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42 CFR Parts 410 and 419

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

[CMS–1471–FC]

RIN 0938–AL19

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements 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. These changes are applicable to services furnished on or after January 1, 2004. Finally, this rule responds to public comments received on the August 12, 2003 proposed rule for revisions to the hospital outpatient prospective payment system and payment rates (68 FR 47966).

DATES: *Effective date:* This final rule is effective January 1, 2004.

Comment date: We will consider comments on the ambulatory payment classification assignments of Healthcare Common Procedure Coding System codes identified in Addendum B with new interim (NI) condition codes, if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 6, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1471–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1471–FC, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

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

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786–0378—outpatient prospective payment issues; Suzanne Asplen, (410) 786–4558 or Jana Petze, (410) 786–9374—partial hospitalization and community mental health centers issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call (410) 786–7195.

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Alphabetical List of Acronyms Appearing in This Final Rule With Comment Period

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
ASC Ambulatory surgical center
AWP Average wholesale price
BBA Balanced Budget Act of 1997
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
CAH Critical access hospital
CCR Cost center specific cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2002, copyrighted by the American Medical Association
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DRG Diagnosis-related group
DSH Disproportionate Share Hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
ESRD End-stage renal disease
FACA Federal Advisory Committee Act
FDA Food and Drug Administration
FI Fiscal intermediary
FSS Federal Supply Schedule
FY Federal fiscal year
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect Medical Education
IPPS (Hospital) inpatient prospective payment system
IVIG Intravenous Immune Globulin
LTC Long Term Care
MedPAC Medicare Payment Advisory Commission
MDH Medicare Dependent Hospital
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OCE Outpatient code editor
OMB Office of Management and Budget
OPD (Hospital) outpatient department
OPPS (Hospital) outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
RFA Regulatory Flexibility Act
RRC Rural Referral Center
SBA Small Business Administration
SCH Sole Community Hospital
SDP Single drug pricer
SI Status Indicator
TEFRA Tax Equity and Fiscal Responsibility Act
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information

I. Background

A. Authority for the Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the 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 OPPS was first implemented for services furnished on or after August 1, 2000.

B. Summary of Rulemaking for the Outpatient Prospective Payment System

- 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 April 7, 2000, we published a final rule with comment period (65 FR

18434) 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, 2000 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 and amended by the BBRA. Medicare regulations governing the hospital OPPS are set forth at 42 CFR part 419. Subsequently, we announced 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 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) to provide the annual update to the amounts and factors for OPPS payment rates effective for services furnished on or after January 1, 2001. We implemented the 2001 OPPS on 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 November 2, 2001, we published a final rule (66 FR 55857) that announced the Medicare OPPS conversion factor for calendar year (CY) 2002. It also described the Secretary s estimate of the total amount of the transitional pass-through payments for CY 2002 and the implementation of a uniform reduction in each of the pass-through payments for that year.
- On November 2, 2001, we also published an interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payments under Medicare's OPPS.
- On November 30, 2001, we published a final rule (66 FR 59856) that revised the Medicare OPPS to implement applicable statutory requirements, including relevant provisions of BIPA, and changes resulting from continuing experience with this system. In addition, it described the CY 2002 payment rates for Medicare hospital outpatient services paid under the PPS. This final rule also announced a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments for certain categories of medical devices and drugs and biologicals.
- On December 31, 2001, we published a final rule (66 FR 67494) that delayed, until no later than April 1, 2002, the effective date of CY 2002 payment rates and the uniform reduction of transitional pass-through payments that were announced in the November 30, 2001 final rule. In addition, this final rule indefinitely delayed certain related regulatory provisions.
- On March 1, 2002, we published a final rule (67 FR 9556) that corrected technical errors that affected the amounts and factors used to determine the payment rates for services paid under the Medicare OPPS and corrected the uniform reduction to be applied to transitional pass-through payments for CY 2002 as published in the November 30, 2001 final rule. These corrections and the regulatory provisions that had been delayed became effective on April 1, 2002.
- On November 1, 2002, we published a final rule (67 FR 66718) that revised the Medicare OPPS to update the payment weights and conversion factor for services payable under the 2003 OPPS on the basis of data from claims for services furnished from April 1, 2001 through March 31, 2002. The rule also removed from pass-through status most drugs and devices that had been paid under pass-through provisions in 2002 as required by the applicable provisions of law governing the duration of pass-through payment.
- On August 12, 2003, we published a proposed rule (68 FR 47966) that proposed the Medicare OPPS conversion factor for CY 2004. In addition, it described proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system.

C. Summary of Changes in the August 12, 2003 Proposed Rule

On August 12, 2003, we published a proposed rule (68 FR 47966) that proposed changes to the Medicare hospital OPPS and CY 2004 payment rates including proposed changes 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 12, 2003 proposed rule.

1. Changes Required by Statute

We proposed the following changes to implement statutory requirements:

- Add APCs, delete APCs, and modify the composition of some existing APCs.
- Recalibrate the relative payment weights of the APCs.
- Update the conversion factor and the wage index.
- Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.
- Cease transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.
- Cease transitional outpatient payments (TOPS payments) for all hospitals paid under OPPS except for cancer hospitals and children s hospitals.

2. Additional Changes to OPPS

We proposed the following additional changes to the OPPS:

- Adjust payment to moderate the effects of decreased median costs for non-pass-through drugs, biologicals, and radiopharmaceuticals.
- Implement a new method for paying for drug administration.
- Create new evaluation and management service codes for outpatient clinic and emergency department encounters.
- Change status indicators for Healthcare Common Procedure Coding System (HCPCS) codes.
- List midyear and proposed HCPCS codes that are paid under OPPS.
- Allocate a portion of the outlier percentage target amount to community mental health centers (CMHCs) and create a separate threshold for outlier payments for partial hospitalization services.
- Create methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004.
- Make several changes in our current payment policy with regard to payment

for Q0081, Q0083, Q0084, and Q0085 to facilitate accurate payments for drugs and drug administration.

• Change the status indicator and payment amount for P9010 by assigning it to APC 0957 (Platelet concentrate) with a payment rate of $37.30.

• Establish new payment bands for new technology APCs.

D. Public Comments and Responses to the August 12, 2003 Proposed Rule

We received approximately 876 timely items of correspondence containing multiple comments on the August 12, 2003 proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate section heading of this final rule with comment period.

We received comments from various sources including but not limited to health care facilities, physicians, drug and device manufacturers, and beneficiaries. Hospital associations and the Medicare Payment Advisory Commission (MedPAC) generally supported our proposed approach to revising the relative weights for APCs. Pharmaceutical and medical device manufacturers and some individual hospitals that furnish particular devices or drugs were concerned with the proposed reductions in payment for medical devices and drugs. We received many thoughtful comments from a wide range of commenters with regard to methodological issues in OPPS. In addition, several comments provided external data to support their assertions. The following are the major issues addressed by the commenters:

• The proposal to use $150 as the packaging threshold for separate payment of drugs.

• The proposal to pay for orphan drugs within the OPPS, basing payment on claims data.

• The proposal to pay for generic drugs at 43 percent of average wholesale prices (AWP) beginning with the time of the generic drug's Food and Drug Administration (FDA) approval.

• The proposed payments for blood and blood products under OPPS.

• The proposal to establish a separate outlier pool for community mental health centers(CMHCs).The proposal to apply an adjustment to increase payment to small rural hospitals' clinic and emergency room (ER) visit rates to ameliorate the effect of the sunsetting of the transitional corridor payments.

• The proposal to reinstitute drug and device coding requirements.

• Propose APC assignments and status indicators for numerous services.

In addition to comments regarding the policy proposals in the August 12, 2003 proposed rule, we received comments about the publication date of the proposed rule and the comment period.

Comment: Some commenters objected to the use of the date on which the August 12, 2003 proposed rule was made public by web posting and by public display at the Office of the Federal Register as the beginning of the comment period. They indicated that we should start the comment period only on the publication of the proposed rule in the **Federal Register** because that is where subscribers look for it. They objected to what they view as a 55-day comment period if it were to start on the date of **Federal Register** publication (August 12, 2003). Some commenters objected to the publication of the proposed rule so late in the year. They indicated that our publication on August 9 resulted in the comment period ending so close to the publication deadline for the final rule that they believed that their comments could not be fully analyzed and used and would not be as effective as if the proposed rule were published in June or early July. They urged us to publish the proposed rule in late spring. Some commenters objected to the scheduling of the APC Panel meeting so soon after the issuance of the proposed rule because they felt that it gave them inadequate time to prepare their presentations for the Panel.

Response: The comment period on a proposed rule begins on the day that the proposed rule is available for public comment. We believe that putting the document on display at the Office of the Federal Register and also making it available on the CMS Web site meets the test of being publicly available and that, therefore, is the start of the comment period. The publication of the proposed rule on the internet makes it available to many more people than routinely access the **Federal Register** or can visit the Office of the Federal Register where the display copy is located. The public had 60 days to comment on the proposed rule. This is the standard amount of time generally allowed for comment on notices of proposed rulemaking. Therefore, we do not believe the public was at a disadvantage or limited in the amount of time available to make public comments.

Our review of the public comments is extensive, with the comments being read and considered carefully, often by many staff. We agree that it is preferable, when possible, to issue the proposed rule as early as possible. However, the important issue is whether we have sufficient time to carefully and thoughtfully consider all comments in development of the final rule, rather than the amount of time between the end of the comment period and the publication of the final rule.

II. Changes to the Ambulatory Payment Classification (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. 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, relative payment weights, and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act requires the Secretary, beginning in 2001, to consult with an outside panel of experts to review the APC groups and the relative payment 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, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (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 purposes of the proposed rule and 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 on APC Groups

Section 1833(t)(9)(A) of the Social Security Act (the Act) requires that we consult with an outside panel of experts, the Panel, to review the clinical integrity of the APC groups and their

weights. The Act specifies that the Panel will act in an advisory capacity. This expert panel, which is to be composed of representatives of providers subject to the OPPS (currently employed full-time, in their respective areas of expertise), reviews and advises 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 is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA) as amended (Pub. L. 92–463).

On November 1, 2002, the Secretary renewed the charter. The new charter indicates that the Panel continues to be technical in nature, is governed by the provisions of the FACA, may convene ''up to three meetings per year,'' and is chaired by a Federal official.

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 a colleague or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the Panel.

Because of the loss of 6 Panel members in March 2003 due to the expiration of terms of office, retirement, and a career change, a **Federal Register** notice was published on February 28, 2003 (68 FR 9671), requesting nominations of Panel members. From the 40 nominations we received, 6 new members have been chosen and have been identified on the CMS web site.

We received one comment regarding our selection of Panel members.

