-ray of mammary duct	0263	1.61	$81.96	$44.26	$16.39
76088	X	X-ray of mammary ducts	0263	1.61	$81.96	$44.26	$16.39
76090	S	Mammogram, one breast	0271	0.60	$30.54	$16.79	$6.11
76091	S	Mammogram, both breasts	0271	0.60	$30.54	$16.79	$6.11
76092	A	Mammogram, screening					
76093	E	Magnetic image, breast					
76094	E	Magnetic image, both breasts					
76095	X	Stereotactic breast biopsy	0187	4.22	$214.81		$42.96
76096	X	X-ray of needle wire, breast	0289	1.63	$82.97	$44.80	$16.59
76098	X	X-ray exam, breast specimen	0260	0.70	$35.63	$19.59	$7.13
76100	X	X-ray exam of body section	0261	1.21	$61.59	$33.87	$12.32
76101	X	Complex body section x-ray	0263	1.61	$81.96	$44.26	$16.39
76102	X	Complex body section x-rays	0264	3.71	$188.85	$103.86	$37.77
76120	X	Cinematic x-rays	0261	1.21	$61.59	$33.87	$12.32
76125	X	Cinematic x-rays add-on	0261	1.21	$61.59	$33.87	$12.32
76140	E	X-ray consultation					
76150	X	X-ray exam, dry process	0260	0.70	$35.63	$19.59	$7.13
76350	N	Special x-ray contrast study					
76355	S	CAT scan for localization	0283	4.48	$228.05	$125.42	$45.61
76360	S	CAT scan for needle biopsy	0283	4.48	$228.05	$125.42	$45.61
*76362	N	Cat scan for tissue ablation					
76370	S	CAT scan for therapy guide	0282	1.58	$80.43	$44.23	$16.09
76375	S	3d/holograph reconstr add-on	0282	1.58	$80.43	$44.23	$16.09
76380	S	CAT scan follow-up study	0282	1.58	$80.43	$44.23	$16.09
76390	E	Mr spectroscopy					
76393	N	Mr guidance for needle place					
*76394	N	Mri for tissue ablation					
76400	S	Magnetic image, bone marrow	0335	5.39	$274.37	$150.90	$54.87
*76490	N	Us for tissue ablation					
76499	X	Radiographic procedure	0260	0.70	$35.63	$19.59	$7.13
76506	S	Echo exam of head	0266	1.54	$78.39	$43.11	$15.68
76511	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76512	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76513	S	Echo exam of eye, water bath	0265	0.95	$48.36	$26.59	$9.67
76516	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76519	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76529	S	Echo exam of eye	0265	0.95	$48.36	$26.59	$9.67
76536	S	Echo exam of head and neck	0266	1.54	$78.39	$43.11	$15.68
76604	S	Echo exam of chest	0266	1.54	$78.39	$43.11	$15.68

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76645	S	Echo exam of breast(s)	0265	0.95	$48.36	$26.59	$9.67
76700	S	Echo exam of abdomen	0266	1.54	$78.39	$43.11	$15.68
76705	S	Echo exam of abdomen	0266	1.54	$78.39	$43.11	$15.68
76770	S	Echo exam abdomen back wall	0266	1.54	$78.39	$43.11	$15.68
76775	S	Echo exam abdomen back wall	0266	1.54	$78.39	$43.11	$15.68
76778	S	Echo exam kidney transplant	0266	1.54	$78.39	$43.11	$15.68
76800	S	Echo exam spinal canal	0266	1.54	$78.39	$43.11	$15.68
76805	S	Echo exam of pregnant uterus	0266	1.54	$78.39	$43.11	$15.68
76810	S	Echo exam of pregnant uterus	0265	0.95	$48.36	$26.59	$9.67
76815	S	Echo exam of pregnant uterus	0265	0.95	$48.36	$26.59	$9.67
76816	S	Echo exam follow-up/repeat	0265	0.95	$48.36	$26.59	$9.67
76818	S	Fetl biophys profil w/stress	0266	1.54	$78.39	$43.11	$15.68
76819	S	Fetl biophys profil w/o strs	0266	1.54	$78.39	$43.11	$15.68
76825	S	Echo exam of fetal heart	0269	3.85	$195.98	$101.91	$39.20
76826	S	Echo exam of fetal heart	0697	2.08	$105.88	$55.06	$21.18
76827	S	Echo exam of fetal heart	0269	3.85	$195.98	$101.91	$39.20
76828	S	Echo exam of fetal heart	0697	2.08	$105.88	$55.06	$21.18
76830	S	Echo exam, transvaginal	0266	1.54	$78.39	$43.11	$15.68
76831	S	Echo exam, uterus	0266	1.54	$78.39	$43.11	$15.68
76856	S	Echo exam of pelvis	0266	1.54	$78.39	$43.11	$15.68
76857	S	Echo exam of pelvis	0265	0.95	$48.36	$26.59	$9.67
76870	S	Echo exam of scrotum	0266	1.54	$78.39	$43.11	$15.68
76872	S	Echo exam, transrectal	0266	1.54	$78.39	$43.11	$15.68
76873	N	Echograp trans r, pros study					
76880	S	Echo exam of extremity	0266	1.54	$78.39	$43.11	$15.68
76885	S	Echo exam, infant hips	0266	1.54	$78.39	$43.11	$15.68
76886	S	Echo exam, infant hips	0266	1.54	$78.39	$43.11	$15.68
76930	N	Echo guide, cardiocentesis					
76932	N	Echo guide for heart biopsy					
76936	N	Echo guide for artery repair					
76941	N	Echo guide for transfusion					
76942	N	Echo guide for biopsy					
76945	N	Echo guide, villus sampling					
76946	N	Echo guide for amniocentesis					
76948	N	Echo guide, ova aspiration					
76950	N	Echo guidance radiotherapy					
76965	N	Echo guidance radiotherapy					
76970	S	Ultrasound exam follow-up	0265	0.95	$48.36	$26.59	$9.67
76975	S	GI endoscopic ultrasound	0266	1.54	$78.39	$43.11	$15.68
76977	S	Us bone density measure	0265	0.95	$48.36	$26.59	$9.67
76986	S	Ultrasound guide intraoper	0266	1.54	$78.39	$43.11	$15.68
76999	S	Echo examination procedure	0266	1.54	$78.39	$43.11	$15.68
77261	E	Radiation therapy planning					
77262	E	Radiation therapy planning					
77263	E	Radiation therapy planning					
77280	X	Set radiation therapy field	0304	1.63	$82.97	$41.52	$16.59
77285	X	Set radiation therapy field	0305	3.71	$188.85	$90.65	$37.77
77290	X	Set radiation therapy field	0305	3.71	$188.85	$90.65	$37.77
77295	X	Set radiation therapy field	0310	14.51	$738.62	$339.05	$147.72
77299	E	Radiation therapy planning					
77300	X	Radiation therapy dose plan	0304	1.63	$82.97	$41.52	$16.59
*77301	S	Radioltherapy dos plan, imrt	0712		$875.00		$175.00
77305	X	Radiation therapy dose plan	0304	1.63	$82.97	$41.52	$16.59
77310	X	Radiation therapy dose plan	0304	1.63	$82.97	$41.52	$16.59
77315	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77321	X	Radiation therapy port plan	0305	3.71	$188.85	$90.65	$37.77
77326	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77327	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77328	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77331	X	Special radiation dosimetry	0304	1.63	$82.97	$41.52	$16.59
77332	X	Radiation treatment aid(s)	0303	3.00	$152.71	$69.28	$30.54
77333	X	Radiation treatment aid(s)	0303	3.00	$152.71	$69.28	$30.54
77334	X	Radiation treatment aid(s)	0303	3.00	$152.71	$69.28	$30.54
77336	X	Radiation physics consult	0304	1.63	$82.97	$41.52	$16.59
77370	X	Radiation physics consult	0305	3.71	$188.85	$90.65	$37.77
77399	X	External radiation dosimetry	0304	1.63	$82.97	$41.52	$16.59
77401	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77402	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77403	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77404	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77406	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77407	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77408	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77409	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77411	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77412	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77413	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77414	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77416	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77417	X	Radiology port film(s)	0260	0.70	$35.63	$19.59	$7.13
*77418	S	Radiation tx delivery, imrt	0710	.....	$400.00	.....	$80.00
77427	E	Radiation tx management, x5	.....	.....	.....	.....	.....
77431	E	Radiation therapy management	.....	.....	.....	.....	.....
77432	E	Stereotactic radiation trmt	.....	.....	.....	.....	.....
77470	S	Special radiation treatment	0299	0.21	$10.69	$4.06	$2.14
77499	E	Radiation therapy management	.....	.....	.....	.....	.....
77520	S	Proton trmt, simple w/o comp	0710	.....	$400.00	.....	$80.00
77522	S	Proton trmt, simple w/comp	0710	.....	$400.00	.....	$80.00
77523	S	Proton trmt, intermediate	0712	.....	$875.00	.....	$175.00
77525	S	Proton treatment, complex	0712	.....	$875.00	.....	$175.00
77600	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77605	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77610	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77615	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77620	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77750	S	Infuse radioactive materials	0301	5.15	$262.16	$52.53	$52.43
77761	S	Apply intrcav radiat simple	0312	32.40	$1,649.29	.....	$329.86
77762	S	Apply intrcav radiat interm	0312	32.40	$1,649.29	.....	$329.86
77763	S	Apply intrcav radiat compl	0312	32.40	$1,649.29	.....	$329.86
77776	S	Apply interstit radiat simpl	0312	32.40	$1,649.29	.....	$329.86
77777	S	Apply interstit radiat inter	0312	32.40	$1,649.29	.....	$329.86
77778	S	Apply iterstit radiat compl	0312	32.40	$1,649.29	.....	$329.86
77781	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77782	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77783	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77784	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77789	S	Apply surface radiation	0300	2.07	$105.37	$47.72	$21.07
77790	N	Radiation handling	.....	.....	.....	.....	.....
77799	S	Radium/radioisotope therapy	0313	14.84	$755.42	$164.02	$151.08
78000	S	Thyroid, single uptake	0290	1.75	$89.08	$48.99	$17.82
78001	S	Thyroid, multiple uptakes	0290	1.75	$89.08	$48.99	$17.82
78003	S	Thyroid suppress/stimul	0290	1.75	$89.08	$48.99	$17.82
78006	S	Thyroid imaging with uptake	0291	3.50	$178.16	$90.20	$35.63
78007	S	Thyroid image, mult uptakes	0291	3.50	$178.16	$90.20	$35.63
78010	S	Thyroid imaging	0290	1.75	$89.08	$48.99	$17.82
78011	S	Thyroid imaging with flow	0290	1.75	$89.08	$48.99	$17.82
78015	S	Thyroid met imaging	0291	3.50	$178.16	$90.20	$35.63
78016	S	Thyroid met imaging/studies	0291	3.50	$178.16	$90.20	$35.63
78018	S	Thyroid met imaging, body	0292	4.20	$213.80	$117.59	$42.76
78020	S	Thyroid met uptake	0291	3.50	$178.16	$90.20	$35.63
78070	S	Parathyroid nuclear imaging	0291	3.50	$178.16	$90.20	$35.63
78075	S	Adrenal nuclear imaging	0292	4.20	$213.80	$117.59	$42.76
78099	S	Endocrine nuclear procedure	0290	1.75	$89.08	$48.99	$17.82
78102	S	Bone marrow imaging, ltd	0291	3.50	$178.16	$90.20	$35.63
78103	S	Bone marrow imaging, mult	0292	4.20	$213.80	$117.59	$42.76
78104	S	Bone marrow imaging, body	0291	3.50	$178.16	$90.20	$35.63
78110	S	Plasma volume, single	0291	3.50	$178.16	$90.20	$35.63
78111	S	Plasma volume, multiple	0291	3.50	$178.16	$90.20	$35.63
78120	S	Red cell mass, single	0291	3.50	$178.16	$90.20	$35.63
78121	S	Red cell mass, multiple	0291	3.50	$178.16	$90.20	$35.63
78122	S	Blood volume	0292	4.20	$213.80	$117.59	$42.76
78130	S	Red cell survival study	0291	3.50	$178.16	$90.20	$35.63
78135	S	Red cell survival kinetics	0292	4.20	$213.80	$117.59	$42.76
78140	S	Red cell sequestration	0291	3.50	$178.16	$90.20	$35.63
78160	S	Plasma iron turnover	0291	3.50	$178.16	$90.20	$35.63
78162	S	Iron absorption exam	0291	3.50	$178.16	$90.20	$35.63
78170	S	Red cell iron utilization	0291	3.50	$178.16	$90.20	$35.63
78172	S	Total body iron estimation	0291	3.50	$178.16	$90.20	$35.63
78185	S	Spleen imaging	0291	3.50	$178.16	$90.20	$35.63
78190	S	Platelet survival, kinetics	0291	3.50	$178.16	$90.20	$35.63
78191	S	Platelet survival	0291	3.50	$178.16	$90.20	$35.63
78195	S	Lymph system imaging	0291	3.50	$178.16	$90.20	$35.63
78199	S	Blood/lymph nuclear exam	0290	1.75	$89.08	$48.99	$17.82
78201	S	Liver imaging	0291	3.50	$178.16	$90.20	$35.63
78202	S	Liver imaging with flow	0291	3.50	$178.16	$90.20	$35.63
78205	S	Liver imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78206	S	Liver image (3d) w/flow	0292	4.20	$213.80	$117.59	$42.76
78215	S	Liver and spleen imaging	0291	3.50	$178.16	$90.20	$35.63
78216	S	Liver & spleen image/flow	0291	3.50	$178.16	$90.20	$35.63
78220	S	Liver function study	0291	3.50	$178.16	$90.20	$35.63

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78223	S	Hepatobiliary imaging	0292	4.20	$213.80	$117.59	$42.76
78230	S	Salivary gland imaging	0291	3.50	$178.16	$90.20	$35.63
78231	S	Serial salivary imaging	0291	3.50	$178.16	$90.20	$35.63
78232	S	Salivary gland function exam	0291	3.50	$178.16	$90.20	$35.63
78258	S	Esophageal motility study	0291	3.50	$178.16	$90.20	$35.63
78261	S	Gastric mucosa imaging	0291	3.50	$178.16	$90.20	$35.63
78262	S	Gastroesophageal reflux exam	0291	3.50	$178.16	$90.20	$35.63
78264	S	Gastric emptying study	0291	3.50	$178.16	$90.20	$35.63
78267	A	Breath tst attain/anal c–14					
78268	A	Breath test analysis, c–14					
78270	S	Vit B–12 absorption exam	0290	1.75	$89.08	$48.99	$17.82
78271	S	Vit B–12 absorp exam, IF	0290	1.75	$89.08	$48.99	$17.82
78272	S	Vit B–12 absorp, combined	0291	3.50	$178.16	$90.20	$35.63
78278	S	Acute GI blood loss imaging	0291	3.50	$178.16	$90.20	$35.63
78282	S	GI protein loss exam	0290	1.75	$89.08	$48.99	$17.82
78290	S	Meckel's divert exam	0291	3.50	$178.16	$90.20	$35.63
78291	S	Leveen/shunt patency exam	0291	3.50	$178.16	$90.20	$35.63
78299	S	GI nuclear procedure	0290	1.75	$89.08	$48.99	$17.82
78300	S	Bone imaging, limited area	0291	3.50	$178.16	$90.20	$35.63
78305	S	Bone imaging, multiple areas	0291	3.50	$178.16	$90.20	$35.63
78306	S	Bone imaging, whole body	0291	3.50	$178.16	$90.20	$35.63
78315	S	Bone imaging, 3 phase	0292	4.20	$213.80	$117.59	$42.76
78320	S	Bone imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78350	X	Bone mineral, single photon	0261	1.21	$61.59	$33.87	$12.32
78351	E	Bone mineral, dual photon					
78399	S	Musculoskeletal nuclear exam	0290	1.75	$89.08	$48.99	$17.82
78414	S	Non-imaging heart function	0292	4.20	$213.80	$117.59	$42.76
78428	S	Cardiac shunt imaging	0292	4.20	$213.80	$117.59	$42.76
78445	S	Vascular flow imaging	0291	3.50	$178.16	$90.20	$35.63
78455	S	Venous thrombosis study	0291	3.50	$178.16	$90.20	$35.63
78456	S	Acute venous thrombus image	0291	3.50	$178.16	$90.20	$35.63
78457	S	Venous thrombosis imaging	0291	3.50	$178.16	$90.20	$35.63
78458	S	Ven thrombosis images, bilat	0291	3.50	$178.16	$90.20	$35.63
78459	E	Heart muscle imaging (PET)					
78460	S	Heart muscle blood, single	0286	5.41	$275.39	$151.46	$55.08
78461	S	Heart muscle blood, multiple	0286	5.41	$275.39	$151.46	$55.08
78464	S	Heart image (3d), single	0286	5.41	$275.39	$151.46	$55.08
78465	S	Heart image (3d), multiple	0286	5.41	$275.39	$151.46	$55.08
78466	S	Heart infarct image	0291	3.50	$178.16	$90.20	$35.63
78468	S	Heart infarct image (ef)	0292	4.20	$213.80	$117.59	$42.76
78469	S	Heart infarct image (3D)	0292	4.20	$213.80	$117.59	$42.76
78472	S	Gated heart, planar, single	0286	5.41	$275.39	$151.46	$55.08
78473	S	Gated heart, multiple	0286	5.41	$275.39	$151.46	$55.08
78478	S	Heart wall motion add-on	0286	5.41	$275.39	$151.46	$55.08
78480	S	Heart function add-on	0286	5.41	$275.39	$151.46	$55.08
78481	S	Heart first pass, single	0286	5.41	$275.39	$151.46	$55.08
78483	S	Heart first pass, multiple	0286	5.41	$275.39	$151.46	$55.08
78491	E	Heart image (pet), single					
78492	E	Heart image (pet), multiple					
78494	S	Heart image, spect	0296	3.39	$172.56	$94.90	$34.51
78496	S	Heart first pass add-on	0296	3.39	$172.56	$94.90	$34.51
78499	S	Cardiovascular nuclear exam	0291	3.50	$178.16	$90.20	$35.63
78580	S	Lung perfusion imaging	0291	3.50	$178.16	$90.20	$35.63
78584	S	Lung V/Q image single breath	0292	4.20	$213.80	$117.59	$42.76
78585	S	Lung V/Q imaging	0292	4.20	$213.80	$117.59	$42.76
78586	S	Aerosol lung image, single	0292	4.20	$213.80	$117.59	$42.76
78587	S	Aerosol lung image, multiple	0291	3.50	$178.16	$90.20	$35.63
78588	S	Perfusion lung image	0292	4.20	$213.80	$117.59	$42.76
78591	S	Vent image, 1 breath, 1 proj	0291	3.50	$178.16	$90.20	$35.63
78593	S	Vent image, 1 proj, gas	0292	4.20	$213.80	$117.59	$42.76
78594	S	Vent image, mult proj, gas	0292	4.20	$213.80	$117.59	$42.76
78596	S	Lung differential function	0292	4.20	$213.80	$117.59	$42.76
78599	S	Respiratory nuclear exam	0291	3.50	$178.16	$90.20	$35.63
78600	S	Brain imaging, ltd static	0292	4.20	$213.80	$117.59	$42.76
78601	S	Brain imaging, ltd w/ flow	0291	3.50	$178.16	$90.20	$35.63
78605	S	Brain imaging, complete	0291	3.50	$178.16	$90.20	$35.63
78606	S	Brain imaging, compl w/flow	0292	4.20	$213.80	$117.59	$42.76
78607	S	Brain imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78608	E	Brain imaging (PET)					
78609	E	Brain imaging (PET)					
78610	S	Brain flow imaging only	0291	3.50	$178.16	$90.20	$35.63
78615	S	Cerebral blood flow imaging	0291	3.50	$178.16	$90.20	$35.63
78630	S	Cerebrospinal fluid scan	0292	4.20	$213.80	$117.59	$42.76
78635	S	CSF ventriculography	0292	4.20	$213.80	$117.59	$42.76
78645	S	CSF shunt evaluation	0291	3.50	$178.16	$90.20	$35.63