Comment: One commenter stated that Community Mental Health Centers (CMHCs) have not been represented on the APC Panel even though the names of qualified nominees have been submitted. The commenter went on to say that the **Federal Register** (February 28, 2003, at 68 FR 9671 through 9672) specifically states, ''Qualified nominees will meet those requirements necessary to be a Panel member. Panel members must be representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPS * * * [therefore,] I feel that it is imperative to have a freestanding CMHC representative on the Panel.''

Response: The **Federal Register** notice on the APC Panel to which the commenter referred, states in section II, Criteria for Nominees, the following: ''The Panel shall consist of up to 15 members selected by the Secretary, or designee, from among representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPS.'' The language does not mandate that a CMHC representative will be on the Panel. In the regulation, we simply identified representatives from CMHCs—or any other organizations—as possible nominees.

This year, when we requested nominations for the APC Panel, the list of nominees was long, prestigious, and included representatives from all aspects of the health care industry: Doctors, nurses, hospital administrators, coders, etc. Therefore, our choices were difficult; however, since there are definite Federal guidelines governing our selections, and specific Panel and Agency needs to address, given the clinical range of services paid under the OPPS, we were able to identify the most qualified individuals. Since the needs of the Agency and the Panel change due to members leaving, we invite all concerned Medicare providers to continue to nominate qualified individuals when the need arises.

The Panel's biannual meetings are forums to discuss APCs and representatives from the CMCHs—and other organizations—are invited to attend Panel meetings and to make presentations to the Panel on relevant agenda items.

Comment: The commenter also stated that the APC Panel sets the payment rates for the outpatient services.

Response: While the Panel is an advisory committee mandated by law to review the APC groups, and their associated weights, and to advise the Secretary of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services concerning the clinical integrity of the APC groups and their weights, the APC Panel does not set payment rates for outpatient services. The advice provided by the Panel is considered by us in our development of the annual rulemaking to update the hospital OPPS. The APC Panel's activities most often address whether or not the HCPCS codes within the APCs are comparable clinically and with respect to resource use, assigning new codes to new or existing APCs, reassigning codes to different APCs, and the configuring of existing APCs into new APCs.

2. August 2003 Meeting

The APC Panel met on August 22, 2003 to discuss issues presented in the proposed rule of August 12. We announced the meeting in the **Federal Register** on July 25 and invited the public to make presentations to the Panel on issues discussed in the proposed rule. In this section, we summarize the issues discussed by the Panel, their recommendations on those issues, and our decisions with respect to their recommendations.

a. Blood and Blood Products

The Panel heard testimony by suppliers of blood and blood products and their representatives who expressed significant concerns about the proposed payment rates, particularly in light of new safety and testing requirements. These presenters to the Panel recommended that we exclude blood and blood products from the OPPS and pay for them at reasonable cost. After listening to the testimony, reviewing the median costs and proposed payments rate from our hospital claims data, and deliberating the issue, the Panel recommended that we continue to pay for blood and blood products within the OPPS. However, the Panel further recommended that we freeze the payment rates for blood and blood products at 2003 levels for 2004 and 2005 while we undertake further analysis of the cost data. The Panel also recommended that hospitals be educated on the proper billing for blood and blood products.

As discussed elsewhere in this final rule, we will accept the Panel's recommendation with respect to 2004. We will freeze the payment rates for blood and blood products at the 2003 payment levels. However, we are not making a decision with respect to 2005 at this time. Any proposals regarding our 2005 payment rates or policies for these items will be discussed in our proposed rule for the CY 2005 update. The Panel also recommended that the APCs for blood and blood products be on the agenda for the winter 2004 meeting in time for consideration of the 2005 payment rates. We agree to place this item on the agenda for the next APC Panel meeting.

b. Nuclear Medicine, Brachytherapy, and Radiosurgery Services

(1) Nuclear Medicine APCs and Radiopharmaceuticals

The Panel heard testimony on and considered the proposed restructuring of the nuclear medicine APCs discussed in the August 12, 2003 proposed rule. The Panel recommended that we move forward with the categorization system in the proposed OPPS 2004 rule absent strong, reasoned opposition from provider groups. If strong opposition was revealed in the public comments,

the Panel recommended that we maintain the classification system that is in place for 2003. The Panel also recommended that we change the HCPCS code descriptors for radiopharmaceuticals to be on a ''per-dose'' basis—not on a ''per-unit'' basis.

We have accepted the Panel's recommendation that we move forward with the proposed restructuring, after considering public comments on this issue. As discussed in section II.A.3 of this final rule, we will implement the restructuring with certain changes to the proposed reclassification based on our review of the public comments. For reasons discussed in section VI.B.3 of this final rule, we are not accepting the Panel's recommendation to change the HCPCS code descriptors at this time.

The Panel further recommended that APCs for radiopharmaceuticals be on the agenda for the January 2004 meeting. In preparation for that meeting, the Panel recommended that our staff analyze the claims for the nuclear medicine APCs and do the following: Itemize the costs, determine what proportion of the median cost can be attributed to radiopharmaceuticals, and present the data at the Panel's January 2004 meeting. The Panel recommended that the issue of packaging the costs of radiopharmaceuticals under the 2003 threshold of $150 be placed on the agenda for the Panel's winter 2004 meeting.

We will consider this topic for placement on the agenda for the Panel's 2004 meeting. As discussed in section VI.B.3 of this rule, however, we are revising our threshold for packaging radiopharmaceuticals from $150 to $50.

(2) Brachytherapy Services

The Panel recommended that we review whether the codes for needles and catheters were included in the payment rate proposed for APC 0313. The Panel also recommended that we consider outside data presented by commenters in establishing payment rates for APCs 312 and 651 to arrive at an appropriate payment rate. See our discussion, below, regarding APCs 312, 313, and 651 and our considerations concerning the claims used to set the relative weights for these APCs.

The Panel further recommended that we discontinue use of G codes for prostate brachytherapy and use appropriate Current Procedural Terminology (CPT) codes paid in clinical APCs when making payment for these services. The Panel recommended we pay separately for brachytherapy sources for the treatment of prostate cancer in the same manner by which we are paying separately for the brachytherapy sources for the treatment of other types of cancer. We have accepted the Panel's recommendation. As discussed in section II.B.4 of this final rule, we will discontinue use of the special G codes for prostate brachytherapy and allow separate payment for the sources used in these treatments.

(3) Radiation Therapy and Radiosurgery APC Issues

The APC Panel heard testimony concerning radiation treatment delivery codes CPT 77412 through 77416, which we proposed to assign to APC 0301 and CPT 77417, assigned to APC 0260. The presenter stated that many hospital billing departments had not updated their charge masters since the inception of OPPS to reflect the costs of newer technology, specifically with respect to the use of x-ray guidance during external beam radiation treatment delivery. The APC Panel recommended that we review whether the use of x-ray guidance (as opposed to CT or ultrasound guidance) for radiation therapy is being properly reported and included in the payment rates for the radiation treatment delivery codes. We agree that we should review these issues further and will do so in preparation for the 2005 update. However, we did not receive sufficient or convincing information upon which to base a change for 2004. Therefore, we encourage interested parties to submit any additional information on the use of these codes and cost of providing these services in the outpatient hospital setting in response to this final rule with comment period.

The APC Panel also heard testimony concerning the proposed payment rate for CPT 77418, assigned to APC 0412 (IMRT treatment delivery). The presenter stated that the proposed amount was too low. However, the APC Panel supported the proposal in the absence of compelling evidence that the rate derived from the claims data is wrong. We concur with the APC Panel's recommendation and will retain CPT 77418 in APC 0412. We used approximately 113,000 claims to set the weight for this procedure, which we believe is a sufficiently robust set of data.

During this section of the APC Panel's August 22 meeting, the Panel members also heard testimony concerning HCPCS codes G0251 and G0173 used to report stereotactic radiosurgery. The APC Panel supported the proposed payment rates for these codes until more data become available. The APC Panel also asked to review this issue further at its winter 2004 meeting. We discuss stereotactic radiosurgery in further detail below. We have decided to make certain changes to the payment for these procedures. However, the APC assignment for these codes for 2004 is interim final. We solicit comments on the 2004 assignments, and we will also include this on the APC Panel's agenda for its winter 2004 meeting.

The final topic in this section of the APC Panel's August 22 meeting pertained to HCPCS codes G0242 and G0243 (multi source photon stereotactic planning). The APC Panel was requested to recommend that we combine the coding for these procedures under one code, with the payment for the new code derived by adding the payment for G0242 and G0243 together. The information presented to the APC Panel stated that the services represented by the two G codes represent one continuous procedure, that it is a surgical procedure, and the cost center mapping should be to a surgical cost center. The APC Panel will review this request at its winter 2004 meeting. The APC Panel is interested in receiving comments on this topic from professional societies representing neurosurgeons, radiation oncologists and others concerning this proposal.

c. Payment and Coding for Drug Administration and for Certain Drugs, Biologicals, and Radiopharmaceuticals

The APC Panel heard testimony and discussed the proposals described in the August 12, 2003 proposed rule on payment for drug administration and the packaging of the costs of drugs, biologicals, and radiopharmaceuticals. The APC Panel recommended that:

- We continue to use the current ''Q'' codes for drug administration and not institute new ''G'' codes to represent the administration of either packaged or separately paid drugs.
- We allow billing of Q0081 on a per-visit basis, rather than on a per-day basis as proposed.
- We delete Q0085 and allow hospitals to use both Q0083 and Q0084 when billing for chemotherapy administered by both infusion and other techniques in a given visit.
- That we consider adopting the final option among the three new methods of paying for drug administration that we proposed, as options to the current policy, in the August 12, 2003 proposed rule.
- That we look further at hospital pharmacies' costs for preparing drugs and radiopharmaceuticals and this issue be examined more closely by the Panel during its winter 2004 meeting.

The APC Panel also expressed serious concern about the dollar threshold for

the packaging of drugs and the adequacy of payment for separately paid drugs. However, in the absence of alternative proposals by us, the APC Panel did not make further recommendations on that issue. The APC Panel requested that we present alternative options during the winter 2004 meeting, including a new APC structure for drugs and radiopharmaceuticals. As for specific drug issues, after hearing testimony concerning the codes for Baclofin refill kits, the APC Panel recommended that we delete code C9010 and retain the other codes for this product used in the treatment of Parkinson's disease and spasticity.

We have carefully considered each of the APC Panel's recommendations along with comments on the subject of drug administration and payment for drugs, biologicals, and radiopharmaceuticals. For the reasons discussed more fully elsewhere in this final rule, we have decided to accept the APC Panel's recommendations that we continue using Q0081 through Q0084 in 2004; that we continue to define these codes on a per-visit, rather than per-day basis; that we delete code Q0085; and that we delete code C9010. We have decided to continue paying for the drug administration ''Q'' codes according to our current rules and discuss that decision further in section VI.B.4 of this final rule. We will consider the Panel's recommendation that we investigate other approaches for paying for drugs and radiopharmaceuticals. However, for 2004, we have determined that we will pay separately under their own APCs for drugs, biologicals and radiopharmaceuticals for which the median per day costs are in excess of $50.