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78647	S	Cerebrospinal fluid scan	0292	4.20	$213.80	$117.59	$42.76
78650	S	CSF leakage imaging	0292	4.20	$213.80	$117.59	$42.76
78660	S	Nuclear exam of tear flow	0291	3.50	$178.16	$90.20	$35.63
78699	S	Nervous system nuclear exam	0291	3.50	$178.16	$90.20	$35.63
78700	S	Kidney imaging, static	0291	3.50	$178.16	$90.20	$35.63
78701	S	Kidney imaging with flow	0291	3.50	$178.16	$90.20	$35.63
78704	S	Imaging renogram	0291	3.50	$178.16	$90.20	$35.63
78707	S	Kidney flow/function image	0292	4.20	$213.80	$117.59	$42.76
78708	S	Kidney flow/function image	0292	4.20	$213.80	$117.59	$42.76
78709	S	Kidney flow/function image	0292	4.20	$213.80	$117.59	$42.76
78710	S	Kidney imaging (3D)	0291	3.50	$178.16	$90.20	$35.63
78715	S	Renal vascular flow exam	0291	3.50	$178.16	$90.20	$35.63
78725	S	Kidney function study	0291	3.50	$178.16	$90.20	$35.63
78730	S	Urinary bladder retention	0291	3.50	$178.16	$90.20	$35.63
78740	S	Ureteral reflux study	0291	3.50	$178.16	$90.20	$35.63
78760	S	Testicular imaging	0291	3.50	$178.16	$90.20	$35.63
78761	S	Testicular imaging/flow	0291	3.50	$178.16	$90.20	$35.63
78799	S	Genitourinary nuclear exam	0292	4.20	$213.80	$117.59	$42.76
78800	S	Tumor imaging, limited area	0291	3.50	$178.16	$90.20	$35.63
78801	S	Tumor imaging, mult areas	0292	4.20	$213.80	$117.59	$42.76
78802	S	Tumor imaging, whole body	0292	4.20	$213.80	$117.59	$42.76
78803	S	Tumor imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78805	S	Abscess imaging, ltd area	0292	4.20	$213.80	$117.59	$42.76
78806	S	Abscess imaging, whole body	0292	4.20	$213.80	$117.59	$42.76
78807	S	Nuclear localization/abscess	0292	4.20	$213.80	$117.59	$42.76
78810	E	Tumor imaging (PET)					
78890	N	Nuclear medicine data proc					
78891	N	Nuclear med data proc					
78990	N	Provide diag radionuclide(s)					
78999	S	Nuclear diagnostic exam	0291	3.50	$178.16	$90.20	$35.63
79000	S	Init hyperthyroid therapy	0294	5.01	$255.03	$140.26	$51.01
79001	S	Repeat hyperthyroid therapy	0294	5.01	$255.03	$140.26	$51.01
79020	S	Thyroid ablation	0294	5.01	$255.03	$140.26	$51.01
79030	S	Thyroid ablation, carcinoma	0294	5.01	$255.03	$140.26	$51.01
79035	S	Thyroid metastatic therapy	0294	5.01	$255.03	$140.26	$51.01
79100	S	Hematopoetic nuclear therapy	0294	5.01	$255.03	$140.26	$51.01
79200	S	Intracavitary nuclear trmt	0295	12.10	$615.94	$338.76	$123.19
79300	S	Interstitial nuclear therapy	0294	5.01	$255.03	$140.26	$51.01
79400	S	Nonhemato nuclear therapy	0295	12.10	$615.94	$338.76	$123.19
79420	S	Intravascular nuclear ther	0295	12.10	$615.94	$338.76	$123.19
79440	S	Nuclear joint therapy	0294	5.01	$255.03	$140.26	$51.01
79900	N	Provide ther radiopharm(s)					
79999	S	Nuclear medicine therapy	0294	5.01	$255.03	$140.26	$51.01
80048	A	Basic metabolic panel					
80050	A	General health panel					
80051	A	Electrolyte panel					
80053	A	Comprehen metabolic panel					
80055	A	Obstetric panel					
80061	A	Lipid panel					
80069	A	Renal function panel					
80072	D	Arthritis panel					
80074	A	Acute hepatitis panel					
80076	A	Hepatic function panel					
80090	A	Torch antibody panel					
80100	A	Drug screen, qualitate/multi					
80101	A	Drug screen, single					
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, total					
80157	A	Assay, carbamazepine, free					
80158	A	Assay of cyclosporine					
80160	A	Assay of desipramine					
80162	A	Assay of digoxin					
80164	A	Assay, dipropylacetic acid					
80166	A	Assay of doxepin					
80168	A	Assay of ethosuximide					
80170	A	Assay of gentamicin					
80172	A	Assay of gold					
80173	A	Assay of haloperidol					
80174	A	Assay of imipramine					
80176	A	Assay of lidocaine					
80178	A	Assay of lithium					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80182	A	Assay of nortriptyline					
80184	A	Assay of phenobarbital					
80185	A	Assay of phenytoin, total					
80186	A	Assay of phenytoin, free					
80188	A	Assay of primidone					
80190	A	Assay of procainamide					
80192	A	Assay of procainamide					
80194	A	Assay of quinidine					
80196	A	Assay of salicylate					
80197	A	Assay of tacrolimus					
80198	A	Assay of theophylline					
80200	A	Assay of tobramycin					
80201	A	Assay of topiramate					
80202	A	Assay of 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 stimul 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	0343	0.39	$19.85	$10.72	$3.97
80502	X	Lab pathology consultation	0342	0.21	$10.69	$5.87	$2.14
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 of blood acetaldehyde					
82003	A	Assay of acetaminophen					
82009	A	Test for acetone/ketones					
82010	A	Acetone assay					
82013	A	Acetylcholinesterase assay					
82016	A	Acylcarnitines, qual					
82017	A	Acylcarnitines, quant					
82024	A	Assay of acth					
82030	A	Assay of adp & amp					
82040	A	Assay of serum albumin					
82042	A	Assay of urine albumin					
82043	A	Microalbumin, quantitative					
82044	A	Microalbumin, semiquant					
82055	A	Assay of ethanol					
82075	A	Assay of breath ethanol					
82085	A	Assay of aldolase					
82088	A	Assay of 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 of aluminum					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82120	A	Amines, vaginal fluid qual					
82127	A	Amino acid, single qual					
82128	A	Amino acids, mult qual					
82131	A	Amino acids, single quant					
82135	A	Assay, aminolevulinic acid					
82136	A	Amino acids, quant, 2–5					
82139	A	Amino acids, quan, 6 or more					
82140	A	Assay of ammonia					
82143	A	Amniotic fluid scan					
82145	A	Assay of amphetamines					
82150	A	Assay of amylase					
82154	A	Androstanediol glucuronide					
82157	A	Assay of androstenedione					
82160	A	Assay of androsterone					
82163	A	Assay of angiotensin II					
82164	A	Angiotensin I enzyme test					
82172	A	Assay of apolipoprotein					
82175	A	Assay of arsenic					
82180	A	Assay of ascorbic acid					
82190	A	Atomic absorption					
82205	A	Assay of barbiturates					
82232	A	Assay of beta-2 protein					
82239	A	Bile acids, total					
82240	A	Bile acids, cholylglycine					
82247	A	Bilirubin, total					
82248	A	Bilirubin, direct					
82252	A	Fecal bilirubin test					
82261	A	Assay of biotinidase					
82270	A	Test for blood, feces					
82273	A	Test for blood, other source					
*82274	A	Assay test for blood, fecal					
82286	A	Assay of bradykinin					
82300	A	Assay of cadmium					
82306	A	Assay of vitamin D					
82307	A	Assay of vitamin D					
82308	A	Assay of calcitonin					
82310	A	Assay of calcium					
82330	A	Assay of calcium					
82331	A	Calcium infusion test					
82340	A	Assay of calcium in urine					
82355	A	Calculus (stone) analysis					
82360	A	Calculus (stone) assay					
82365	A	Calculus (stone) assay					
82370	A	X-ray assay, calculus					
82373	A	Assay, c-d transfer measure					
82374	A	Assay, blood carbon dioxide					
82375	A	Assay, blood carbon monoxide					
82376	A	Test for carbon monoxide					
82378	A	Carcinoembryonic antigen					
82379	A	Assay of carnitine					
82380	A	Assay of carotene					
82382	A	Assay, urine catecholamines					
82383	A	Assay, blood catecholamines					
82384	A	Assay, three catecholamines					
82387	A	Assay of cathepsin-d					
82390	A	Assay of ceruloplasmin					
82397	A	Chemiluminescent assay					
82415	A	Assay of chloramphenicol					
82435	A	Assay of blood chloride					
82436	A	Assay of urine chloride					
82438	A	Assay, other fluid chlorides					
82441	A	Test for chlorohydrocarbons					
82465	A	Assay, bld/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	Chromotography, quant, sing					
82492	A	Chromotography, quant, mult					
82495	A	Assay of chromium					
82507	A	Assay of citrate					
82520	A	Assay of cocaine					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82523	A	Collagen crosslinks					
82525	A	Assay of copper					
82528	A	Assay of corticosterone					
82530	A	Cortisol, free					
82533	A	Total cortisol					
82540	A	Assay of creatine					
82541	A	Column chromotography, qual					
82542	A	Column chromotography, quant					
82543	A	Column chromotograph/isotope					
82544	A	Column chromotograph/isotope					
82550	A	Assay of ck (cpk)					
82552	A	Assay of cpk in blood					
82553	A	Creatine, MB fraction					
82554	A	Creatine, isoforms					
82565	A	Assay of creatinine					
82570	A	Assay of urine creatinine					
82575	A	Creatinine clearance test					
82585	A	Assay of cryofibrinogen					
82595	A	Assay of cryoglobulin					
82600	A	Assay of 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	Desoxycorticosterone					
82634	A	Deoxycortisol					
82638	A	Assay of dibucaine number					
82646	A	Assay of dihydrocodeinone					
82649	A	Assay of dihydromorphinone					
82651	A	Assay of dihydrotestosterone					
82652	A	Assay of dihydroxyvitamin d					
82654	A	Assay of dimethadione					
82657	A	Enzyme cell activity					
82658	A	Enzyme cell activity, ra					
82664	A	Electrophoretic test					
82666	A	Assay of epiandrosterone					
82668	A	Assay of erythropoietin					
82670	A	Assay of estradiol					
82671	A	Assay of estrogens					
82672	A	Assay of estrogen					
82677	A	Assay of estriol					
82679	A	Assay of estrone					
82690	A	Assay of ethchlorvynol					
82693	A	Assay of ethylene glycol					
82696	A	Assay of etiocholanolone					
82705	A	Fats/lipids, feces, qual					
82710	A	Fats/lipids, feces, quant					
82715	A	Assay of fecal fat					
82725	A	Assay of blood fatty acids					
82726	A	Long chain fatty acids					
82728	A	Assay of ferritin					
82731	A	Assay of fetal fibronectin					
82735	A	Assay of fluoride					
82742	A	Assay of flurazepam					
82746	A	Blood folic acid serum					
82747	A	Assay of folic acid, rbc					
82757	A	Assay of semen fructose					
82759	A	Assay of rbc galactokinase					
82760	A	Assay of galactose					
82775	A	Assay galactose transferase					
82776	A	Galactose transferase test					
82784	A	Assay of gammaglobulin igm					
82785	A	Assay of gammaglobulin ige					
82787	A	Igg 1, 2, 3 or 4, each					
82800	A	Blood pH					
82803	A	Blood gases: pH, pO2 & pCO2					
82805	A	Blood gases W/02 saturation					
82810	A	Blood gases, O2 sat only					
82820	A	Hemoglobin-oxygen affinity					
82926	A	Assay of gastric acid					
82928	A	Assay of gastric acid					
82938	A	Gastrin test					
82941	A	Assay of gastrin					
82943	A	Assay of glucagon					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82945	A	Glucose other fluid					
82946	A	Glucagon tolerance test					
82947	A	Assay, glucose, blood quant					
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 of g6pd enzyme					
82960	A	Test for G6PD enzyme					
82962	A	Glucose blood test					
82963	A	Assay of glucosidase					
82965	A	Assay of gdh enzyme					
82975	A	Assay of glutamine					
82977	A	Assay of GGT					
82978	A	Assay of glutathione					
82979	A	Assay, rbc glutathione					
82980	A	Assay of glutethimide					
82985	A	Glycated protein					
83001	A	Gonadotropin (FSH)					
83002	A	Gonadotropin (LH)					
83003	A	Assay, growth hormone (hgh)					
83008	A	Assay of guanosine					
83010	A	Assay of haptoglobin, quant					
83012	A	Assay of haptoglobins					
83013	A	H pylori analysis					
83014	A	H pylori drug admin/collect					
83015	A	Heavy metal screen					
83018	A	Quantitative screen, metals					
83020	A	Hemoglobin electrophoresis					
83021	A	Hemoglobin chromotography					
83026	A	Hemoglobin, copper sulfate					
83030	A	Fetal hemoglobin, chemical					
83033	A	Fetal hemoglobin assay, qual					
83036	A	Glycated hemoglobin test					
83045	A	Blood methemoglobin test					
83050	A	Blood methemoglobin assay					
83051	A	Assay of plasma hemoglobin					
83055	A	Blood sulfhemoglobin test					
83060	A	Blood sulfhemoglobin assay					
83065	A	Assay of hemoglobin heat					
83068	A	Hemoglobin stability screen					
83069	A	Assay of urine hemoglobin					
83070	A	Assay of hemosiderin, qual					
83071	A	Assay of hemosiderin, quant					
83080	A	Assay of b hexosaminidase					
83088	A	Assay of histamine					
83090	A	Assay of homocystine					
83150	A	Assay of for hva					
83491	A	Assay of corticosteroids					
83497	A	Assay of 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, nonantibody					
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 of intrinsic factor					
83540	A	Assay of iron					
83550	A	Iron binding test					
83570	A	Assay of idh enzyme					
83582	A	Assay of ketogenic steroids					
83586	A	Assay 17- ketosteroids					
83593	A	Fractionation, ketosteroids					
83605	A	Assay of lactic acid					
83615	A	Lactate (LD) (LDH) enzyme					
83625	A	Assay of ldh enzymes					
83632	A	Placental lactogen					
83633	A	Test urine for lactose					
83634	A	Assay of urine for lactose					
83655	A	Assay of lead					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83661	A	L/s ratio, fetal lung					
83662	A	Foam stability, fetal lung					
83663	A	Fluoro polarize, fetal lung					
83664	A	Lamellar bdy, fetal lung					
83670	A	Assay of lap enzyme					
83690	A	Assay of lipase					
83715	A	Assay of blood lipoproteins					
83716	A	Assay of blood lipoproteins					
83718	A	Assay of lipoprotein					
83719	A	Assay of blood lipoprotein					
83721	A	Assay of blood lipoprotein					
83727	A	Assay of lrh hormone					
83735	A	Assay of magnesium					
83775	A	Assay of md enzyme					
83785	A	Assay of manganese					
83788	A	Mass spectrometry qual					
83789	A	Mass spectrometry quant					
83805	A	Assay of meprobamate					
83825	A	Assay of mercury					
83835	A	Assay of metanephrines					
83840	A	Assay of methadone					
83857	A	Assay of methemalbumin					
83858	A	Assay of methsuximide					
83864	A	Mucopolysaccharides					
83866	A	Mucopolysaccharides screen					
83872	A	Assay synovial fluid mucin					
83873	A	Assay of csf protein					
83874	A	Assay of myoglobin					
83883	A	Assay, nephelometry not spec					
83885	A	Assay of nickel					
83887	A	Assay of nicotine					
83890	A	Molecule isolate					
83891	A	Molecule isolate nucleic					
83892	A	Molecular diagnostics					
83893	A	Molecule dot/slot/blot					
83894	A	Molecule gel electrophor					
83896	A	Molecular diagnostics					
83897	A	Molecule nucleic transfer					
83898	A	Molecule nucleic ampli					
83901	A	Molecule nucleic ampli					
83902	A	Molecular diagnostics					
83903	A	Molecule mutation scan					
83904	A	Molecule mutation identify					
83905	A	Molecule mutation identify					
83906	A	Molecule mutation identify					
83912	A	Genetic examination					
83915	A	Assay of nucleotidase					
83916	A	Oligoclonal bands					
83918	A	Organic acids, total, quant					
83919	A	Organic acids, qual, each					
83921	A	Organic acid, single, quant					
83925	A	Assay of opiates					
83930	A	Assay of blood osmolality					
83935	A	Assay of urine osmolality					
83937	A	Assay of osteocalcin					
83945	A	Assay of oxalate					
*83950	A	Oncorprotein, her-2/neu					
83970	A	Assay of parathormone					
83986	A	Assay of body fluid acidity					
83992	A	Assay for phencyclidine					
84022	A	Assay of phenothiazine					
84030	A	Assay of blood pku					
84035	A	Assay of 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 of rbc pg6d enzyme					
84087	A	Assay phosphohexose enzymes					
84100	A	Assay of phosphorus					
84105	A	Assay of urine phosphorus					
84106	A	Test for porphobilinogen					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84110	A	Assay of porphobilinogen					
84119	A	Test urine for porphyrins					
84120	A	Assay of urine porphyrins					
84126	A	Assay of feces porphyrins					
84127	A	Assay of feces porphyrins					
84132	A	Assay of serum potassium					
84133	A	Assay of urine potassium					
84134	A	Assay of prealbumin					
84135	A	Assay of pregnanediol					
84138	A	Assay of pregnanetriol					
84140	A	Assay of pregnenolone					
84143	A	Assay of 17-hydroxypregneno					
84144	A	Assay of progesterone					
84146	A	Assay of prolactin					
84150	A	Assay of prostaglandin					
84152	A	Assay of psa, complexed					
84153	A	Assay of psa, total					
84154	A	Assay of psa, free					
84155	A	Assay of protein					
84160	A	Assay of serum protein					
84165	A	Assay of 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 of vitamin b–6					
84210	A	Assay of pyruvate					
84220	A	Assay of pyruvate kinase					
84228	A	Assay of quinine					
84233	A	Assay of estrogen					
84234	A	Assay of progesterone					
84235	A	Assay of endocrine hormone					
84238	A	Assay, nonendocrine receptor					
84244	A	Assay of renin					
84252	A	Assay of vitamin b–2					
84255	A	Assay of selenium					
84260	A	Assay of serotonin					
84270	A	Assay of sex hormone globul					
84275	A	Assay of sialic acid					
84285	A	Assay of silica					
84295	A	Assay of serum sodium					
84300	A	Assay of urine sodium					
84305	A	Assay of somatomedin					
84307	A	Assay of somatostatin					
84311	A	Spectrophotometry					
84315	A	Body fluid specific gravity					
84375	A	Chromatogram assay, sugars					
84376	A	Sugars, single, qual					
84377	A	Sugars, multiple, qual					
84378	A	Sugars single quant					
84379	A	Sugars multiple quant					
84392	A	Assay of urine sulfate					
84402	A	Assay of testosterone					
84403	A	Assay of total testosterone					
84425	A	Assay of vitamin b–1					
84430	A	Assay of thiocyanate					
84432	A	Assay of thyroglobulin					
84436	A	Assay of total thyroxine					
84437	A	Assay of neonatal thyroxine					
84439	A	Assay of free thyroxine					
84442	A	Assay of thyroid activity					
84443	A	Assay thyroid stim hormone					
84445	A	Assay of tsi					
84446	A	Assay of vitamin e					
84449	A	Assay of transcortin					
84450	A	Transferase (AST) (SGOT)					
84460	A	Alanine amino (ALT) (SGPT)					
84466	A	Assay of transferrin					
84478	A	Assay of triglycerides					
84479	A	Assay of thyroid (t3 or t4)					
84480	A	Assay, triiodothyronine (t3)					
84481	A	Free assay (FT–3)					
84482	A	T3 reverse					
84484	A	Assay of troponin, quant					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84485	A	Assay duodenal fluid trypsin					
84488	A	Test feces for trypsin					
84490	A	Assay of feces for trypsin					
84510	A	Assay of tyrosine					
84512	A	Assay of troponin, qual					
84520	A	Assay of urea nitrogen					
84525	A	Urea nitrogen semi-quant					
84540	A	Assay of urine/urea-n					
84545	A	Urea-N clearance test					
84550	A	Assay of blood/uric acid					
84560	A	Assay of urine/uric acid					
84577	A	Assay of feces/urobilinogen					
84578	A	Test urine urobilinogen					
84580	A	Assay of urine urobilinogen					
84583	A	Assay of urine urobilinogen					
84585	A	Assay of urine vma					
84586	A	Assay of vip					
84588	A	Assay of vasopressin					
84590	A	Assay of vitamin a					
84591	A	Assay of nos vitamin					
84597	A	Assay of vitamin k					
84600	A	Assay of volatiles					
84620	A	Xylose tolerance test					
84630	A	Assay of zinc					
84681	A	Assay of 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					
85031	A	Manual hemogram, cbc					
85041	A	Red blood cell (RBC) count					
85044	A	Reticulocyte count					
85045	A	Reticulocyte count					
85046	A	Reticyte/hgb concentrate					
85048	A	White blood cell (WBC) count					
85060	X	Blood smear interpretation	0342	0.21	$10.69	$5.87	$2.14
85095	D	Bone marrow aspiration	0003	1.03	$52.43	$27.99	$10.49
85097	X	Bone marrow interpretation	0344	0.56	$28.51	$15.68	$5.70
85102	D	Bone marrow biopsy	0003	1.03	$52.43	$27.99	$10.49
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85305	A	Blood clot inhibitor assay					
85306	A	Blood clot inhibitor test					
85307	A	Assay activated protein c					
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	D	Iron stain, blood cells					
85536	A	Iron stain peripheral blood					
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 count, manual					
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, nonautomated					
85652	A	Rbc sed rate, automated					
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					
86001	A	Allergen specific igg					
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	0343	0.39	$19.85	$10.72	$3.97
86078	X	Physician blood bank service	0344	0.56	$28.51	$15.68	$5.70
86079	X	Physician blood bank service	0344	0.56	$28.51	$15.68	$5.70
86140	A	C-reactive protein					
*86141	A	C-reactive protein, hs					
86146	A	Glycoprotein antibody					
86147	A	Cardiolipin antibody					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
86294	A	Immunoassay, tumor qual					
86300	A	Immunoassay, tumor ca 15–3					
86301	A	Immunoassay, tumor, ca 19–9					
86304	A	Immunoassay, tumor ca 125					
86308	A	Heterophile antibodies					
86309	A	Heterophile antibodies					
86310	A	Heterophile antibodies					
86316	A	Immunoassay, tumor other					
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					
*86336	A	Inhibin A					
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	0341	0.10	$5.09	$2.79	$1.02
86490	X	Coccidioidomycosis skin test	0341	0.10	$5.09	$2.79	$1.02
86510	X	Histoplasmosis skin test	0341	0.10	$5.09	$2.79	$1.02
86580	X	TB intradermal test	0341	0.10	$5.09	$2.79	$1.02
86585	X	TB tine test	0341	0.10	$5.09	$2.79	$1.02
86586	X	Skin test, unlisted	0341	0.10	$5.09	$2.79	$1.02
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					
86611	A	Bartonella 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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
86666	A	Ehrlichia antibody					
86668	A	Francisella tularensis					
86671	A	Fungus antibody					
86674	A	Giardia lamblia antibody					
86677	A	Helicobacter pylori					
86682	A	Helminth antibody					
86683	D	Hemoglobin, fecal antibody					
86684	A	Hemophilus influenza					
86687	A	Htlv-i antibody					
86688	A	Htlv-ii antibody					
86689	A	HTLV/HIV confirmatory test					
86692	A	Hepatitis, delta agent					
86694	A	Herpes simplex test					
86695	A	Herpes simplex test					
86696	A	Herpes simplex type 2					
86698	A	Histoplasma					
86701	A	HIV–1					
86702	A	HIV–2					
86703	A	HIV–1/HIV–2, single assay					
86704	A	Hep b core antibody, total					
86705	A	Hep b core antibody, igm					
86706	A	Hep b surface antibody					
86707	A	Hep be antibody					
86708	A	Hep a antibody, total					
86709	A	Hep a antibody, igm					
86710	A	Influenza virus antibody					
86713	A	Legionella antibody					
86717	A	Leishmania antibody					
86720	A	Leptospira antibody					
86723	A	Listeria monocytogenes ab					
86727	A	Lymph choriomeningitis ab					
86729	A	Lympho venereum antibody					
86732	A	Mucormycosis antibody					
86735	A	Mumps antibody					
86738	A	Mycoplasma antibody					
86741	A	Neisseria meningitidis					
86744	A	Nocardia antibody					
86747	A	Parvovirus antibody					
86750	A	Malaria antibody					
86753	A	Protozoa antibody nos					
86756	A	Respiratory virus antibody					
86757	A	Rickettsia antibody					
86759	A	Rotavirus antibody					
86762	A	Rubella antibody					
86765	A	Rubeola antibody					
86768	A	Salmonella antibody					
86771	A	Shigella antibody					
86774	A	Tetanus antibody					
86777	A	Toxoplasma antibody					
86778	A	Toxoplasma antibody, igm					
86781	A	Treponema pallidum, confirm					
86784	A	Trichinella antibody					
86787	A	Varicella-zoster antibody					
86790	A	Virus antibody nos					
86793	A	Yersinia antibody					
86800	A	Thyroglobulin antibody					
86803	A	Hepatitis c ab test					
86804	A	Hep c ab test, confirm					
86805	A	Lymphocytotoxicity assay					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	X	RBC antibody screen	0345	0.26	$13.24	$5.37	$2.65
86860	X	RBC antibody elution	0345	0.26	$13.24	$5.37	$2.65
86870	X	RBC antibody identification	0346	0.77	$39.20	$12.03	$7.84
86880	X	Coombs test	0341	0.10	$5.09	$2.79	$1.02
86885	X	Coombs test	0341	0.10	$5.09	$2.79	$1.02
86886	X	Coombs test	0341	0.10	$5.09	$2.79	$1.02
86890	X	Autologous blood process	0346	0.77	$39.20	$12.03	$7.84
86891	X	Autologous blood, op salvage	0345	0.26	$13.24	$5.37	$2.65
86900	X	Blood typing, ABO	0341	0.10	$5.09	$2.79	$1.02
86901	X	Blood typing, Rh (D)	0345	0.26	$13.24	$5.37	$2.65
86903	X	Blood typing, antigen screen	0345	0.26	$13.24	$5.37	$2.65
86904	X	Blood typing, patient serum	0345	0.26	$13.24	$5.37	$2.65
86905	X	Blood typing, RBC antigens	0345	0.26	$13.24	$5.37	$2.65
86906	X	Blood typing, Rh phenotype	0345	0.26	$13.24	$5.37	$2.65
86910	E	Blood typing, paternity test					
86911	E	Blood typing, antigen system					
86915	X	Bone marrow/stem cell prep	0346	0.77	$39.20	$12.03	$7.84
86920	X	Compatibility test	0346	0.77	$39.20	$12.03	$7.84
86921	X	Compatibility test	0345	0.26	$13.24	$5.37	$2.65
86922	X	Compatibility test	0346	0.77	$39.20	$12.03	$7.84
86927	X	Plasma, fresh frozen	0346	0.77	$39.20	$12.03	$7.84
86930	X	Frozen blood prep	0347	1.56	$79.41	$20.13	$15.88
86931	X	Frozen blood thaw	0347	1.56	$79.41	$20.13	$15.88
86932	X	Frozen blood freeze/thaw	0346	0.77	$39.20	$12.03	$7.84
86940	A	Hemolysins/agglutinins, auto					
86941	A	Hemolysins/agglutinins					
86945	X	Blood product/irradiation	0345	0.26	$13.24	$5.37	$2.65
86950	X	Leukacyte transfusion	0347	1.56	$79.41	$20.13	$15.88
86965	X	Pooling blood platelets	0347	1.56	$79.41	$20.13	$15.88
86970	X	RBC pretreatment	0345	0.26	$13.24	$5.37	$2.65
86971	X	RBC pretreatment	0345	0.26	$13.24	$5.37	$2.65
86972	X	RBC pretreatment	0345	0.26	$13.24	$5.37	$2.65
86975	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86976	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86977	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86978	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86985	X	Split blood or products	0347	1.56	$79.41	$20.13	$15.88
86999	X	Transfusion procedure	0346	0.77	$39.20	$12.03	$7.84
87001	A	Small animal inoculation					
87003	A	Small animal inoculation					
87015	A	Specimen concentration					
87040	A	Blood culture for bacteria					
87045	A	Stool culture, bacteria					
87046	A	Stool cultr, bacteria, each					
87070	A	Culture, bacteria, other					
87071	A	Culture bacteri aerobic othr					
87073	A	Culture bacteria anaerobic					
87075	A	Culture bacteria anaerobic					
87076	A	Culture anaerobe ident, each					
87077	A	Culture aerobic identify					
87081	A	Culture screen only					
87084	A	Culture of specimen by kit					
87086	A	Urine culture/colony count					
87088	A	Urine bacteria culture					
87101	A	Skin fungi culture					
87102	A	Fungus isolation culture					
87103	A	Blood fungus culture					
87106	A	Fungi identification, yeast					
87107	A	Fungi identification, mold					
87109	A	Mycoplasma					
87110	A	Chlamydia culture					
87116	A	Mycobacteria culture					
87118	A	Mycobacteric identification					
87140	A	Cultur type immunofluoresc					
87143	A	Culture typing, glc/hplc					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87147	A	Culture type, immunologic					
87149	A	Culture type, nucleic acid					
87152	A	Culture type pulse field gel					
87158	A	Culture typing, added method					
87164	A	Dark field examination					
87166	A	Dark field examination					
87168	A	Macroscopic exam arthropod					
87169	A	Macacroscopic exam parasite					
87172	A	Pinworm exam					
87176	A	Tissue homogenization, cultr					
87177	A	Ova and parasites smears					
87181	A	Microbe susceptible, diffuse					
87184	A	Microbe susceptible, disk					
87185	A	Microbe susceptible, enzyme					
87186	A	Microbe susceptible, mic					
87187	A	Microbe susceptible, mlc					
87188	A	Microbe suscept, macrobroth					
87190	A	Microbe suscept, mycobacteri					
87197	A	Bactericidal level, serum					
*87198	A	Cytomegalovirus antibody dfa					
*87199	A	Enterovirus antibody, dfa					
87205	A	Smear, gram stain					
87206	A	Smear, fluorescent/acid stai					
87207	A	Smear, special stain					
87210	A	Smear, wet mount, saline/ink					
87220	A	Tissue exam for fungi					
87230	A	Assay, toxin or antitoxin					
87250	A	Virus inoculate, eggs/animal					
87252	A	Virus inoculation, tissue					
87253	A	Virus inoculate tissue, addl					
87254	A	Virus inoculation, shell via					
87260	A	Adenovirus ag, if					
87265	A	Pertussis ag, if					
87270	A	Chlamydia trachomatis ag, if					
87272	A	Cryptosporidum/gardia ag, if					
87273	A	Herpes simplex 2, ag, if					
87274	A	Herpes simplex 1, ag, if					
87275	A	Influenza b, ag, if					
87276	A	Influenza a, ag, if					
87277	A	Legionella micdadei, ag, if					
87278	A	Legion pneumophilia ag, if					
87279	A	Parainfluenza, ag, if					
87280	A	Respiratory syncytial ag, if					
87281	A	Pneumocystis carinii, ag, if					
87283	A	Rubeola, ag, if					
87285	A	Treponema pallidum, ag, if					
87290	A	Varicella zoster, ag, if					
87299	A	Antibody detection, nos, if					
87300	A	Ag detection, polyval, if					
87301	A	Adenovirus ag, eia					
87320	A	Chylmd trach ag, eia					
87324	A	Clostridium ag, eia					
87327	A	Cryptococcus neoform ag, eia					
87328	A	Cryptospor ag, eia					
87332	A	Cytomegalovirus ag, eia					
87335	A	E coli 0157 ag, eia					
87336	A	Entamoeb hist dispr, ag, eia					
87337	A	Entamoeb hist group, ag, eia					
87338	A	Hpylori, stool, eia					
87339	A	Hpylori ag, eia					
87340	A	Hepatitis b surface ag, eia					
87341	A	Hepatitis b surface, ag, eia					
87350	A	Hepatitis be 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					
87400	A	Influenza a/b, ag, eia					
87420	A	Resp syncytial ag, eia					
87425	A	Rotavirus ag, eia					
87427	A	Shiga-like toxin ag, eia					
87430	A	Strep a ag, eia					
87449	A	Ag detect nos, eia, mult					
87450	A	Ag detect nos, eia, single					
87451	A	Ag detect polyval, eia, mult					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
87800	A	Detect agnt mult, dna, direc					
87801	A	Detect agnt mult, dna, ampli					
*87802	A	Strep b assay w/optic					
*87803	A	Clostridium toxin a w/optic					
*87804	A	Influenza assay w/optic					
87810	A	Chylmd trach assay w/optic					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87850	A	N. gonorrhoeae assay w/optic					
87880	A	Strep a assay w/optic					
87899	A	Agent nos assay w/optic					
87901	A	Genotype, dna, hiv reverse t					
*87902	A	Genotype, dna, hepatitis C					
87903	A	Phenotype, dna hiv w/culture					
87904	A	Phenotype, dna hiv w/clt add					
87999	A	Microbiology procedure					
88000	E	Autopsy (necropsy), gross					
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	0343	0.39	$19.85	$10.72	$3.97
88106	X	Cytopathology, fluids	0343	0.39	$19.85	$10.72	$3.97
88107	X	Cytopathology, fluids	0343	0.39	$19.85	$10.72	$3.97
88108	X	Cytopath, concentrate tech	0343	0.39	$19.85	$10.72	$3.97
88125	X	Forensic cytopathology	0342	0.21	$10.69	$5.87	$2.14
88130	A	Sex chromatin identification					
88140	A	Sex chromatin identification					
88141	N	Cytopath, c/v, interpret					
88142	A	Cytopath, c/v, thin layer					
88143	A	Cytopath c/v thin layer redo					
88144	A	Cytopath, c/v thin lyr redo					
88145	A	Cytopath, c/v thin lyr sel					
88147	A	Cytopath, c/v, automated					
88148	A	Cytopath, c/v, auto rescreen					
88150	A	Cytopath, c/v, manual					
88152	A	Cytopath, c/v, auto redo					
88153	A	Cytopath, c/v, redo					
88154	A	Cytopath, c/v, select					
88155	A	Cytopath, c/v, index add-on					
88160	X	Cytopath smear, other source	0342	0.21	$10.69	$5.87	$2.14
88161	X	Cytopath smear, other source	0343	0.39	$19.85	$10.72	$3.97
88162	X	Cytopath smear, other source	0343	0.39	$19.85	$10.72	$3.97
88164	A	Cytopath tbs, c/v, manual					
88165	A	Cytopath tbs, c/v, redo					
88166	A	Cytopath tbs, c/v, auto redo					
88167	A	Cytopath tbs, c/v, select					
88170	D	Fine needle aspiration	0002	0.42	$21.38	$11.75	$4.28
88171	D	Fine needle aspiration	0004	2.47	$125.73	$32.57	$25.15
88172	X	Cytopathology eval of fna	0343	0.39	$19.85	$10.72	$3.97
88173	X	Cytopath eval, fna, report	0343	0.39	$19.85	$10.72	$3.97
88180	X	Cell marker study	0344	0.56	$28.51	$15.68	$5.70
88182	X	Cell marker study	0344	0.56	$28.51	$15.68	$5.70
88199	A	Cytopathology procedure					
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, tumor					
88240	A	Cell cryopreserve/storage					
88241	A	Frozen cell preparation					
88245	A	Chromosome analysis, 20–25					
88248	A	Chromosome analysis, 50–100					
88249	A	Chromosome analysis, 100					
88261	A	Chromosome analysis, 5					
88262	A	Chromosome analysis, 15–20					
88263	A	Chromosome analysis, 45					
88264	A	Chromosome analysis, 20–25					
88267	A	Chromosome analys, placenta					
88269	A	Chromosome analys, amniotic					
88271	A	Cytogenetics, dna probe					
88272	A	Cytogenetics, 3–5					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88273	A	Cytogenetics, 10–30					
88274	A	Cytogenetics, 25–99					
88275	A	Cytogenetics, 100–300					
88280	A	Chromosome karyotype study					
88283	A	Chromosome banding study					
88285	A	Chromosome count, additional					
88289	A	Chromosome study, additional					
88291	A	Cyto/molecular report					
88299	X	Cytogenetic study	0342	0.21	$10.69	$5.87	$2.14
88300	X	Surgical path, gross	0342	0.21	$10.69	$5.87	$2.14
88302	X	Tissue exam by pathologist	0342	0.21	$10.69	$5.87	$2.14
88304	X	Tissue exam by pathologist	0343	0.39	$19.85	$10.72	$3.97
88305	X	Tissue exam by pathologist	0343	0.39	$19.85	$10.72	$3.97
88307	X	Tissue exam by pathologist	0344	0.56	$28.51	$15.68	$5.70
88309	X	Tissue exam by pathologist	0344	0.56	$28.51	$15.68	$5.70
88311	X	Decalcify tissue	0342	0.21	$10.69	$5.87	$2.14
88312	X	Special stains	0342	0.21	$10.69	$5.87	$2.14
88313	X	Special stains	0342	0.21	$10.69	$5.87	$2.14
88314	X	Histochemical stain	0342	0.21	$10.69	$5.87	$2.14
88318	X	Chemical histochemistry	0342	0.21	$10.69	$5.87	$2.14
88319	X	Enzyme histochemistry	0342	0.21	$10.69	$5.87	$2.14
88321	X	Microslide consultation	0342	0.21	$10.69	$5.87	$2.14
88323	X	Microslide consultation	0343	0.39	$19.85	$10.72	$3.97
88325	X	Comprehensive review of data	0343	0.39	$19.85	$10.72	$3.97
88329	X	Path consult introp	0342	0.21	$10.69	$5.87	$2.14
88331	X	Path consult intraop, 1 bloc	0343	0.39	$19.85	$10.72	$3.97
88332	X	Path consult intraop, addl	0342	0.21	$10.69	$5.87	$2.14
88342	X	Immunocytochemistry	0344	0.56	$28.51	$15.68	$5.70
88346	X	Immunofluorescent study	0343	0.39	$19.85	$10.72	$3.97
88347	X	Immunofluorescent study	0344	0.56	$28.51	$15.68	$5.70
88348	X	Electron microscopy	0344	0.56	$28.51	$15.68	$5.70
88349	X	Scanning electron microscopy	0344	0.56	$28.51	$15.68	$5.70
88355	X	Analysis, skeletal muscle	0344	0.56	$28.51	$15.68	$5.70
88356	X	Analysis, nerve	0344	0.56	$28.51	$15.68	$5.70
88358	X	Analysis, tumor	0344	0.56	$28.51	$15.68	$5.70
88362	X	Nerve teasing preparations	0343	0.39	$19.85	$10.72	$3.97
88365	X	Tissue hybridization	0344	0.56	$28.51	$15.68	$5.70
88371	A	Protein, western blot tissue					
88372	A	Protein analysis w/probe					
*88380	A	Microdissection					
88399	A	Surgical pathology procedure					
88400	A	Bilirubin total transcut					
89050	A	Body fluid cell count					
89051	A	Body fluid cell count					
89060	A	Exam,synovial fluid crystals					
89100	X	Sample intestinal contents	0360	1.35	$68.72	$34.36	$13.74
89105	X	Sample intestinal contents	0360	1.35	$68.72	$34.36	$13.74
89125	A	Specimen fat stain					
89130	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89132	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89135	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89136	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89140	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89141	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89160	A	Exam feces for meat fibers					
89190	A	Nasal smear for eosinophils					
89250	X	Fertilization of oocyte	0348	0.77	$39.20		$7.84
89251	X	Culture oocyte w/embryos	0348	0.77	$39.20		$7.84
89252	X	Assist oocyte fertilization	0348	0.77	$39.20		$7.84
89253	X	Embryo hatching	0348	0.77	$39.20		$7.84
89254	X	Oocyte identification	0348	0.77	$39.20		$7.84
89255	X	Prepare embryo for transfer	0348	0.77	$39.20		$7.84
89256	X	Prepare cryopreserved embryo	0348	0.77	$39.20		$7.84
89257	X	Sperm identification	0348	0.77	$39.20		$7.84
89258	X	Cryopreservation, embryo	0348	0.77	$39.20		$7.84
89259	X	Cryopreservation, sperm	0348	0.77	$39.20		$7.84
89260	X	Sperm isolation, simple	0348	0.77	$39.20		$7.84
89261	X	Sperm isolation, complex	0348	0.77	$39.20		$7.84
89264	X	Identify sperm tissue	0348	0.77	$39.20		$7.84
89300	A	Semen analysis					
89310	A	Semen analysis					
89320	A	Semen analysis					
89321	A	Semen analysis					
89325	A	Sperm antibody test					
89329	A	Sperm evaluation test					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89330	A	Evaluation, cervical mucus					
89350	X	Sputum specimen collection	0344	0.56	$28.51	$15.68	$5.70
89355	A	Exam feces for starch					
89360	X	Collect sweat for test	0344	0.56	$28.51	$15.68	$5.70
89365	A	Water load test					
89399	A	Pathology lab procedure					
90281	E	Human ig, im					
90283	E	Human ig, iv					
90287	E	Botulinum antitoxin					
90288	E	Botulism ig, iv					
90291	E	Cmv ig, iv					
90296	K	Diphtheria antitoxin	0356	1.11	$56.50		$11.30
90371	K	Hep b ig, im	0356	1.11	$56.50		$11.30
90375	K	Rabies ig, im/sc	0356	1.11	$56.50		$11.30
90376	K	Rabies ig, heat treated	0356	1.11	$56.50		$11.30
90378	K	Rsv ig, im, 50 mg	0356	1.11	$56.50		$11.30
90379	K	Rsv ig, iv	0356	1.11	$56.50		$11.30
90384	E	Rh ig, full-dose, im					
90385	K	Rh ig, minidose, im	0356	1.11	$56.50		$11.30
90386	E	Rh ig, iv					
90389	K	Tetanus ig, im	0356	1.11	$56.50		$11.30
90393	K	Vaccina ig, im	0356	1.11	$56.50		$11.30
90396	K	Varicella-zoster ig, im	0356	1.11	$56.50		$11.30
90399	E	Immune globulin					
90471	N	Immunization admin					
90472	N	Immunization admin, each add					
*90473	E	Immune admin oral/nasal					
*90474	E	Immune admin oral/nasal addl					
90476	K	Adenovirus vaccine, type 4	0356	1.11	$56.50		$11.30
90477	K	Adenovirus vaccine, type 7	0356	1.11	$56.50		$11.30
90581	K	Anthrax vaccine, sc	0356	1.11	$56.50		$11.30
90585	K	Bcg vaccine, percut	0356	1.11	$56.50		$11.30
90586	K	Bcg vaccine, intravesical	0356	1.11	$56.50		$11.30
90632	K	Hep a vaccine, adult im	0356	1.11	$56.50		$11.30
90633	K	Hep a vacc, ped/adol, 2 dose	0356	1.11	$56.50		$11.30
90634	K	Hep a vacc, ped/adol, 3 dose	0356	1.11	$56.50		$11.30
90636	K	Hep a/hep b vacc, adult im	0355	0.19	$9.67		$1.93
90645	K	Hib vaccine, hboc, im	0355	0.19	$9.67		$1.93
90646	K	Hib vaccine, prp-d, im	0355	0.19	$9.67		$1.93
90647	K	Hib vaccine, prp-omp, im	0355	0.19	$9.67		$1.93
90648	K	Hib vaccine, prp-t, im	0355	0.19	$9.67		$1.93
90657	K	Flu vaccine, 6–35 mo, im	0354	0.10	$5.09		
90658	K	Flu vaccine, 3 yrs, im	0354	0.10	$5.09		
90659	K	Flu vaccine, whole, im	0354	0.10	$5.09		
90660	E	Flu vaccine, nasal					
90665	K	Lyme disease vaccine, im	0356	1.11	$56.50		$11.30
90669	E	Pneumococcal vacc, ped<5					
90675	K	Rabies vaccine, im	0356	1.11	$56.50		$11.30
90676	K	Rabies vaccine, id	0356	1.11	$56.50		$11.30
90680	K	Rotovirus vaccine, oral	0356	1.11	$56.50		$11.30
90690	K	Typhoid vaccine, oral	0356	1.11	$56.50		$11.30
90691	K	Typhoid vaccine, im	0356	1.11	$56.50		$11.30
90692	K	Typhoid vaccine, h-p, sc/id	0355	0.19	$9.67		$1.93
90693	K	Typhoid vaccine, akd, sc	0356	1.11	$56.50		$11.30
90700	K	Dtap vaccine, im	0355	0.19	$9.67		$1.93
90701	K	Dtp vaccine, im	0355	0.19	$9.67		$1.93
90702	K	Dt vaccine < 7, im	0355	0.19	$9.67		$1.93
90703	K	Tetanus vaccine, im	0355	0.19	$9.67		$1.93
90704	K	Mumps vaccine, sc	0355	0.19	$9.67		$1.93
90705	K	Measles vaccine, sc	0356	1.11	$56.50		$11.30
90706	K	Rubella vaccine, sc	0355	0.19	$9.67		$1.93
90707	K	Mmr vaccine, sc	0356	1.11	$56.50		$11.30
90708	K	Measles-rubella vaccine, sc	0356	1.11	$56.50		$11.30
90709	K	Rubella & mumps vaccine, sc	0356	1.11	$56.50		$11.30
90710	K	Mmrv vaccine, sc	0356	1.11	$56.50		$11.30
90712	K	Oral poliovirus vaccine	0355	0.19	$9.67		$1.93
90713	K	Poliovirus, ipv, sc	0355	0.19	$9.67		$1.93
90716	K	Chicken pox vaccine, sc	0355	0.19	$9.67		$1.93
90717	K	Yellow fever vaccine, sc	0356	1.11	$56.50		$11.30
90718	K	Td vaccine > 7, im	0355	0.19	$9.67		$1.93
90719	K	Diphtheria vaccine, im	0356	1.11	$56.50		$11.30
90720	K	Dtp/hib vaccine, im	0355	0.19	$9.67		$1.93
90721	K	Dtap/hib vaccine, im	0355	0.19	$9.67		$1.93
90723	K	Dtap-hep b-ipv vaccine, im	0356	1.11	$56.50		$11.30
90725	K	Cholera vaccine, injectable	0355	0.19	$9.67		$1.93

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90727	K	Plague vaccine, im	0355	0.19	$9.67	.....	$1.93
90732	K	Pneumococcal vacc, adult/ill	0354	0.10	$5.09	.....	.....
90733	K	Meningococcal vaccine, sc	0356	1.11	$56.50	.....	$11.30
90735	K	Encephalitis vaccine, sc	0356	1.11	$56.50	.....	$11.30
90740	K	Hepb vacc, ill pat 3 dose im	0356	1.11	$56.50	.....	$11.30
90743	K	Hep b vacc, adol, 2 dose, im	0356	1.11	$56.50	.....	$11.30
90744	K	Hepb vacc ped/adol 3 dose im	0356	1.11	$56.50	.....	$11.30
90746	K	Hep b vaccine, adult, im	0356	1.11	$56.50	.....	$11.30
90747	K	Hepb vacc, ill pat 4 dose im	0356	1.11	$56.50	.....	$11.30
90748	K	Hep b/hib vaccine, im	0355	0.19	$9.67	.....	$1.93
90749	K	Vaccine toxoid	0355	0.19	$9.67	.....	$1.93
90780	E	IV infusion therapy, 1 hour	.....	.....	.....	.....	.....
90781	E	IV infusion, additional hour	.....	.....	.....	.....	.....
90782	X	Injection, sc/im	0352	0.41	$20.87	.....	$4.17
90783	X	Injection, ia	0359	1.79	$91.12	.....	$18.22
90784	X	Injection, iv	0359	1.79	$91.12	.....	$18.22
90788	X	Injection of antibiotic	0359	1.79	$91.12	.....	$18.22
90799	X	Ther/prophylactic/dx inject	0352	0.41	$20.87	.....	$4.17
90801	S	Psy dx interview	0323	1.73	$88.06	$21.13	$17.61
90802	S	Intac psy dx interview	0323	1.73	$88.06	$21.13	$17.61
90804	S	Psytx, office, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90805	S	Psytx, off, 20–30 min w/e&m	0322	1.15	$58.54	$12.29	$11.71
90806	S	Psytx, off, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90807	S	Psytx, off, 45–50 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90808	S	Psytx, office, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90809	S	Psytx, off, 75–80, w/e&m	0323	1.73	$88.06	$21.13	$17.61
90810	S	Intac psytx, off, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90811	S	Intac psytx, 20–30, w/e&m	0322	1.15	$58.54	$12.29	$11.71
90812	S	Intac psytx, off, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90813	S	Intac psytx, 45–50 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90814	S	Intac psytx, off, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90815	S	Intac psytx, 75–80 w/e&m	0323	1.73	$88.06	$21.13	$17.61
90816	S	Psytx, hosp, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90817	S	Psytx, hosp, 20–30 min w/e&m	0322	1.15	$58.54	$12.29	$11.71
90818	S	Psytx, hosp, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90819	S	Psytx, hosp, 45–50 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90821	S	Psytx, hosp, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90822	S	Psytx, hosp, 75–80 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90823	S	Intac psytx, hosp, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90824	S	Intac psytx, hsp 20–30 w/e&m	0322	1.15	$58.54	$12.29	$11.71
90826	S	Intac psytx, hosp, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90827	S	Intac psytx, hsp 45–50 w/e&m	0323	1.73	$88.06	$21.13	$17.61
90828	S	Intac psytx, hosp, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90829	S	Intac psytx, hsp 75–80 w/e&m	0323	1.73	$88.06	$21.13	$17.61
90845	S	Psychoanalysis	0323	1.73	$88.06	$21.13	$17.61
90846	S	Family psytx w/o patient	0324	2.69	$136.93	$20.19	$27.39
90847	S	Family psytx w/patient	0324	2.69	$136.93	$20.19	$27.39
90849	S	Multiple family group psytx	0325	1.38	$70.25	$18.27	$14.05
90853	S	Group psychotherapy	0325	1.38	$70.25	$18.27	$14.05
90857	S	Intac group psytx	0325	1.38	$70.25	$18.27	$14.05
90862	X	Medication management	0374	0.89	$45.30	$9.97	$9.06
90865	S	Narcosynthesis	0323	1.73	$88.06	$21.13	$17.61
90870	S	Electroconvulsive therapy	0320	3.88	$197.51	$80.06	$39.50
90871	S	Electroconvulsive therapy	0320	3.88	$197.51	$80.06	$39.50
90875	E	Psychophysiological therapy	.....	.....	.....	.....	.....
90876	E	Psychophysiological therapy	.....	.....	.....	.....	.....
90880	S	Hypnotherapy	0323	1.73	$88.06	$21.13	$17.61
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	0322	1.15	$58.54	$12.29	$11.71
90901	S	Biofeedback train, any meth	0321	0.93	$47.34	$21.78	$9.47
90911	S	Biofeedback peri/uro/rectal	0321	0.93	$47.34	$21.78	$9.47
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	.....	.....	.....	.....	.....
90925	A	Esrd related services, day	.....	.....	.....	.....	.....
90935	S	Hemodialysis, one evaluation	0170	0.28	$14.25	$3.14	$2.85
90937	E	Hemodialysis, repeated eval	.....	.....	.....	.....	.....
*90939	N	Hemodialysis study, transcut	.....	.....	.....	.....	.....

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90940	N	Hemodialysis access study					
90945	S	Dialysis, one evaluation	0170	0.28	$14.25	$3.14	$2.85
90947	E	Dialysis, repeated eval					
90989	E	Dialysis training, complete					
90993	E	Dialysis training, incompl					
90997	E	Hemoperfusion					
90999	E	Dialysis procedure					
91000	X	Esophageal intubation	0361	3.25	$165.44	$82.72	$33.09
91010	X	Esophagus motility study	0361	3.25	$165.44	$82.72	$33.09
91011	X	Esophagus motility study	0361	3.25	$165.44	$82.72	$33.09
91012	X	Esophagus motility study	0361	3.25	$165.44	$82.72	$33.09
91020	X	Gastric motility	0361	3.25	$165.44	$82.72	$33.09
91030	X	Acid perfusion of esophagus	0361	3.25	$165.44	$82.72	$33.09
91032	X	Esophagus, acid reflux test	0361	3.25	$165.44	$82.72	$33.09
91033	X	Prolonged acid reflux test	0361	3.25	$165.44	$82.72	$33.09
91052	X	Gastric analysis test	0361	3.25	$165.44	$82.72	$33.09
91055	X	Gastric intubation for smear	0360	1.35	$68.72	$34.36	$13.74
91060	X	Gastric saline load test	0360	1.35	$68.72	$34.36	$13.74
91065	X	Breath hydrogen test	0360	1.35	$68.72	$34.36	$13.74
91100	X	Pass intestine bleeding tube	0360	1.35	$68.72	$34.36	$13.74
91105	X	Gastric intubation treatment	0361	3.25	$165.44	$82.72	$33.09
91122	T	Anal pressure record	0156	2.45	$124.71	$37.41	$24.94
*91123	N	Irrigate fecal impaction					
91132	X	Electrogastrography	0360	1.35	$68.72	$34.36	$13.74
91133	X	Electrogastrography w/test	0360	1.35	$68.72	$34.36	$13.74
91299	X	Gastroenterology procedure	0360	1.35	$68.72	$34.36	$13.74
92002	V	Eye exam, new patient	0601	0.95	$48.36		$9.67
92004	V	Eye exam, new patient	0602	1.38	$70.25		$14.05
92012	V	Eye exam established pat	0600	0.86	$43.78		$8.76
92014	V	Eye exam & treatment	0602	1.38	$70.25		$14.05
92015	E	Refraction					
92018	T	New eye exam & treatment	0699	6.46	$328.84	$147.98	$65.77
92019	S	Eye exam & treatment	0698	1.03	$52.43	$19.92	$10.49
92020	S	Special eye evaluation	0230	0.61	$31.05	$14.28	$6.21
92060	S	Special eye evaluation	0230	0.61	$31.05	$14.28	$6.21
92065	S	Orthoptic/pleoptic training	0230	0.61	$31.05	$14.28	$6.21
92070	N	Fitting of contact lens					
92081	S	Visual field examination(s)	0230	0.61	$31.05	$14.28	$6.21
92082	S	Visual field examination(s)	0698	1.03	$52.43	$19.92	$10.49
92083	S	Visual field examination(s)	0698	1.03	$52.43	$19.92	$10.49
92100	N	Serial tonometry exam(s)					
92120	S	Tonography & eye evaluation	0230	0.61	$31.05	$14.28	$6.21
92130	S	Water provocation tonography	0698	1.03	$52.43	$19.92	$10.49
92135	S	Opthalmic dx imaging	0230	0.61	$31.05	$14.28	$6.21
*92136	S	Ophthalmic biometry	0230	0.61	$31.05	$14.28	$6.21
92140	S	Glaucoma provocative tests	0231	2.03	$103.34	$46.50	$20.67
92225	S	Special eye exam, initial	0698	1.03	$52.43	$19.92	$10.49
92226	S	Special eye exam, subsequent	0231	2.03	$103.34	$46.50	$20.67
92230	T	Eye exam with photos	0699	6.46	$328.84	$147.98	$65.77
92235	S	Eye exam with photos	0231	2.03	$103.34	$46.50	$20.67
92240	S	Icg angiography	0231	2.03	$103.34	$46.50	$20.67
92250	S	Eye exam with photos	0230	0.61	$31.05	$14.28	$6.21
92260	S	Ophthalmoscopy/dynamometry	0230	0.61	$31.05	$14.28	$6.21
92265	S	Eye muscle evaluation	0231	2.03	$103.34	$46.50	$20.67
92270	S	Electro-oculography	0698	1.03	$52.43	$19.92	$10.49
92275	S	Electroretinography	0216	2.61	$132.86	$59.79	$26.57
92283	S	Color vision examination	0230	0.61	$31.05	$14.28	$6.21
92284	S	Dark adaptation eye exam	0231	2.03	$103.34	$46.50	$20.67
92285	S	Eye photography	0230	0.61	$31.05	$14.28	$6.21
92286	S	Internal eye photography	0698	1.03	$52.43	$19.92	$10.49
92287	S	Internal eye photography	0231	2.03	$103.34	$46.50	$20.67
92310	E	Contact lens fitting					
92311	X	Contact lens fitting	0362	0.86	$43.78	$9.63	$8.76
92312	X	Contact lens fitting	0362	0.86	$43.78	$9.63	$8.76
92313	X	Contact lens fitting	0362	0.86	$43.78	$9.63	$8.76
92314	E	Prescription of contact lens					
92315	X	Prescription of contact lens	0362	0.86	$43.78	$9.63	$8.76
92316	X	Prescription of contact lens	0362	0.86	$43.78	$9.63	$8.76
92317	X	Prescription of contact lens	0362	0.86	$43.78	$9.63	$8.76
92325	X	Modification of contact lens	0362	0.86	$43.78	$9.63	$8.76
92326	X	Replacement of contact lens	0362	0.86	$43.78	$9.63	$8.76
92330	S	Fitting of artificial eye	0230	0.61	$31.05	$14.28	$6.21
92335	N	Fitting of artificial eye					
92340	E	Fitting of spectacles					
92341	E	Fitting of spectacles					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92342	E	Fitting of spectacles					
92352	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92353	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92354	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92355	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92358	X	Eye prosthesis service	0362	0.86	$43.78	$9.63	$8.76
92370	E	Repair & adjust spectacles					
92371	X	Repair & adjust spectacles	0362	0.86	$43.78	$9.63	$8.76
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	S	Eye service or procedure	0230	0.61	$31.05	$14.28	$6.21
92502	T	Ear and throat examination	0251	2.43	$123.70	$27.99	$24.74
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	Nasopharyngoscopy	0071	1.03	$52.43	$14.22	$10.49
92512	X	Nasal function studies	0363	1.73	$88.06	$32.58	$17.61
92516	X	Facial nerve function test	0363	1.73	$88.06	$32.58	$17.61
92520	X	Laryngeal function studies	0363	1.73	$88.06	$32.58	$17.61
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	0363	1.73	$88.06	$32.58	$17.61
92542	X	Positional nystagmus test	0363	1.73	$88.06	$32.58	$17.61
92543	X	Caloric vestibular test	0363	1.73	$88.06	$32.58	$17.61
92544	X	Optokinetic nystagmus test	0363	1.73	$88.06	$32.58	$17.61
92545	X	Oscillating tracking test	0363	1.73	$88.06	$32.58	$17.61
92546	X	Sinusoidal rotational test	0363	1.73	$88.06	$32.58	$17.61
92547	X	Supplemental electrical test	0363	1.73	$88.06	$32.58	$17.61
92548	X	Posturography	0363	1.73	$88.06	$32.58	$17.61
92551	E	Pure tone hearing test, air					
92552	X	Pure tone audiometry, air	0364	0.58	$29.52	$11.51	$5.90
92553	X	Audiometry, air & bone	0365	1.31	$66.68	$20.00	$13.34
92555	X	Speech threshold audiometry	0364	0.58	$29.52	$11.51	$5.90
92556	X	Speech audiometry, complete	0364	0.58	$29.52	$11.51	$5.90
92557	X	Comprehensive hearing test	0365	1.31	$66.68	$20.00	$13.34
92559	E	Group audiometric testing					
92560	E	Bekesy audiometry, screen					
92561	X	Bekesy audiometry, diagnosis	0365	1.31	$66.68	$20.00	$13.34
92562	X	Loudness balance test	0364	0.58	$29.52	$11.51	$5.90
92563	X	Tone decay hearing test	0364	0.58	$29.52	$11.51	$5.90
92564	X	Sisi hearing test	0364	0.58	$29.52	$11.51	$5.90
92565	X	Stenger test, pure tone	0364	0.58	$29.52	$11.51	$5.90
92567	X	Tympanometry	0364	0.58	$29.52	$11.51	$5.90
92568	X	Acoustic reflex testing	0364	0.58	$29.52	$11.51	$5.90
92569	X	Acoustic reflex decay test	0364	0.58	$29.52	$11.51	$5.90
92571	X	Filtered speech hearing test	0364	0.58	$29.52	$11.51	$5.90
92572	X	Staggered spondaic word test	0364	0.58	$29.52	$11.51	$5.90
92573	X	Lombard test	0364	0.58	$29.52	$11.51	$5.90
92575	X	Sensorineural acuity test	0365	1.31	$66.68	$20.00	$13.34
92576	X	Synthetic sentence test	0364	0.58	$29.52	$11.51	$5.90
92577	X	Stenger test, speech	0365	1.31	$66.68	$20.00	$13.34
92579	X	Visual audiometry (vra)	0365	1.31	$66.68	$20.00	$13.34
92582	X	Conditioning play audiometry	0365	1.31	$66.68	$20.00	$13.34
92583	X	Select picture audiometry	0364	0.58	$29.52	$11.51	$5.90
92584	X	Electrocochleography	0363	1.73	$88.06	$32.58	$17.61
92585	S	Auditor evoke potent, compre	0216	2.61	$132.86	$59.79	$26.57
92586	S	Auditor evoke potent, limit	0707		$75.00		$15.00
92587	X	Evoked auditory test	0363	1.73	$88.06	$32.58	$17.61
92588	X	Evoked auditory test	0363	1.73	$88.06	$32.58	$17.61
92589	X	Auditory function test(s)	0364	0.58	$29.52	$11.51	$5.90
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 hearng aid test, one					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92595	E	Electro hearng aid tst, both					
92596	X	Ear protector evaluation	0365	1.31	$66.68	$20.00	$13.34
92599	X	ENT procedure/service	0364	0.58	$29.52	$11.51	$5.90
92950	S	Heart/lung resuscitation cpr	0094	6.08	$309.50	$105.29	$61.90
92953	S	Temporary external pacing	0094	6.08	$309.50	$105.29	$61.90
92960	S	Cardioversion electric, ext	0094	6.08	$309.50	$105.29	$61.90
92961	S	Cardioversion, electric, int	0094	6.08	$309.50	$105.29	$61.90
92970	C	Cardioassist, internal					
92971	C	Cardioassist, external					
*92973	T	Percut coronary thrombectomy	0973		$250.00		$50.00
*92974	T	Cath place, cardio brachytx	0981		$2,250.00		$450.00
92975	C	Dissolve clot, heart vessel					
92977	T	Dissolve clot, heart vessel	0120	3.08	$156.78	$42.67	$31.36
92978	S	Intravasc us, heart add-on	0267	2.33	$118.61	$65.23	$23.72
92979	S	Intravasc us, heart add-on	0267	2.33	$118.61	$65.23	$23.72
92980	T	Insert intracoronary stent	0104	87.98	$4,478.53		$895.71
92981	T	Insert intracoronary stent	0104	87.98	$4,478.53		$895.71
92982	T	Coronary artery dilation	0083	59.49	$3,028.28	$794.30	$605.66
92984	T	Coronary artery dilation	0083	59.49	$3,028.28	$794.30	$605.66
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	T	Coronary atherectomy	0082	92.00	$4,683.17	$1,351.74	$936.63
92996	T	Coronary atherectomy add-on	0082	92.00	$4,683.17	$1,351.74	$936.63
92997	C	Pul art balloon repr, percut					
92998	C	Pul art balloon repr, percut					
93000	E	Electrocardiogram, complete					
93005	S	Electrocardiogram, tracing	0099	0.35	$17.82	$9.80	$3.56
93010	A	Electrocardiogram report					
93012	N	Transmission of ecg					
93014	E	Report on transmitted ecg					
93015	E	Cardiovascular stress test					
93016	E	Cardiovascular stress test					
93017	X	Cardiovascular stress test	0100	1.47	$74.83	$41.15	$14.97
93018	E	Cardiovascular stress test					
93024	X	Cardiac drug stress test	0100	1.47	$74.83	$41.15	$14.97
*93025	X	Microvolt t-wave assess	0100	1.47	$74.83	$41.15	$14.97
93040	E	Rhythm ECG with report					
93041	S	Rhythm ECG, tracing	0099	0.35	$17.82	$9.80	$3.56
93042	E	Rhythm ECG, report					
93224	E	ECG monitor/report, 24 hrs					
93225	X	ECG monitor/record, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93226	X	ECG monitor/report, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93227	E	ECG monitor/review, 24 hrs					
93230	E	ECG monitor/report, 24 hrs					
93231	X	Ecg monitor/record, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93232	X	ECG monitor/report, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93233	E	ECG monitor/review, 24 hrs					
93235	E	ECG monitor/report, 24 hrs					
93236	X	ECG monitor/report, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93237	E	ECG monitor/review, 24 hrs					
93268	E	ECG record/review					
93270	X	ECG recording	0097	0.84	$42.76	$23.51	$8.55
93271	X	Ecg/monitoring and analysis	0097	0.84	$42.76	$23.51	$8.55
93272	E	Ecg/review, interpret only					
93278	S	ECG/signal-averaged	0099	0.35	$17.82	$9.80	$3.56
93303	S	Echo transthoracic	0269	3.85	$195.98	$101.91	$39.20
93304	S	Echo transthoracic	0697	2.08	$105.88	$55.06	$21.18
93307	S	Echo exam of heart	0269	3.85	$195.98	$101.91	$39.20
93308	S	Echo exam of heart	0697	2.08	$105.88	$55.06	$21.18
93312	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93313	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93314	N	Echo transesophageal					
93315	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93316	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93317	N	Echo transesophageal					
93318	S	Echo transesophageal intraop	0270	5.30	$269.79	$145.69	$53.96
93320	S	Doppler echo exam, heart	0269	3.85	$195.98	$101.91	$39.20
93321	S	Doppler echo exam, heart	0697	2.08	$105.88	$55.06	$21.18
93325	S	Doppler color flow add-on	0697	2.08	$105.88	$55.06	$21.18
93350	S	Echo transthoracic	0269	3.85	$195.98	$101.91	$39.20
93501	T	Right heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93503	T	Insert/place heart catheter	0103	15.95	$811.92	$295.70	$162.38

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93505	T	Biopsy of heart lining	0103	15.95	$811.92	$295.70	$162.38
93508	T	Cath placement, angiography	0080	34.73	$1,767.90	$838.92	$353.58
93510	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93511	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93514	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93524	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93526	T	Rt & Lt heart catheters	0080	34.73	$1,767.90	$838.92	$353.58
93527	T	Rt & Lt heart catheters	0080	34.73	$1,767.90	$838.92	$353.58
93528	T	Rt & Lt heart catheters	0080	34.73	$1,767.90	$838.92	$353.58
93529	T	Rt, Lt heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93530	T	Rt heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93531	T	R & l heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93532	T	R & l heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93533	T	R & l heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93536	D	Insert circulation assi	0103	15.95	$811.92	$295.70	$162.38
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	Inject for coronary x-rays					
93555	N	Imaging, cardiac cath					
93556	N	Imaging, cardiac cath					
93561	N	Cardiac output measurement					
93562	N	Cardiac output measurement					
93571	N	Heart flow reserve measure					
93572	N	Heart flow reserve measure					
93600	T	Bundle of His recording	0087	52.46	$2,670.42		$534.08
93602	T	Intra-atrial recording	0087	52.46	$2,670.42		$534.08
93603	T	Right ventricular recording	0087	52.46	$2,670.42		$534.08
93607	D	Left ventricular recording	0087	52.46	$2,670.42		$534.08
93609	T	Mapping of tachycardia	0087	52.46	$2,670.42		$534.08
93610	T	Intra-atrial pacing	0087	52.46	$2,670.42		$534.08
93612	T	Intraventricular pacing	0087	52.46	$2,670.42		$534.08
*93613	T	Electrophys map, 3d, add-on	0087	52.46	$2,670.42		$534.08
93615	T	Esophageal recording	0087	52.46	$2,670.42		$534.08
93616	T	Esophageal recording	0087	52.46	$2,670.42		$534.08
93618	T	Heart rhythm pacing	0087	52.46	$2,670.42		$534.08
93619	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93620	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93621	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93622	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93623	T	Stimulation, pacing heart	0087	52.46	$2,670.42		$534.08
93624	T	Electrophysiologic study	0087	52.46	$2,670.42		$534.08
93631	T	Heart pacing, mapping	0087	52.46	$2,670.42		$534.08
93640	S	Evaluation heart device	0084	199.65	$10,162.98		$2,032.60
93641	S	Electrophysiology evaluation	0084	199.65	$10,162.98		$2,032.60
93642	S	Electrophysiology evaluation	0084	199.65	$10,162.98		$2,032.60
93650	T	Ablate heart dysrhythm focus	0086	72.72	$3,701.74	$1,265.37	$740.35
93651	T	Ablate heart dysrhythm focus	0086	72.72	$3,701.74	$1,265.37	$740.35
93652	T	Ablate heart dysrhythm focus	0086	72.72	$3,701.74	$1,265.37	$740.35
93660	S	Tilt table evaluation	0101	3.74	$190.38	$104.70	$38.08
93662	S	Intracardiac ecg (ice)	0270	5.30	$269.79	$145.69	$53.96
93668	E	Peripheral vascular rehab					
*93701	T	Bioimpedance, thoracic	0970		$25.00		$5.00
93720	E	Total body plethysmography					
93721	S	Plethysmography tracing	0096	1.71	$87.05	$47.87	$17.41
93722	E	Plethysmography report					
93724	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93727	S	Analyze ilr system	0690	0.37	$18.83	$10.35	$3.77
93731	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93732	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93733	S	Telephone analy, pacemaker	0690	0.37	$18.83	$10.35	$3.77
93734	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93735	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93736	S	Telephone analy, pacemaker	0690	0.37	$18.83	$10.35	$3.77
93737	D	Analyze cardio/defibrillator	0689	0.43	$21.89	$12.03	$4.38
93738	D	Analyze cardio/defibrillator	0689	0.43	$21.89	$12.03	$4.38
93740	S	Temperature gradient studies	0096	1.71	$87.05	$47.87	$17.41
93741	S	Analyze ht pace device sngl	0689	0.43	$21.89	$12.03	$4.38
93742	S	Analyze ht pace device sngl	0689	0.43	$21.89	$12.03	$4.38
93743	S	Analyze ht pace device dual	0689	0.43	$21.89	$12.03	$4.38
93744	S	Analyze ht pace device dual	0689	0.43	$21.89	$12.03	$4.38
93760	E	Cephalic thermogram					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	S	Cardiac rehab	0095	0.61	$31.05	$16.46	$6.21
93798	S	Cardiac rehab/monitor	0095	0.61	$31.05	$16.46	$6.21
93799	S	Cardiovascular procedure	0096	1.71	$87.05	$47.87	$17.41
93875	S	Extracranial study	0096	1.71	$87.05	$47.87	$17.41
93880	S	Extracranial study	0267	2.33	$118.61	$65.23	$23.72
93882	S	Extracranial study	0267	2.33	$118.61	$65.23	$23.72
93886	S	Intracranial study	0267	2.33	$118.61	$65.23	$23.72
93888	S	Intracranial study	0267	2.33	$118.61	$65.23	$23.72
93922	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93923	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93924	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93925	S	Lower extremity study	0267	2.33	$118.61	$65.23	$23.72
93926	S	Lower extremity study	0267	2.33	$118.61	$65.23	$23.72
93930	S	Upper extremity study	0267	2.33	$118.61	$65.23	$23.72
93931	S	Upper extremity study	0267	2.33	$118.61	$65.23	$23.72
93965	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93970	S	Extremity study	0267	2.33	$118.61	$65.23	$23.72
93971	S	Extremity study	0267	2.33	$118.61	$65.23	$23.72
93975	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93976	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93978	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93979	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93980	S	Penile vascular study	0267	2.33	$118.61	$65.23	$23.72
93981	S	Penile vascular study	0267	2.33	$118.61	$65.23	$23.72
93990	S	Doppler flow testing	0267	2.33	$118.61	$65.23	$23.72
94010	X	Breathing capacity test	0367	0.70	$35.63	$17.82	$7.13
94014	X	Patient recorded spirometry	0367	0.70	$35.63	$17.82	$7.13
94015	X	Patient recorded spirometry	0367	0.70	$35.63	$17.82	$7.13
94016	X	Review patient spirometry	0369	3.49	$177.65	$58.50	$35.53
94060	X	Evaluation of wheezing	0368	1.47	$74.83	$38.16	$14.97
94070	X	Evaluation of wheezing	0368	1.47	$74.83	$38.16	$14.97
94150	N	Vital capacity test					
94200	X	Lung function test (MBC/MVV)	0367	0.70	$35.63	$17.82	$7.13
94240	X	Residual lung capacity	0368	1.47	$74.83	$38.16	$14.97
94250	X	Expired gas collection	0367	0.70	$35.63	$17.82	$7.13
94260	X	Thoracic gas volume	0368	1.47	$74.83	$38.16	$14.97
94350	X	Lung nitrogen washout curve	0368	1.47	$74.83	$38.16	$14.97
94360	X	Measure airflow resistance	0368	1.47	$74.83	$38.16	$14.97
94370	X	Breath airway closing volume	0368	1.47	$74.83	$38.16	$14.97
94375	X	Respiratory flow volume loop	0367	0.70	$35.63	$17.82	$7.13
94400	X	CO2 breathing response curve	0368	1.47	$74.83	$38.16	$14.97
94450	X	Hypoxia response curve	0367	0.70	$35.63	$17.82	$7.13
94620	X	Pulmonary stress test/simple	0368	1.47	$74.83	$38.16	$14.97
94621	X	Pulm stress test/complex	0369	3.49	$177.65	$58.50	$35.53
94640	S	Airway inhalation treatment	0077	0.39	$19.85	$10.91	$3.97
94642	S	Aerosol inhalation treatment	0078	0.86	$43.78	$18.83	$8.76
94650	S	Pressure breathing (IPPB)	0077	0.39	$19.85	$10.91	$3.97
94651	S	Pressure breathing (IPPB)	0077	0.39	$19.85	$10.91	$3.97
94652	C	Pressure breathing (IPPB)					
94656	S	Initial ventilator mgmt	0079	0.60	$30.54	$16.79	$6.11
94657	S	Continued ventilator mgmt	0079	0.60	$30.54	$16.79	$6.11
94660	S	Pos airway pressure, CPAP	0068	3.02	$153.73	$84.55	$30.75
94662	S	Neg press ventilation, cnp	0079	0.60	$30.54	$16.79	$6.11
94664	S	Aerosol or vapor inhalations	0077	0.39	$19.85	$10.91	$3.97
94665	S	Aerosol or vapor inhalations	0077	0.39	$19.85	$10.91	$3.97
94667	S	Chest wall manipulation	0077	0.39	$19.85	$10.91	$3.97
94668	S	Chest wall manipulation	0077	0.39	$19.85	$10.91	$3.97
94680	X	Exhaled air analysis, o2	0368	1.47	$74.83	$38.16	$14.97
94681	X	Exhaled air analysis, o2/co2	0368	1.47	$74.83	$38.16	$14.97
94690	X	Exhaled air analysis	0367	0.70	$35.63	$17.82	$7.13
94720	X	Monoxide diffusing capacity	0367	0.70	$35.63	$17.82	$7.13
94725	X	Membrane diffusion capacity	0368	1.47	$74.83	$38.16	$14.97
94750	X	Pulmonary compliance study	0368	1.47	$74.83	$38.16	$14.97
94760	N	Measure blood oxygen level					
94761	N	Measure blood oxygen level					
94762	N	Measure blood oxygen level					
94770	X	Exhaled carbon dioxide test	0367	0.70	$35.63	$17.82	$7.13
94772	X	Breath recording, infant	0369	3.49	$177.65	$58.50	$35.53
94799	X	Pulmonary service/procedure	0367	0.70	$35.63	$17.82	$7.13

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95004	X	Allergy skin tests	0370	0.80	$40.72	$11.81	$8.14
95010	X	Sensitivity skin tests	0370	0.80	$40.72	$11.81	$8.14
95015	X	Sensitivity skin tests	0370	0.80	$40.72	$11.81	$8.14
95024	X	Allergy skin tests	0370	0.80	$40.72	$11.81	$8.14
95027	X	Skin end point titration	0370	0.80	$40.72	$11.81	$8.14
95028	X	Allergy skin tests	0370	0.80	$40.72	$11.81	$8.14
95044	X	Allergy patch tests	0370	0.80	$40.72	$11.81	$8.14
95052	X	Photo patch test	0370	0.80	$40.72	$11.81	$8.14
95056	X	Photosensitivity tests	0370	0.80	$40.72	$11.81	$8.14
95060	X	Eye allergy tests	0370	0.80	$40.72	$11.81	$8.14
95065	X	Nose allergy test	0370	0.80	$40.72	$11.81	$8.14
95070	X	Bronchial allergy tests	0369	3.49	$177.65	$58.50	$35.53
95071	X	Bronchial allergy tests	0369	3.49	$177.65	$58.50	$35.53
95075	X	Ingestion challenge test	0361	3.25	$165.44	$82.72	$33.09
95078	X	Provocative testing	0370	0.80	$40.72	$11.81	$8.14
95115	X	Immunotherapy, one injection	0353	0.25	$12.73	.....	$2.55
95117	X	Immunotherapy injections	0353	0.25	$12.73	.....	$2.55
95120	E	Immunotherapy, one injection	.....	.....	.....	.....	.....
95125	E	Immunotherapy, many antigens	.....	.....	.....	.....	.....
95130	E	Immunotherapy, insect venom	.....	.....	.....	.....	.....
95131	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95132	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95133	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95134	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95144	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95145	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95146	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95147	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95148	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95149	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95165	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95170	X	Antigen therapy services	0371	0.70	$35.63	.....	$7.13
95180	X	Rapid desensitization	0370	0.80	$40.72	$11.81	$8.14
95199	X	Allergy immunology services	0370	0.80	$40.72	$11.81	$8.14
*95250	T	Glucose monitoring, cont	0972	.....	$150.00	.....	$30.00
95805	S	Multiple sleep latency test	0209	10.54	$536.53	$279.00	$107.31
95806	S	Sleep study, unattended	0213	2.65	$134.90	$70.15	$26.98
95807	S	Sleep study, attended	0209	10.54	$536.53	$279.00	$107.31
95808	S	Polysomnography, 1–3	0209	10.54	$536.53	$279.00	$107.31
95810	S	Polysomnography, 4 or more	0209	10.54	$536.53	$279.00	$107.31
95811	S	Polysomnography w/cpap	0209	10.54	$536.53	$279.00	$107.31
95812	S	Electroencephalogram (EEG)	0213	2.65	$134.90	$70.15	$26.98
95813	S	Electroencephalogram (EEG)	0213	2.65	$134.90	$70.15	$26.98
95816	S	Electroencephalogram (EEG)	0214	2.10	$106.90	$53.45	$21.38
95819	S	Electroencephalogram (EEG)	0214	2.10	$106.90	$53.45	$21.38
95822	S	Sleep electroencephalogram	0214	2.10	$106.90	$53.45	$21.38
95824	S	Electroencephalography	0214	2.10	$106.90	$53.45	$21.38
95827	S	Night electroencephalogram	0209	10.54	$536.53	$279.00	$107.31
95829	S	Surgery electrocorticogram	0214	2.10	$106.90	$53.45	$21.38
95830	E	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	S	Tensilon test	0218	1.03	$52.43	$23.59	$10.49
95858	S	Tensilon test & myogram	0215	0.66	$33.60	$17.47	$6.72
95860	S	Muscle test, one limb	0218	1.03	$52.43	$23.59	$10.49
95861	S	Muscle test, two limbs	0218	1.03	$52.43	$23.59	$10.49
95863	S	Muscle test, 3 limbs	0218	1.03	$52.43	$23.59	$10.49
95864	S	Muscle test, 4 limbs	0218	1.03	$52.43	$23.59	$10.49
95867	S	Muscle test, head or neck	0218	1.03	$52.43	$23.59	$10.49
95868	S	Muscle test, head or neck	0218	1.03	$52.43	$23.59	$10.49
95869	S	Muscle test, thor paraspinal	0215	0.66	$33.60	$17.47	$6.72
95870	S	Muscle test, nonparaspinal	0218	1.03	$52.43	$23.59	$10.49
95872	S	Muscle test, one fiber	0215	0.66	$33.60	$17.47	$6.72
95875	S	Limb exercise test	0215	0.66	$33.60	$17.47	$6.72
95900	S	Motor nerve conduction test	0218	1.03	$52.43	$23.59	$10.49
95903	S	Motor nerve conduction test	0218	1.03	$52.43	$23.59	$10.49
95904	S	Sense/mixed n conduction tst	0215	0.66	$33.60	$17.47	$6.72
95920	S	Intraop nerve test add-on	0218	1.03	$52.43	$23.59	$10.49
95921	S	Autonomic nerv function test	0215	0.66	$33.60	$17.47	$6.72
95922	S	Autonomic nerv function test	0215	0.66	$33.60	$17.47	$6.72
95923	S	Autonomic nerv function test	0215	0.66	$33.60	$17.47	$6.72