(4) Device-Related Procedures

The APC Panel heard testimony from the device manufacturing community and others concerning payment for procedures that involve the implantation of devices. The presenters discussed concerns that affected such procedures in general, such as the absence of a proposal to limit payment reductions for such procedures between 2003 and 2004 and issues related to the hospital claims for these procedures. Presentations to the APC Panel also discussed inadequacies in the claims data or our methodology for using the claims data to set relative weights for specific device-related APCs (APCs 0046, 0107, 0108, 0222, 0225, 0385, and 0386. Presenters urged that the APC Panel advise us to use the best external data possible, including proprietary data that would be held confidential. Presentations to the APC Panel also addressed the multiple surgical reduction with respect to device-related APCs.

The APC Panel recommended:

- That we use credible external data that can be made publicly available for establishing the median costs for APCs 0107 and 0386.
- That we change the status indicator for CPT 61885 so that it is not subject to the multiple procedure discounting.
- That we assign the new CPT codes for central venous access devices into appropriate APCs, either clinical APCs or new technology APCs.
- That the APC assignments of the new central venous access devices be reviewed by the APC Panel at its next meeting.
- That we provide the APC Panel with median cost data for all APCs in spreadsheet format for its consideration in advance of and during its next meeting.
- That we review the presenter's suggestions with respect to APC 0046 and make recommendations for any changes to this APC to the APC Panel at its next meeting.
- That we change the status indicator for CPT 93571 and 93572 from ''N'' (packaged status) to an appropriate indicator that allows separate payment under the APC.

We considered the final set of recommendations from the APC Panel's August 2003 meeting and have accepted several of them. Specifically, we decided to use external data in setting the median cost for 2004 for APC 0107. We have not used external data for APC 0386. Each of these decisions is discussed in greater detail elsewhere in this final rule. We accepted the Panel's recommendation to change the status indicator for CPT 61885. In order to do so, we moved this code into its own APC, 0039, Implant neurostim, one array. We have assigned the new CPT codes for central venous access devices to New Technology APCs as displayed in Addendum B. The range of new CPT codes is 36555 through 36597, and the new APC assignments include APCs 0032, 0115, 0109, 0187, and 1541.

The assignment of these codes is subject to public comment and will be placed on the APC Panel's agenda for its next meeting. During that meeting, we will also provide the APC Panel with spreadsheet data on the median costs of all APCs. With respect to APC 0046, we are sympathetic to the presenter's concerns. However, we were not provided with data that we considered sufficient to assess whether a new coding structure with increased payment rates is warranted for the treatment of bone fractures with external fixation devices. However, we would support the specialty societies' efforts to request changes to the existing CPT coding structure. For reasons discussed elsewhere, we have not accepted the Panel's recommendation with respect to CPT codes 93571 and 93572.

Comment: An association voiced concern that the Panel meeting on August 22, 2003 came too soon after the publication of the August 12, 2003 proposed rule for its members to prepare adequately for presentation to the Panel.

Response: The agency must schedule the Panel meetings sufficiently in advance of the meeting in order to provide ample notice to the public of the meeting and to allow sufficient time for the Panel members to arrange their schedules. We attempted to balance those needs with the goal of conducting the first mid-year meeting of the Panel during the comment period so that issues discussed in the August 12, 2003 proposed rule could be topics for the Panel's consideration and interested parties' testimony before the Panel. The July 25, 2003 **Federal Register** notice (68 FR 44089) announced the second 2003 meeting of the APC Panel, which we believe provided sufficient advance notice of the meeting.

While it is true that the proposed rule was placed on display on August 6, published on August 12, and the meeting was held on August 22, 2003, many interested parties attended the meeting and presented thoughtful comments on most issues discussed in the proposed rule. Nevertheless, we will take this comment into consideration for future planning of APC Panel meetings.

Comment: Several commenters expressed concern about the length of the meeting and time allotted on the agenda to particular issues. One commenter stated that scheduling only [1] day for Panel deliberations was inadequate. A commenter was concerned that device-related issues were relegated to the last hour, that presenters were given only 2 minutes, and that there was little time for Panel discussion and consideration of the issues presented.

Response: We appreciate the commenter's interest in ensuring that adequate time be allowed for the public to present issues for the Panel's consideration and for the Panel to have sufficient time for their discussion and deliberation.

Although the device issues were scheduled for the last hour of the meeting, the Panel members received the written presentations beforehand, and had an opportunity to review them

before the meeting. Placing a limit on presentations is a prerogative of the Panel Chair and must at times be done in order to allow all interested parties to make presentations on agenda items. However, we will take all of the concerns into consideration when scheduling future meetings.

3. Recommendations of the Advisory Panel and Our Responses

January 2003 Meeting

In this section, we consider the Panel's recommendations affecting specific APCs. The Panel based its recommendations on claims data for the period April 1, 2002 through September 30, 2002. This data set comprises a portion of the data that will be used to set 2004 payment rates. APC titles in this discussion are those that existed when the APC Panel met in January 2003. In a few cases, APC titles have been changed for this final rule, and, therefore, some APCs do not have the same title in Addendum A as they have in this section.

The Panel's agenda included APCs that our staff believed violated the 2 times rule as well as APCs for which comments were submitted. As discussed below, the Panel sometimes declined to recommend a change in an APC even though the APC appeared to violate the 2 times rule. In section II.B of the August 12, 2003 proposed rule, we discuss our proposals regarding the 2 times rule based on the April 1 through December 31, 2002 data that we used to determine the final 2004 APC relative weights. Section II.B (68 FR 47977) of the August 12, 2003 proposed rule also details the criteria we used when deciding to propose exceptions to the 2 times rule.

Unless otherwise specified in each of the following discussions of the APC Panel's recommendations, our proposed actions are finalized in this final rule.

a. Debridement and Destruction

APC 0012: Level I Debridement & Destruction

APC 0013: Level II Debridement & Destruction

We expressed concern to the Panel that APCs 0012 and 0013 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following codes from APC 0013 to APC 0012:

HCPCS	Description
11001	Debride infected skin add-on.
11302	Shave skin lesion.
15786	Abrasion, lesion, single.
15793	Chemical peel, nonfacial.
15851	Removal of sutures.
16000	Initial treatment of burn(s).
16025	Treatment of burn(s).

(2) Move code 11057 (Trim skin lesions, over 4) from APC 0012 to APC 0013.

The Panel agreed with our staff and recommended that we make these changes. We proposed to accept the Panel's recommendation.

However, we received comments from a group of hospitals concerning the proposed change for CPT code 15851, removal of sutures under anesthesia (other than local), same surgeon. In their comments, the hospitals noted that the descriptor for CPT codes 15851 and 15850 (removal of sutures under anesthesia (other than local), other surgeon, were virtually identical with the exception of which surgeon performs the suture removal. The commenters did not believe that the identity of the surgeon could result in a significant difference in resource costs to the hospital. Our clinical staff agree and believe that the difference in hospital median costs derived from our claims data may be due to a misunderstanding about the coding. For 2004, we have decided that we will place both CPT codes for suture remove under anesthesia in APC 0016.

b. Excision/Biopsy

APC 0019: Level I Excision/Biopsy

APC 0020: Level II Excision/Biopsy

APC 0021: Level III Excision/Biopsy

We expressed concern to the Panel that APCs 0019 and 0020 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following HCPCS codes from APC 0019 to a new APC:

HCPCS	Description
11755	Biopsy, nail unit.
11976	Removal of contraceptive cap.
24200	Removal of arm foreign body.
28190	Removal of foot foreign body.
56605	Biopsy of vulva/perineum.
56606	Biopsy of vulva/perineum.
69100	Biopsy of external ear.

The APC Panel recommended that we make these changes, and we proposed to do so in our August 12, 2003 proposed rule.

(2) Move the following HCPCS codes from APC 0020 to APC 0021:

HCPCS	Description
11404	Removal of skin lesion.
11423	Removal of skin lesion.
11604	Removal of skin lesion.
11623	Removal of skin lesion.

The Panel recommended that we not change the structure of APCs 0019, 0020, and 0021 at this time in the interest of preserving clinical homogeneity. In August, we proposed to accept the Panel's recommendation that we make no changes to the structure of these APCs for 2004. However, following our review of the median costs developed for the final rule, using a more complete set of claims for services from April through December 2002, we determined that CPT codes 11404 and 11623 should be moved to APC 0021. We plan to place these APCs on the Panel's agenda for the 2005 update.

c. Thoracentesis/Lavage Procedures and Endoscopies

APC 0071: Level I Endoscopy Upper Airway

APC 0072: Level II Endoscopy Upper Airway

APC 0073: Level III Endoscopy Upper Airway

We expressed concern to the Panel that APCs 0071 and 0072 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the changes below.

Move the following HCPCS codes as described below:

TABLE 1.—HCPCS CODES FINAL TO BE REDISTRIBUTED FROM APCS 0071 AND 0072 TO APCS 0071, 0072, AND 0073

HCPCS	Description	2003 APC	2004 APC
31505	Diagnostic laryngoscopy.	0072	0071
31575	Diagnostic laryngoscopy.	0071	0072
31720	Clearance of airways.	0072	0073

The Panel recommended that we make the above changes. We proposed to accept the Panel's recommendation, with the exception of CPT code 31720. After reviewing an additional quarter of claims data that were not available at the time the Panel convened, placement of CPT code 31720 into APC 0072 better reflects its resource consumption. Therefore, we proposed to keep CPT code 31720 in APC 0072.

d. Cardiac and Ambulatory Blood Pressure Monitoring

APC 0097: Cardiac and Ambulatory Blood Pressure Monitoring

We expressed concern to the Panel that APC 0097 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation and suggested splitting APC 0097 into two APCs. The Panel recommended that the structure of APC 0097 should not be changed at this time based on clinical homogeneity considerations. We proposed to accept the Panel's recommendation that we make no changes to APC 0097 for 2004. We received no comments disagreeing with this proposal, and we will adopt it for 2004. We also plan to place this APC on the Panel's agenda for the 2005 update.

e. Electrocardiograms

APC 0099: Electrocardiograms

APC 0340: Minor Ancillary Procedures

We expressed concern to the Panel that APC 0099 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation, and suggested moving CPT code 93701 (Bioimpedance, thoracic) from APC 0099 to APC 0340. The Panel believed, however, that the structure of APC 0099 should not be changed at this time based on clinical homogeneity considerations. We proposed to accept the Panel's recommendation that we make no changes to APC 0099 for 2004. We plan to place this APC on the Panel's agenda for the 2005 update.

f. Cardiac Stress Tests

APC 0100: Cardiac Stress Tests

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 93025 (Microvolt t-wave assessment) out of APC 0100. The presenter believes that the actual cost for this procedure is significantly higher than for other procedures in the same APC. Since this technology is often billed in conjunction with other procedures (for example, stress tests, CPT code 93017), few single-APC claims were available to evaluate the presenter's contention.