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95925	S	Somatosensory testing	0216	2.61	$132.86	$59.79	$26.57
95926	S	Somatosensory testing	0216	2.61	$132.86	$59.79	$26.57
95927	S	Somatosensory testing	0216	2.61	$132.86	$59.79	$26.57
95930	S	Visual evoked potential test	0216	2.61	$132.86	$59.79	$26.57
95933	S	Blink reflex test	0215	0.66	$33.60	$17.47	$6.72
95934	S	H-reflex test	0215	0.66	$33.60	$17.47	$6.72
95936	S	H-reflex test	0215	0.66	$33.60	$17.47	$6.72
95937	S	Neuromuscular junction test	0218	1.03	$52.43	$23.59	$10.49
95950	S	Ambulatory eeg monitoring	0213	2.65	$134.90	$70.15	$26.98
95951	S	EEG monitoring/videorecord	0209	10.54	$536.53	$279.00	$107.31
95953	S	EEG monitoring/computer	0209	10.54	$536.53	$279.00	$107.31
95954	S	EEG monitoring/giving drugs	0213	2.65	$134.90	$70.15	$26.98
95955	S	EEG during surgery	0214	2.10	$106.90	$53.45	$21.38
95956	N	Eeg monitoring, cable/radio					
95957	N	EEG digital analysis					
95958	S	EEG monitoring/function test	0213	2.65	$134.90	$70.15	$26.98
95961	S	Electrode stimulation, brain	0216	2.61	$132.86	$59.79	$26.57
95962	S	Electrode stim, brain add-on	0216	2.61	$132.86	$59.79	$26.57
*95965	T	Meg, spontaneous	0972		$150.00		$30.00
*95966	T	Meg, evoked, single	0972		$150.00		$30.00
*95967	T	Meg, evoked, each addl	0972		$150.00		$30.00
95970	S	Analyze neurostim, no prog	0692	14.34	$729.96	$401.47	$145.99
95971	S	Analyze neurostim, simple	0692	14.34	$729.96	$401.47	$145.99
95972	S	Analyze neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95973	S	Analyze neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95974	S	Cranial neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95975	S	Cranial neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95999	N	Neurological procedure					
*96000	T	Motion analysis, video/3d	0972		$150.00		$30.00
*96001	T	Motion test w/ft press meas	0972		$150.00		$30.00
*96002	T	Dynamic surface emg	0972		$150.00		$30.00
*96003	T	Dynamic fine wire emg	0972		$150.00		$30.00
*96004	E	Phys review of motion tests					
96100	X	Psychological testing	0373	1.00	$50.90	$14.25	$10.18
96105	X	Assessment of aphasia	0373	1.00	$50.90	$14.25	$10.18
96110	X	Developmental test, lim	0373	1.00	$50.90	$14.25	$10.18
96111	X	Developmental test, extend	0373	1.00	$50.90	$14.25	$10.18
96115	X	Neurobehavior status exam	0373	1.00	$50.90	$14.25	$10.18
96117	X	Neuropsych test battery	0373	1.00	$50.90	$14.25	$10.18
*96150	S	Assess hlth/behave, init	0322	1.15	$58.54	$12.29	$11.71
*96151	S	Assess hlth/behave, subseq	0322	1.15	$58.54	$12.29	$11.71
*96152	S	Intervene hlth/behave, indiv	0322	1.15	$58.54	$12.29	$11.71
*96153	S	Intervene hlth/behave, group	0322	1.15	$58.54	$12.29	$11.71
*96154	S	Interv hlth/behav, fam w/pt	0322	1.15	$58.54	$12.29	$11.71
*96155	S	Interv hlth/behav fam no pt	0322	1.15	$58.54	$12.29	$11.71
96400	E	Chemotherapy, sc/im					
96405	E	Intralesional chemo admin					
96406	E	Intralesional chemo admin					
96408	E	Chemotherapy, push technique					
96410	E	Chemotherapy,infusion method					
96412	E	Chemo, infuse method add-on					
96414	E	Chemo, infuse method add-on					
96420	E	Chemotherapy, push technique					
96422	E	Chemotherapy,infusion method					
96423	E	Chemo, infuse method add-on					
96425	E	Chemotherapy,infusion method					
96440	E	Chemotherapy, intracavitary					
96445	E	Chemotherapy, intracavitary					
96450	E	Chemotherapy, into CNS					
96520	T	Pump refilling, maintenance	0125	3.00	$152.71		$30.54
96530	T	Pump refilling, maintenance	0125	3.00	$152.71		$30.54
96542	E	Chemotherapy injection					
96545	E	Provide chemotherapy agent					
96549	E	Chemotherapy, unspecified					
*96567	T	Photodynamic tx, skin	0972		$150.00		$30.00
96570	T	Photodynamic tx, 30 min	0973		$250.00		$50.00
96571	T	Photodynamic tx, addl 15 min	0973		$250.00		$50.00
96900	S	Ultraviolet light therapy	0001	0.43	$21.89	$7.88	$4.38
96902	N	Trichogram					
96910	S	Photochemotherapy with UV–B	0001	0.43	$21.89	$7.88	$4.38
96912	S	Photochemotherapy with UV–A	0001	0.43	$21.89	$7.88	$4.38
96913	S	Photochemotherapy, UV–A or B	0001	0.43	$21.89	$7.88	$4.38
96999	S	Dermatological procedure	0001	0.43	$21.89	$7.88	$4.38
97001	A	Pt evaluation					
97002	A	Pt re-evaluation					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97003	A	Ot evaluation					
97004	A	Ot re-evaluation					
*97005	E	Athletic train eval					
*97006	E	Athletic train reeval					
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					
97124	A	Massage therapy					
97139	A	Physical medicine procedure					
97140	A	Manual therapy					
97150	A	Group therapeutic procedures					
97504	A	Orthotic training					
97520	A	Prosthetic training					
97530	A	Therapeutic activities					
97532	A	Cognitive skills development					
97533	A	Sensory integration					
97535	A	Self care mngment training					
97537	A	Community/work reintegration					
97542	A	Wheelchair mngment training					
97545	A	Work hardening					
97546	A	Work hardening add-on					
97601	A	Wound care selective					
97602	N	Wound care non-selective					
97703	A	Prosthetic checkout					
97750	A	Physical performance test					
97780	E	Acupuncture w/o stimul					
97781	E	Acupuncture w/stimul					
97799	A	Physical medicine procedure					
97802	A	Medical nutrition, indiv, in					
97803	A	Med nutrition, indiv, subseq					
97804	A	Medical nutrition, group					
98925	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98926	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98927	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98928	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98929	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98940	S	Chiropractic manipulation	0060	0.23	$11.71		$2.34
98941	S	Chiropractic manipulation	0060	0.23	$11.71		$2.34
98942	S	Chiropractic manipulation	0060	0.23	$11.71		$2.34
98943	E	Chiropractic manipulation					
99000	E	Specimen handling					
99001	E	Specimen handling					
99002	E	Device handling					
99024	E	Postop follow-up visit					
99025	E	Initial surgical evaluation					
99050	E	Medical services after hrs					
99052	E	Medical services at night					
99054	E	Medical servcs, unusual hrs					
99056	E	Non-office medical services					
99058	E	Office emergency care					
99070	E	Special supplies					
99071	E	Patient education materials					
99075	E	Medical testimony					
99078	N	Group health education					
99080	E	Special reports or forms					
99082	E	Unusual physician travel					
99090	E	Computer data analysis					
*99091	E	Collect/review data from pt					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99100	E	Special anesthesia service					
99116	E	Anesthesia with hypothermia					
99135	E	Special anesthesia procedure					
99140	E	Emergency anesthesia					
99141	N	Sedation, iv/im or inhalant					
99142	N	Sedation, oral/rectal/nasal					
99170	T	Anogenital exam, child	0191	0.23	$11.71	$3.40	$2.34
99172	E	Ocular function screen					
99173	E	Visual acuity screen					
99175	N	Induction of vomiting					
99183	E	Hyperbaric oxygen therapy					
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	0372	0.53	$26.98	$10.09	$5.40
99199	E	Special service/proc/report					
99201	V	Office/outpatient visit, new	0600	0.86	$43.78		$8.76
99202	V	Office/outpatient visit, new	0600	0.86	$43.78		$8.76
99203	V	Office/outpatient visit, new	0601	0.95	$48.36		$9.67
99204	V	Office/outpatient visit, new	0602	1.38	$70.25		$14.05
99205	V	Office/outpatient visit, new	0602	1.38	$70.25		$14.05
99211	V	Office/outpatient visit, est	0600	0.86	$43.78		$8.76
99212	V	Office/outpatient visit, est	0600	0.86	$43.78		$8.76
99213	V	Office/outpatient visit, est	0601	0.95	$48.36		$9.67
99214	V	Office/outpatient visit, est	0602	1.38	$70.25		$14.05
99215	V	Office/outpatient visit, est	0602	1.38	$70.25		$14.05
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	N	Observ/hosp same date					
99235	N	Observ/hosp same date					
99236	N	Observ/hosp same date					
99238	E	Hospital discharge day					
99239	E	Hospital discharge day					
99241	V	Office consultation	0600	0.86	$43.78		$8.76
99242	V	Office consultation	0600	0.86	$43.78		$8.76
99243	V	Office consultation	0601	0.95	$48.36		$9.67
99244	V	Office consultation	0602	1.38	$70.25		$14.05
99245	V	Office consultation	0602	1.38	$70.25		$14.05
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					
99271	V	Confirmatory consultation	0600	0.86	$43.78		$8.76
99272	V	Confirmatory consultation	0600	0.86	$43.78		$8.76
99273	V	Confirmatory consultation	0601	0.95	$48.36		$9.67
99274	V	Confirmatory consultation	0602	1.38	$70.25		$14.05
99275	V	Confirmatory consultation	0602	1.38	$70.25		$14.05
99281	V	Emergency dept visit	0610	1.23	$62.61	$19.41	$12.52
99282	V	Emergency dept visit	0610	1.23	$62.61	$19.41	$12.52
99283	V	Emergency dept visit	0611	2.16	$109.95	$36.47	$21.99
99284	V	Emergency dept visit	0612	3.49	$177.65	$54.14	$35.53
99285	V	Emergency dept visit	0612	3.49	$177.65	$54.14	$35.53
99288	E	Direct advanced life support					
*99289	N	Pt transport, 30–74 min					
*99290	N	Pt transport, addl 30 min					
99291	S	Critical care, first hour	0620	8.40	$427.59	$149.66	$85.52
99292	N	Critical care, addl 30 min					
99295	C	Neonatal critical care					
99296	C	Neonatal critical care					
99297	C	Neonatal critical care					
99298	C	Neonatal critical care					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99301	E	Nursing facility care					
99302	E	Nursing facility care					
99303	E	Nursing facility care					
99311	E	Nursing fac care, subseq					
99312	E	Nursing fac care, subseq					
99313	E	Nursing fac care, subseq					
99315	E	Nursing fac discharge day					
99316	E	Nursing fac discharge day					
99321	E	Rest home visit, new patient					
99322	E	Rest home visit, new patient					
99323	E	Rest home visit, new patient					
99331	E	Rest home visit, est pat					
99332	E	Rest home visit, est pat					
99333	E	Rest home visit, est pat					
99341	E	Home visit, new patient					
99342	E	Home visit, new patient					
99343	E	Home visit, new patient					
99344	E	Home visit, new patient					
99345	E	Home visit, new patient					
99347	E	Home visit, est patient					
99348	E	Home visit, est patient					
99349	E	Home visit, est patient					
99350	E	Home visit, est 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					
99377	E	Hospice care supervision					
99379	E	Nursing fac care supervision					
99380	E	Nursing fac care supervision					
99381	E	Prev visit, new, infant					
99382	E	Prev visit, new, age 1–4					
99383	E	Prev visit, new, age 5–11					
99384	E	Prev visit, new, age 12–17					
99385	E	Prev visit, new, age 18–39					
99386	E	Prev visit, new, age 40–64					
99387	E	Prev visit, new, 65 & over					
99391	E	Prev visit, est, infant					
99392	E	Prev visit, est, age 1–4					
99393	E	Prev visit, est, age 5–11					
99394	E	Prev visit, est, age 12–17					
99395	E	Prev visit, est, age 18–39					
99396	E	Prev visit, est, age 40–64					
99397	E	Prev visit, est, 65 & over					
99401	E	Preventive counseling, indiv					
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 hosp					
99433	C	Normal newborn care/hospital					
99435	E	Newborn discharge day hosp					
99436	N	Attendance, birth					
99440	S	Newborn resuscitation	0094	6.08	$309.50	$105.29	$61.90
99450	E	Life/disability evaluation					
99455	E	Disability examination					
99456	E	Disability examination					
99499	E	Unlisted e&m service					
*99500	E	Home visit, prenatal					
*99501	E	Home visit, postnatal					
*99502	E	Home visit, nb care					
*99503	E	Home visit, resp therapy					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*99504	E	Home visit mech ventilator					
*99505	E	Home visit, stoma care					
*99506	E	Home visit, im injection					
*99507	E	Home visit, cath maintain					
*99508	E	Home visit, sleep studies					
*99509	E	Home visit day life activity					
*99510	E	Home visit, sing/m/fam couns					
*99511	E	Home visit, fecal/enema mgmt					
*99512	E	Home visit, hemodialysis					
*99539	E	Home visit, nos					
*99551	E	Home infus, pain mgmt, iv/sc					
*99552	E	Hm infus pain mgmt, epid/ith					
*99553	E	Home infuse, tocolytic tx					
*99554	E	Home infus, hormone/platelet					
*99555	E	Home infuse, chemotheraphy					
*99556	E	Home infus, antibio/fung/vir					
*99557	E	Home infuse, anticoagulant					
*99558	E	Home infuse, immunotherapy					
*99559	E	Home infus, periton dialysis					
*99560	E	Home infus, entero nutrition					
*99561	E	Home infuse, hydration tx					
*99562	E	Home infus, parent nutrition					
*99563	E	Home admin, pentamidine					
*99564	E	Hme infus, antihemophil agnt					
*99565	E	Home infus, proteinase inhib					
*99566	E	Home infuse, iv therapy					
*99567	E	Home infuse, sympath agent					
*99568	E	Home infus, misc drug, daily					
*99569	E	Home infuse, each addl tx					
A0021	E	Outside state ambulance serv					
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 escrt					
A0210	E	Noner transport meals escort					
A0225	A	Neonatal emergency transport					
A0380	A	Basic life support mileage					
A0382	A	Basic support routine suppls					
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 suppls					
A0398	A	Als routine disposble suppls					
A0420	A	Ambulance waiting 1/2 hr					
A0422	A	Ambulance 02 life sustaining					
A0424	A	Extra ambulance attendant					
A0425	A	Ground mileage					
A0426	A	Als 1					
A0427	A	ALS1-emergency					
A0428	A	bls					
A0429	A	BLS-emergency					
A0430	A	Fixed wing air transport					
A0431	A	Rotary wing air transport					
A0432	A	PI volunteer ambulance co					
A0433	A	als 2					
A0434	A	Specialty care transport					
A0435	A	Fixed wing air mileage					
A0436	A	Rotary wing air mileage					
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					
A4209	E	5+ CC sterile syringe&needle					
A4210	E	Nonneedle injection device					
A4211	E	Supp for self-adm injections					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4212	E	Non coring needle or stylet					
A4213	E	20+ CC syringe only					
A4214	A	30 CC sterile water/saline					
A4215	E	Sterile needle					
A4220	A	Infusion pump refill kit					
A4221	A	Maint drug infus cath per wk					
A4222	A	Drug infusion pump supplies					
A4230	A	Infus insulin pump non needl					
A4231	A	Infusion insulin pump needle					
A4232	A	Syringe w/needle insulin 3cc					
A4244	E	Alcohol or peroxide per pint					
A4245	E	Alcohol wipes per box					
A4246	E	Betadine/phisohex solution					
A4247	E	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					
*A4257	A	Replace Lensshield Cartridge					
A4258	A	Lancet device each					
A4259	A	Lancets per box					
A4260	E	Levonorgestrel implant					
A4261	E	Cervical cap contraceptive					
A4262	N	Temporary tear duct plug					
A4263	N	Permanent tear duct plug					
A4265	A	Paraffin					
A4270	A	Disposable endoscope sheath					
A4280	A	Brst prsths adhsv attchmnt					
A4290	E	Sacral nerve stim test lead					
A4300	E	Cath impl vasc access portal					
A4301	E	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					
A4319	A	Sterile H2O irrigation solut					
A4320	A	Irrigation tray					
A4321	A	Cath therapeutic irrig agent					
A4322	A	Irrigation syringe					
A4323	A	Saline irrigation solution					
A4324	A	Male ext cath w/adh coating					
A4325	A	Male ext cath w/adh strip					
A4326	A	Male external catheter					
A4327	A	Fem urinary collect dev cup					
A4328	A	Fem urinary collect pouch					
A4329	D	External catheter start set					
A4330	A	Stool collection pouch					
A4331	A	Extension drainage tubing					
A4332	A	Lubricant for cath insertion					
A4333	A	Urinary cath anchor device					
A4334	A	Urinary cath leg strap					
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					
A4348	A	Male ext cath extended wear					
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					
*A4360	A	Adult incontinence garment					
A4361	A	Ostomy face plate					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4362	A	Solid skin barrier					
A4364	A	Adhesive, liquid or equal					
A4365	A	Adhesive remover wipes					
A4367	A	Ostomy belt					
A4368	A	Ostomy filter					
A4369	A	Skin barrier liquid per oz					
A4370	A	Skin barrier paste per oz					
A4371	A	Skin barrier powder per oz					
A4372	A	Skin barrier solid 4x4 equiv					
A4373	A	Skin barrier with flange					
A4374	A	Skin barrier extended wear					
A4375	A	Drainable plastic pch w fcpl					
A4376	A	Drainable rubber pch w fcplt					
A4377	A	Drainable plstic pch w/o fp					
A4378	A	Drainable rubber pch w/o fp					
A4379	A	Urinary plastic pouch w fcpl					
A4380	A	Urinary rubber pouch w fcplt					
A4381	A	Urinary plastic pouch w/o fp					
A4382	A	Urinary hvy plstc pch w/o fp					
A4383	A	Urinary rubber pouch w/o fp					
A4384	A	Ostomy faceplt/silicone ring					
A4385	A	Ost skn barrier sld ext wear					
A4386	A	Ost skn barrier w flng ex wr					
A4387	A	Ost clsd pouch w att st barr					
A4388	A	Drainable pch w ex wear barr					
A4389	A	Drainable pch w st wear barr					
A4390	A	Drainable pch ex wear convex					
A4391	A	Urinary pouch w ex wear barr					
A4392	A	Urinary pouch w st wear barr					
A4393	A	Urine pch w ex wear bar conv					
A4394	A	Ostomy pouch liq deodorant					
A4395	A	Ostomy pouch solid deodorant					
A4396	A	Peristomal hernia supprt blt					
A4397	A	Irrigation supply sleeve					
A4398	A	Ostomy irrigation bag					
A4399	A	Ostomy irrig cone/cath w brs					
A4400	A	Ostomy irrigation set					
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					
A4464	A	Joint support device/garment					
A4465	A	Non-elastic extremity binder					
A4470	A	Gravlee jet washer					
A4480	A	Vabra aspirator					
A4481	A	Tracheostoma filter					
A4483	A	Moisture exchanger					
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, pair					
A4557	A	Lead wires, pair					
A4558	A	Conductive paste or gel					
A4561	N	Pessary rubber, any type					
A4562	N	Pessary, non rubber,any type					
A4565	A	Slings					
A4570	N	Splint					
A4572	A	Rib belt					
A4575	E	Hyperbaric o2 chamber disps					
A4580	N	Cast supplies (plaster)					
A4590	N	Special casting material					
A4595	A	TENS suppl 2 lead per month					
A4608	A	Transtracheal oxygen cath					
A4611	A	Heavy duty battery					
A4612	A	Battery cables					
A4613	A	Battery charger					
A4614	A	Hand-held PEFR meter					
A4615	A	Cannula nasal					
A4616	A	Tubing (oxygen) per foot					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	G	Satumomab pendetide per dose	0704		$1,591.25		$227.80
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	D	Supp esrd centrifuge					
*A4651	A	Calibrated microcap tube					
*A4652	A	Microcapillary tube sealant					
A4655	D	Esrd syringe/needle					
*A4656	A	Dialysis needle					
*A4657	A	Dialysis syringe w/wo 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	D	Standard dialysate solution					
A4705	D	Bicarb dialysate solution					
*A4706	A	Bicarbonate conc sol per gal					
*A4707	A	Bicarbonate conc pow per pac					
*A4708	A	Acetate conc sol per gallon					
*A4709	A	Acid conc sol per gallon					
A4712	A	Sterile water					
A4714	A	Treated water for dialysis					
*A4719	A	oY seto tubing					
*A4720	A	Dialysat sol fld vol > 249cc					
*A4721	A	Dialysat sol fld vol > 999cc					
*A4722	A	Dialys sol fld vol > 1999cc					
*A4723	A	Dialys sol fld vol > 2999cc					
*A4724	A	Dialys sol fld vol > 3999cc					
*A4725	A	Dialys sol fld vol > 4999cc					
*A4726	A	Dialys sol fld vol > 5999cc					
A4730	A	Fistula cannulation set dial					
A4735	D	Local/topical anesthetics					
*A4736	A	Topical anesthetic, per gram					
*A4737	A	Inj anesthetic per 10 ml					
A4740	A	Esrd shunt accessory					
A4750	A	Arterial or venous tubing					
A4755	A	Arterial and venous tubing					
A4760	A	Standard testing solution					
A4765	A	Dialysate concentrate					
*A4766	A	Dialysate conc sol add 10 ml					
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	D	Esrd sterilizing agent					
A4790	D	Esrd cleansing agents					
A4800	D	Heparin/antidote dialysis					
*A4801	A	Heparin per 1000 units					
*A4802	A	Protamine sulfate per 50 mg					
A4820	D	Supplies hemodialysis kit					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4850	D	Rubber tipped hemostats					
A4860	A	Disposable catheter caps					
A4870	A	Plumbing/electrical work					
A4880	D	Water storage tanks					
A4890	A	Contracts/repair/maintenance					
A4900	D	Capd supply kit					
A4901	D	Ccpd supply kit					
A4905	D	Ipd supply kit					
A4910	D	Esrd nonmedical supplies					
*A4911	A	Drain bag/bottle					
A4912	D	Gomco drain bottle					
A4913	A	Esrd supply					
A4914	D	Preparation kit					
A4918	A	Venous pressure clamp					
A4919	D	Supp dialysis dialyzer holde					
A4920	D	Harvard pressure clamp					
A4921	D	Measuring cylinder					
A4927	A	Gloves					
*A4928	A	Surgical mask					
*A4929	A	Tourniquet for dialysis, ea					
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	D	Drain ostomy pouch w/fceplte					
A5071	A	Urinary pouch w/barrier					
A5072	A	Urinary pouch w/o barrier					
A5073	A	Urinary pouch on barr w/flng					
A5074	D	Urinary pouch w/faceplate					
A5075	D	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	Disk/foam pad +or- adhesive					
A5131	A	Appliance cleaner					
A5200	A	Percutaneous catheter anchor					
A5500	A	Diab shoe for density insert					
A5501	A	Diabetic custom molded shoe					
A5502	D	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					
A5508	A	Diabetic deluxe shoe					
*A5509	A	Direct heat form shoe insert					
*A5510	A	Compression form shoe insert					
*A5511	A	Custom fab molded shoe inser					
*A6000	A	Wound warming wound cover					
*A6010	A	Collagen based wound filler					
A6021	A	Collagen dressing <=16 sq in					
A6022	A	Collagen drsg>6<=48 sq in					
A6023	A	Collagen dressing >48 sq in					
A6024	A	Collagen dsg wound filler					
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					
A6200	A	Compos drsg <=16 no border					
A6201	A	Compos drsg >16<=48 no bdr					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6202	A	Compos drsg >48 no border					
A6203	A	Composite drsg <= 16 sq in					
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 brdr					
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/bordr					
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/salne					
A6231	A	Hydrogel dsg<=16 sq in					
A6232	A	Hydrogel dsg>16<=48 sq in					
A6233	A	Hydrogel dressing >48 sq in					
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/yd					
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 /yd					
A6406	A	Sterile non-elastic gauze/yd					
A7000	A	Disposable canister for pump					
A7001	A	Nondisposable pump canister					
A7002	A	Tubing used w suction pump					
A7003	A	Nebulizer administration set					
A7004	A	Disposable nebulizer sml vol					
A7005	A	Nondisposable nebulizer set					
A7006	A	Filtered nebulizer admin set					
A7007	A	Lg vol nebulizer disposable					
A7008	A	Disposable nebulizer prefill					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7009	A	Nebulizer reservoir bottle					
A7010	A	Disposable corrugated tubing					
A7011	A	Nondispos corrugated tubing					
A7012	A	Nebulizer water collec devic					
A7013	A	Disposable compressor filter					
A7014	A	Compressor nondispos filter					
A7015	A	Aerosol mask used w nebulize					
A7016	A	Nebulizer dome & mouthpiece					
A7017	A	Nebulizer not used w oxygen					
A7018	A	Water distilled w/nebulizer					
A7019	A	Saline solution dispenser					
A7020	A	Sterile H2O or NSS w lgv neb					
A7501	A	Tracheostoma valve w diaphra					
A7502	A	Replacement diaphragm/fplate					
A7503	A	HMES filter holder or cap					
A7504	A	Tracheostoma HMES filter					
A7505	A	HMES or trach valve housing					
A7506	A	HMES/trachvalve adhesivedisk					
A7507	A	Integrated filter & holder					
A7508	A	Housing & Integrated Adhesiv					
A7509	A	Heat & moisture exchange sys					
A9150	E	Misc/exper non-prescript dru					
A9160	D	Podiatrist non-covered servi					
A9170	D	Chiropractor non-covered ser					
A9190	D	Misc/expe personal comfort i					
A9270	E	Non-covered item or service					
A9300	E	Exercise equipment					
A9500	G	Technetium TC 99m sestamibi	1600		$121.70		$17.42
A9502	G	Technetium tc99m tetrofosmin, per unit dose	0705		$114.00		$16.32
A9503	G	Technetium TC 99m medronate	1601		$42.18		$5.42
A9504	G	Technetium tc 99m apcitide	1602		$475.00		$68.00
A9505	G	Thallous chloride TL 201/mci	1603		$78.16		$7.08
A9507	G	Indium/111 capromab pendetid, per dose	1604		$2,192.13		$313.82
A9508	G	Iobenguane sulfate I–31 per 0.5 mCi	1045		$495.65		$70.96
A9510	G	Technetium TC99m Disofenin	1205		$79.17		$11.33
*A9511	G	Technetium TC 99m depreotide	1095		$38.00		$5.44
A9600	G	Strontium-89 chloride per mCi	0701		$963.42		$137.92
A9605	G	Samarium sm153 lexidronamm 50 mCi	0702		$1,020.00		$146.02
A9700	G	Echocardiography contrast per study [per 3 ml]	9016		$118.75		$17.00
A9900	A	Supply/accessory/service					
A9901	A	Delivery/set up/dispensing					
B4034	A	Enter feed supkit syr by day					
B4035	A	Enteral feed supp pump per d					
B4036	A	Enteral feed sup kit grav by					
B4081	A	Enteral ng tubing w/ stylet					
B4082	A	Enteral ng tubing w/o stylet					
B4083	A	Enteral stomach tube levine					
B4084	D	Gastrostomy/jejunostomy tubi					
B4085	D	Gastrostomy tube w/ring each					
*B4086	A	Gastrostomy/jejunostomy tube					
B4150	A	Enteral formulae category i					
B4151	A	Enteral formulae cat1natural					
B4152	A	Enteral formulae category ii					
B4153	A	Enteral formulae categoryIII					
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-amirosy					
B5100	A	Parenteral sol hepatic-fream					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
C1010	K	Blood, L/R, CMV-neg	1010	2.72	$138.46		$27.69
C1011	K	Platelets, HLA-m, L/R, unit	1011	11.21	$570.63		$114.13
C1012	K	Platelet conc, L/R, irrad	1012	1.81	$92.14		$18.43
C1013	K	Platelet conc, L/R, unit	1013	1.11	$56.50		$11.30
C1014	K	Platelet,aph/pher, L/R, unit	1014	8.45	$430.14		$86.03
C1016	K	Blood,l/r,froz/degly/washed	1016	6.76	$344.11		$68.82
C1017	K	Plt, aph/pher,l/r,cmv-neg	1017	8.82	$448.97		$89.79
C1018	K	Blood, L/R, irradiated	1018	2.96	$150.68		$30.14
C1019	D	Plt, APH,PHER, L/R, IRRAD	1019	9.11	$463.74		$92.75
C1050	D	Prosorba Column	0976		$875.00		$175.00
*C1058	G	TC 99M oxidronate, per vial	1058		$36.74		$5.26
*C1064	G	I–131 cap, each add mCi	1064		$5.86		$.75
*C1065	G	I–131 sol, each add mCi	1065		$15.81		$2.03
*C1066	G	IN 111 satumomab pendetide	1066		$1,591.25		$227.80
C1079	G	Co 57/58 0.5 uCi	1079		$253.84		$36.34
C1087	G	I–123 per 100 uCi	1087		$.65		$.06
C1088	T	Laser optic tr sys	0980		$1,875.00		$375.00
C1090	D	IN 111 chloride, per mCi					
C1091	G	IN111 oxyquinoline,per0.5mCi	1091		$427.50		$61.20
C1092	G	IN 111 pentetate, per 0.5 mCi	1092		$256.50		$23.22
C1094	G	TC 99M albumin aggr, 1.0 mCi	1094		$33.09		$4.25
C1095	D	TC 99M Depreotide, per vial	1095		$38.00		$5.44
C1096	G	TC 99M exametazime, per dose	1096		$445.31		$63.75
C1097	G	TC 99M mebrofenin, per vial	1097		$51.44		$7.36
C1098	G	TC 99M pentetate, per vial	1098		$22.43		$2.88
C1099	G	TC 99M pyrophosphate,per vial	1099		$39.11		$5.60
C1122	G	TC 99M arcitumomab per vial	1122		$1,235.00		$176.80
C1166	G	Cytarabine liposomal, 10 mg	1166		$371.45		$53.18
C1167	G	Epirubicin hcl, 2 mg	1167		$24.94		$3.57
C1178	G	Busulfan IV, 6 mg	1178		$26.48		$3.79
C1188	G	I–131 cap, per 1–5 mCi	1188		$117.25		$15.06
C1200	G	TC 99M Sodium Glucoheptonat	1200		$22.61		$3.24
C1201	G	TC 99M succimer, per vial	1201		$135.66		$19.42
C1202	G	TC 99M sulfur colloid, dose	1202		$76.00		$9.76
C1207	G	Octreotide acetate depot 1 mg	1207		$138.08		$19.77
C1300	T	Hyperbaric oxygen	0971		$75.00		$15.00
C1305	G	Apligraf	1305		$1,157.81		$165.75
C1348	G	I–131 sol, per 1–6 mCi	1348		$146.57		$18.82
C1713	H	Anchor/screw bn/bn,tis/bn	1713				
C1714	H	Cath, trans atherectomy, dir	1714				
C1715	H	Brachytherapy needle	1715				
C1716	H	Brachytx seed, Gold 198	1716				
C1717	H	Brachytx seed, HDR Ir–192	1717				
C1718	H	Brachytx seed, Iodine 125	1718				
C1719	H	Brachytxseed, Non-HDR Ir–192	1719				
C1720	H	Brachytx seed, Palladium 103	1720				
C1721	H	AICD, dual chamber	1721				
C1722	H	AICD, single chamber	1722				
C1723	D	Cath, ablation, non-cardiac					
C1724	H	Cath, trans atherec,rotation	1724				
C1725	H	Cath, translumin non-laser	1725				
C1726	H	Cath, bal dil, non-vascular	1726				
C1727	H	Cath, bal tis dis, non-vas	1727				
C1728	H	Cath, brachytx seed adm	1728				
C1729	H	Cath, drainage	1729				
C1730	H	Cath, EP, 19 or fewer elect	1730				
C1731	H	Cath, EP, 20 or more elec	1731				
C1732	H	Cath, EP, diag/abl, 3D/vect	1732				
C1733	H	Cath, EP, othr than cool-tip	1733				
C1750	H	Cath, hemodialysis,long-term	1750				
C1751	H	Cath, inf, per/cent/midline	1751				
C1752	H	Cath, hemodialysis,short-term	1752				
C1753	H	Cath, intravas ultrasound	1753				
C1754	H	Catheter, intradiscal	1754				
C1755	H	Catheter, intraspinal	1755				
C1756	H	Cath, pacing, transesoph	1756				
C1757	H	Cath, thrombectomy/embolect	1757				
C1758	H	Cath, ureteral	1758				