The Panel believed the data presented are insufficient to merit moving the code and recommended that CPT code 93025 remain in APC 0100 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 93025 remain in APC 0100 until more claims data become available for review. We will adopt this proposal for 2004.

g. Revision/Removal of Pacemakers or Automatic Implantable Cardioverter Defibrillators

APC 0105: Revision/Removal of Pacemakers, AICD, or Vascular

We asked the Panel to review the codes within APC 0105 for an apparent violation of the 2 times rule, stating that we believe the apparent violation is a result of incorrectly coded claims. The Panel agreed and recommended no changes to APC 0105 at this time. We proposed to accept the Panel's recommendation that we make no changes to APC 0105 until more accurate claims data become available and support the need for a change. We will adopt this proposal for 2004.

h. Sigmoidoscopy

APC 0146: Level I Sigmoidoscopy

APC 0147: Level II Sigmoidoscopy

We expressed concern to the Panel that relatively simple procedures such as anoscopy and rigid sigmoidoscopy have higher median costs than more complex procedures such as flexible sigmoidoscopy. Panel members suggested the high costs may be due to the need to perform an otherwise minor office procedure in a hospital setting (for example, due to the clinical condition of the patient). Panel members also suggested that claims may be incorrectly coded because coding instructions do not clearly state how to code when the procedure performed is not as extensive as the procedure planned (for example, when a colonoscopy is planned but only a sigmoidoscopy is performed). In these cases, coding instructions are unclear as to whether the planned procedure should be reported with a modifier for reduced services or with the code for the actual procedure performed.

The Panel recommended that we make no changes to APCs 0146 and 0147 at this time. We proposed to accept the Panel's recommendation that we make no changes to APCs 0146 and 0147. We will adopt this proposal for 2004. However, we plan to place this APC on the Panel's agenda for the 2005 update.

i. Anal/Rectal Procedures

APC 0148: Level I Anal/Rectal Procedure

APC 0149: Level III Anal/Rectal Procedure

APC 0155: Level II Anal/Rectal Procedure

We expressed concern to the Panel that APCs 0148 and 0149 appear to violate the 2 times rule. We asked the Panel to recommend options for resolving these violations, and suggested rearranging some of the CPT codes within APCs 0148, 0149, and 0155. The Panel recommended that we move CPT code 46040 (Incision of rectal abscess) from APC 0155 to APC 0149. We proposed to accept the Panel's recommendation, and we will adopt it for 2004.

j. Insertion of Penile Prosthesis

APC 0179: Urinary Incontinence Procedures

APC 0182: Insertion of Penile Prosthesis

A presenter to the Panel representing manufacturers and providers requested that APC 0182 be split into two APCs, based on whether the procedure used inflatable or non-inflatable penile prostheses. The presenter stated that the complexity of the procedure, the cost of the devices, and related resources were all significantly higher with inflatable prostheses.

The Panel recommended that we eliminate APCs 0179 and 0182 and create two new APCs, 0385 and 0386, that contain the following CPT codes:

APC 0385

HCPCS	Description
52282	Cystoscopy, implant stent.
53440	Correct bladder function.
53444	Insert tandem cuff.
54400	Insert semi-rigid prosthesis.
54416	Remv/repl penis contain prosthesis.

APC 0386

HCPCS	Description
53445	Insert uro/ves nck sphincter.
53447	Remove/replace ur sphincter.
54401	Insert self-contained prosthesis.
54405	Insert multi-comp penis prosthesis.
54410	Remove/replace penis prosthesis.

We proposed to accept the Panel's recommendation to eliminate APCs 0179 and 0182 and create two new APCs, 0385 and 0386, containing the above CPT code configurations.

k. Surgical Hysteroscopy

APC 0190: Surgical Hysteroscopy

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 58563 (Hysteroscopy, ablation) from APC 0190 to a higher paying APC. The presenter noted that endometrial cryoablation is included in a new technology APC, while a thermal ablation system is included with older, less costly

techniques. The presenter expressed concern that cryoablation may be reimbursed at a higher rate than the thermal ablation system, giving its manufacturers an unfair competitive advantage.

Panel members agreed that new, more expensive technologies that prove to be more effective merit review for a higher payment rate. Without substantial evidence of greater effectiveness, however, the Panel was reluctant to create APCs that provide an incentive to use a more expensive device. In its discussion of whether or not to recommend moving CPT code 58563 to a higher paying APC, the Panel recommended that we take into account different methods of endometrial ablation associated with hysteroscopy, adequately reflect the resources used for the various procedures, avoid creating a competitive advantage or disadvantage, and collect data needed to track costs on the type of technologies used for this procedure.

After consulting with experts in the field, we proposed to split APC 0190 (Surgical Hysteroscopy) into two APCs that are more clinically homogeneous. We proposed to change the description for APC 0190 from ''Surgical Hysteroscopy'' to ''Level I Hysteroscopy'' and keep the following HCPCS codes in APC 0190:

HCPCS	Description
58558	Hysteroscopy, biopsy.
58559	Hysteroscopy, lysis.
58562	Hysteroscopy, remove fb.
58579	Hysteroscope procedure.

We also proposed to move the following HCPCS codes from APC 0190 to newly created APC 0387 titled ''Level II Hysteroscopy'':

HCPCS	Description
58560	Hysteroscopy, resect septum.
58561	Hysteroscopy, remove myoma.
58563	Hysteroscopy, ablation.

In addition, we proposed to move the following HCPCS codes as described below:

TABLE 2.—HCPCS CODES TO BE REDISTRIBUTED TO APCS 0130, 0195, AND 0190

HCPCS	Description	2003 APC	2004 APC
58578	Laparoscopic procedure, uterus.	0190	0130

TABLE 2.—HCPCS CODES TO BE REDISTRIBUTED TO APCS 0130, 0195, AND 0190—Continued

HCPCS	Description	2003 APC	2004 APC
58353	Endometrial ablate, thermal.	0193	0195
58555	Hysteroscopy, diagnostic, sep. procedure.	0194	0190

We believe these final changes take into account the different technologies used to perform these procedures while maintaining the clinical comparability of these APCs as well as improving their homogeneity in terms of resource consumption.

1. Female Reproductive Procedures

APC 0195: Level VII Female Reproductive Proc

APC 0202: Level VIII Female Reproductive Proc

A commenter requested that we place CPT code 57288 (Repair bladder defect) in its own APC because it requires the use of a device. Our staff suggested that CPT codes 57288 and 57287 remain in APC 0202, while the remaining codes in APC 0202 be moved to APC 0195:

HCPCS	Description
57109	Vaginectomy partial w/ nodes.
58920	Partial removal of ovary(s).
58925	Removal of ovarian cyst(s).

The Panel agreed with our staff, and we proposed to accept the Panel's recommendation to move CPT codes 57109, 58920, and 58925 from APC 0202 to APC 0195. We will adopt the Panel's recommendation for 2004.

m. Nerve Injections

APC 0203: Level IV Nerve Injections

APC 0204: Level I Nerve Injections

APC 0206: Level II Nerve Injections

APC 0207: Level III Nerve Injections

Several commenters suggested changes in the configuration of APCs 0203, 0204, 0206, and 0207 because of concerns that the current classifications result in payment rates that are too low relative to the resource costs associated with certain procedures in these APCs. Several of these APCs include procedures associated with drugs or devices for which pass-through payments are scheduled to expire in 2003.

We requested the Panel's input regarding whether or not these APCs should be restructured. The Panel stated that the current configuration of APCs 0203, 0204, 0206, and 0207 is more clinically cohesive than the previous year's configuration and that more data should be collected before making any changes. We proposed to accept the Panel's recommendation that we make no changes to the structure of these APCs until more data become available for review. We will adopt the Panel's recommendation for 2004.

n. Laminotomies and Laminectomies; Implantation of Pain Management Device

APC 0208: Laminotomies and Laminectomies

APC 0223: Implantation of Pain Management Device

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 62351 (Implant spinal canal catheter) from APC 0208 to APC 0223 to better capture the device cost that may be involved with the procedure. The Panel believed the data were insufficient to merit moving the code and recommended that CPT code 62351 remain in APC 0208 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 62351 remain in APC 0208 until more claims data become available for review. We will adopt the Panel's recommendation for 2004.

o. Extended EEG Studies and Sleep Studies; Electroencephalogram

APC 0209: Extended EEG Studies and Sleep Studies, Level II

APC 0213: Extended EEG Studies and Sleep Studies, Level I

APC 0214: Electroencephalogram

We expressed concern to the Panel that APC 0213 appears to minimally violate the 2 times rule. In order to remedy this violation, we asked the Panel to consider a commenter's suggestion that we move CPT code 95955 (EEG during surgery) from APC 0214 to APC 0213. The Panel agreed with the commenter's suggestion. We proposed to accept the Panel's recommendation to move CPT code 95955 from APC 0214 to APC 0213.

p. Nerve and Muscle Tests

APC 0215: Level I Nerve and Muscle Tests

APC 0216: Level III Nerve and Muscle Tests APC 0218:

Level II Nerve and Muscle Tests

We expressed concern to the Panel that APC 0218 appears to violate the 2 times rule. In order to remedy this violation, one commenter requested that we move CPT codes 95921 (Autonomic nerve function test) and 95922 (Autonomic nerve function test) from APC 0218 to APC 0216, while another

commenter requested that we move CPT code 95904 (Sensory nerve conduction test) from APC 0215 to APC 0218. Alternatively, our staff suggested to the Panel that the following CPT codes be moved from APC 0218 to APC 0215.

HCPCS	Description
95858	Tensilon test & myogram.
95870	Muscle test, nonparaspinal.
95900	Motor nerve conduction test.
95903	Motor nerve conduction test.

After considering all of the above proposals, the Panel recommended that we move CPT codes 95858, 95870, 95900, and 95903 from APC 0218 to APC 0215. We proposed to accept the Panel's recommendation.

q. Implantation of Drug Infusion Device

APC 0227: Implantation of Drug Infusion Device

APC 0227 contains only two CPT codes: Implantation of programmable spine infusion pumps, 62362, and Implantation of non-programmable spine infusion pumps, 62361. A commenter requested that we split APC 0227 into two APCs to recognize the cost difference between CPT code 62361 and CPT code 62362. However, since our cost data do not show a significant cost difference between the two devices and APC 0227 does not violate the 2 times rule, the Panel recommended that CPT codes 62361 and 62362 remain in APC 0227. We proposed to accept the Panel's recommendation, which we will adopt for 2004.

r. Ophthalmologic APCs

APC 0230: Level I Eye Tests & Treatments

APC 0235: Level I Posterior Segment Eye Procedures

APC 0236: Level II Posterior Segment Eye Procedures

APC 0698: Level II Eye Tests & Treatments

We advised the Panel that APCs 0230 and 0235 violate the 2 times rule but that the current configuration of these APCs reflects the Panel's previous recommendations. A presenter to the Panel, who represented a device manufacturer, expressed concern that the pass-through device category ''New Technology: Intraocular Lens'' was discontinued and these devices are now packaged. The presenter asked the Panel to recommend that future new intraocular lens devices be considered for a new pass-through category.

To remedy the violations to the 2 times rule, we asked the Panel to consider moving CPT code 67820 (Revise eyelashes) from APC 0230 to APC 0698 and CPT code 67110 (Repair detached retina) from APC 0235 to APC 0236. The Panel recommended that we make these changes. We proposed to accept the Panel's recommendation and monitor the data for APC 0235 for possible review next year. We will adopt this recommendation for 2004. The Panel also acknowledged that making recommendations concerning pass-through categories is beyond their purview.

s. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures

APC 0341: Skin Tests and Miscellaneous Red Blood Cell Tests

APC 0345: Level I Transfusion Laboratory Procedures We advised the Panel that APCs 0341 and 0345 minimally violate the 2 times rule and suggested moving several CPT codes within these APCs into a new APC because a commenter expressed concern over the combination of skin tests and miscellaneous red blood cell tests in APC 0341, asserting that services within this APC cannot be considered comparable with respect to resource usage.

In order to remedy these violations to the 2 times rule, we suggested moving CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to a new APC along with the following CPT codes from APC 0341:

HCPCS	Description
86880	Coombs test, direct.
86885	Coombs test, indirect, qualitative.
86886	Coombs test, indirect, titer.
86900	Blood typing, ABO.

The Panel recommended that we make the above changes. We proposed to accept the Panel's recommendation to move HCPCS codes 86880, 86885, 86886, and 86900 from APC 0341 to new APC 0409 and to move CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to new APC 0409. We will adopt the Panel's recommendation for 2004.

t. Otorhinolaryngologic Function Tests

APC 0363: Level I Otorhinolaryngologic Function Tests

APC 0660: Level II Otorhinolaryngologic Function Tests

We expressed concern to the Panel that APC 0660 appears to violate the 2 times rule and suggested moving CPT codes 92543 (Caloric vestibular test) and 92588 (Evoked auditory test) from APC 0660 to APC 0363. The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 92543 and 92588 from APC 0660 to APC 0363, and we will adopt the proposal for 2004.

u. Tube Changes and Repositioning

APC 0121: Level I Tube changes and Repositioning

APC 0122: Level II Tube changes and Repositioning

We expressed concern to the Panel that APC 0121 appears to violate the 2 times rule. In order to remedy this violation, we suggested moving the following CPT codes from APC 0121 to APC 0122:

HCPCS	Description
47530	Revise/reinsert bile tube.
50688	Change of ureter tube.
51710	Change of bladder tube.
62225	Replace/irrigate catheter.

The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 47530, 50688, 51710, and 62225 from APC 0121 to APC 0122. We will adopt the proposal for 2004.

v. Myelography

APC 0274: Myelography

We advised the Panel that APC 0274 minimally violates the 2 times rule and suggested moving CPT codes 72285 (X-ray c/t spine disk) and 72295 (X-ray c/t spine disk) from APC 0274 to a new APC. A presenter, from an organization representing radiologists, agreed with our proposal. The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 72285 and 72295 from APC 0274 to new APC 0388. We will adopt the recommendation for 2004.

w. Therapeutic Radiologic Procedures

APC 0296: Level I Therapeutic Radiologic Procedures

APC 0297: Level II Therapeutic Radiologic Procedures

We advised the Panel that APCs 0296 and 0297 appear to minimally violate the 2 times rule as a result of changes recommended by the Panel and adopted by us last year. The Panel recommended that no changes be made to APCs 0296 and 0297 in the interest of preserving the clinical homogeneity of these APCs. We proposed to accept the Panel's recommendation that we make no CPT code changes to APCs 0296 and 0297, and we are adopting the proposal for 2004.

x. Vascular Procedures; Cannula/Access Device Procedures

APC 0103: Miscellaneous Vascular Procedures

APC 0115: Cannula/Access Device Procedures

A commenter requested that we move CPT code 36860 (External cannula declotting) from APC 0103 to APC 0115, asserting that this procedure is more similar to other procedures in APC 0115 and does not fit well in its current miscellaneous APC. The Panel found that the claims data were insufficient to support moving CPT code 36860 from APC 0103 to the higher paying APC 0115 and recommended that CPT code 36860 remain in APC 0103 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 36860 remain in APC 0103 until more claims data become available for review. We will adopt this proposal for 2004.

y. Angiography and Venography Except Extremity

APC 0279: Level II Angiography and Venography except Extremity

APC 0280: Level III Angiography and Venography except Extremity

APC 0668: Level I Angiography and Venography except Extremity

A commenter requested that we move CPT code 75978 (Repair venous blockage) from APC 0668 to APC 0280 and that we move CPT code 75774 (Artery x-ray, each vessel) from APC 0668 to APC 0279. A presenter to the Panel testified that CPT code 75978 is commonly used for dialysis patients and often requires multiple intraoperative attempts to succeed; thus, it should be paid under APC 0280. The Panel believed that APCs 0279, 0280, and 0668 were clinically homogenous and recommended that we only make changes after consulting with experts in the field. We proposed to accept the Panel's recommendation to make no changes to APCs 0279, 0280, and 0668 until we have consulted with experts in the field. We plan to place these APCs on the Panel's agenda for the 2005 update.

z. Computed Tomography (CT), Magnetic Resonance (MR), and Ultrasound Guidance Procedures Currently Packaged

APC 0332: Computerized Axial Tomography and Computerized Angiography without Contrast Material

APC 0335: Magnetic Resonance Imaging, Miscellaneous

APC 0268: Ultrasound Guidance Procedures

A presenter to the Panel expressed concern that the packaging of guidance procedures for tissue ablation does not recognize the significant difference in cost and time required to perform each procedure (for example, MRI vs. CT). This presenter believed that hospitals needed more education on the appropriate application of these codes. Another commenter requested that CPT codes 76362, 76394, and 76490 be changed from a status indicator of N to a status indicator of S and be included in an appropriate clinical or new technology APC.

The Panel agreed with the above comments and stated that the packaging of these three procedures made it difficult for hospitals to track their use for the purpose of allocating funds. The Panel recommended changing the following CPT codes from a packaged status (N status indicator) to a separately payable status (S status indicator) within the indicated APCs:

TABLE 3.—HCPCS CODES TO BE DESIGNATED AS SEPARATELY PAYABLE

HCPCS	Description	2003 SI	2004 SI	2004 APC
76362	CT scan for tissue ablation	N	S	0332
76394	MRI for tissue ablation	N	S	0335
76490	US for tissue ablation	N	S	0268

We proposed to accept the Panel's recommendation to change HCPCS codes 76362, 76394, and 76490 from a packaged status to a separately payable status as indicated above. HCPCS 76490 has been deleted for 2004. However, we will pay for it under APC 0268 during the grace period from January through March 2004.

aa. Magnetic Resonance Imaging and Magnetic Resonance Angiography Without Contrast

APC 0336: Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast

A commenter requested that we change CPT code 76393 (MR guidance for needle placement) from a packaged status to a separately payable status within APC 0336. Based on clinical homogeneity considerations, the Panel agreed with the commenter and recommended that CPT code 76393 be changed from a status indicator of N to a status indicator of S and placed in APC 0335. We proposed to accept the Panel's recommendation.

bb. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement

APC 0260: Level I Plain Film Except Teeth

APC 0261: Level II Plain Film Except Teeth Including Bone Density Measurement

APC 0272: Level I Fluoroscopy

A commenter requested that we move CPT codes 76120 (Cine/video x-rays) and 76125 (Cine/video x-rays add-on) from APC 0260 to APC 0261. However, a presenter to the Panel argued that these CPT codes are fluoroscopic procedures that should not be grouped with Level I radiography procedures. The Panel recommended that we move CPT code 76120 from APC 0260 to APC 0272 and that CPT code 76125 remain in APC 0260. This change makes the APCs more clinically coherent. We proposed to accept the Panel's recommendation, and we will adopt the proposal for 2004.

cc. Chemotherapy Administration by Other Technique Except Infusion

APC 0116: Chemotherapy Administration by Other Technique Except Infusion

A presenter to the Panel requested that we split APC 0116 into three APCs according to the method of administration: (a) Subcutaneous or intramuscular administration (CPT code 96400); (b) ''push'' administration (CPT code 96408); and (c) central nervous system administration (CPT code 96450). The presenter also requested that existing CPT codes should replace the more nonspecific Q codes for administration of chemotherapy because the CPT codes will provide more detailed data on methods of chemotherapy administration, which could be used for future payment policy decisions. Another presenter agreed with this request and stated that CPT codes are preferable to Q codes because other payers require CPT codes.

The Panel agreed with the above suggestions to split APC 0116 into 3 APCs according to the method of

administration. The Panel recommended that we require hospitals to use the existing CPT codes (for example, 96400, 96408, and 96450) for administration of chemotherapy and map them to APCs 0116, 0117, and 0118, as appropriate. The Panel also recommended that payment rates be based on current Q code cost data until cost data for the CPT codes are available. These cost data will be used to determine whether to change the APC structure for chemotherapy administration.

We proposed not to accept the Panel's recommendations to split APC 0116 into three APCs and to use CPT codes for administration of chemotherapy. We will consider such a split in the future but would like to first address the administration of drugs issue. Based on the comments we received on our proposed drug administration coding, we believe that making a change in APC 0116 will be too complicated and burdensome for hospitals at this time. (See a full discussion of this in section VI.B.4 of this final rule.)

We will consider such a split for APC 0116 for CY 2005. We also believe the use of CPT codes will be burdensome to hospitals, will require extensive education, and will result in a significant amount of miscoding. The CPT codes for infusion therapy are based on the service furnished per hour. We do not believe that all hospitals routinely record the start and stop time for infusion therapy and that doing so in order to be able to bill the proper number of hours of infusion therapy could be very burdensome for them. Moreover, the historic cost data on which we base the payment for the service are reported on a per visit basis (much easier to cull from the record than the number of hours of service) and if we changed to CPT codes for these services, we will be unable to convert the charge/cost data now on a per visit basis to a per hour basis (as required by the CPT code) for budget neutrality purposes. *See* section VI of this final rule for further discussion on payments for drugs and drug administration.

dd. Capturing the Costs of Drugs, Biologicals and Radiopharmaceuticals Packaged Into APCs

APC 0290: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0291: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0292: Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0294: Level II Therapeutic Nuclear Medicine

APC 0666: Myocardial Add-on Scans

At the January 2003 meeting, we told the Panel that APCs 0290 and 0291 appear to violate the 2 times rule. Several presenters to the Panel expressed concern that our cost data are inadequate because of confusion over coding due to changes in codes and coding instructions for these procedures, poor hospital reporting of radiopharmaceutical use, and the use of single (not multiple) claims in determining costs. One presenter claimed that the current cost data used for CPT code 78122 (Whole blood volume determination) underestimated real costs because of confusion about whether to code radiopharmaceuticals on a ''per dose'' basis or ''per millicurie'' basis. This presenter requested that we move CPT code 78122 from APC 0290 to the higher paying APC 0292.