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1759	H	Cath, intra echocardiography	1759				
C1760	H	Closure dev, vasc, imp/insert	1760				
C1762	H	Conn tiss, human (inc fascia)	1762				
C1763	H	Conn tiss, non-human	1763				
C1764	H	Event recorder, cardiac	1764				
C1765	H	Adhesion barrier	1765				
C1766	H	Intro/sheath,strble,non-peel	1766				
C1767	H	Generator, neurostim, imp	1767				
C1768	H	Graft, vascular	1768				
C1769	H	Guide wire	1769				
C1770	H	Imaging coil, MR, insertable	1770				
C1771	H	Rep dev, urinary, w/sling	1771				
C1772	H	Infusion pump, programmable	1772				
C1773	H	Retrieval dev, insert	1773				
C1776	H	Joint device (implantable)	1776				
C1777	H	Lead, AICD, endo single coil	1777				
C1778	H	Lead, neurostimulator	1778				
C1779	H	Lead, pmkr, transvenous VDD	1779				
C1780	H	Lens, intraocular	1780				
C1781	H	Mesh (implantable)	1781				
C1782	H	Morcellator	1782				
C1784	H	Ocular dev, intraop, det ret	1784				
C1785	H	Pmkr, dual, rate-resp	1785				
C1786	H	Pmkr, single, rate-resp	1786				
C1787	H	Patient progr, neurostim	1787				
C1788	H	Port, indwelling, imp	1788				
C1789	H	Prosthesis, breast, imp	1789				
C1813	H	Prosthesis, penile, inflatab	1813				
C1815	H	Pros, urinary sph, imp	1815				
C1816	H	Receiver/transmitter, neuro	1816				
C1817	H	Septal defect imp sys	1817				
C1874	H	Stent, coated/cov w/del sys	1874				
C1875	H	Stent, coated/cov w/o del sy	1875				
C1876	H	Stent, non-coa/no-cov w/del	1876				
C1877	H	Stent, non-coat/cov w/o del	1877				
C1878	H	Matrl for vocal cord	1878				
C1879	H	Tissue marker, imp	1879				
C1880	H	Vena cava filter	1880				
C1881	H	Dialysis access system	1881				
C1882	H	AICD, other than sing/dual	1882				
C1883	H	Adapt/ext, pacing/neuro lead	1883				
C1885	H	Cath, translumin angio laser	1885				
C1887	H	Catheter, guiding	1887				
C1891	H	Infusion pump,non-prog,perm	1891				
C1892	H	Intro/sheath,fixed,peel-away	1892				
C1893	H	Intro/sheath,fixed,non-peel	1893				
C1894	H	Intro/sheath, non-laser	1894				
C1895	H	Lead, AICD, endo dual coil	1895				
C1896	H	Lead, AICD, non sing/dual	1896				
C1897	H	Lead, neurostim test kit	1897				
C1898	H	Lead, pmkr, other than trans	1898				
C1899	H	Lead, pmkr/AICD combination	1899				
C2615	H	Sealant, pulmonary, liquid	2615				
C2616	H	Brachytx seed, Yttrium-90	2616				
C2617	H	Stent, non-cor, tem w/o del	2617				
C2618	H	Probe, cryoablation	2618				
C2619	H	Pmkr, dual, non rate-resp	2619				
C2620	H	Pmkr, single, non rate-resp	2620				
C2621	H	Pmkr, other than sing/dual	2621				
C2622	H	Prosthesis, penile, non-inf	2622				
C2625	H	Stent, non-cor, tem w/del sys	2625				
C2626	H	Infusion pump, non-prog,temp	2626				
C2627	H	Cath, suprapubic/cystoscopic	2627				
C2628	H	Catheter, occlusion	2628				
C2629	H	Intro/sheath, laser	2629				
C2630	H	Cath, EP, cool-tip	2630				
C2631	H	Rep dev, urinary, w/o sling	2631				
C8900	S	MRA w/cont, abd	0284	7.15	$363.96	$200.17	$72.79
C8901	S	MRA w/o cont, abd	0336	6.29	$320.19	$176.10	$64.04
C8902	S	MRA w/o fol w/cont, abd	0337	8.54	$434.72	$239.09	$86.94
C8903	S	MRI w/cont, breast, uni	0284	7.15	$363.96	$200.17	$72.79
C8904	S	MRI w/o cont, breast, uni	0336	6.29	$320.19	$176.10	$64.04
C8905	S	MRI w/o fol w/cont, brst, uni	0337	8.54	$434.72	$239.09	$86.94
C8906	S	MRI w/cont, breast, bi	0284	7.15	$363.96	$200.17	$72.79
C8907	S	MRI w/o cont, breast, bi	0336	6.29	$320.19	$176.10	$64.04

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C8908	S	MRI w/o fol w/cont, breast, bi	0337	8.54	$434.72	$239.09	$86.94
C8909	S	MRA w/cont, chest	0284	7.15	$363.96	$200.17	$72.79
C8910	S	MRA w/o cont, chest	0336	6.29	$320.19	$176.10	$64.04
C8911	S	MRA w/o fol w/cont, chest	0337	8.54	$434.72	$239.09	$86.94
C8912	S	MRA w/cont, lwr ext	0284	7.15	$363.96	$200.17	$72.79
C8913	S	MRA w/o cont, lwr ext	0336	6.29	$320.19	$176.10	$64.04
C8914	S	MRA w/o fol w/cont, lwr ext	0337	8.54	$434.72	$239.09	$86.94
C9000	G	Na chromatecr51, per 0.25mCi	9000	.....	$.52	.....	$.07
C9001	D	Linezolid inj, 200 mg	9001	.....	$24.13	.....	$3.45
C9002	D	Tenecteplase, 50 mg/vial	9002	.....	$2,612.50	.....	$374.00
C9003	G	Palivizumab, per 50 mg	9003	.....	$664.49	.....	$95.13
C9004	D	Gemtuzumab ozogaminicin inj, 5m	9004	.....	$1,929.69	.....	$276.25
C9006	D	Tacrolimus inj, per 5 mg	9006	.....	$113.15	.....	$16.20
C9007	G	Baclofen intrathecal kit-1amp	9007	.....	$79.80	.....	$11.42
C9008	G	Baclofen Refill Kit-500 mcg	9008	.....	$11.69	.....	$1.67
C9009	G	Baclofen Refill Kit-2000 mcg	9009	.....	$49.12	.....	$7.03
C9010	G	Baclofen refill kitu per 4000 mcg	9010	.....	$43.08	.....	$6.17
C9011	D	Caffeine Citrate, inj, 1ml	9011	.....	$3.05	.....	$.44
C9012	D	Injection, arsenic trioxide	9012	.....	$23.75	.....	$3.40
C9013	G	Co 57 cobaltous chloride	9013	.....	$81.10	.....	$10.41
C9018	D	Botulinum tox B, per 100 u	9018	.....	$8.79	.....	$1.26
C9019	G	Caspofungin acetate, per 5 mg	9019	.....	$34.20	.....	$4.90
C9020	G	Sirolimus tablet, 1 mg	9020	.....	$6.51	.....	$.93
C9100	G	Iodinated I–131 Albumin	9100	.....	$10.34	.....	$1.48
C9102	G	51 Na Chromate, 50mCi	9102	.....	$64.84	.....	$9.28
C9103	G	Na Iothalamate I–125, 10 uCi	9103	.....	$17.18	.....	$2.46
C9104	D	Anti-thymocyct globulin, 25 mg	9104	.....	$325.09	.....	$46.54
C9105	G	Hep B imm glob, per 1 ml	9105	.....	$133.00	.....	$17.08
C9108	G	Thyrotropin alfa, 1.1 mg	9108	.....	$531.05	.....	$76.02
C9109	G	Tirofiban hcl, 6.25 mg	9109	.....	$207.81	.....	$29.75
C9110	G	Alemtuzumab, per 10 mg/ml	9110	.....	$486.88	.....	$69.70
*C9111	G	Inj, bivalirudin, 250 mg vial	9111	.....	$397.81	.....	$56.95
*C9112	G	Perflutren lipid micro, 2ml	9112	.....	$148.20	.....	$21.22
*C9113	G	Inj pantoprazole sodium, vial	9113	.....	$22.80	.....	$3.26
*C9114	G	Nesiritide, per 1.5 mg vial	9114	.....	$433.20	.....	$62.02
*C9115	G	Inj, zoledronic acid, 2 mg	9115	.....	$406.78	.....	$58.23
*C9200	G	Orcel, per 36 cm2	9200	.....	$1,135.25	.....	$162.52
*C9201	G	Dermagraft, per 37.5 sq cm	9201	.....	$577.60	.....	$82.69
C9503	K	Fresh frozen plasma, ea unit	9503	1.56	$79.41	.....	$15.88
C9506	D	Granulocytes, pheresis	9506	27.75	$1,412.59	.....	$282.52
C9700	D	Water induced thermo	0977	.....	$1,125.00	.....	$225.00
C9701	T	Stretta procedure	0980	.....	$1,875.00	.....	$375.00
C9702	D	Chkmate/Novost/Galileo Brach	0981	.....	$2,250.00	.....	$450.00
*C9703	T	Bard Endoscopic Suturing Sys	0979	.....	$1,625.00	.....	$325.00
C9708	T	Preview Tx Planning Software	0975	.....	$625.00	.....	$125.00
C9711	T	H.E.L.P. Apheresis System	0978	.....	$1,375.00	.....	$275.00
D0120	E	Periodic oral evaluation	.....	.....	.....	.....	.....
D0140	E	Limit oral eval problm focus	.....	.....	.....	.....	.....
D0150	S	Comprehensve oral evaluation	0330	10.97	$558.42	.....	$111.68
D0160	E	Extensv oral eval prob focus	.....	.....	.....	.....	.....
D0170	E	Re-eval,est pt,problem focus	.....	.....	.....	.....	.....
D0210	E	Intraor complete film series	.....	.....	.....	.....	.....
D0220	E	Intraoral periapical first f	.....	.....	.....	.....	.....
D0230	E	Intraoral periapical ea add	.....	.....	.....	.....	.....
D0240	S	Intraoral occlusal film	0330	10.97	$558.42	.....	$111.68
D0250	S	Extraoral first film	0330	10.97	$558.42	.....	$111.68
D0260	S	Extraoral ea additional film	0330	10.97	$558.42	.....	$111.68
D0270	S	Dental bitewing single film	0330	10.97	$558.42	.....	$111.68
D0272	S	Dental bitewings two films	0330	10.97	$558.42	.....	$111.68
D0274	S	Dental bitewings four films	0330	10.97	$558.42	.....	$111.68
D0277	S	Vert bitewings-sev to eight	0330	10.97	$558.42	.....	$111.68
D0290	E	Dental film skull/facial bon	.....	.....	.....	.....	.....
D0310	E	Dental saliography	.....	.....	.....	.....	.....
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	.....	.....	.....	.....	.....
D0350	E	Oral/facial images	.....	.....	.....	.....	.....
D0415	E	Bacteriologic study	.....	.....	.....	.....	.....
D0425	E	Caries susceptibility test	.....	.....	.....	.....	.....
D0460	S	Pulp vitality test	0330	10.97	$558.42	.....	$111.68
D0470	E	Diagnostic casts	.....	.....	.....	.....	.....
D0472	S	Gross exam, prep & report	0330	10.97	$558.42	.....	$111.68
D0473	S	Micro exam, prep & report	0330	10.97	$558.42	.....	$111.68

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0474	S	Micro w exam of surg margins	0330	10.97	$558.42		$111.68
D0480	S	Cytopath smear prep & report	0330	10.97	$558.42		$111.68
D0501	S	Histopathologic examinations	0330	10.97	$558.42		$111.68
D0502	S	Other oral pathology procedu	0330	10.97	$558.42		$111.68
D0999	S	Unspecified diagnostic proce	0330	10.97	$558.42		$111.68
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					
D1510	S	Space maintainer fxd unilat	0330	10.97	$558.42		$111.68
D1515	S	Fixed bilat space maintainer	0330	10.97	$558.42		$111.68
D1520	S	Remove unilat space maintain	0330	10.97	$558.42		$111.68
D1525	S	Remove bilat space maintain	0330	10.97	$558.42		$111.68
D1550	S	Recement space maintainer	0330	10.97	$558.42		$111.68
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					
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					
D2337	E	Compo resin crown ant-perm					
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					
D2388	E	Resin four/more, post perm					
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 metallic 2 surf					
D2530	E	Dental inlay metl 3/more sur					
D2542	E	Dental onlay metallic 2 surf					
D2543	E	Dental onlay metallic 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					
D2780	E	Crown 3/4 cast hi noble met					
D2781	E	Crown 3/4 cast base metal					
D2782	E	Crown 3/4 cast noble metal					
D2783	E	Crown 3/4 porcelain/ceramic					
D2790	E	Crown full cast high noble m					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2791	E	Crown full cast base metal					
D2792	E	Crown full cast noble metal					
D2799	E	Provisional crown					
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					
D2953	E	Each addtnl cast post					
D2954	E	Prefab post/core + crown					
D2955	E	Post removal					
D2957	E	Each addtnl prefab post					
D2960	E	Laminate labial veneer					
D2961	E	Lab labial veneer resin					
D2962	E	Lab labial veneer porcelain					
D2970	S	Temporary- fractured tooth	0330	10.97	$558.42		$111.68
D2980	E	Crown repair					
D2999	S	Dental unspec restorative pr	0330	10.97	$558.42		$111.68
D3110	E	Pulp cap direct					
D3120	E	Pulp cap indirect					
D3220	E	Therapeutic pulpotomy					
D3221	E	Gross pulpal debridement					
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					
D3331	E	Non-surg tx root canal obs					
D3332	E	Incomplete endodontic tx					
D3333	E	Internal root repair					
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	0330	10.97	$558.42		$111.68
D3470	E	Intentional replantation					
D3910	E	Isolation- tooth w rubb dam					
D3920	E	Tooth splitting					
D3950	E	Canal prep/fitting of dowel					
D3999	S	Endodontic procedure	0330	10.97	$558.42		$111.68
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					
D4245	E	Apically positioned flap					
D4249	E	Crown lengthen hard tissue					
D4260	S	Osseous surgery per quadrant	0330	10.97	$558.42		$111.68
D4263	S	Bone replce graft first site	0330	10.97	$558.42		$111.68
D4264	S	Bone replce graft each add	0330	10.97	$558.42		$111.68
D4266	E	Guided tiss regen resorble					
D4267	E	Guided tiss regen nonresorb					
D4268	S	Surgical revision procedure	0330	10.97	$558.42		$111.68
D4270	S	Pedicle soft tissue graft pr	0330	10.97	$558.42		$111.68
D4271	S	Free soft tissue graft proc	0330	10.97	$558.42		$111.68
D4273	S	Subepithelial tissue graft	0330	10.97	$558.42		$111.68
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	0330	10.97	$558.42		$111.68
D4381	S	Localized chemo delivery	0330	10.97	$558.42		$111.68
D4910	E	Periodontal maint procedures					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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 condtin mandbl					
D5860	E	Overdenture complete					
D5861	E	Overdenture partial					
D5862	E	Precision attachment					
D5867	E	Replacement of precision att					
D5875	E	Prosthesis modification					
D5899	E	Removable prosthodontic proc					
D5911	S	Facial moulage sectional	0330	10.97	$558.42		$111.68
D5912	S	Facial moulage complete	0330	10.97	$558.42		$111.68
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					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5959	E	Intraoral con def mod palat					
D5960	E	Modify speech aid prosthesis					
D5982	E	Surgical stent					
D5983	S	Radiation applicator	0330	10.97	$558.42		$111.68
D5984	S	Radiation shield	0330	10.97	$558.42		$111.68
D5985	S	Radiation cone locator	0330	10.97	$558.42		$111.68
D5986	E	Fluoride applicator					
D5987	S	Commissure splint	0330	10.97	$558.42		$111.68
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					
D6056	E	Prefabricated abutment					
D6057	E	Custom abutment					
D6058	E	Abutment supported crown					
D6059	E	Abutment supported mtl crown					
D6060	E	Abutment supported mtl crown					
D6061	E	Abutment supported mtl crown					
D6062	E	Abutment supported mtl crown					
D6063	E	Abutment supported mtl crown					
D6064	E	Abutment supported mtl crown					
D6065	E	Implant supported crown					
D6066	E	Implant supported mtl crown					
D6067	E	Implant supported mtl crown					
D6068	E	Abutment supported retainer					
D6069	E	Abutment supported retainer					
D6070	E	Abutment supported retainer					
D6071	E	Abutment supported retainer					
D6072	E	Abutment supported retainer					
D6073	E	Abutment supported retainer					
D6074	E	Abutment supported retainer					
D6075	E	Implant supported retainer					
D6076	E	Implant supported retainer					
D6077	E	Implant supported retainer					
D6078	E	Implnt/abut suprtd fixd dent					
D6079	E	Implnt/abut suprtd fixd dent					
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					
D6245	E	Bridge porcelain/ceramic					
D6250	E	Bridge resin w/high noble					
D6251	E	Bridge resin base metal					
D6252	E	Bridge resin w/noble metal					
D6519	E	Inlay/onlay porce/ceramic					
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					
D6548	E	Porcelain/ceramic retainer					
D6720	E	Retain crown resin w hi nble					
D6721	E	Crown resin w/base metal					
D6722	E	Crown resin w/noble metal					
D6740	E	Crown porcelain/ceramic					
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					
D6781	E	Crown 3/4 cast based metal					
D6782	E	Crown 3/4 cast noble metal					
D6783	E	Crown 3/4 porcelain/ceramic					
D6790	E	Crown full high noble metal					
D6791	E	Crown full base metal cast					
D6792	E	Crown full noble metal cast					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6920	S	Dental connector bar	0330	10.97	$558.42	.....	$111.68
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	.....	.....	.....	.....	.....
D6976	E	Each addtnl cast post	.....	.....	.....	.....	.....
D6977	E	Each addtl prefab post	.....	.....	.....	.....	.....
D6980	E	Bridge repair	.....	.....	.....	.....	.....
D6999	E	Fixed prosthodontic proc	.....	.....	.....	.....	.....
D7110	S	Oral surgery single tooth	0330	10.97	$558.42	.....	$111.68
D7120	S	Each add tooth extraction	0330	10.97	$558.42	.....	$111.68
D7130	S	Tooth root removal	0330	10.97	$558.42	.....	$111.68
D7210	S	Rem imp tooth w mucoper flp	0330	10.97	$558.42	.....	$111.68
D7220	S	Impact tooth remov soft tiss	0330	10.97	$558.42	.....	$111.68
D7230	S	Impact tooth remov part bony	0330	10.97	$558.42	.....	$111.68
D7240	S	Impact tooth remov comp bony	0330	10.97	$558.42	.....	$111.68
D7241	S	Impact tooth rem bony w/comp	0330	10.97	$558.42	.....	$111.68
D7250	S	Tooth root removal	0330	10.97	$558.42	.....	$111.68
D7260	S	Oral antral fistula closure	0330	10.97	$558.42	.....	$111.68
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	0330	10.97	$558.42	.....	$111.68
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	.....	.....	.....	.....	.....
D7471	E	Rem exostosis any site	.....	.....	.....	.....	.....
D7480	E	Partial ostectomy	.....	.....	.....	.....	.....
D7490	E	Mandible resection	.....	.....	.....	.....	.....
D7510	E	I&d absc 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	Closd rductn splint alveolus	.....	.....	.....	.....	.....
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 reduc 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	.....	.....	.....	.....	.....

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
D7871	E	Lysis + lavage w catheters					
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	0330	10.97	$558.42		$111.68
D7941	E	Bone cutting ramus closed					
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					
D7997	E	Appliance removal					
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 transitn					
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 orthodontc tx visit					
D8680	E	Orthodontic retention					
D8690	E	Orthodontic treatment					
D8691	E	Repair ortho appliance					
D8692	E	Replacement retainer					
D8999	E	Orthodontic procedure					
D9110	N	Tx dental pain minor proc					
D9210	E	Dent anesthesia w/o surgery					
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					
D9241	E	Intravenous sedation					
D9242	E	IV sedation ea ad 30 m					
D9248	N	Sedation (non-iv)					
D9310	E	Dental consultation					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0330	10.97	$558.42		$111.68
D9910	E	Dent appl desensitizing med					
D9911	E	Appl desensitizing resin					
D9920	E	Behavior management					
D9930	S	Treatment of complications	0330	10.97	$558.42		$111.68
D9940	S	Dental occlusal guard	0330	10.97	$558.42		$111.68
D9941	E	Fabrication athletic guard					
D9950	S	Occlusion analysis	0330	10.97	$558.42		$111.68
D9951	S	Limited occlusal adjustment	0330	10.97	$558.42		$111.68
D9952	S	Complete occlusal adjustment	0330	10.97	$558.42		$111.68
D9970	E	Enamel microabrasion					
D9971	E	Odontoplasty 1–2 teeth					
D9972	E	Extrnl bleaching per arch					
D9973	E	Extrnl bleaching per tooth					
D9974	E	Intrnl bleaching per tooth					
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					
E0144	A	Enclosed walker w rear seat					
E0145	A	Walker whled seat/crutch att					
E0146	A	Folding walker wheels w seat					
E0147	A	Walker variable wheel resist					
E0148	A	Heavyduty walker no wheels					
E0149	A	Heavy duty wheeled walker					
E0153	A	Forearm crutch platform atta					
E0154	A	Walker platform attachment					
E0155	A	Walker wheel attachment,pair					
E0156	A	Walker seat attachment					
E0157	A	Walker crutch attachment					
E0158	A	Walker leg extenders set of4					
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					
E0168	A	Heavyduty/wide commode chair					
*E0169	A	Seatlift incorp commodechair					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0196	A	Gel pressure mattress					
E0197	A	Air pressure pad for mattres					
E0198	A	Water pressure pad for mattr					
E0199	A	Dry pressure pad for mattres					
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	E	Water circ cold pad w pump					
E0220	A	Hot water bottle					
*E0221	A	Infrared heating pad system					
E0225	A	Hydrocollator unit					
E0230	A	Ice cap or collar					
*E0231	A	Wound warming device					
*E0232	A	Warming card for NWT					
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	E	Transfer tub rail attachment					
E0249	A	Pad water circulating heat u					
E0250	A	Hosp bed fixed ht w/ mattres					
E0251	A	Hosp bed fixd ht w/o mattres					
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/ mat					
E0266	A	Hosp bed total elec w/o matt					
E0270	E	Hospital bed institutional t					
E0271	A	Mattress innerspring					
E0272	A	Mattress foam rubber					
E0273	E	Bed board					
E0274	E	Over-bed table					
E0275	A	Bed pan standard					
E0276	A	Bed pan fracture					
E0277	A	Powered pres-redu air mattrs					
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					
E0298	D	Heavyduty/xtra wide hosp bed					
E0305	A	Rails bed side half length					
E0310	A	Rails bed side full length					
E0315	E	Bed accessory brd/tbl/supprt					
*E0316	A	Bed safety enclosure					
E0325	A	Urinal male jug-type					
E0326	A	Urinal female jug-type					
E0350	E	Control unit bowel system					
E0352	E	Disposable pack w/bowel syst					
E0370	E	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 02					
E0425	E	Gas system stationary compre					
E0430	E	Oxygen system gas portable					
E0431	A	Portable gaseous 02					
E0434	A	Portable liquid 02					
E0435	E	Oxygen system liquid portabl					
E0439	A	Stationary liquid 02					
E0440	E	Oxygen system liquid station					
E0441	A	Oxygen contents, gaseous					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0442	A	Oxygen contents, liquid					
E0443	A	Portable 02 contents, gas					
E0444	A	Portable 02 contents, liquid					
E0450	A	Volume vent stationary/porta					
E0455	A	Oxygen tent excl croup/ped t					
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					
*E0481	A	Intrpulmnry percuss vent sys					
*E0482	A	Cough stimulating device					
E0500	A	Ippb all types					
E0550	A	Humidif extens supple 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					
E0571	A	Aerosol compressor for svneb					
E0572	A	Aerosol compressor adjust pr					
E0574	A	Ultrasonic generator w svneb					
E0575	A	Nebulizer ultrasonic					
E0580	A	Nebulizer for use w/ regulat					
E0585	A	Nebulizer w/ compressor & he					
E0590	A	Dispensing fee dme neb drug					
E0600	A	Suction pump portab hom modl					
E0601	A	Cont airway pressure device					
E0602	E	Breast pump					
*E0603	A	Electric breast pump					
*E0604	A	Hosp grade elec breast pump					
E0605	A	Vaporizer room type					
E0606	A	Drainage board postural					
E0607	A	Blood glucose monitor home					
E0608	A	Apnea monitor					
E0609	D	Blood gluc mon w/special fea					
E0610	A	Pacemaker monitr audible/vis					
E0615	A	Pacemaker monitr digital/vis					
E0616	N	Cardiac event recorder					
E0617	A	Automatic ext defibrillator					
*E0620	A	Cap bld skin piercing laser					
E0621	A	Patient lift sling or seat					
E0625	E	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	E	Safety equipment					
E0710	E	Restraints any type					
E0720	A	Tens two lead					
E0730	A	Tens four lead					
E0731	A	Conductive garment for tens/					
E0740	E	Incontinence treatment systm					
E0744	A	Neuromuscular stim for scoli					
E0745	A	Neuromuscular stim for shock					
E0746	E	Electromyograph biofeedback					
E0747	A	Elec osteogen stim not spine					
E0748	A	Elec osteogen stim spinal					
E0749	N	Elec osteogen stim implanted					
*E0752	E	Neurostimulator electrode					
E0753	D	Neurostimulator electrodes					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*E0754	A	Pulsegenerator pt programmer					
E0755	E	Electronic salivary reflex s					
E0756	E	Implantable pulse generator					
E0757	E	Implantable RF receiver					
E0758	A	External RF transmitter					
*E0759	A	Replace rdfrquncy transmittr					
E0760	E	Osteogen ultrasound stimltor					
E0765	E	Nerve stimulator for tx n&v					
E0776	A	Iv pole					
E0779	A	Amb infusion pump mechanical					
E0780	A	Mech amb infusion pump <8hrs					
E0781	A	External ambulatory infus pu					
E0782	E	Non-programble infusion pump					
E0783	E	Programmable infusion pump					
E0784	A	Ext amb infusn pump insulin					
E0785	E	Replacement impl pump cathet					
E0786	E	Implantable pump replacement					
E0791	A	Parenteral infusion pump sta					
E0830	N	Ambulatory traction device					
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					
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	E	Tray					
E0951	E	Loop heel					
E0952	E	Loop tie					
E0953	E	Pneumatic tire					
E0954	E	Wheelchair semi-pneumatic ca					
E0958	A	Whlchr att- conv 1 arm drive					
E0959	E	Amputee adapter					
E0961	E	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	E	Wheelchair head rest extensi					
E0967	E	Wheelchair hand rims					
E0968	A	Wheelchair commode seat					
E0969	E	Wheelchair narrowing device					
E0970	E	Wheelchair no. 2 footplates					
E0971	E	Wheelchair anti-tipping devi					
E0972	A	Transfer board or device					
E0973	E	Wheelchair adjustabl height					
E0974	E	Wheelchair grade-aid					
E0975	E	Wheelchair reinforced seat u					
E0976	E	Wheelchair reinforced back u					
E0977	E	Wheelchair wedge cushion					
E0978	E	Wheelchair belt w/airplane b					
E0979	E	Wheelchair belt with velcro					
E0980	E	Wheelchair safety vest					
E0990	E	Whellchair elevating leg res					
E0991	E	Wheelchair upholstry seat					
E0992	E	Wheelchair solid seat insert					
E0993	E	Wheelchair back upholstery					
E0994	E	Wheelchair arm rest					
E0995	E	Wheelchair calf rest					
E0996	E	Wheelchair tire solid					
E0997	E	Wheelchair caster w/ a fork					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0998	E	Wheelchair caster w/o a fork					
E0999	E	Wheelchr pneumatic tire w/wh					
E1000	E	Wheelchair tire pneumatic ca					
E1001	E	Wheelchair wheel					
E1031	A	Rollabout chair with casters					
E1035	E	Patient transfer system					
E1050	A	Whelchr fxd full length arms					
E1060	A	Wheelchair detachable arms					
E1065	E	Wheelchair power attachment					
E1066	E	Wheelchair battery charger					
E1069	E	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					
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	E	Wheelchair spec sz full-recl					
E1227	E	Wheelchair spec sz spec ht a					
E1228	A	Wheelchair spec sz spec ht b					
E1230	A	Power operated vehicle					
E1240	A	Whchr 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	Whchr 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	E	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					
E1390	A	Oxygen concentrator					
E1399	A	Durable medical equipment mi					
E1405	A	O2/water vapor enrich w/heat					
E1406	A	O2/water vapor enrich w/o he					
*E1500	A	Centrifuge					
E1510	A	Kidney dialysate delivry sys					
E1520	A	Heparin infusion pump for di					
E1530	A	Air bubble detector for dial					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
E1635	A	Compact travel hemodialyzer					
E1636	A	Sorbent cartridges for dialy					
*E1637	A	Hemostats for dialysis, each					
*E1638	A	Peri dialysis heating pad					
*E1639	A	Dialysis scale					
E1640	D	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					
*E1801	A	SPS elbow device					
E1805	A	Adjust wrist ext/flex device					
*E1806	A	SPS wrist device					
E1810	A	Adjust knee ext/flex device					
*E1811	A	SPS knee device					
E1815	A	Adjust ankle ext/flex device					
*E1816	A	SPS ankle device					
*E1818	A	SPS forearm device					
E1820	A	Soft interface material					
*E1821	A	Replacement interface SPSD					
E1825	A	Adjust finger ext/flex devc					
E1830	A	Adjust toe ext/flex device					
*E1840	A	Adj shoulder ext/flex device					
E1900	D	Speech communication device					
*E1902	A	AAC non-electronic board					
*E2000	A	Gastric suction pump hme mdl					
*E2100	A	Bld glucose monitor w voice					
*E2101	A	Bld glucose monitor w lance					
G0001	A	Drawing blood for specimen					
G0002	N	Temporary urinary catheter					
G0004	E	ECG transm phys review & int					
G0005	X	ECG 24 hour recording	0097	0.84	$42.76	$23.51	$8.55
G0006	X	ECG transmission & analysis	0097	0.84	$42.76	$23.51	$8.55
G0007	N	ECG phy review & interpret					
G0008	K	Admin influenza virus vac	0354	0.10	$5.09		
G0009	K	Admin pneumococcal vaccine	0354	0.10	$5.09		
G0010	N	Admin hepatitis b vaccine					
G0015	X	Post symptom ECG tracing	0097	0.84	$42.76	$23.51	$8.55
G0016	D	Post symptom ECG md review					
G0025	N	Collagen skin test kit					
G0026	A	Fecal leukocyte examination					
G0027	A	Semen analysis					
G0030	S	PET imaging prev PET single	0285	18.72	$952.92	$415.21	$190.58
G0031	S	PET imaging prev PET multple	0285	18.72	$952.92	$415.21	$190.58
G0032	S	PET follow SPECT 78464 singl	0285	18.72	$952.92	$415.21	$190.58
G0033	S	PET follow SPECT 78464 mult	0285	18.72	$952.92	$415.21	$190.58
G0034	S	PET follow SPECT 76865 singl	0285	18.72	$952.92	$415.21	$190.58
G0035	S	PET follow SPECT 78465 mult	0285	18.72	$952.92	$415.21	$190.58
G0036	S	PET follow cornry angio sing	0285	18.72	$952.92	$415.21	$190.58
G0037	S	PET follow cornry angio mult	0285	18.72	$952.92	$415.21	$190.58
G0038	S	PET follow myocard perf sing	0285	18.72	$952.92	$415.21	$190.58
G0039	S	PET follow myocard perf mult	0285	18.72	$952.92	$415.21	$190.58
G0040	S	PET follow stress echo singl	0285	18.72	$952.92	$415.21	$190.58
G0041	S	PET follow stress echo mult	0285	18.72	$952.92	$415.21	$190.58
G0042	S	PET follow ventriculogm sing	0285	18.72	$952.92	$415.21	$190.58
G0043	S	PET follow ventriculogm mult	0285	18.72	$952.92	$415.21	$190.58
G0044	S	PET following rest ECG singl	0285	18.72	$952.92	$415.21	$190.58
G0045	S	PET following rest ECG mult	0285	18.72	$952.92	$415.21	$190.58