Other presenters agreed with these concerns and stated they were applicable to payments for all drugs, not just radiopharmaceuticals. These commenters were also concerned about the loss of drug-specific data due to packaging because hospitals will have no incentive to code, and thereby identify, packaged drugs.

Pass-through payments for 236 drugs, biologicals, and radiopharmaceuticals expired as of 2003, were then paid either separately or packaged with the procedures with which they are associated. Drugs and radiopharmaceuticals with median costs for administration of $150 or less were packaged. Beginning in 2003, claims data do not provide specific cost information for packaged items. We requested input from the Panel on methods for determining drug costs in the future.

Panel members were concerned that packaging the costs of radiopharmaceuticals into procedures would result in underpayments for the service because we lack adequate data on the cost of radiopharmaceuticals. They were also concerned about creating incentives to use radiopharmaceuticals based on cost rather than clinical efficacy. The Panel recommended that we consider grouping drugs and radiopharmaceuticals into new APCs taking into account both their cost and clinical use. The Panel further recommended that, if new APCs for radionuclides are created, the descriptors should be as simple as possible and use of confusing units of measure should be limited.

Due to the packaging of radiopharmaceuticals into the APC payments for nuclear medicine procedures, we, along with commenters have expressed concern to the Panel regarding whether the current nuclear medicine APC structure is homogeneous in terms of resource consumption. We have reviewed information about the use and cost of various radiopharmaceuticals and believe that restructuring the APCs for nuclear medicine will result in greater clinical and resource homogeneity. Therefore, we proposed to eliminate APCs 0286, 0290, 0291, 0292, 0294, and 0666 and create 20 new APCs for nuclear medicine.

Comment: We received many comments about the proposed nuclear medicine APCs. Generally, commenters supported our proposal for the new APCs but had suggestions for modifications to improve clinical and resource use homogeneity. The suggested modifications are:

- Split APC 0398 into three levels to account for differences in the number of sessions provided and type and amount of radiopharmaceutical used with these procedures.
- Split APC 0401 into two levels to account for the different number of sessions, type and amount of radiopharmaceuticals used, and whether or not ventilation imaging and perfusion imaging are part of the procedure.
- Delete codes G0273 and G0274 and use the newly created CPT codes 78804 and 79403. They recommended that we assign 78804 to a new APC 0406T, Tumor/Infection Imaging Level II and that we assign 79403 to the new APC for Radionucliide Therapy APC, created by combining proposed APCs 0407 and 0408.
- Move codes 78015, 78016, and 78018 from APC 0390 to APC 0406 because they are for metastatic tumor imaging rather than for one organ system.
- Move all of the nuclear medicine ''add-on'' codes into one APC to be named ''Nuclear Medicine Add-On Imaging.'' Three of the codes, 78478, Heart wall motion add-on, 78480 Heart function add-on, and 78496, Heart function first pass add-on, are assigned to proposed APC 0399. They recommended moving the remaining add-on code, 78020, Thyroid carcinoma metastases uptake, to proposed APC 0399 with the other three add-on codes, to create an APC comprised of add-on codes with a status indicator ''X.''
- Move each of the codes in the series of codes, 78X99 into the appropriate APCs based on the organ system to be consistent with the proposed APC structure.
- Reassign codes 78270, 78271, and 78272 to APC 0389 because they are

non-imaging nuclear medicine procedures with resource use more similar to the procedures in APC 0389.

• Combine APCs 0390, 0391, and 0392 to create two new APCs composed of thyroid, parathyroid, and adrenal systems. They suggest that the codes should be reassigned to two levels of endocrine imaging based on the number of sessions and radiopharmaceuticals used in the procedure. The titles suggested for the new APCs are ''Endocrine Level I'' and ''Endocrine Level II.''

• Combine proposed APCs 0407 and 0408 into one APC because hospital claims data do not reflect any logical division between the two proposed APCs. Further, they request that all of the nuclear medicine therapy codes in the new APC should be paid separately since they know of no nuclear medicine therapeutic radiopharmaceutical that has costs below the proposed $150 threshold for packaging.

• Collapse and redistribute code assignments in APCs 0404 and 0405 to create two new APCs for Level I and Level II Renal and Genitourinary Studies. They recommended assigning only one code, 78709, Kidney imaging, multiple studies, with and without pharmaceutical intervention, to the Level II APC.

Response: After careful review of the recommendations, with one exception, we concur with the commenters that their recommended modifications to the proposed APC classifications improve clinical homogeneity and payment equity. The shifts in median cost that result from the adjustments are minor in most cases and overall, the increased cost is not significant.

The one exception to our agreement with the commenters' recommendation is regarding the assignment of 78708, Kidney imaging with vascular flow and function, single study. Commenters recommended that it be assigned to APC 0404. We believe that it is more appropriately assigned to APC 0405 based on both clinical and resource use considerations.

Although we do not disagree with the commenters' suggestions, we also will not assign the new code 78804, pre-treatment planning, non-Hodgkins to the APC suggested by the commenters. Instead, we will assign it to new technology APC 1508. A detailed discussion of this assignment and other issues related to Zevalin is below in section VI.B.

Thus, we will finalize the nuclear medicine APCs as shown below.

APC 0376: CARDIAC IMAGING LEVEL II

HCPCS	Description
78473	Gated heart, multiple.
78483	Heart first pass, multiple.

APC 0377: CARDIAC IMAGING LEVEL III

HCPCS	Description
78461	Heart muscle blood, multiple.
78465	Heart image (3D), multiple.

APC 0378: PULMONARY IMAGING LEVEL II

HCPCS	Description
78584	Lung V/Q image gas, single breath.
78585	Lung V/Q imaging gas.
78588	Lung V/Q imaging aerosol.
78596	Lung differential function.

APC 0389: NON-IMAGING NUCLEAR MEDICINE

HCPCS	Description
78000	Thyroid, single uptake.
78001	Thyroid, multiple uptakes.
78003	Thyroid suppress/stimuli.
78190	Platelet survival, kinetics.
78191	Platelet survival.
78270	Vitamin B–12 absorption exam.
78271	Vitamin B–12 absorp. exam, intrin. Fac.
78272	Vitamin B–12 absorp, combined.
78725	Kidney function study.

APC 0390: ENDOCRINE LEVEL I

HCPCS	Description
78006	Thyroid imaging with uptake.
78010	Thyroid imaging.
78011	Thyroid imaging with flow.
78099	Endocrine nuclear procedure.

APC 0391: ENDOCRINE LEVEL II

HCPCS	Description
78007	Thyroid image, mult uptakes.
78070	Parathyroid nuclear imaging.
78075	Adrenal nuclear imaging.

APC 0393: RED CELL/PLASMA STUDIES

HCPCS	Description
78110	Plasma volume, single.
78111	Plasma volume, multiple.
78120	Red cell mass, single.
78121	Red cell mass, multiple.
78122	Blood volume.
78130	Red cell survival study.
78135	Red cell survival kinetics.
78140	Red cell sequestration.
78160	Plasma iron turnover.
78162	Radioiron absorption exam.
78170	Red cell iron utilization.
78172	Total body iron estimation.

APC 0394: HEPATOBILIARY IMAGING

HCPCS	Description
78201	Liver imaging.
78202	Liver imaging with flow.
78205	Liver imaging (3D).
78206	Liver image (3D) with flow.
78215	Liver and spleen imaging.
78216	Liver & spleen image/flow.
78220	Liver function study.
78223	Hepatobiliary imaging.

APC 0395: GASTROINTESTINAL IMAGING

HCPCS	Description
78230	Salivary gland imaging.
78231	Serial salivary imaging.
78232	Salivary gland function exam.
78258	Esophageal motility study.
78261	Gastric mucosa imaging.
78262	Gastroesophageal reflux exam.
78264	Gastric emptying study.
78278	Acute GI blood loss imaging.
78282	GI protein loss exam.
78290	Meckel's divert exam.
78291	Leveen/shunt patency exam.
78299	GI nuclear procedure.

APC 0396: BONE IMAGING

HCPCS	Description
78300	Bone imaging, limited area.
78305	Bone imaging, multiple areas.
78306	Bone imaging, whole body.
78315	Bone imaging, 3 phase.
78320	Bone imaging (3D).
78399	Musculoskeletal nuclear exam.

APC 0397: VASCULAR IMAGING

HCPCS	Description
78445	Venous thrombosis study.
78455	Venous thrombosis study.

APC 0397: VASCULAR IMAGING—Continued

HCPCS	Description
78456	Acute venous thrombus image.
78457	Venous thrombosis imaging.
78458	Ven thrombosis images, bilat.

APC 0398: CARDIAC IMAGING LEVEL I

HCPCS	Description
78414	Non-imaging heart function.
78428	Cardiac shunt imaging.
78460	Heart muscle blood, single.
78464	Heart image (3D), single.
78466	Heart infarct image.
78468	Heart infarct image (ef).
78469	Heart infarct image (3D).
78472	Gated heart, planar, single.
78481	Heart first pass, single.
78494	Heart image, spect.
78499	Unlisted cardiovascular.

APC 0399: NUCLEAR MEDICINE ADD-ON IMAGING

HCPCS	Description
78020	Thyroid met uptake.
78478	Heart wall motion add-on.
78480	Heart function add-on.
78496	Heart first pass add-on.

APC 0400: HEMATOPOIETIC IMAGING

HCPCS	Description
78102	Bone marrow imaging, ltd.
78103	Bone marrow imaging, mult.
78104	Bone marrow imaging, body.
78185	Spleen imaging.
78195	Lymph system imaging.
78199	Blood/lymph nuclear exam.

APC 0401: PULMONARY IMAGING, LEVEL 1

HCPCS	Description
78580	Lung perfusion imaging.
78586	Aerosol lung image, single.
78587	Aerosol lung image, multiple.
78591	Vent image, 1 breath, 1 proj.
78593	Vent image, 1 proj, gas.
78594	Vent image, mult proj, gas.
78599	Respiratory Nuclear Exam.

APC 0402: BRAIN IMAGING

HCPCS	Description
78600	Brain imaging, ltd static.
78601	Brain imaging, ltd w/flow.
78605	Brain imaging, complete.
78606	Brain imaging, compl w/flow.
78607	Brain imaging (3D).

APC 0402: BRAIN IMAGING—Continued

HCPCS	Description
78610	Brain flow imaging only.
78615	Cerebral vascular flow image.
78699	Nervous system nuclear exam.

APC 0403: CSF IMAGING

HCPCS	Description
78630	Cerebrospinal fluid scan.
78635	CSF ventriculography.
78645	CSF shunt evaluation.
78647	Cerebrospinal fluid scan.
78650	CSF leakage imaging.
78660	Nuclear exam of tear flow.

APC 0404: RENAL & GENITOURINARY STUDIES LEVEL I

HCPCS	Description
78700	Kidney imaging, static.
78701	Kidney imaging with flow.
78704	Imaging renogram.
78707	Kidney flow/function image.
78710	Kidney imaging (3D).
78715	Renal vascular flow exam.

APC 0405: RENAL & GENITOURINARY STUDIES LEVEL II

HCPCS	Description
78708	Kidney flow/function image.
78709	Kidney flow/function image.

APC 0406: TUMOR/INFECTION IMAGING

HCPCS	Description
78015	Thyroid metastases imaging.
78016	Thyroid metastases imaging/studies.
78018	Thyroid metastases imaging/body.
78800	Tumor imaging, limited area.
78801	Tumor imaging, mult areas.
78802	Tumor imaging, whole body.
78803	Tumor imaging, whole body.
78805	Abscess imaging, ltd area.
78806	Abscess imaging, whole body.
78807	Nuclear localization/abscess.

APC 0407: RADIONUCLIIDE THERAPY

HCPCS	Description
79000	Init hyperthyroid therapy.
79001	Repeat hyperthyroid therapy.
79020	Thyroid ablation.
79030	Thyroid ablation, carcinoma.
79035	Thyroid metastatic therapy.

APC 0407: RADIONUCLIIDE THERAPY—Continued

HCPCS	Description
79100	Hematopoetic nuclear therapy.
79200	Intracavitary nuclear treatment.
79300	Interstitial nuclear therapy.
79400	Nonhemato nuclear therapy.
79420	Intravascular nuclear therapy.
79440	Nuclear joint therapy.
79999	Nuclear medicine therapy.

APC 1507: NEW TECHNOLOGY LEVEL VII ($500–$600)

79403	Hematopoetic nuclear therapy.

APC 1508: TUMOR/INFECTION IMAGING LEVEL II

HCPCS	Description
78804	Pre-tx planning, non-Hodgkins.

We believe that the final APC structure, which takes into account the organ(s) being examined (or treated) as well as the type and complexity of the procedure, is more homogeneous both clinically and in terms of resource consumption than the current APC structure.

ee. Endoscopy Lower Airway

APC 0076: Endoscopy Lower Airway

A presenter to the Panel expressed concern that APC 0076 apparently violates the 2 times rule and requested that we move CPT code 31631 (bronchoscopy with tracheal stent placement) from APC 0076 and into a new APC.

The Panel suggested that a new APC comprised of the four most costly procedures in APC 0076 will result in a more homogenous grouping, and recommended that we move the following CPT codes from APC 0076 and into newly created APC 0415.

HCPCS	Description
31630	Bronchoscopy dilate/fracture reduction.
31631	Bronchoscopy, dilate w/stent.
31640	Bronchoscopy w/tumor excise.
31641	Bronchoscopy, treat blockage.

We proposed to accept the Panel's recommendation that we move CPT codes 31630, 31631, 31640, and 31641 from APC 0076 to new APC 0415. We

received no comments disagreeing with this proposal and will adopt this recommendation for 2004.

ff. Gastrointestinal Endoscopic Stenting Procedures

APC 0141: Upper GI Procedures
APC 0142: Small Intestine Endoscopy
APC 0143: Lower GI Endoscopy
APC 0147: Level II Sigmoidoscopy

A commenter requested that we create a new APC that will be comprised of all the gastrointestinal endoscopic stent codes. The Panel agreed with the commenter's suggestion because the resource requirements for all gastrointestinal endoscopic stents appear to be similar. The Panel recommended that we move the following CPT codes from their 2003 APCs to newly created APC 0384 for 2004:

TABLE 4.—HCPCS CODES TO BE MOVED INTO NEW APC 0384

HCPCS	Description	2003 APC	2004 APC
43219	Esophagus endoscopy	0141	0384
43256	Upper GI endoscopy w/stent	0141	0384
44370	Small bowel endoscopy w/stent	0142	0384
44379	Small bowel endoscopy w/stent	0142	0384
44383	Small bowel endoscopy	0142	0384
44397	Colonoscopy w/stent	0143	0384
45387	Colonoscopy w/stent	0143	0384
45327	Proctosigmoidoscopy w/stent	0147	0384
45345	Sigmoidoscopy w/stent	0147	0384

We proposed to accept the Panel's recommendation to move the following gastrointestinal endoscopic stent CPT codes into newly created APC 0384: 43219, 43256 (from APC 0141); 44370, 44379, 44383 (from APC 0142); 44397, 45387 (from APC 0143); 45327, 45345 (from APC 0147). We received no comments disagreeing with this proposal, and we will adopt it for 2004.

gg. Capturing the Costs of Devices That Are Packaged Into APCs

APC 0081: Non-Coronary Angioplasty or Atherectomy
APC 0083: Coronary Angioplasty and Percutaneous Valvuloplasty
APC 0104: Transcatheter Placement of Intracoronary Stents
APC 0222: Implantation of Neurological Device
APC 0223: Implantation of Pain Management Device
APC 0227: Implantation of Drug Infusion Device
APC 0229: Transcatheter Placement of Intravascular Shunts

Several commenters requested that the status indicators for the above APCs (all of which include high-cost devices) be changed from T (multiple-procedure discount applies) to S (multiple-procedure discount does not apply). Two presenters to the Panel stated that hospitals do not pay less for devices when they are used in the context of a multiple-procedure claim and suggested that we apply the multiple-procedure reduction to the non-device portion of the claim only. Alternatively, these presenters recommended that we apply the discount policy only when the device cost is below a predetermined proportion of the APC cost. Another presenter to the Panel requested that APCs 0222, 0223, and 0227 be exempt from the multiple-procedure discount policy because the cost of the devices used in these procedures makes up more than 50 percent of the APC cost.

We sought the Panel's input as to whether there are situations in which we should not apply our multiple procedure discount policy. The Panel recommended no changes to the status indicators for any of the device-related APCs discussed because they were concerned that exemptions from the discount policy could result in incentives to use more devices than necessary. However, the Panel asked that we analyze our data to determine if we may be underpaying for devices when the multiple procedure discounting policy is applied and recommended that we develop some methodology to track device costs. In section II.B of this preamble, we discuss the issue of device costs and multiple procedure reductions and our progress to date in developing ''combination APCs'' to address the Panel's concern.

hh. Discussion of Ways To Increase the Use of Multiple Claims To Set APC Payment Rates

A presenter to the Panel suggested that we use dates of service on multiple procedure claims to increase the number of claims we use to set payment rates. Another presenter suggested that we could further increase the number of multiple procedure claims that could be used to set payment rates by ignoring codes with status indicator K. Other suggestions were to exclude from consideration those APCs with small dollar values and to create a new code or APC specifically for the insertion and removal of devices.

The Panel recommended that our staff explore ways to increase the number of claims used to set payment rates, including the following methodologies: sort multiple claims by date of service; exclude codes with K status indicator from evaluation; exclude those APCs with nominal costs (the definition of ''nominal'' can be determined by modeling a variety of possible dollar amounts). In addition, the Panel recommended that we not create G codes as part of the effort to use multiple procedure claims for developing relative weights. If new codes are needed, the Panel suggested that our staff work with the American Medical Association's CPT Board to identify possible new codes.

B. Other Changes Affecting the APCs

1. Limit on Variation of Costs of Services Classified Within an APC 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 an APC group is more than 2 times greater than the lowest cost item or service within the same group. However, the statute authorizes the Secretary to make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low volume items and services. No exception may be made 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.

Taking into account the proposed APC changes discussed in relation to the APC Panel recommendations in section II.A.4 of this preamble and the use of 2002 claims 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 following table contains the final list of APCs that we exempt from the 2 times rule based on the criteria cited above. In cases in which a recommendation of the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the Panel recommendation 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.

The median cost for hospital outpatient services for these and all other APCs can be found at Web site: *http://www.cms.hhs.gov.*

TABLE 5.—APCS EXEMPTED FROM 2 TIMES RULE

Final Rule APC	Description
0006	Level I Incision & Drainage.
0012	Level I Debridement & Destruction.
0018	Biopsy of Skin/Puncture of Lesion.
0019	Level I Excision/Biopsy.
0020	Level II Excision/Biopsy.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0046	Open/Percutaneous Treatment Fracture or Dislocation.
0058	Level I Strapping and Cast Application.
0060	Manipulation Therapy.
0071	Level I Endoscopy Upper Airway.
0074	Level IV Endoscopy Upper Airway.
0084	Level I Electrophysiologic Evaluation.
0093	Vascular Reconstruction/Fistula Repair without Device.
0097	Cardiac and Ambulatory Blood Pressure Monitoring.
0099	Electrocardiograms.
0103	Miscellaneous Vascular Procedures.
0105	Revision/Removal of Pacemakers, AICD, or Vascular.
0109	Removal of Implanted Devices.
0130	Level I Laparoscopy.
0147	Level II Sigmoidoscopy.
0148	Level I Anal/Rectal Procedure.
0155	Level II Anal/Rectal Procedure.
0165	Level III Urinary and Anal Procedures.
0192	Level IV Female Reproductive Proc.
0203	Level IV Nerve Injections.
0204	Level I Nerve Injections.
0207	Level III Nerve Injections.
0213	Extended EEG Studies and Sleep Studies, Level I.
0214	Electroencephalogram.
0218	Level II Nerve and Muscle Tests.
0231	Level III Eye Tests & Treatments.
0233	Level II Anterior Segment Eye Procedures.
0235	Level I Posterior Segment Eye Procedures.
0239	Level II Repair and Plastic Eye Procedures.
0245	Level I Cataract Procedures without IOL Insert.
0252	Level II ENT Procedures.
0262	Plain Film of Teeth.
0266	Level II Diagnostic Ultrasound Except Vascular.
0274	Myelography.
0279	Level II Angiography and Venography except Extremity.
0297	Level II Therapeutic Radiologic Procedures.
0303	Treatment Device Construction.
0314	Hyperthermic Therapies.
0323	Extended Individual Psychotherapy.
0340	Minor Ancillary Procedures.
0341	Skin Tests.
0344	Level III Pathology.
0355	Level III Immunizations.
0356	Level IV Immunizations.
0363	Level I Otorhinolaryngologic Function Tests.
0364	Level I Audiometry.
0367	Level I Pulmonary Test.
0368	Level II Pulmonary Tests.
0370	Allergy Tests.
0373	Neuropsychological Testing.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0402	Brain Imaging.
0404	Renal and Genitourinary Studies Level I.