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0046	S	PET follow stress ECG singl	0285	18.72	$952.92	$415.21	$190.58
G0047	S	PET follow stress ECG mult	0285	18.72	$952.92	$415.21	$190.58
G0050	S	Residual urine by ultrasound	0265	0.95	$48.36	$26.59	$9.67
G0101	V	CA screen;pelvic/breast exam	0600	0.86	$43.78		$8.76
G0102	N	Prostate ca screening; dre					
G0103	A	Psa, total screening					
G0104	S	CA screen;flexi sigmoidscope	0159	2.33	$118.61	$29.65	$23.72
G0105	T	Colorectal scrn; hi risk ind	0158	6.55	$333.42	$83.36	$66.68
G0106	S	Colon CA screen;barium enema	0157	1.98	$100.79	$22.19	$20.16
G0107	A	CA screen; fecal blood test					
G0108	A	Diab manage trn per indiv					
G0109	A	Diab manage trn ind/group					
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					
*G0117	S	Glaucoma scrn hgh risk direc	0230	0.61	$31.05	$14.28	$6.21
*G0118	S	Glaucoma scrn hgh risk direc	0230	0.61	$31.05	$14.28	$6.21
G0120	S	Colon ca scrn; barium enema	0157	1.98	$100.79	$22.19	$20.16
G0121	T	Colon ca scrn not hi rsk ind	0158	6.55	$333.42	$83.36	$66.68
G0122	E	Colon ca scrn; barium enema					
G0123	A	Screen cerv/vag thin layer					
G0124	A	Screen c/v thin layer by MD					
G0125	T	PET image pulmonary nodule	0976		$875.00		$175.00
G0126	D	Lung image (PET) staging					
G0127	T	Trim nail(s)	0009	0.63	$32.07	$8.34	$6.41
G0128	E	CORF skilled nursing service					
G0129	P	Partial hosp prog service	0033	4.17	$212.27	$48.17	$42.45
G0130	X	Single energy x-ray study	0261	1.21	$61.59	$33.87	$12.32
G0131	S	CT scan, bone density study	0288	1.17	$59.56	$32.75	$11.91
G0132	S	CT scan, bone density study	0288	1.17	$59.56	$32.75	$11.91
G0141	E	Scr c/v cyto,autosys and md					
G0143	A	Scr c/v cyto,thinlayer,rescr					
G0144	A	Scr c/v cyto,thinlayer,rescr					
G0145	A	Scr c/v cyto,thinlayer,rescr					
G0147	A	Scr c/v cyto, automated sys					
G0148	A	Scr c/v cyto, autosys, rescr					
G0151	E	HHCP-serv of pt,ea 15 min					
G0152	E	HHCP-serv of ot,ea 15 min					
G0153	E	HHCP-svs of s/l path,ea 15mn					
G0154	E	HHCP-svs of rn,ea 15 min					
G0155	E	HHCP-svs of csw,ea 15 min					
G0156	E	HHCP-svs of aide,ea 15 min					
G0163	D	Pet for rec of colorectal ca					
G0164	D	Pet for lymphoma staging					
G0165	D	Pet,rec of melanoma/met ca					
G0166	T	Extrnl counterpulse, per tx	0972		$150.00		$30.00
G0167	E	Hyperbaric oz tx;no md reqrd					
G0168	T	Wound closure by adhesive	0970		$25.00		$5.00
G0173	S	Stereo radoisurgery,complete	0721		$5,500.00		$1,100.00
G0174	D	Intensitymodulatedradiation					
G0175	V	OPPS Service,sched team conf	0602	1.38	$70.25		$14.05
G0176	P	OPPS/PHP;activity therapy	0033	4.17	$212.27	$48.17	$42.45
G0177	P	OPPS/PHP; train & educ serv	0033	4.17	$212.27	$48.17	$42.45
G0178	D	Intensitymodulatedradiation					
G0179	E	MD recertification HHA PT					
G0180	E	MD certification HHA patient					
G0181	E	Home health care supervision					
G0182	E	Hospice care supervision					
G0184	D	Ocular photdynamicTx 2nd eye	0235	5.57	$283.54	$78.91	$56.71
G0185	T	Transpuppillary thermotx	0235	5.57	$283.54	$78.91	$56.71
G0186	T	Dstry eye lesn,fdr vssl tech	0235	5.57	$283.54	$78.91	$56.71
G0187	T	Dstry mclr drusen,photocoag	0235	5.57	$283.54	$78.91	$56.71
G0188	D	Xray lwr extrmty-full lngth	0261	1.21	$61.59	$33.87	$12.32
G0190	D	Immunization administration					
G0191	D	Immunization admin,each add					
G0192	N	Immunization oral/intranasal					
G0193	A	Endoscopicstudyswallowfunctn					
G0194	A	Sensorytestingendoscopicstud					
G0195	A	Clinicalevalswallowingfunct					
G0196	A	Evalofswallowingwithradioopa					
G0197	A	Evalofptforprescipspeechdevi					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0198	A	Patientadapation&trainforspe					
G0199	A	Reevaluationofpatientusespec					
G0200	A	Evalofpatientprescipofvoicep					
G0201	A	Modifortraininginusevoicepro					
G0202	A	Screeningmammographydigital					
G0203	D	Screenmammographyfilmdigital					
G0204	S	Diagnosticmammographydigital	0707		$75.00		$15.00
G0205	D	Diagnosticmammographyfilmpro					
G0206	S	Diagnosticmammographydigital	0707		$75.00		$15.00
G0207	D	Diagnostic mammography film					
G0210	S	PET img wholebody dxlung ca	0712		$875.00		$175.00
G0211	S	PET img wholebody init lung	0712		$875.00		$175.00
G0212	S	PET img wholebod restag lung	0712		$875.00		$175.00
G0213	S	PET img wholebody dx colorec	0712		$875.00		$175.00
G0214	S	PET img wholebod init colore	0712		$875.00		$175.00
G0215	S	PETimg wholebod restag colre	0712		$875.00		$175.00
G0216	S	PET img wholebod dx melanoma	0712		$875.00		$175.00
G0217	S	PET img wholebod init melano	0712		$875.00		$175.00
G0218	S	PET img wholebod restag mela	0712		$875.00		$175.00
G0219	S	PET img wholbod melano nonco	0712		$875.00		$175.00
G0220	S	PET img wholebod dx lymphoma	0712		$875.00		$175.00
G0221	S	PET imag wholbod init lympho	0712		$875.00		$175.00
G0222	S	PET imag wholbod resta lymph	0712		$875.00		$175.00
G0223	S	PET imag wholbod reg dx head	0712		$875.00		$175.00
G0224	S	PET imag wholbod reg ini hea	0712		$875.00		$175.00
G0225	S	PET whol restag headneck onl	0712		$875.00		$175.00
G0226	S	PET img wholbody dx esophagl	0712		$875.00		$175.00
G0227	S	PET img wholbod ini esophage	0712		$875.00		$175.00
G0228	S	PET img wholbod restg esopha	0712		$875.00		$175.00
G0229	S	PET img metabolic brain pres	0712		$875.00		$175.00
G0230	S	PET myocard viability post s	0712		$875.00		$175.00
*G0231	S	PET WhBD colorec; gamma cam	0712		$875.00		$175.00
*G0232	S	PET WhBD lymphoma; gamma cam	0712		$875.00		$175.00
*G0233	S	PET WhBD melanoma; gamma cam	0712		$875.00		$175.00
*G0234	S	PET WhBD pulm nod; gamma cam	0712		$875.00		$175.00
*G0236	S	digital film convert diag ma	0706		$25.00		$5.00
*G0237	T	Therapeutic procd strg endur	0970		$25.00		$5.00
*G0238	T	Oth resp proc, indiv	0970		$25.00		$5.00
*G0239	T	Oth resp proc, group	0970		$25.00		$5.00
G0240	A	Critic care by MD transport					
G0241	A	Each additional 30 minutes					
*G0242	S	Multisource photon ster plan	0714		$1,375.00		$275.00
*G0243	S	Multisour photon stereo treat	0721		$5,500.00		$1,100.00
*G0244	X	Observ care by facility topt	0339	6.85	$348.69		$69.74
G9001	E	MCCD, initial rate					
G9002	E	MCCD, maintenance rate					
G9003	E	MCCD, risk adj hi, initial					
G9004	E	MCCD, risk adj lo, initial					
G9005	E	MCCD, risk adj, maintenance					
G9006	E	MCCD, Home monitoring					
G9007	E	MCCD, sch team conf					
G9008	E	Mccd,phys coor-care ovrsght					
G9009	E	MCCD, risk adj, level 3					
G9010	E	MCCD, risk adj, level 4					
G9011	E	MCCD, risk adj, level 5					
G9012	E	Other Specified Case Mgmt					
G9016	A	Demo-smoking cessation coun					
H0001	E	Alcohol and/or drug assess					
H0002	E	Alcohol and/or drug screenin					
H0003	E	Alcohol and/or drug screenin					
H0004	E	Alcohol and/or drug services					
H0005	E	Alcohol and/or drug services					
H0006	E	Alcohol and/or drug services					
H0007	E	Alcohol and/or drug services					
H0008	E	Alcohol and/or drug services					
H0009	E	Alcohol and/or drug services					
H0010	E	Alcohol and/or drug services					
H0011	E	Alcohol and/or drug services					
H0012	E	Alcohol and/or drug services					
H0013	E	Alcohol and/or drug services					
H0014	E	Alcohol and/or drug services					
H0015	E	Alcohol and/or drug services					
H0016	E	Alcohol and/or drug services					
H0017	E	Alcohol and/or drug services					
H0018	E	Alcohol and/or drug services					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
H0019	E	Alcohol and/or drug services					
H0020	E	Alcohol and/or drug services					
H0021	E	Alcohol and/or drug training					
H0022	E	Alcohol and/or drug interven					
H0023	E	Alcohol and/or drug outreach					
H0024	E	Alcohol and/or drug preventi					
H0025	E	Alcohol and/or drug preventi					
H0026	E	Alcohol and/or drug preventi					
H0027	E	Alcohol and/or drug preventi					
H0028	E	Alcohol and/or drug preventi					
H0029	E	Alcohol and/or drug preventi					
H0030	E	Alcohol and/or drug hotline					
*H1000	A	Prenatal care atrisk assessm					
*H1001	A	Antepartum management					
*H1002	A	Carecoordination prenatal					
*H1003	A	Prenatal at risk education					
*H1004	A	Follow up home visit/prental					
*H1005	A	Prenatalcare enhanced srv pk					
J0120	N	Tetracyclin injection					
J0130	G	Abciximab injection [10 mg]	1605		$513.02		$73.44
J0150	K	Adenosine, 6 mg	0917	0.34	$17.31		$3.46
J0151	E	Adenosine injection					
J0170	N	Adrenalin epinephrin inject					
J0190	N	Inj biperiden lactate/5 mg					
J0200	N	Alatrofloxacin mesylate					
J0205	G	Alglucerase injection per 10 units	0900		$37.53		$5.37
J0207	G	Amifostine 500 mg	7000		$392.06		$56.13
J0210	N	Methyldopate hcl injection					
J0256	G	Alpha 1 proteinase inhibitor 10 mg	0901		$2.09		$.30
J0270	E	Alprostadil for injection					
J0275	E	Alprostadil urethral suppos					
J0280	N	Aminophyllin 250 MG inj					
J0282	N	Amiodarone HCl					
J0285	N	Amphotericin B					
J0286	G	Amphotericin b lipid complex 50 mg	7001		$109.25		$15.64
J0290	N	Ampicillin 500 MG inj					
J0295	N	Ampicillin sodium per 1.5 gm					
J0300	N	Amobarbital 125 MG inj					
J0330	N	Succinycholine chloride inj					
J0340	D	Nandrolon phenpropionate inj					
J0350	G	anistreplase per 30 u	1606		$2,693.80		$385.64
J0360	N	Hydralazine hcl injection					
J0380	N	Inj metaraminol bitartrate					
J0390	N	Chloroquine injection					
J0395	N	Arbutamine HCl injection					
J0400	D	Inj trimethaphan camsylate					
J0456	N	Azithromycin					
J0460	N	Atropine sulfate injection					
J0470	N	Dimecaprol injection					
J0475	N	Baclofen 10 MG injection					
J0476	E	Baclofen intrathecal trial					
J0500	N	Dicyclomine injection					
J0510	D	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	G	Botulinum toxin A per unit	0902		$4.39		$.63
*J0587	G	Botulinum toxin B, per 100 u	9018		$8.79		$1.26
J0590	D	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	G	Leucovorin calcium injection per 50 mg	0725		$4.15		$.38
J0670	N	Inj mepivacaine HCL/10 ml					
J0690	N	Cefazolin sodium injection					
*J0692	N	Cefepime HCl for injection					
J0694	N	Cefoxitin sodium injection					
J0695	D	Cefonocid sodium injection					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
*J0706	G	Caffeine citrate injection	9011		$3.05		$.44
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	D	Chlorpheniramin maleate inj					
J0735	N	Clonidine hydrochloride					
J0740	N	Cidofovir injection					
J0743	N	Cilastatin sodium injection					
*J0744	N	Ciprofloxacin iv					
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	D	Cortisone injection					
J0835	N	Inj cosyntropin per 0.25 MG					
J0850	G	Cytomegalovirus imm IV /vial	0903		$370.50		$47.58
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					
*J1056	E	MA/EC contraceptiveinjection					
J1060	N	Testosterone cypionate 1 ML					
J1070	N	Testosterone cypionat 100 MG					
J1080	N	Testosterone cypionat 200 MG					
J1090	D	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					
J1180	N	Dyphylline injection					
J1190	G	Dexrazoxane HCL injection per 250 mg	0726		$194.52		$24.98
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	K	Dipyridamole injection, per 10 mg	0917	0.34	$17.31		$3.46
J1250	N	Inj dobutamine HCL/250 mg					
J1260	G	Dolasetron mesylate, per 10 mg	0750		$16.45		$2.11
*J1270	N	Injection, doxercalciferol					
J1320	N	Amitriptyline injection					
J1325	G	Epoprostenol injection 0.5 mg	7003		$12.04		$1.72
J1327	G	Eptifibatide injection, 5 mg	1607		$11.31		$1.45
J1330	N	Ergonovine maleate injection					
J1362	D	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	G	Etidronate disodium inj,per 300 mg	0727		$63.65		$9.11
J1438	G	Etanercept injection, 25 mg	1608		$141.01		$20.19
J1440	G	Filgrastim 300 mcg injection	0728		$179.08		$23.00
J1441	G	Filgrastim 480 mcg injection	7049		$285.38		$36.65
J1450	N	Fluconazole					
J1452	N	Intraocular Fomivirsen na					
J1455	N	Foscarnet sodium injection					
J1460	N	Gamma globulin 1 CC inj					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1470	E	Gamma globulin 2 CC inj					
J1480	E	Gamma globulin 3 CC inj					
J1490	E	Gamma globulin 4 CC inj					
J1500	E	Gamma globulin 5 CC inj					
J1510	E	Gamma globulin 6 CC inj					
J1520	E	Gamma globulin 7 CC inj					
J1530	E	Gamma globulin 8 CC inj					
J1540	E	Gamma globulin 9 CC inj					
J1550	E	Gamma globulin 10 CC inj					
J1560	E	Gamma globulin > 10 CC inj					
J1561	G	Immune globulin 500 mg	0905		$35.63		$3.23
J1563	E	IV immune globulin					
J1565	G	RSV-IVIG 50 mg	0906		$15.51		$1.99
J1570	K	Ganciclovir sodium injection 500 mg	0907	0.42	$21.38		$4.28
J1580	N	Garamycin gentamicin inj					
*J1590	N	Gatifloxacin injection					
J1600	N	Gold sodium thiomaleate inj					
J1610	N	Glucagon hydrochloride/1 MG					
J1620	G	Gonadorelin hydroch/ 100 mcg	7005		$192.37		$27.54
J1626	G	Granisetron HCL injection 100 mcg	0764		$18.54		$2.65
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	E	Inj enoxaparin sodium					
*J1655	N	Tinzaparin sodium injection					
J1670	G	Tetanus immune globulin inj up to 250 units	0908		$102.60		$13.18
J1690	D	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	D	Hydroxyprogesterone cap 125					
J1741	D	Hydroxyprogesterone cap 250					
J1742	N	Ibutilide fumarate injection					
J1745	G	Infliximab injection 10 mg	7043		$63.24		$9.05
J1750	N	Iron dextran					
*J1755	N	Iron sucrose injection					
J1785	G	Injection imiglucerase /unit	0916		$3.75		$.54
J1790	N	Droperidol injection					
J1800	N	Propranolol injection					
J1810	E	Droperidol/fentanyl inj, up to 2 ml					
J1820	N	Insulin injection					
J1825	G	Interferon beta-1a; 33 mcg	0909		$225.22		$32.24
J1830	G	Interferon beta-1b / .25 MG	0910		$68.40		$9.79
*J1835	N	Intraconazole injection					
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	D	Propiomazine injection					
J1940	N	Furosemide injection					
J1950	G	Leuprolide acetate /3.75 mg	0800		$93.47		$12.00
J1955	E	Inj levocarnitine per 1 gm					
J1956	N	Levofloxacin injection					
J1960	N	Levorphanol tartrate inj					
J1970	D	Methotrimeprazine injection					
J1980	N	Hyoscyamine sulfate inj					
J1990	N	Chlordiazepoxide injection					
J2000	N	Lidocaine injection					
J2010	N	Lincomycin injection					
*J2020	G	Linezolid inj, 200 mg	9001		$24.13		$3.45
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	D	Metocurine iodide injection					
J2250	N	Inj midazolam hydrochloride					
J2260	K	Milrinone lactate / 5 ml	7007	0.44	$22.40		$4.48
J2270	N	Morphine sulfate injection					
J2271	N	Morphine so4 injection 100 mg					
J2275	G	Morphine sulfate injection, per 10 mg	7010		$1.02		$.09

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	D	Thiothixene injection					
J2350	D	Niacinamide/niacin injection					
J2352	G	Octreotide acetate injection	7031		$138.08		$19.77
J2355	G	Oprelvekin injection, 5 mg	7011		$245.81		$35.19
J2360	N	Orphenadrine injection					
J2370	N	Phenylephrine hcl injection					
J2400	N	Chloroprocaine hcl injection					
J2405	G	Ondansetron HCL injection, per 1 mg	0768		$6.09		$.78
J2410	N	Oxymorphone hcl injection					
J2430	G	Pamidronate disodium /30 mg	0730		$265.87		$38.06
J2440	N	Papaverin hcl injection					
J2460	N	Oxytetracycline injection					
J2480	D	Hydrochlorides of opium inj					
J2500	N	Paricalcitol					
J2510	N	Penicillin g procaine inj					
J2512	D	Inj pentagastrin per 2 ML					
J2515	N	Pentobarbital sodium inj					
J2540	N	Penicillin g potassium inj					
J2543	N	Piperacillin/tazobactam					
J2545	A	Pentamidine isethionte/300 mg					
J2550	N	Promethazine hcl injection					
J2560	N	Phenobarbital sodium inj					
J2590	N	Oxytocin injection					
J2597	N	Inj desmopressin acetate					
J2640	D	Prednisolone sodium ph inj					
J2650	N	Prednisolone acetate inj					
J2670	N	Totazoline hcl injection					
J2675	D	Inj progesterone per 50 MG					
J2680	N	Fluphenazine decanoate 25 MG					
J2690	N	Procainamide hcl injection					
J2700	N	Oxacillin sodium injeciton					
J2710	N	Neostigmine methylslfte 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	G	Metoclopramide HCL injection up to 10 mg	0754		$1.17		$.11
J2770	G	Quinupristin/dalfopristin	1024		$102.05		$13.11
J2780	N	Ranitidine hydrochloride inj					
J2790	G	Rho d immune globulin inj [one dose package]	0884		$34.11		$4.38
J2792	G	Rho(d) immune globulin h, sd, 100 I.U.	1609		$20.55		$2.64
J2795	N	Ropivacaine HCl injection					
J2800	N	Methocarbamol injection					
J2810	N	Inj theophylline per 40 MG					
J2820	G	Sargramostim injection, 50 mcg	0731		$29.06		$4.16
J2860	D	Secobarbital sodium inj					
J2910	N	Aurothioglucose injeciton					
J2912	N	Sodium chloride injection					
J2915	N	NA Ferric Gluconate Complex					
J2920	N	Methylprednisolone injection					
J2930	N	Methylprednisolone injection					
*J2940	G	Somatrem injection	7033		$209.48		$29.99
*J2941	G	Somatropin injection	7034		$39.90		$5.12
J2950	N	Promazine hcl injeciton					
J2970	D	Methicillin sodium injection					
J2993	G	Reteplase injection	9005		$1,306.25		$187.00
J2995	K	Inj streptokinase /250000 IU	0911	1.66	$84.50		$16.90
J2997	K	Alteplase recombinant, 1 mg	7048	0.36	$18.33		$3.67
J3000	N	Streptomycin injection					
J3010	G	Fentanyl citrate injeciton	7014		$1.23		$.11
J3030	N	Sumatriptan succinate / 6 MG					
J3070	N	Pentazocine hcl injeciton					
J3080	D	Chlorprothixene injection					
*J3100	G	Tenecteplase, 50 mg/vial	9002		$2,612.50		$374.00
J3105	N	Terbutaline sulfate inj					
J3120	N	Testosterone enanthate inj					
J3130	N	Testosterone enanthate inj					
J3140	N	Testosterone suspension inj					
J3150	N	Testosteron propionate inj					
J3230	N	Chlorpromazine hcl injection					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3240	E	Thyrotropin injection					
J3245	G	Tirofiban hydrochloride 12.5 mg	7041		$436.41		$62.48
J3250	N	Trimethobenzamide hcl inj					
J3260	N	Tobramycin sulfate injection					
J3265	N	Injection torsemide 10 mg/ml					
J3270	D	Imipramine hcl injection					
J3280	G	Thiethylperazine maleate inj, up to 10 mg	0755		$4.60		$.66
J3301	N	Triamcinolone acetonide inj					
J3302	N	Triamcinolone diacetate inj					
J3303	N	Triamcinolone hexacetonl inj					
J3305	G	Inj trimetrexate glucoronate	7045		$118.75		$17.00
J3310	N	Perphenazine injeciton					
J3320	N	Spectinomycn di-hcl inj					
J3350	N	Urea injection					
J3360	N	Diazepam injection					
J3364	N	Urokinase 5000 IU injection					
J3365	K	Urokinase 250,000 iu inj	7036	6.41	$326.29		$65.26
J3370	N	Vancomycin hcl injeciton					
J3390	D	Methoxamine injection					
*J3395	G	Verteporfin for injection -15 mg	1203		$1,458.25		$208.76
J3400	N	Triflupromazine hcl inj					
J3410	N	Hydroxyzine hcl injeciton					
J3420	N	Vitamin b12 injection					
J3430	N	Vitamin k phytonadione inj					
J3450	D	Mephentermine sulfate inj					
J3470	N	Hyaluronidase injection					
J3475	N	Inj magnesium sulfate					
J3480	N	Inj potassium chloride					
J3485	N	Zidovudine					
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	N	Normal saline solution infus					
J7040	N	Normal saline solution infus					
J7042	N	5% dextrose/normal saline					
J7050	N	Normal saline solution infus					
J7051	N	Sterile saline/water					
J7060	N	5% dextrose/water					
J7070	N	D5w infusion					
J7100	N	Dextran 40 infusion					
J7110	N	Dextran 75 infusion					
J7120	N	Ringers lactate infusion					
J7130	N	Hypertonic saline solution					
J7190	G	Factor viii, per I.U.	0925		$.87		$.08
J7191	G	Factor VIII (porcine)	0926		$2.09		$.30
J7192	G	Factor viii recombinant, per I.U.	0927		$1.12		$.14
*J7193	G	Factor IX non-recombinant	0931		$26.13		$3.74
J7194	G	Factor IX complex per I.U.	0928		$.48		$.04
*J7195	G	Factor IX recombinant	0932		$1.12		$.16
J7197	G	Antithrombin iii injection per I.U.	0930		$1.05		$.15
J7198	G	Anti-inhibitor, per I.U.	0929		$1.43		$.18
J7199	E	Hemophilia clot factor noc					
J7300	E	Intraut copper contraceptive					
*J7302	E	Levonorgestrel iu contracept					
*J7308	N	Aminolevulinic acid hcl top					
J7310	G	Ganciclovir long act implant, 4.5 mg	0913		$4,750.00		$680.00
J7315	D	Sodium hyaluronate injection	7315		$26.13		$3.74
*J7316	G	Sodium hyaluronate injection	7315		$26.13		$3.74
J7320	G	Hylan g-f 20 injection, 16 mg	1611		$213.87		$27.47
J7330	G	Cultured chondrocytes implnt, 16 mg	1059		$14,250.00		$2,040.00
*J7340	E	Metabolic active D/E tissue					
J7500	G	Azathioprine oral 50 mg	0886		$1.25		$.11
J7501	G	Azathioprine parenteral 100 mg	0887		$1.06		$.10
J7502	G	Cyclosporine oral 100 mg	0888		$5.22		$.67
J7504	G	Lymphocyte immune globulin, 250 mg	0890		$269.06		$38.52
J7505	G	Muromonab CD3, per 5 mg	7038		$269.06		$38.52
J7506	G	Prednisone oral	7050		$.07		$.01
J7507	G	Tacrolimus oral per 1 mg	0891		$2.91		$.42
J7508	E	Tacrolimus oral per 5 MG					
J7509	N	Methylprednisolone oral					
J7510	N	Prednisolone oral per 5 mg					
*J7511	G	Antithymocyte globuln rabbit	9104		$325.09		$46.54
J7513	G	Daclizumab, parenteral 25 mg	1612		$397.29		$56.88

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7515	N	Cyclosporine oral 25 mg					
J7516	G	Cyclosporin parenteral 250 mg	0889		$25.08		$3.22
J7517	G	Mycophenolate mofetil oral 250 mg	9015		$2.40		$.34
J7520	G	Sirolimus 1 mg/ml	9106		$6.51		$.93
J7525	G	Tacrolimus injection	9006		$113.15		$16.20
J7599	E	Immunosuppressive drug noc					
J7608	A	Acetylcysteine inh sol u d					
J7618	A	Albuterol inh sol con					
J7619	A	Albuterol inh sol u d					
*J7622	A	Beclomethasome inhalatn sol					
*J7624	A	Betamethasome inhalation sol					
*J7626	A	Budesonide inhalation sol					
J7628	A	Bitolterol mes inhal sol con					
J7629	A	Bitolterol mes inh sol u d					
J7631	A	Cromolyn sodium inh sol u d					
J7635	A	Atropine inhal sol con					
J7636	A	Atropine inhal sol unit dose					
J7637	A	Dexamethasone inhal sol con					
J7638	A	Dexamethasone inhal sol u d					
J7639	A	Dornase alpha inhal sol u d					
*J7641	A	Flunisolide, inhalation sol					
J7642	A	Glycopyrrolate inhal sol con					
J7643	A	Glycopyrrolate inhal sol u d					
J7644	A	Ipratropium brom inh sol u d					
J7648	A	Isoetharine hcl inh sol con					
J7649	A	Isoetharine hcl inh sol u d					
J7658	A	Isoproterenolhcl inh sol con					
J7659	A	Isoproterenol hcl inh sol ud					
J7668	A	Metaproterenol inh sol con					
J7669	A	Metaproterenol inh sol u d					
J7680	A	Terbutaline so4 inh sol con					
J7681	A	Terbutaline so4 inh sol u d					
J7682	A	Tobramycin inhalation sol					
J7683	A	Triamcinolone inh sol con					
J7684	A	Triamcinolone inh sol u d					
J7699	A	Inhalation solution for DME					
J7799	A	Non-inhalation drug for DME					
J8499	E	Oral prescrip drug non chemo					
J8510	G	Oral busulfan, 2 mg	7015		$1.91		$.27
J8520	G	Capecitabine, oral, 150 mg	7042		$2.43		$.35
J8521	N	Capecitabine, oral, 500 mg					
J8530	G	Cyclophosphamide oral 25 mg	0801		$2.03		$.18
J8560	G	Etoposide oral 50 mg	0802		$52.43		$6.73
J8600	G	Melphalan oral 2 mg	0803		$2.29		$.33
J8610	G	Methotrexate oral 2.5 mg	0826		$3.45		$.31
J8700	G	Temozolomide, oral 5 mg	1086		$6.05		$.87
J8999	E	Oral prescription drug chemo					
J9000	G	Doxorubicin HCL 10 mg	0847		$37.46		$4.81
J9001	G	Doxorubicin HCL liposome inj, 10 mg	7046		$358.95		$51.39
J9015	G	Aldesleukin/single use vial	0807		$672.60		$96.29
*J9017	G	Arsenic trioxide	9012		$23.75		$3.40
J9020	G	Asparaginase injection 10,000 units	0814		$62.61		$8.96
J9031	G	Bcg live intravesical vac [per installation]	0809		$166.49		$21.38
J9040	G	Bleomycin sulfate injection, 15 units	0857		$289.37		$37.16
J9045	G	Carboplatin injection, 50 mg	0811		$114.46		$16.39
J9050	G	Carmustine, 100 mg	0812		$117.84		$16.87
J9060	G	Cisplatin 10 mg injection	0813		$42.18		$3.82
J9062	E	Cisplatin 50 MG injeciton					
J9065	G	cladribine per 1 mg	0858		$53.39		$4.83
J9070	G	Cyclophosphamide 100 mg inj	0815		$5.82		$.75
J9080	E	Cyclophosphamide 200 MG inj					
J9090	E	Cyclophosphamide 500 MG inj					
J9091	E	Cyclophosphamide 1.0 grm inj					
J9092	E	Cyclophosphamide 2.0 grm inj					
J9093	G	Cyclophosphamide lyophilized, 100 mg	0816		$4.89		$.63
J9094	E	Cyclophosphamide lyophilized					
J9095	E	Cyclophosphamide lyophilized					
J9096	E	Cyclophosphamide lyophilized					
J9097	E	Cyclophosphamide lyophilized					
J9100	G	Cytarabine HCL 100 mg inj	0817		$6.10		$.55
J9110	E	Cytarabine hcl 500 MG inj					
J9120	G	Dactinomycin actinomycin 0.5 mg	0818		$13.87		$1.99
J9130	G	Dacarbazine 100 mg inj	0819		$12.68		$1.15
J9140	E	Dacarbazine 200 MG inj					
J9150	G	Daunorubicin, 10 mg	0820		$76.62		$6.94

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9151	G	Daunorubicin citrate liposom, 10 mg	0821		$64.60		$9.25
J9160	G	Denileukin diftitox, 300 MCG	1084		$999.88		$143.14
J9165	G	Diethylstilbestrol injection, 250 mg	0822		$14.41		$1.30
J9170	G	Docetaxel, 20 mg	0823		$297.83		$42.64
J9180	E	Epirubicin HCl injection					
J9181	G	Etoposide 10 mg inj	0824		$10.45		$.95
J9182	E	Etoposide 100 MG inj					
J9185	G	Fludarabine phosphate inj 50 mg	0842		$271.82		$38.91
J9190	G	Fluorouracil injection, 500 mg	0859		$2.73		$.25
J9200	G	Floxuridine injection [500 mg]	0827		$129.56		$16.64
J9201	G	Gemcitabine hcl 200 mg	0828		$106.72		$15.28
J9202	G	Goserelin acetate implant, per 3.6 mg	0810		$446.49		$63.92
J9206	G	Irinotecan injection, 20 mg	0830		$134.25		$19.22
J9208	G	Ifosfamide injection, per 1g	0831		$156.64		$22.42
J9209	G	Mesna injection, 200 mg	0732		$36.48		$3.30
J9211	G	Idarubicin HCL injection, 5 mg	0832		$412.21		$59.01
J9212	G	Interferon alfacon-1, 1 mcg	0833		$4.10		$.59
J9213	G	Interferon alfa-2a inj, 3 million units	0834		$34.86		$4.99
J9214	G	Interferon alfa-2b inj, 1 million units	0836		$11.28		$1.45
J9215	G	Interferon alfa-n3 inj, 250, 000 I.U.	0865		$7.86		$1.12
J9216	G	Interferon gamma 1-b inj, 3 million units	0838		$285.65		$40.89
J9217	G	Leuprolide acetate suspnsion, 7.5 mg	9217		$592.60		$84.84
J9218	G	Leuprolide acetate injection, per 1 mg	0861		$69.79		$6.32
J9219	G	Leuprolide acetate implant, 65 mg	7051		$5,399.80		$773.02
J9230	G	Mechlorethamine HCL inj, 10 mg	0839		$12.01		$1.72
J9245	G	melphalan hydrochl 50 mg	0840		$400.74		$57.37
J9250	G	Methotrexate sodium inj, 5 mg	0841		$.45		$.04
J9260	E	Methotrexate sodium inj					
J9265	G	Paclitaxel injection, 30 mg	0863		$173.50		$22.28
J9266	E	Pegaspargase/singl dose vial					
J9268	G	Pentostatin injection, 10 mg	0844		$1,654.14		$236.80
J9270	G	Plicamycin (mithramycin) inj, 2.5 mg	0860		$93.80		$13.43
J9280	G	Mitomycin 5 mg inj	0862		$121.65		$11.01
J9290	E	Mitomycin 20 MG inj					
J9291	E	Mitomycin 40 MG inj					
J9293	G	Mitoxantrone hydrochl per 5 mg	0864		$244.21		$34.96
*J9300	G	Gemtuzumab ozogamicin inj, per 5 mg	9004		$1,929.69		$276.25
J9310	G	Rituximab cancer treatment, 100 mg	0849		$454.55		$65.07
J9320	G	Streptozocin injection, 1 g	0850		$117.64		$16.84
J9340	G	Thiotepa injection, 15 mg	0851		$116.97		$10.59
J9350	G	Topotecan, 4 mg	0852		$664.19		$95.08
J9355	G	Trastuzumab, 10 mg	1613		$52.83		$7.56
J9357	G	Valrubicin, 200 mg	1614		$423.22		$60.59
J9360	G	Vinblastine sulfate inj, 1 mg	0853		$4.11		$.37
J9370	G	Vincristine sulfate 1 mg inj	0854		$30.16		$3.87
J9375	E	Vincristine sulfate 2 MG inj					
J9380	E	Vincristine sulfate 5 MG inj					
J9390	G	Vinorelbine tartrate/10 mg	0855		$88.83		$12.72
J9600	G	Porfimer sodium, 75 mg	0856		$2,603.66		$372.74
J9999	E	Chemotherapy drug					
K0001	A	Standard wheelchair					
K0002	A	Stnd 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	D	Cstm manual wheelchair/base					
K0009	A	Other manual wheelchair/base					
K0010	A	Stnd wt frame power whlchr					
K0011	A	Stnd wt pwr whlchr w control					
K0012	A	Ltwt portbl power whlchr					
K0013	D	Custom power whlchr base					
K0014	A	Other power whlchr base					
K0015	A	Detach non-adjus hght armrst					
K0016	A	Detach adjust armrst cmplete					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0026	A	Back upholst lgtwt whlchr					
K0027	A	Back upholst other whlchr					
K0028	A	Manual fully reclining back					
K0029	A	Reinforced seat upholstery					
K0030	A	Solid plnr seat sngl dnsfoam					
K0031	A	Safety belt/pelvic strap					
K0032	A	Seat uphols 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 legrst low extension					
K0047	A	Elevat legrst up hangr brack					
K0048	A	Elevate legrest complete					
K0049	A	Calf pad each					
K0050	A	Ratchet assembly					
K0051	A	Cam relese 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					
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	Pwr wheelchair front caster					
K0100	A	Amputee adapter pair					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	W/c component-accessory NOS					
K0112	A	Trunk vest supprt innr frame					
K0113	A	Trunk vest suprt w/o inr frm					
K0114	A	Whlchr back suprt inr frame					
K0115	A	Back module orthotic system					
K0116	A	Back & seat modul orthot sys					
K0183	A	Nasal application device					
K0184	A	Nasal pillows/seals pair					
K0185	A	Pos airway pressure headgear					
K0186	A	Pos airway prssure chinstrap					
K0187	A	Pos airway pressure tubing					
K0188	A	Pos airway pressure filter					
K0189	A	Filter nondisposable w PAP					
K0195	A	Elevating whlchair leg rests					
K0268	A	Humidifier nonheated w PAP					
K0415	E	RX antiemetic drg, oral NOS					
K0416	E	Rx antiemetic drg,rectal NOS					
K0452	A	Wheelchair bearings					
K0455	A	Pump uninterrupted infusion					
K0460	A	WC power add-on joystick					
K0461	A	WC power add-on tiller cntrl					
K0462	A	Temporary replacement eqpmnt					
K0531	A	Heated humidifier used w pap					
K0532	A	Noninvasive assist wo backup					
K0533	A	Noninvasive assist w backup					
K0534	A	Invasive assist w backup					
K0538	A	Neg pressure wnd thrpy pump					
K0539	A	Neg pres wnd thrpy dsg set					
K0540	A	Neg pres wnd thrp canister					
K0541	A	Speech generating device					
K0542	A	Speech generating device					
K0543	A	Speech generating device					
K0544	A	Speech generating device					
K0545	A	Speech generating software					
K0546	A	Accessory for sgd,mntng syst					
K0547	A	Accessory for sgd,not clasfd					
K0548	A	Insulin lispro					
K0549	A	Hosp bed hvy dty xtra wide					
K0550	A	Hosp bed xtra hvy dty x wide					
K0551	A	Residual limb support system					
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					
*L0321	A	Tlso anti-post-cntrl prefab					
L0330	A	Tlso ant-pos-lateral control					
*L0331	A	Tlso ant-post-lat cntrl prfb					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0390	A	Tlso a-p-l control molded					
*L0391	A	Tlso ant-post-lat-rot cntrl					
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					
*L0561	A	Prefab lso					
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/postsurgical support					
L0950	A	Post surg support custom fab					
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					
*L0986	A	Spinal orth abdm pnl prefab					
L0999	A	Add to spinal orthosis NOS					
L1000	A	Ctlso milwauke initial model					
*L1005	A	Tension based scoliosis orth					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
L1690	A	Combination bilateral HO					
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					
L1847	A	KO adjustable w air chambers					
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					
L1880	A	Ko doub upright cuffs/lacers					
L1885	A	Knee upright w/resistance					
L1900	A	Afo sprng wir drsflx calf bd					
L1902	A	Afo ankle gauntlet					
L1904	A	Afo molded ankle gauntlet					
L1906	A	Afo multiligamentus 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					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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					
*L2768	A	Ortho sidebar disconnect					
L2770	A	Low ext orthosis per bar/jnt					
L2780	A	Non-corrosive finish					
L2785	A	Drop lock retainer each					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	E	Ft insert ucb berkeley shell					
L3001	E	Foot insert remov molded spe					
L3002	E	Foot insert plastazote or eq					
L3003	E	Foot insert silicone gel eac					
L3010	E	Foot longitudinal arch suppo					
L3020	E	Foot longitud/metatarsal sup					
L3030	E	Foot arch support remov prem					
L3040	E	Ft arch suprt premold longit					
L3050	E	Foot arch supp premold metat					
L3060	E	Foot arch supp longitud/meta					
L3070	E	Arch suprt att to sho longit					
L3080	E	Arch supp att to shoe metata					
L3090	E	Arch supp att to shoe long/m					
L3100	E	Hallus-valgus nght dynamic s					
L3140	E	Abduction rotation bar shoe					
L3150	E	Abduct rotation bar w/o shoe					
L3160	E	Shoe styled positioning dev					
L3170	E	Foot plastic heel stabilizer					
L3201	E	Oxford w supinat/pronat inf					
L3202	E	Oxford w/ supinat/pronator c					
L3203	E	Oxford w/ supinator/pronator					
L3204	E	Hightop w/ supp/pronator inf					
L3206	E	Hightop w/ supp/pronator chi					
L3207	E	Hightop w/ supp/pronator jun					
L3208	E	Surgical boot each infant					
L3209	E	Surgical boot each child					
L3211	E	Surgical boot each junior					
L3212	E	Benesch boot pair infant					
L3213	E	Benesch boot pair child					
L3214	E	Benesch boot pair junior					
L3215	E	Orthopedic ftwear ladies oxf					
L3216	E	Orthoped ladies shoes dpth i					
L3217	E	Ladies shoes hightop depth i					
L3218	E	Ladies surgical boot each					
L3219	E	Orthopedic mens shoes oxford					
L3221	E	Orthopedic mens shoes dpth i					
L3222	E	Mens shoes hightop depth inl					
L3223	E	Mens surgical boot each					
L3224	A	Woman's shoe oxford brace					
L3225	A	Man's shoe oxford brace					
L3230	E	Custom shoes depth inlay					
L3250	E	Custom mold shoe remov prost					
L3251	E	Shoe molded to pt silicone s					
L3252	E	Shoe molded plastazote cust					
L3253	E	Shoe molded plastazote cust					
L3254	E	Orth foot non-stndard size/w					
L3255	E	Orth foot non-standard size/					
L3257	E	Orth foot add charge split s					
L3260	E	Ambulatory surgical boot eac					
L3265	E	Plastazote sandal each					
L3300	E	Sho lift taper to metatarsal					
L3310	E	Shoe lift elev heel/sole neo					
L3320	E	Shoe lift elev heel/sole cor					
L3330	E	Lifts elevation metal extens					
L3332	E	Shoe lifts tapered to one-ha					
L3334	E	Shoe lifts elevation heel /i					
L3340	E	Shoe wedge sach					
L3350	E	Shoe heel wedge					
L3360	E	Shoe sole wedge outside sole					
L3370	E	Shoe sole wedge between sole					
L3380	E	Shoe clubfoot wedge					
L3390	E	Shoe outflare wedge					
L3400	E	Shoe metatarsal bar wedge ro					
L3410	E	Shoe metatarsal bar between					
L3420	E	Full sole/heel wedge btween					
L3430	E	Sho heel count plast reinfor					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3440	E	Heel leather reinforced					
L3450	E	Shoe heel sach cushion type					
L3455	E	Shoe heel new leather standa					
L3460	E	Shoe heel new rubber standar					
L3465	E	Shoe heel thomas with wedge					
L3470	E	Shoe heel thomas extend to b					
L3480	E	Shoe heel pad & depress for					
L3485	E	Shoe heel pad removable for					
L3500	E	Ortho shoe add leather insol					
L3510	E	Orthopedic shoe add rub insl					
L3520	E	O shoe add felt w leath insl					
L3530	E	Ortho shoe add half sole					
L3540	E	Ortho shoe add full sole					
L3550	E	O shoe add standard toe tap					
L3560	E	O shoe add horseshoe toe tap					
L3570	E	O shoe add instep extension					
L3580	E	O shoe add instep velcro clo					
L3590	E	O shoe convert to sof counte					
L3595	E	Ortho shoe add march bar					
L3600	E	Trans shoe calip plate exist					
L3610	E	Trans shoe caliper plate new					
L3620	E	Trans shoe solid stirrup exi					
L3630	E	Trans shoe solid stirrup new					
L3640	E	Shoe dennis browne splint bo					
L3649	E	Orthopedic shoe modifica NOS					
L3650	A	Shlder fig 8 abduct restrain					
L3660	A	Abduct restrainer canvas&web					
L3670	A	Acromio/clavicular canvas&we					
L3675	A	Canvas vest SO					
*L3677	A	SO hard plastic stabilizer					
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					
L3760	E	EO withjoint, Prefabricated					
L3800	A	Whfo short opponen no attach					
L3805	A	Whfo long opponens no attach					
L3807	A	WHFO,no joint, prefabricated					
L3810	A	Whfo thumb abduction bar					
L3815	A	Whfo second m.p. abduction a					
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	E	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					
L3923	A	HFO, no joint, prefabricated					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
L4210	A	Orth dev repair/repl minor p					
L4350	A	Pneumatic ankle cntrl splint					
L4360	A	Pneumatic walking splint					
L4370	A	Pneumatic full leg splint					
L4380	A	Pneumatic knee splint					
L4392	A	Replace AFO soft interface					
L4394	A	Replace foot drop spint					
L4396	A	Static AFO					
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	D	Bk sach soft cover & finish					
*L5301	A	BK mold socket SACH ft endo					
L5310	D	Knee disart sach soft cv/fin					
*L5311	A	Knee disart, SACH ft, endo					
L5320	D	Ak open end sach soft cv/fin					
*L5321	A	AK open end SACH					
L5330	D	Hip canadian sach sft cv/fin					
*L5331	A	Hip disart canadian SACH ft					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5340	D	Hemipelvectomy canad cv/fin					
*L5341	A	Hemipelvectomy canadian SACH					
L5400	A	Postop dress & 1 cast chg bk					
L5410	A	Postop dsg bk ea add cast ch					
L5420	A	Postop dsg & 1 cast chg ak/d					
L5430	A	Postop dsg ak ea add cast ch					
L5450	A	Postop app non-wgt bear dsg					
L5460	A	Postop app non-wgt bear dsg					
L5500	A	Init bk ptb plaster direct					
L5505	A	Init ak ischal plstr direct					
L5510	A	Prep BK ptb plaster molded					
L5520	A	Perp 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					
L5642	A	Above knee leather socket					
L5643	A	Hip flex inner socket ext fr					
L5644	A	Above knee wood socket					
L5645	A	Bk flex inner socket ext fra					
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 articulat					
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	D	Socket insert w lock lower					
L5668	A	Socket insert w/o lock lower					
L5669	D	Below knee socket w/o lock					
L5670	A	Bk molded supracondylar susp					
*L5671	A	BK/AK locking mechanism					
L5672	A	Bk removable medial brim sus					
L5674	A	Bk suspension sleeve					
L5675	A	Bk heavy duty susp sleeve					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	Kne-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 ultralt 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 hydral 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					
L5826	A	Miniature 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					
*L5847	A	Microprocessor cntrl feature					
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					
L5968	A	Multiaxial ankle w dorsiflex					
L5970	A	Foot external keel sach foot					
L5972	A	Flexible keel foot					
L5974	A	Foot single axis ankle/foot					
L5975	A	Combo ankle/foot prosthesis					
L5976	A	Energy storing foot					
L5978	A	Ft prosth multiaxial ankl/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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
L5988	A	Vertical shock reducing pylo					
*L5989	A	Pylon w elctrnc force sensor					
*L5990	A	User adjustable heel height					
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 sck flx 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	Shlder 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 shlder/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 disar 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					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6690	A	Frame typ sock interscap-tho					
L6691	A	Removable insert each					
L6692	A	Silicone gel insert or equal					
L6693	A	Lockingelbow forearm cntrbal					
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					
*L6881	A	Autograsp feature ul term dv					
*L6882	A	Microprocessor control uplmb					
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					
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					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
*L8001	A	Breast prosthesis bra and form					
*L8002	A	Brst prsth bra & bilat form					
L8010	A	Mastectomy sleeve					
L8015	A	Ext breastprosthesis garment					
L8020	A	Mastectomy form					
L8030	A	Breast prosthesis silicone/e					
L8035	A	Custom breast prosthesis					
L8039	A	Breast prosthesis NOS					
L8040	A	Nasal prosthesis					
L8041	A	Midfacial prosthesis					
L8042	A	Orbital prosthesis					
L8043	A	Upper facial prosthesis					
L8044	A	Hemi-facial prosthesis					
L8045	A	Auricular prosthesis					
L8046	A	Partial facial prosthesis					
L8047	A	Nasal septal prosthesis					
L8048	A	Unspec maxillofacial prosth					
L8049	A	Repair maxillofacial prosth					
L8100	E	Compression stocking BK18–30					
L8110	E	Compression stocking BK30–40					
L8120	E	Compression stocking BK40–50					
L8130	E	Gc stocking thighlngth 18–30					
L8140	E	Gc stocking thighlngth 30–40					
L8150	E	Gc stocking thighlngth 40–50					
L8160	E	Gc stocking full lngth 18–30					
L8170	E	Gc stocking full lngth 30–40					
L8180	E	Gc stocking full lngth 40–50					
L8190	E	Gc stocking waistlngth 18–30					
L8195	E	Gc stocking waistlngth 30–40					
L8200	E	Gc stocking waistlngth 40–50					
L8210	E	Gc stocking custom made					
L8220	E	Gc stocking lymphedema					
L8230	E	Gc stocking garter belt					
L8239	E	G compression stocking 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	Prosthetic sock multi ply BK					
L8430	A	Prosthetic sock multi ply AK					
L8435	A	Pros sock multi ply upper lm					
L8440	A	Shrinker below knee					
L8460	A	Shrinker above knee					
L8465	A	Shrinker upper limb					
L8470	A	Pros sock single ply BK					
L8480	A	Pros sock single ply AK					
L8485	A	Pros sock single ply upper l					
L8490	A	Air seal suction reten systm					
L8499	A	Unlisted misc prosthetic ser					
L8500	A	Artificial larynx					
L8501	A	Tracheostomy speaking valve					
*L8505	A	Artificial larynx, accessory					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*L8507	A	Trach-esoph voice pros pt in					
*L8509	A	Trach-esoph voice pros md in					
*L8510	A	Voice amplifier					
L8600	N	Implant breast silicone/eq					
L8603	N	Collagen imp urinary 2.5 ml					
L8606	A	Synthetic implnt urinary 1ml					
L8610	N	Ocular implant					
L8612	N	Aqueous shunt prosthesis					
L8613	N	Ossicular implant					
L8614	E	Cochlear device/system					
L8619	A	Replace cochlear processor					
L8630	N	Metacarpophalangeal implant					
L8641	N	Metatarsal joint implant					
L8642	N	Hallux implant					
L8658	N	Interphalangeal joint implnt					
L8670	N	Vascular graft, synthetic					
L8699	N	Prosthetic implant NOS					
L9900	A	O&P supply/accessory/service					
M0064	X	Visit for drug monitoring	0374	0.89	$45.30	$9.97	$9.06
M0075	E	Cellular therapy					
M0076	E	Prolotherapy					
M0100	E	Intragastric hypothermia					
M0300	E	IV chelationtherapy					
M0301	E	Fabric wrapping of aneurysm					
M0302	D	Assessment of cardiac output	0970		$25.00		$5.00
P2028	A	Cephalin floculation 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	E	Screening pap smear by phys					
P7001	E	Culture bacterial urine					
P9010	K	Whole blood for transfusion	0950	1.97	$100.28		$20.06
P9011	E	Blood split unit					
P9012	K	Cryoprecipitate each unit	0952	0.66	$33.60		$6.72
P9016	K	RBC leukocytes reduced	0954	2.67	$135.91		$27.18
P9017	K	One donor fresh frozn plasma	0955	2.13	$108.43		$21.69
P9019	K	Platelets, each unit	0957	0.93	$47.34		$9.47
P9020	K	Plaelet rich plasma unit	0958	1.10	$55.99		$11.20
P9021	K	Red blood cells unit	0959	1.93	$98.24		$19.65
P9022	K	Washed red blood cells unit	0960	3.60	$183.25		$36.65
P9023	K	Frozen plasma, pooled, sd	0949	2.78	$141.51		$28.30
P9031	K	Platelets leukocytes reduced	0954	2.67	$135.91		$27.18
P9032	K	Platelets, irradiated	9500	1.68	$85.52		$17.10
P9033	K	Platelets leukoreduced irrad	0954	2.67	$135.91		$27.18
P9034	K	Platelets, pheresis	9501	9.16	$466.28		$93.26
P9035	K	Platelet pheres leukoreduced	9501	9.16	$466.28		$93.26
P9036	K	Platelet pheresis irradiated	9502	9.94	$505.99		$101.20
P9037	K	Plt, aph/pher, L/R, irrad	1019	9.11	$463.74		$92.75
P9038	K	RBC irradiated	9505	2.44	$124.21		$24.84
P9039	K	RBC deglycerolized	9504	4.11	$209.22		$41.84
P9040	K	RBC leukoreduced irradiated	9504	4.11	$209.22		$41.84
P9041	K	Albumin(human), 5%, 50ml	0961	2.07	$105.37		$21.07
P9042	D	Albumin (human), 25%, 10ml	0962	1.04	$52.94		$10.59
P9043	K	Plasma protein fraction	0956	1.19	$60.58		$12.12
P9044	K	Cryoprecipitatereducedplasma	1009	0.82	$41.74		$8.35
*P9045	K	Albumin (human), 5%, 250 ml	0963	10.35	$526.86		$105.37
*P9046	K	Albumin (human), 25%, 20 ml	0964	2.08	$105.88		$21.18
*P9047	K	Albumin (human), 25%, 50ml	0965	5.20	$264.70		$52.94
*P9048	K	Plasmaprotein fract,5%,250ml	0966	5.95	$302.88		$60.58
*P9050	K	Granulocytes, pheresis unit	9506	27.75	$1,412.59		$282.52
P9603	A	One-way allow prorated miles					
P9604	A	One-way allow prorated trip					
P9612	N	Catheterize for urine spec					
P9615	N	Urine specimen collect mult					
Q0035	X	Cardiokymography	0100	1.47	$74.83	$41.15	$14.97
Q0081	D	Infusion ther other than che	0120	3.08	$156.78	$42.67	$31.36
Q0083	S	Chemo by other than infusion	0116	0.91	$46.32		$9.26
Q0084	S	Chemotherapy by infusion	0117	4.01	$204.13	$52.69	$40.83
Q0085	S	Chemo by both infusion and o	0118	4.20	$213.80	$72.03	$42.76
Q0086	D	Physical therapy evaluation/					
Q0091	T	Obtaining screen pap smear	0191	0.23	$11.71	$3.40	$2.34
Q0092	N	Set up port xray equipment					
Q0111	A	Wet mounts/ w preparations					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0112	A	Potassium hydroxide preps					
Q0113	A	Pinworm examinations					
Q0114	A	Fern test					
Q0115	A	Post-coital mucous exam					
Q0136	G	Non esrd epoetin alpha inj per 1000 units	0733		$12.26		$1.57
Q0144	D	Azithromycin dihydrate, oral					
Q0160	D	Factor IX non-recombinant	0931		$26.13		$3.74
Q0161	D	Factor IX recombinant	0932		$1.12		$.14
Q0163	G	Diphenhydramine HCL 50 mg	1400		$.23		$.02
Q0164	G	Prochlorperazine maleate 5 mg	1401		$.65		$.06
Q0165	E	Prochlorperazine maleate 10 mg					
Q0166	G	Granisetron HCL 1 mg oral	0765		$44.69		$6.40
Q0167	G	Dronabinol 2.5 mg oral	0762		$3.28		$.42
Q0168	E	Dronabinol 5 mg oral					
Q0169	G	Promethazine HCL 12.5 mg oral	1402		$.01		$.00
Q0170	E	Promethazine HCl 25 mg oral					
Q0171	G	Chlorpromazine HCL 10 mg oral	1403		$.27		$.02
Q0172	E	Chlorpromazine HCl 25 mg oral					
Q0173	G	Trimethobenzamide HCL 250 mg	1404		$.38		$.03
Q0174	G	Thiethylperazine maleate 10 mg	1405		$.56		$.08
Q0175	G	Perphenazine 4 mg oral	1406		$.62		$.06
Q0176	E	Perphenazine 8 mg oral					
Q0177	G	Hydroxyzine pamoate 25 mg	1407		$.28		$.03
Q0178	E	Hydroxyzine pamoate 50 mg					
Q0179	G	Ondansetron HCL 8 mg oral	0769		$26.41		$3.39
Q0180	G	Dolasetron mesylate oral, 100 mg	0763		$69.64		$8.94
Q0181	E	Unspecified oral anti-emetic					
Q0183	N	Nonmetabolic active tissue					
Q0184	N	Metabolically active tissue					
Q0185	D	Metabolic active D/E tissue					
Q0187	G	Factor VIII recombinant, per 1.2 mg	1409		$1,596.00		$228.48
Q1001	E	Ntiol category 1					
Q1002	E	Ntiol category 2					
Q1003	E	Ntiol category 3					
Q1004	E	Ntiol category 4					
Q1005	E	Ntiol category 5					
Q2001	N	Oral cabergoline 0.5 mg					
Q2002	G	Elliotts b solution per ml	7022		$1.43		$.20
Q2003	G	Aprotinin, 10,000 kiu	7019		$2.16		$.31
Q2004	G	Bladder calculi irrig sol	7023		$24.70		$3.54
Q2005	G	Corticorelin ovine triflutat	7024		$368.03		$52.69
Q2006	G	Digoxin immune fab (ovine)	7025		$551.66		$78.97
Q2007	G	Ethanolamine oleate 100 mg	7026		$39.73		$5.69
Q2008	G	Fomepizole, 15 mg	7027		$10.93		$1.56
Q2009	G	Fosphenytoin, 50 mg	7028		$5.73		$.82
Q2010	G	Glatiramer acetate, per dose	7029		$30.07		$4.30
Q2011	G	Hemin, per 1 mg	7030		$.99		$.14
Q2012	G	Pegademase bovine, 25 iu	7039		$139.33		$19.95
Q2013	G	Pentastarch 10% solution	7040		$15.11		$2.16
Q2014	G	Sermorelin acetate, 0.5 mg	7032		$13.60		$1.95
Q2015	D	Somatrem, 5 mg	7033		$209.48		$29.99
Q2016	D	Somatropin, 1 mg	7034		$39.90		$5.12
Q2017	G	Teniposide, 50 mg	7035		$222.80		$31.90
Q2018	G	Urofollitropin, 75 iu	7037		$73.29		$10.49
Q2019	G	Basiliximab 20 mg	1615		$1,437.78		$205.83
Q2020	E	Histrelin acetate, 10 mg					
Q2021	G	Lepirudin	1617		$131.96		$18.89
Q2022	G	VonWillebrandFactrCmplxperIU	1618		$.95		$.14
Q3001	E	Brachytherapy Radioelements					
Q3002	G	Gallium ga 67, per mCi	1619		$25.62		$2.32
Q3003	G	Technetium tc99m bicisate	1620		$403.99		$57.83
Q3004	G	Xenon xe 133	1621		$29.93		$2.71
Q3005	G	Technetium tc99m mertiatide	1622		$137.75		$19.72
Q3006	G	Technetium tc99m glucepatate	1623		$22.61		$3.24
Q3007	G	Sodium phosphate p32	1624		$54.34		$7.78
Q3008	G	Indium 111-in pentetreotide	1625		$935.75		$133.96
Q3009	G	Technetium tc99m oxidronate	1626		$1.47		$.21
Q3010	G	Technetium tc99mlabeledrbcs	1627		$40.90		$5.85
Q3011	G	Chromic phosphate p32	1628		$150.86		$21.60
Q3012	G	Co 57, 0.5 Mci	1089		$81.10		$10.41
Q3013	D	Verteporfin injection					
Q3014	A	Telehealth facility fee					
Q3017	A	Amb srv, ALS assmt, no oth als					
Q4001	A	Cast sup body cast plaster					
Q4002	A	Cast sup body cast fiberglas					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4003	A	Cast sup shoulder cast plstr					
Q4004	A	Cast sup shoulder cast fbrgl					
Q4005	A	Cast sup long arm adult plst					
Q4006	A	Cast sup long arm adult fbrg					
Q4007	A	Cast sup long arm ped plster					
Q4008	A	Cast sup long arm ped fbrgls					
Q4009	A	Cast sup sht arm adult plstr					
Q4010	A	Cast sup sht arm adult fbrgl					
Q4011	A	Cast sup sht arm ped plaster					
Q4012	A	Cast sup sht arm ped fbrglas					
Q4013	A	Cast sup gauntlet plaster					
Q4014	A	Cast sup gauntlet fiberglass					
Q4015	A	Cast sup gauntlet ped plster					
Q4016	A	Cast sup gauntlet ped fbrgls					
Q4017	A	Cast sup lng arm splint plst					
Q4018	A	Cast sup lng arm splint fbrg					
Q4019	A	Cast sup lng arm splnt ped p					
Q4020	A	Cast sup lng arm splnt ped f					
Q4021	A	Cast sup sht arm splint plst					
Q4022	A	Cast sup sht arm splint fbrg					
Q4023	A	Cast sup sht arm splnt ped p					
Q4024	A	Cast sup sht arm splnt ped f					
Q4025	A	Cast sup hip spica plaster					
Q4026	A	Cast sup hip spica fiberglas					
Q4027	A	Cast sup hip spica ped plstr					
Q4028	A	Cast sup hip spica ped fbrgl					
Q4029	A	Cast sup long leg plaster					
Q4030	A	Cast sup long leg fiberglass					
Q4031	A	Cast sup lng leg ped plaster					
Q4032	A	Cast sup lng leg ped fbrgls					
Q4033	A	Cast sup lng leg cylinder pl					
Q4034	A	Cast sup lng leg cylinder fb					
Q4035	A	Cast sup lngleg cylndr ped p					
Q4036	A	Cast sup lngleg cylndr ped f					
Q4037	A	Cast sup shrt leg plaster					
Q4038	A	Cast sup shrt leg fiberglass					
Q4039	A	Cast sup shrt leg ped plster					
Q4040	A	Cast sup shrt leg ped fbrgls					
Q4041	A	Cast sup lng leg splnt plstr					
Q4042	A	Cast sup lng leg splnt fbrgl					
Q4043	A	Cast sup lng leg splnt ped p					
Q4044	A	Cast sup lng leg splnt ped f					
Q4045	A	Cast sup sht leg splnt plstr					
Q4046	A	Cast sup sht leg splnt fbrgl					
Q4047	A	Cast sup sht leg splnt ped p					
Q4048	A	Cast sup sht leg splnt ped f					
Q4049	A	Finger splint, static					
Q4050	A	Cast supplies unlisted					
Q4051	A	Splint supplies misc					
Q9920	A	Epoetin with hct <= 20					
Q9921	A	Epoetin with hct = 21					
Q9922	A	Epoetin with hct = 22					
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					
*T1015	E	Clinic service					
V2020	A	Vision svcs frames purchases					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2025	E	Eyeglasses delux frames					
V2100	A	Lens spher single plano 4.00					
V2101	A	Single visn sphere 4.12–7.00					
V2102	A	Singl visn sphere 7.12–20.00					
V2103	A	Spherocylindr 4.00d/12–2.00d					
V2104	A	Spherocylindr 4.00d/2.12–4d					
V2105	A	Spherocylinder 4.00d/4.25–6d					
V2106	A	Spherocylinder 4.00d/>6.00d					
V2107	A	Spherocylinder 4.25d/12–2d					
V2108	A	Spherocylinder 4.25d/2.12–4d					
V2109	A	Spherocylinder 4.25d/4.25–6d					
V2110	A	Spherocylinder 4.25d/over 6d					
V2111	A	Spherocylindr 7.25d/.25–2.25					
V2112	A	Spherocylindr 7.25d/2.25–4d					
V2113	A	Spherocylindr 7.25d/4.25–6d					
V2114	A	Spherocylinder 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 spher 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.					
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					

* Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	E	Progressive lens per lens					
V2785	F	Corneal tissue processing					
V2790	N	Amniotic membrane					
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	Hearing aid monaural 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					
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					
*V5241	E	Dispensing fee, monaural					
*V5242	E	Hearing aid, monaural, cic					
*V5243	E	Hearing aid, monaural, itc					
*V5244	E	Hearing aid, prog, mon, cic					
*V5245	E	Hearing aid, prog, mon, itc					
*V5246	E	Hearing aid, prog, mon, ite					
*V5247	E	Hearing aid, prog, mon, bte					
*V5248	E	Hearing aid, binaural, cic					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*V5249	E	Hearing aid, binaural, itc					
*V5250	E	Hearing aid, prog, bin, cic					
*V5251	E	Hearing aid, prog, bin, itc					
*V5252	E	Hearing aid, prog, bin, ite					
*V5253	E	Hearing aid, prog, bin, bte					
*V5254	E	Hearing id, digit, mon, cic					
*V5255	E	Hearing aid, digit, mon, itc					
*V5256	E	Hearing aid, digit, mon, ite					
*V5257	E	Hearing aid, digit, mon, bte					
*V5258	E	Hearing aid, digit, bin, cic					
*V5259	E	Hearing aid, digit, bin, itc					
*V5260	E	Hearing aid, digit, bin, ite					
*V5261	E	Hearing aid, digit, bin, bte					
*V5262	E	Hearing aid, disp, monaural					
*V5263	E	Hearing aid, disp, binaural					
*V5264	E	Ear mold/insert					
*V5265	E	Ear mold/insert, disp					
*V5266	E	Battery for hearing device					
*V5267	E	Hearing aid supply/accessory					
*V5268	E	ALD Telephone Amplifier					
*V5269	E	Alerting device, any type					
*V5270	E	ALD, TV amplifier, any type					
*V5271	E	ALD, TV caption decoder					
*V5272	E	Tdd					
*V5273	E	ALD for cochlear implant					
*V5274	E	ALD unspecified					
*V5275	E	Ear impression					
V5299	E	Hearing service					
V5336	E	Repair communication device					
V5362	A	Speech screening					
V5363	A	Language screening					
V5364	A	Dysphagia screening					

*Code is new in 2002.

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Service	Status
A	Pulmonary Rehabilitation Clinical Trial	Not Paid Under Outpatient PPS
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS Fee Schedule
A	Physical, Occupational and Speech Therapy	Physician 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	Physician Fee Schedule
A	Screening Mammography	Lower of Charges or National Rate
C	Inpatient Procedures	Admit Patient
E	Non-Covered Items and Services	Not Paid Under Outpatient PPS
F	Acquisition of Corneal Tissue	Paid at Reasonable Cost
G	Drug/Biological Pass-Through	Additional Payment
H	Device Pass-Through	Additional Payment
K	Non Pass-Through Drug/Biological	Paid Under Outpatient PPS
N	Incidental Services, packaged into APC Rate	Packaged
P	Partial Hospitalization	Paid Per Diem APC
S	Significant Procedure, Not Discounted When Multiple	Paid Under Outpatient PPS
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid Under Outpatient PPS
V	Visit to Clinic or Emergency Department	Paid Under Outpatient PPS
X	Ancillary Service	Paid Under Outpatient PPS

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
*0001T	C	Endovas repr abdo ao aneurys
*0002T	C	Endovas repr abdo ao aneurys
*0005T	C	Perc cath stent/brain cv art
*0006T	C	Perc cath stent/brain cv art
*0007T	C	Perc cath stent/brain cv art
00174	C	Anesth, pharyngeal surgery
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage
00215	C	Anesth, skull repair/fract
*0021T	C	Fetal oximetry, trnsvag/cerv
*0024T	C	Transcath cardiac reduction
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
00524	C	Anesth, chest drainage
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00544	C	Anesth, chest lining removal
00546	C	Anesth, lung,chest wall surg
00560	C	Anesth, open heart surgery
00562	C	Anesth, open heart surgery
00580	C	Anesth heart/lung transplant
00604	C	Anesth, sitting procedure
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00634	C	Anesth for chemonucleolysis
00670	C	Anesth, spine, cord surgery
00792	C	Anesth, hemorr/excise liver
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant
00802	C	Anesth, fat layer removal
00844	C	Anesth, pelvis surgery
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00928	C	Anesth, removal of testis
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal
00944	C	Anesth, vaginal hysterectomy
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, replacement of hip
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, replacement of knee
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01990	C	Support for organ donor
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
16035	C	Incision of burn scab, initi
16036	C	Incise burn scab, addl incis
19200	C	Removal of breast
19220	C	Removal of breast
19271	C	Revision of chest wall
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction
19368	C	Breast reconstruction
19369	C	Breast reconstruction
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconst lwr jaw w/o graft
21194	C	Reconst lwr jaw w/graft
21195	C	Reconst lwr jaw w/o fixation
21196	C	Reconst lwr jaw w/fixation
21247	C	Reconstruct lower jaw bone
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21268	C	Revise eye sockets
21343	C	Treatment of sinus fracture
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw fracture
21356	C	Treat cheek bone fracture
21360	C	Treat cheek bone fracture
21365	C	Treat cheek bone fracture
21366	C	Treat cheek bone fracture
21385	C	Treat eye socket fracture
21386	C	Treat eye socket fracture
21387	C	Treat eye socket fracture
21390	C	Treat eye socket fracture
21395	C	Treat eye socket fracture
21408	C	Treat eye socket fracture
21422	C	Treat mouth roof fracture
21423	C	Treat mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Treat craniofacial fracture
21433	C	Treat craniofacial fracture
21435	C	Treat craniofacial fracture
21436	C	Treat craniofacial fracture
21495	C	Treat hyoid bone fracture
21510	C	Drainage of bone lesion
21557	C	Remove tumor, neck/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	Treat 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
22318	C	Treat odontoid fx w/o graft
22319	C	Treat odontoid fx w/graft

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
22325	C	Treat spine fracture
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat 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
22819	C	Kyphectomy, 3 or more
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 pelv 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 collar bone
23195	C	Removal of head of humerus
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
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
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
24940	C	Revision of upper arm

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
25170	C	Extensive forearm surgery
25390	C	Shorten radius or ulna
25391	C	Lengthen radius or ulna
25392	C	Shorten radius & ulna
25393	C	Lengthen radius & 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 transfer, toe-hand
26554	C	Double transfer, toe-hand
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
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 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	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27216	C	Treat pelvic ring fracture
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27235	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat 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
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
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/replace knee joint
27487	C	Revise/replace knee joint
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Treatment of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Treatment of thigh fracture
27519	C	Treat thigh fx growth plate
27535	C	Treat knee fracture
27536	C	Treat knee fracture
27540	C	Treat knee fracture
27556	C	Treat knee dislocation
27557	C	Treat knee dislocation
27558	C	Treat 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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
31582	C	Revision of larynx
31584	C	Treat larynx fracture
31587	C	Revision of larynx
31725	C	Clearance of airways
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
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	Drain, open, lung lesion
32201	C	Drain, percut, 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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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 with bypass
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
32997	C	Total lung lavage
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
33140	C	Heart revascularize (tmr)
33141	C	Heart tmr w/other procedure
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/thoracotomy
33237	C	Remove electrode/thoracotomy
33238	C	Remove electrode/thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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 of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of 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 or more
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, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	Cabg, arterial, four or more
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, modified fontan
33617	C	Repair single ventricle
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	Major vessel shunt
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aortic graft
33861	C	Ascending aortic graft
33863	C	Ascending aortic graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aortic 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
*33967	C	Insert ia percut device
33968	C	Remove aortic assist device
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
*33979	C	Insert intracorporeal device
*33980	C	Remove intracorporeal device
34001	C	Removal of artery clot
34051	C	Removal of artery clot
34151	C	Removal of artery clot
34401	C	Removal of vein clot
34451	C	Removal of vein clot
34502	C	Reconstruct vena cava
34800	C	Endovasc abdo repair w/tube
34802	C	Endovasc abdo repr w/device
34804	C	Endovasc abdo repr w/device
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Xpose for endoprosth, femorl
34820	C	Xpose for endoprosth, iliac
34825	C	Endovasc extend prosth, init
34826	C	Endovasc exten prosth, addl
34830	C	Open aortic tube prosth repr
34831	C	Open aortoiliac prosth repr
34832	C	Open aortofemor prosth repr
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	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 add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
35600	C	Harvest artery for cabg
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
*35647	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	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite 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
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
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)
36823	C	Insertion of cannula(s)
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
37616	C	Ligation of chest artery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
37617	C	Ligation of abdomen artery
37618	C	Ligation of extremity artery
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
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
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
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
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
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
42426	C	Excise parotid gland/lesion
42842	C	Extensive surgery of throat
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
43030	C	Throat muscle surgery
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	Parital removal of esophagus
43123	C	Partial removal of esophagus

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
43124	C	Removal of esophagus
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
*43313	C	Esophagoplasty congential
*43314	C	Tracheo-esophagoplasty cong
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
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 of stomach, partial
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of 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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath 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
*44126	C	Enterectomy w/taper, cong
*44127	C	Enterectomy w/o taper, cong
*44128	C	Enterectomy cong, add-on
44130	C	Bowel to bowel fusion
44132	C	Enterectomy, cadaver donor
44133	C	Enterectomy, live donor
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
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/ileostomy
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	Laparo, resect intestine
*44203	C	Lap resect s/intestine, addl
*44204	C	Laparo partial colectomy
*44205	C	Lap colectomy part w/ileum
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain app abscess, open
44901	C	Drain app abscess, percut
44950	C	Appendectomy
44955	C	Appendectomy add-on
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
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
*45136	C	Excise ileoanal reservoir
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 rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/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 of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47001	C	Needle biopsy, liver add-on
47010	C	Open drainage, 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
*47380	C	Open ablate liver tumor rf
*47381	C	Open ablate liver tumor cryo
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
47490	C	Incision of gallbladder
47550	C	Bile duct endoscopy add-on
47570	C	Laparo cholecystoenterostomy
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, intraop add-on
48500	C	Surgery of pancreas cyst
48510	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
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49041	C	Drain, percut, abdom abscess
49060	C	Drain, open, retrop abscess
49061	C	Drain, percut, retroper absc
49062	C	Drain to peritoneal cavity
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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	Renal abscess, open drain
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
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
50545	C	Laparo radical nephrectomy
50546	C	Laparoscopic nephrectomy
50547	C	Laparo removal donor kidney
50548	C	Laparo remove k/ureter
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
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
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
*53448	C	Remov/replc ur sphinctr comp
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis/urethra
54336	C	Revise penis/urethra
54390	C	Repair penis and bladder
*54411	C	Remv/replc penis pros, comp
*54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
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
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl
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
57311	C	Repair urethrovaginal 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
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
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(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
*58953	C	Tah, rad dissect for debulk
*58954	C	Tah rad debulk/lymph remove
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
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
60254	C	Extensive thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60520	C	Removal of thymus gland
60521	C	Removal of 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
60650	C	Laparoscopy adrenalectomy
61105	C	Twist drill hole
61107	C	Drill skull for implantation
61108	C	Drill skull for drainage
61120	C	Burr hole for puncture
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
61332	C	Explore/biopsy eye socket

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
61333	C	Explore orbit/remove lesion
61334	C	Explore orbit/remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull (press 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 foreign body, brain
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	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
61697	C	Brain aneurysm repr, complx
61698	C	Brain aneurysm repr, complx
61700	C	Brain aneurysm repr, simple
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
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61862	C	Implant neurostimul, subcort
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
62000	C	Treat skull fracture
62005	C	Treat 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 & 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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
62351	C	Implant spinal canal cath
63043	C	Laminotomy, addl cervical
63044	C	Laminotomy, addl lumbar
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	Remove vertebral body add-on
63085	C	Removal of vertebral body
63086	C	Remove vertebral body add-on
63087	C	Removal of vertebral body
63088	C	Remove vertebral body add-on
63090	C	Removal of vertebral body
63091	C	Remove vertebral body add-on
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
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	Remove vertebral body add-on

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
65273	C	Repair of eye wound
69150	C	Extensive ear canal surgery
69155	C	Extensive ear/neck surgery
69502	C	Mastoidectomy
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
75900	C	Arterial catheter exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
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
92997	C	Pul art balloon repr, percut
92998	C	Pul art balloon repr, percut
94652	C	Pressure breathing (IPPB)
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services
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
99298	C	Neonatal critical care
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital

*Code is new in 2002.

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

Urban Area (Constituent Counties)	Wage Index
0040 Abilene, TX	0.7983
Taylor, TX	
0060 [2] Aguadilla, PR	0.4832
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9876
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0640
Dougherty, GA	
Lee, GA	
0160 [2] Albany-Schenectady-Troy, NY	0.8547
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9750
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8059
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0077
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9126
Blair, PA	
0320 Amarillo, TX.	
Potter, TX	0.8711
Randall, TX	
0380 Anchorage, AK	1.2696
Anchorage, AK	
0440 Ann Arbor, MI	1.1098
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8276
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9241
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 [2] Arecibo, PR	0.4832
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9200
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9842
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 [1] Atlanta, GA	1.0058
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.1293
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8230
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9970
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 [1] Austin-San Marcos, TX	0.9597
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 [2] Bakersfield, CA	0.9659
Kern, CA	
0720 [1] Baltimore, MD	0.9856
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9593
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3626
Barnstable, MA	
0760 Baton Rouge, LA	0.8149
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8442
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1826
Whatcom, WA	
0870 [2] Benton Harbor, MI	0.9000
Berrien, MI	
0875 [1] Bergen-Passaic, NJ	1.1808
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9352
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8440
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 [2] Binghamton, NY	0.8547
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.8808
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7984
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8842
Monroe, IN	
1040 Bloomington-Normal, IL	0.9038
McLean, IL	
1080 Boise City, ID	0.9050
Ada, ID	
Canyon, ID	
1123 [1,2] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (MA Hospitals)	1.1454
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-Lowell-Brockton, MA-NH (NH Hospitals)	1.1293
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	0.9799
Boulder, CO	
1145 Brazoria, TX	0.8209
Brazoria, TX	
1150 Bremerton, WA	1.0758
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.9012
Cameron, TX	
1260 Bryan-College Station, TX	0.9328
Brazos, TX	
1280 [1] Buffalo-Niagara Falls, NY	0.9459
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9883
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 [2] Caguas, PR	0.4832
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8956
Carroll, OH	
Stark, OH	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
1350 Casper, WY	0.9496
Natrona, WY	
1360 Cedar Rapids, IA	0.8699
Linn, IA	
1400 Champaign-Urbana, IL	0.9306
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9206
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9264
Kanawha, WV	
Putnam, WV	
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9407
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0566
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9369
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 [2] Cheyenne, WY	0.8747
Laramie, WY	
1600 [1] Chicago, IL	1.1046
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	0.9856
Butte, CA	
1640 [1] Cincinnati, OH-KY-IN	0.9473
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	0.8393
Christian, KY	
Montgomery, TN	
1680 [1] Cleveland-Lorain-Elyria, OH	0.9457
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9744
El Paso, CO	
1740 Columbia, MO	0.8686
Boone, MO	
1760 Columbia, SC	0.9492
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL.	
Russell, AL	0.8440
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 [1] Columbus, OH	0.9565
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8341
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1646
Benton, OR	
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.8859
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (WV Hospital)	0.8306
Allegany, MD	
Mineral, WV	
1920 [1] Dallas, TX	0.9936
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8613
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8638
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9225
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.8972
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8775
Lawrence, AL	
Morgan, AL	
2040 [2] Decatur, IL	0.8053
Macon, IL	
2080 [1] Denver, CO	1.0328
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8779
Dallas, IA	
Polk, IA	
Warren, IA	
2160 [1] Detroit, MI	1.0487
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7988
Dale, AL	
Houston, AL	
2190 Dover, DE	1.0296
Kent, DE	
2200 Dubuque, IA	0.8519
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0284
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0532
Dutchess, NY	
2290 [2] Eau Claire, WI	0.9068
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9215
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9638
Elkhart, IN	
2335 [2] Elmira, NY	0.8547
Chemung, NY	
2340 Enid, OK	0.8357
Garfield, OK	
2360 Erie, PA	0.8716
Erie, PA	
2400 Eugene-Springfield, OR	1.1471
Lane, OR	
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8721
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8514
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9267
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.9027
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8445
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0556
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0913
Genesee, MI	
2650 Florence, AL	0.7889
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8722

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0045
Larimer, CO	
2680 [1] Ft. Lauderdale, FL	1.0784
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9374
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0214
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8053
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9002
Okaloosa, FL	
2760 Fort Wayne, IN	0.9203
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 [1] Forth Worth-Arlington, TX	0.9394
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	0.9984
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8792
Etowah, AL	
2900 Gainesville, FL	0.9481
Alachua, FL	
2920 Galveston-Texas City, TX	1.0313
Galveston, TX	
2960 Gary, IN	0.9530
Lake, IN	
Porter, IN	
2975 [2] Glens Falls, NY	0.8547
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8709
Wayne, NC	
2985 Grand Forks, ND-MN	0.9119
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9774
Mesa, CO	
3000 [1] Grand Rapids-Muskegon-Holland, MI	1.0048
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.9195
Cascade, MT	
3060 Greeley, CO	0.9495
Weld, CO	
3080 Green Bay, WI	0.9357
Brown, WI	
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9539
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9289
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9217
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 [2] Hagerstown, MD	0.8859
Washington, MD	
3200 Hamilton-Middletown, OH	0.9287
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9425
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 [1,2] Hartford, CT	1.2077
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7528
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9367
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1544
Honolulu, HI	
3350 Houma, LA	0.7975
Lafourche, LA	
Terrebonne, LA	
3360 [1] Houston, TX	0.9631
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9616
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8883
Limestone, AL	
Madison, AL	
3480 [1] Indianapolis, IN	0.9698
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9859
Johnson, IA	
3520 Jackson, MI	0.9257
Jackson, MI	
3560 Jackson, MS	0.8491
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9013
Madison, TN	
Chester, TN	
3600 [1] Jacksonville, FL	0.9223
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 [2] Jacksonville, NC	0.8535
Onslow, NC	
3610 [2] Jamestown, NY	0.8547
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9739
Rock, WI	
3640 Jersey City, NJ	1.1178
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8617
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8723
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.8425
Craighead, AR	
3710 Joplin, MO	0.8727
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0639
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9889
Kankakee, IL	
3760 [1] Kansas City, KS-MO	0.9536
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9568
Kenosha, WI	
3810 [2] Killeen-Temple, TX	0.7714
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8890
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Union, TN	
3850 Kokomo, IN	0.9184
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9250
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8544
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9121
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7765
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9067
Polk, FL	
4000 Lancaster, PA	0.9296
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9653
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.7849
Webb, TX	
4100 [2] Las Cruces, NM	0.8676
Dona Ana, NM	
4120 [1] Las Vegas, NV-AZ	1.1182
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7812
Douglas, KS	
4200 Lawton, OK	0.8682
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9287
Androscoggin, ME	
4280 Lexington, KY	0.8791
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9470
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0173
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8955
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8571
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 [1] Los Angeles-Long Beach, CA	1.1961
Los Angeles, CA	
4520 [1] Louisville, KY-IN	0.9529
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8463
Lubbock, TX	
4640 Lynchburg, VA	0.9103
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8971
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0367
Dane, WI	
4800 Mansfield, OH	0.8726
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4860
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8378
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0314
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9913
Brevard, Fl	
4920 [1] Memphis, TN-AR-MS	0.8978
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9947
Merced, CA	
5000 [1] Miami, FL	0.9950
Dade, FL	
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1469
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 [1] Milwaukee-Waukesha, WI	0.9971
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 [1] Minneapolis-St. Paul, MN-WI	1.0930
Anoka, MN	
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	
5140 Missoula, MT	0.9364
Missoula, MT	
5160 Mobile, AL	0.8084
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0820
Stanislaus, CA	
5190 [1] Monmouth-Ocean, NJ	1.1257
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8201
Ouachita, LA	
5240 [2] Montgomery, AL	0.7400
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9939
Delaware, IN	
5330 Myrtle Beach, SC	0.8771
Horry, SC	
5345 Naples, FL	0.9699
Collier, FL	
5360 [1] Nashville, TN	0.9754
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 [1] Nassau-Suffolk, NY	1.3643
Nassau, NY	
Suffolk, NY	
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-	1.2294
Danbury, CT	
Fairfield, CT	
New Haven, CT	
5523 [2] New London-Norwich, CT	1.2077
New London, CT	
5560 [1] New Orleans, LA	0.9036
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 [1] New York, NY	1.4427
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 [1] Newark, NJ	1.1622
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1113

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Orange, NY	
Pike, PA	
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8579
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 [1] Oakland, CA	1.5319
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9556
Marion, FL	
5800 Odessa-Midland, TX	1.0104
Ector, TX	
Midland, TX	
5880 [1] Oklahoma City, OK	0.8694
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1350
Thurston, WA	
5920 Omaha, NE-IA	0.9712
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 [1] Orange County, CA	1.1246
Orange, CA	
5960 [1] Orlando, FL	0.9642
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8334
Daviess, KY	
6015 Panama City, FL	0.9061
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8133
Washington, OH	
Wood, WV	
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8668
Washington, OH	
Wood, WV	
6080 [2] Pensacola, FL	0.8794
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8773
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 [1] Philadelphia, PA-NJ	1.0947
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 [1] Phoenix-Mesa, AZ	0.9638
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7895
Jefferson, AR	
6280 [1] Pittsburgh, PA	0.9560
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 [2] Pittsfield, MA	1.1454
Berkshire, MA	
6340 Pocatello, ID	0.9448
Bannock, ID	
6360 Ponce, PR	0.5218
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9427
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 [1] Portland-Vancouver, OR-WA	1.1150
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 [1] Providence-Warwick-Pawtucket, RI	1.0805
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9843
Utah, UT	
6560 [2] Pueblo, CO	0.8811
Pueblo, CO	
6580 Punta Gorda, FL	0.9015
Charlotte, FL	
6600 Racine, WI	0.9333
Racine, WI	
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9818
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8869
Pennington, SD	
6680 Reading, PA	0.9583
Berks, PA	
6690 Redding, CA	1.1155
Shasta, CA	
6720 Reno, NV	1.0421
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0960
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9678
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 [1] Riverside-San Bernardino, CA	1.1112
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8371
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1462
Olmsted, MN	
6840 [1] Rochester, NY	0.9347
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9204
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9109
Edgecombe, NC	
Nash, NC	
6920 [1] Sacramento, CA	1.1831
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9590
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9919
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.7899
Andrew, MO	
Buchanan, MO	
7040 [1] St. Louis, MO-IL	0.8931
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 [2] Salem, OR	1.0033
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4684
Monterey, CA	
7160 [1] Salt Lake City-Ogden, UT	0.9863
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8193
Tom Green, TX	
7240 [1] San Antonio, TX	0.8584
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 [1] San Diego, CA	1.1265
San Diego, CA	
7360 [1] San Francisco, CA	1.4140
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 [1] San Jose, CA	1.4193
Santa Clara, CA	
7440 [1,2]San Juan-Bayamon, PR	0.4832
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0990
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0802
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3970
Santa Cruz, CA	
7490 Santa Fe, NM	1.0194
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3034
Sonoma, CA	
7510 Sarasota-Bradenton, FL	1.0090
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9243
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8683
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 [1] Seattle-Bellevue-Everett, WA	1.1361
Island, WA	
King, WA	
Snohomish, WA	
7610 [2] Sharon, PA	0.8607
Mercer, PA	
7620 [2] Sheboygan, WI	0.9068
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9373
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9050
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8767
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9139
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9993
St. Joseph, IN	
7840 Spokane, WA	1.0668
Spokane, WA	
7880 Springfield, IL	0.8676
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8567
Christian, MO	
Greene, MO	
Webster, MO	
8003 [2] Springfield, MA	1.1454
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9133
Centre, PA	
8080 [2] Steubenville-Weirton, OH-WV (OH Hospitals)	0.8668
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8637
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0988
San Joaquin, CA	
8140 [2] Sumter, SC	0.8512
Sumter, SC	
8160 Syracuse, NY	0.9621
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1616
Pierce, WA	
8240 [2] Tallahassee, FL	0.8794
Gadsden, FL	
Leon, FL	
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.8925
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 [2] Terre Haute, IN	0.8721
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8327
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9809
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.8912
Shawnee, KS	
8480 Trenton, NJ	1.0416
Mercer, NJ	
8520 Tucson, AZ	0.8976
Pima, AZ	
8560 Tulsa, OK	0.8902
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8171
Tuscaloosa, AL	
8640 Tyler, TX	0.9641
Smith, TX	
8680 [2] Utica-Rome, NY	0.8547
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3562
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0994
Ventura, CA	
8750 Victoria, TX	0.8328
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0441
Cumberland, NJ	
8780 [2] Visalia-Tulare-Porterville, CA	0.9659
Tulare, CA	
8800 Waco, TX	0.8150
McLennan, TX	
8840 [1] Washington, DC-MD-VA-WV	1.0962
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
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 ..	0.8677
Black Hawk, IA	
8940 Wausau, WI	0.9696
Marathon, WI	
8960 [1] West Palm Beach-Boca Raton, FL	0.9777
Palm Beach, FL	
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.8067
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8668
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9606
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7946
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8628
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0877
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9409
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0567
Yakima, WA	
9270 Yolo, CA	0.9701
Yolo, CA	
9280 York, PA	0.9441
York, PA	
9320 Youngstown-Warren, OH ..	0.9563
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0359
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8989
Yuma, AZ	

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2002.

ADDEMDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban Area	Wage Index
Alabama	0.7400
Alaska	1.1862
Arizona	0.8681
Arkansas	0.7489
California	0.9659
Colorado	0.8811
Connecticut	1.2077
Delaware	0.9589
Florida	0.8794
Georgia	0.8295
Hawaii	1.1112
Idaho	0.8718
Illinois	0.8053
Indiana	0.8721
Iowa	0.8147
Kansas	0.7812
Kentucky	0.7963
Louisiana	0.7692
Maine	0.8721
Maryland	0.8859
Massachusetts	1.1454
Michigan	0.9000
Minnesota	0.9035
Mississippi	0.7528
Missouri	0.7899
Montana	0.8655
Nebraska	0.8142
Nevada	0.9727
New Hampshire	0.9779
New Jersey [1]	.....
New Mexico	0.8676
New York	0.8547
North Carolina	0.8535
North Dakota	0.7879
Ohio	0.8668
Oklahoma	0.7566
Oregon	1.0038
Pennsylvania	0.8607
Puerto Rico	0.4832
Rhode Island [1]	.....
South Carolina	0.8512
South Dakota	0.7861
Tennessee	0.7928
Texas	0.7714
Utah	0.9051
Vermont	0.9608
Virginia	0.8241
Washington	1.0209
West Virginia	0.8067
Wisconsin	0.9068
Wyoming	0.8747

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED

Area	Wage Index
Abilene, TX	0.7983
Akron, OH	0.9876
Albany, GA	1.0640
Albuquerque, NM	0.9750
Alexandria, LA	0.8059
Allentown-Bethlehem-Easton, PA	1.0077
Altoona, PA	0.9126
Amarillo, TX	0.8502
Anchorage, AK	1.2696

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Ann Arbor, MI	1.1098
Anniston, AL	0.7841
Asheville, NC	0.9200
Athens, GA	0.9706
Atlanta, GA	1.0058
Augusta-Aiken, GA–SC	0.9970
Austin-San Marcos, TX	0.9597
Barnstable-Yarmouth, MA	1.3423
Baton Rouge, LA	0.8149
Bellingham, WA	1.1296
Benton Harbor, MI	0.9000
Bergen-Passaic, NJ	1.1808
Billings, MT	0.9352
Biloxi-Gulfport-Pascagoula, MS	0.8105
Binghamton, NY	0.8607
Birmingham, AL	0.8808
Bismarck, ND	0.7984
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1293
Burlington, VT (VT Hospitals)	0.9608
Burlington, VT (NY Hospitals)	0.9606
Caguas, PR	0.4832
Casper, WY	0.9346
Champaign-Urbana, IL	0.9140
Charleston-North Charleston, SC	0.9206
Charleston, WV	0.8902
Charlotte-Gastonia-Rock Hill, NC–SC	0.9407
Chattanooga, TN–GA	0.9181
Chicago, IL	1.0917
Cincinnati, OH–KY–IN	0.9473
Clarksville-Hopkinsville, TN–KY ...	0.8393
Cleveland-Lorain-Elyria, OH	0.9457
Columbia, MO	0.8686
Columbia, SC	0.9168
Columbus, GA–AL	0.8440
Columbus, OH	0.9565
Corpus Christi, TX	0.8238
Dallas, TX	0.9936
Davenport-Moline-Rock Island, IA–IL	0.8538
Dayton-Springfield, OH	0.9225
Denver, CO	1.0328
Des Moines, IA	0.8779
Dothan, AL	0.7988
Dover, DE	1.0003
Duluth-Superior, MN–WI	1.0284
Eau Claire, WI	0.9068
Elkhart-Goshen, IN	0.9517
Erie, PA	0.8716
Eugene-Springfield, OR	1.1006
Fargo-Moorhead, ND–MN	0.9166
Fayetteville, NC	0.8869
Flagstaff, AZ–UT	1.0105
Flint, MI	1.0810
Florence, AL	0.7889
Florence, SC	0.8722
Fort Collins-Loveland, CO	1.0045
Ft. Lauderdale, FL	1.0784
Fort Pierce-Port St. Lucie, FL	1.0114
Fort Smith, AR–OK	0.7857
Fort Walton Beach, FL	0.8828
Fort Wayne, IN	0.9203
Forth Worth-Arlington, TX	0.9394
Gadsden, AL	0.8386
Gainesville, FL	0.9481
Grand Forks, ND–MN	0.9119
Grand Junction, CO	0.9774

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Grand Rapids-Muskegon-Holland, MI	0.9939
Great Falls, MT	0.9195
Greeley, CO	0.9495
Green Bay, WI	0.9357
Greensboro-Winston-Salem-High Point, NC	0.9395
Greenville, NC	0.9289
Greenville-Spartanburg-Anderson, SC	0.9217
Harrisburg-Lebanon-Carlisle, PA	0.9425
Hartford, CT	1.1571
Hattiesburg, MS	0.7528
Hickory-Morganton-Lenoir, NC	0.9367
Honolulu, HI	1.1544
Houston, TX	0.9631
Huntington-Ashland, WV–KY–OH	0.9238
Huntsville, AL	0.8696
Indianapolis, IN	0.9698
Iowa City, IA	0.9708
Jackson, MS	0.8491
Jackson, TN	0.8843
Jacksonville, FL	0.9223
Johnson City-Kingsport-Bristol, TN–VA	0.8617
Jonesboro, AR	0.8115
Joplin, MO	0.8528
Kalamazoo-Battlecreek, MI	1.0471
Kansas City, KS–MO	0.9536
Knoxville, TN	0.8890
Kokomo, IN	0.9184
Lafayette, LA	0.8395
Lansing-East Lansing, MI	0.9653
Las Vegas, NV–AZ	1.1182
Lawton, OK	0.8281
Lexington, KY	0.8641
Lima, OH	0.9470
Lincoln, NE	0.9843
Little Rock-North Little Rock, AR	0.8800
Longview-Marshall, TX	0.8571
Los Angeles-Long Beach, CA	1.1961
Louisville, KY–IN	0.9416
Lubbock, TX	0.8463
Lynchburg, VA	0.8795
Macon, GA	0.8971
Madison, WI	1.0367
Mansfield, OH	0.8726
Medford-Ashland, OR	1.0033
Memphis, TN–AR–MS	0.8793
Miami, FL	0.9950
Milwaukee-Waukesha, WI	0.9865
Minneapolis-St. Paul, MN–WI	1.0930

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Missoula, MT	0.9177
Mobile, AL	0.8084
Modesto, CA	1.0820
Monmouth-Ocean, NJ	1.1257
Monroe, LA	0.8097
Montgomery, AL	0.7400
Myrtle Beach, SC	0.8577
Nashville, TN	0.9552
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2294
New London-Norwich, CT	1.1526
New Orleans, LA	0.9036
New York, NY	1.4287
Newark, NJ	1.1622
Newburgh, NY–PA	1.0797
Oakland, CA	1.5319
Odessa-Midland, TX	0.9495
Oklahoma City, OK	0.8694
Omaha, NE–IA	0.9712
Orange County, CA	1.1246
Orlando, FL	0.9642
Peoria-Pekin, IL	0.8773
Philadelphia, PA–NJ	1.0947
Pine Bluff, AR	0.7895
Pittsburgh, PA	0.9419
Pittsfield, MA	0.9904
Pocatello, ID	0.9159
Portland, ME	0.9427
Portland-Vancouver, OR–WA	1.1150
Provo-Orem, UT	0.9843
Raleigh-Durham-Chapel Hill, NC	0.9818
Rapid City, SD	0.8869
Reading, PA	0.9216
Redding, CA	1.1155
Reno, NV	1.0421
Richland-Kennewick-Pasco, WA	1.0356
Richmond-Petersburg, VA	0.9678
Roanoke, VA	0.8371
Rochester, MN	1.1462
Rockford, IL	0.9042
Sacramento, CA	1.1831
Saginaw-Bay City-Midland, MI	0.9590
St. Cloud, MN	0.9919
St. Joseph, MO	0.8121
St. Louis, MO–IL	0.8931
Salinas, CA	1.4570
Salt Lake City-Ogden, UT	0.9863
San Diego, CA	1.1265
Santa Fe, NM	0.9765
Santa Rosa, CA	1.2631
Sarasota-Bradenton, FL	1.0090
Savannah, GA	0.9243

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Seattle-Bellevue-Everett, WA	1.1361
Sherman-Denison, TX	0.9003
Shreveport-Bossier City, LA	0.9050
Sioux City, IA–NE	0.8767
Sioux Falls, SD	0.8939
South Bend, IN	0.9993
Spokane, WA	1.0668
Springfield, IL	0.8571
Springfield, MO	0.8357
Stockton-Lodi, CA	1.0988
Syracuse, NY	0.9621
Tampa-St. Petersburg-Clearwater, FL	0.8925
Texarkana,AR-Texarkana, TX	0.8327
Toledo, OH	0.9809
Topeka, KS	0.8749
Tucson, AZ	0.8976
Tulsa, OK	0.8760
Tuscaloosa, AL	0.8171
Tyler, TX	0.9359
Victoria, TX	0.8328
Waco, TX	0.8150
Washington, DC–MD–VA–WV	1.0854
Waterloo-Cedar Falls, IA	0.8677
Wausau, WI	0.9558
West Palm Beach-Boca Raton, FL	0.9777
Wichita, KS	0.9237
Wichita Falls, TX	0.7946
Wilmington-Newark, DE–MD	1.0877
Rural Alabama	0.7528
Rural Florida	0.8794
Rural Illinois (IA Hospitals)	0.8147
Rural Illinois (MO Hospitals)	0.8053
Rural Kentucky	0.7963
Rural Louisiana	0.7692
Rural Minnesota	0.9035
Rural Missouri	0.7899
Rural Montana	0.8655
Rural Nebraska	0.8142
Rural Nevada	0.9161
Rural Oregon	1.0038
Rural Texas	0.7714
Rural Washington	1.0209
Rural Wisconsin	0.9068
Rural Wyoming	0.8747

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