TABLE 5.—APCS EXEMPTED FROM 2 TIMES RULE—Continued

Final Rule APC	Description
0407	Radionuclide Therapy.
0409	Red Blood Cell Tests.
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.
0692	Electronic Analysis of Neurostimulator Pulse Generators.
0698	Level II Eye Tests & Treatments.
0699	Level IV Eye Tests & Treatments.
1528	New Technology—Level XXVIII ($5000-$5500).

2. Procedures Moved From New Technology APCs to Clinically Appropriate APCs

In the November 30, 2001 final rule (66 FR 59903), we made final our proposal to change the period of time during which a service may be paid under a new technology APC. Beginning in 2002, the policy is 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 allows us to move a service from a new technology APC in less than 2 years if sufficient data are available, and it also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

In the context of new technology procedures, we create HCPCS codes for services only. We do not create HCPCS codes for equipment that is used in the course of providing an item or service (except in the case of ''C'' codes for devices that meet the criteria for transitional pass-through payments). Equipment that is used to provide an item or service is not separately coded because it is a resource required to furnish the service. Like other resources that are required to furnish a service (for example, cost of a room, cost of staff, cost of supplies), the hospital should show charges either as part of its charge for the procedure or with a revenue code.

As described below, we proposed to delete four HCPCS codes that are currently paid in new technology APCs. We believed that these four HCPCS codes do not conform to our current policy to not create HCPCS codes for equipment used to provide a service. In addition, we stated that there soon would exist, CPT codes to describe all of the services being furnished, including any equipment that is needed to perform them, so we believe it is appropriate at this time to delete the HCPCS codes. The HCPCS codes which we proposed to delete effective January 1, 2004 were:

C1088; Laser Optic Treatment System, Indigo Laseroptic Treatment System

C9701; Stretta System

C9703; Bard Endoscopic Suturing System, and C9711; H.E.L.P. Apheresis System.

A full description of these HCPCS is available in the proposed rule (67 FR 47978).

We received no comments in response to this proposal. However, we have determined that our proposal to delete codes C9701 and C9703 was in error. Upon further review of this issue, we have determined that these codes were in fact established to represent complete procedures. Therefore, we will retain codes C9701 and C9703.

Comment: A provider of treatment planning software submitted several comments regarding this service. In their first set of comments on the 2003 OPPS final rule with comment, the commenter agreed with our decision to create a new G-code, G0288, for their product, Preview, and other similar treatment planning software and to assign this service to new technology APC 0975. G0288 was created and assigned to new technology APC 0975 for the 2003 final rule and was subject to comment after its publication. In their comments in response to the 2003 final rule with comment, they indicated that the $625 payment rate associated with new technology APC 0975 appropriately reflected the costs of Preview to providers. However, this party recommended that we pay for G0288 under certain circumstances. These included payment only for treatment planning imaging services that are FDA approved; that is, to follow FDA's determinations concerning which imaging software programs are sufficiently comprehensive and accurate. Further, the commenter recommended that we pay for both pre-surgical and post-surgical imaging, claiming optimum effectiveness of the related endovascular repair procedures only occurs when imaging studies are performed both before and after surgery. Third, this party recommended that we use G0288 in the OPPS but not in other Medicare payment systems until cost data were more complete. The commenter believed that we should encourage use of the CPT process to develop codes that describe a wide range of applications for the treatment planning imaging that may develop.

The commenter also commented on our August 12, 2003 proposed rule, in which we proposed assigning G0288 to new APC 0414, with a payment rate of $260.65. This commenter stated that the proposed payment is inadequate and based on flawed, imputed cost data. It also asserted that the descriptors for APC 0414 and G0288 do not restrict the use of this code to services that meet the ''recognized standards and specifications'' for three-dimensional computer-aided measurement planning simulation (''3D–CAMPS'') services and recommended that we revise the proposed payment for APC 0414 based on hospital acquisition cost data that they provided. The commenter also recommended that we create a revenue code specifically for APC 0414 to enable more rational charge determination for the service and that we revise the descriptors for APC 0414 and G0288 to ensure that the codes only are used for the 3D–CAMPS systems, and to clarify that the service may be applied pre- or post-surgically. The recommended descriptor is: ''Three-dimensional computer-aided measurement simulation (3D–CAMPS) services for pre-surgical and post-surgical imaging.''

Response: We proposed to move G0288 from new technology APC 0975 to APC 0414 because we believe that we had sufficient 2002 claims data for our analysis. The predecessor C-code for Preview, C9708, was reported approximately 1,300 times in 2002, with a median cost of $272.48. However, we have reviewed the hospital cost data that the commenting party provided, and believe that there may be some claims in our data that understate the cost of the treatment planning software. We have decided to give equal weight to the median cost based on our claims data and the median cost of $625 provided by the commenter, based on its analysis. Therefore, we are establishing the appropriate cost

amount as $448.74. As a result, we are assigning G0288 to new technology service APC 1506, for a payment rate of $450.00. We are continuing the assignment of G0288 to a new technology APC because this is still a relatively new procedure and we still have concerns regarding our cost data.

We agree that this can be used for treatment planning prior to surgery and for post-surgical monitoring and have revised the code descriptor to clarify this point. The descriptor for this code is revised as follows: G0288 Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery. We assume that hospitals providing this service will abide by the FDA labeling requirements for equipment used in providing this service.

3. Revision of Cost Bands and Payment Amounts for New Technology APCs

We proposed to implement a comprehensive restructuring of all the new technology APCs. First, the cost intervals in the current new technology APCs are inconsistent, ranging from $50 to $1,500. Secondly, as the number of procedures assigned to new technology APCs increases, we believe that narrower cost bands are required to avoid inaccurate payment for new technology services. The increased number of new technology APCs that would result from narrowing the cost bands cannot be accommodated within the current sequence of available APC numbers. Therefore, we proposed to dedicate two new series of APC numbers to the restructured new technology APCs, which would allow us to narrow the cost bands and also afford us flexibility in creating additional bands as future needs may dictate.

We proposed to establish cost bands from $0 to $100 in increments of $50, from $100 through $2,000 in intervals of $100, and from $2,000 through $6,000 in intervals of $500. We believe that these intervals would allow us to price new technology services more appropriately and consistently. We also propose to retain two parallel sets of new technology APCs, one with status indicator ''S'' and the other with status indicator ''T.'' We solicited comments on the hierarchy of cost levels of the restructured new technology APCs.

The final list of restructured new technology APCs is in Addendum A.

We received a number of comments in support of this proposal to restructure the new technology APC bands. Therefore, we will finalize our proposal.

4. Creation of APCs for Combinations of Device Procedures

In the August 12, 2003 proposed rule, we discussed data development that we had undertaken to create median costs for combinations of HCPCS codes in different APCs that we believed were frequently performed on the same day. We focused our work on pairs of APCs, one of which contained a service that required an expensive device. See 68 FR 47979 for a complete description of the data development. We undertook this activity to see if creating larger classification groups of this type might increase the number of multiple procedure claims that we could use to set payment rates for these services. We also thought that the analysis might yield useful information regarding the appropriateness of the multiple procedure reduction for combinations of services that include at least one APC with an expensive device, that are commonly performed on the same date. In many cases, we found that the combination APC medians closely approximated the median that results under the current policy (that is, the sum of single medians for each APC, reducing the median for the lower cost procedure by 50 percent). In other cases, the data revealed combination APC median costs that were considerably higher or lower than under our current policy.

We concluded in the proposed rule that the results of the study provided no compelling reason to change our payment policy. We asked for comment on all aspects of the methodology, analysis, and payment options. We also asked for discussion of how we could use more multiple procedure claims were we not to create combination APCs and for an explanation of why external data should be used in lieu of our single or multiple procedure claims data to set median costs for APCs with large device costs. However, we did not propose to create combination APCs or to make payment based on the combination APC medians for 2004.

We received only a few comments on the combination APC methodology and these were in the context of why we should not apply multiple procedure reductions to specific combinations of APCs. See the discussion of multiple procedure reduction in V.D.2 for a summary of these comments and our responses.

III. Recalibration of APC Weights for CY 2004

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. 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 CY 2001. (See the November 13, 2000 interim final rule (65 FR 67824 to 67827)).

To recalibrate the relative APC weights for services furnished on or after January 1, 2004 and before January 1, 2005, we used the same basic methodology that we described in the April 7, 2000 final rule. That is, we recalibrated the weights based on claims and cost report data for outpatient services. We used the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative weights for CY 2004, the most recent available claims data are the approximately 127 million final action claims for hospital outpatient department services furnished on or after April 1, 2002 and before January 1, 2003. We eliminated 2.6 million claims for bill types other than OPPS bill types and claims for services furnished in Maryland, Guam, and the Virgin Islands. We matched the remaining claims that were paid under the OPPS to the most recent cost report filed by the individual hospitals represented in our claims data. We were left with about 75 million claims for which we could identify cost report data. The APC relative weights continue to be based on the median hospital costs for services in the APC groups.

A. Data Issues

1. Period of Claims Data Used

We used claims for the period beginning April 1, 2002 through and including December 31, 2002 as the basis for the CY 2004 OPPS. The statute requires that we take into account new cost data and other relevant information and factors in reviewing and revising the weights, and we believe that this period will give us the most recent costs. We chose not to include the claims for the period beginning on January 1, 2002 through March 31, 2002 because they were used to set the payment rates for the 2003 OPPS and we believe that the most recent 9 months of claims data will result in payment rates that are most representative of the current relative costs of hospital outpatient services.

Comment: Some commenters supported our use of claims for this 9-month period for setting the weights for

the 2004 OPPS. Other commenters wanted us to use external data in lieu of claims data for specified APCs because they believed that the payments that result from the median costs developed using claims data were inadequate. Other commenters objected to the use of 2002 claims data because they stated that 2002 costs would not be an appropriate proxy for the relative costs of drugs, biologicals, and radiopharmaceuticals in 2004 and they urged us to use hospital acquisition costs instead of claims data.

Response: We used 2002 claims data for services furnished from April 1, 2002 through December 31, 2002 as the basis for the relative weights used to create payment amounts for the 2004 OPPS. Our established policy is to use the most recent claims data available. For the August 12, 2003 proposed rule and this final rule, those data are for services in the last 3 quarters of 2002. These data are used to calculate median costs upon which to base our relative weights. The OPPS seeks and uses relative costs to create weights that are used to distribute a fixed amount of Medicare payment for OPPS services appropriately among hospitals. Therefore, the accuracy of the relativity is more important than whether the median costs derived from the claims data accurately reflect the costs of the services. *See* section III.B for our discussion of the use of external data.

2. Treatment of ''Multiple Procedure'' Claims

Since the inception of the OPPS, we have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the OPPS relative payment weights. Those making the requests believe that relying solely on single-procedure claims to recalibrate APC weights fails to take into account data for many frequently performed and complex procedures, particularly those commonly performed in combination with other procedures.

We agree that it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. For CY 2003, we identified a number of multiple-procedure claims that could be treated as single-procedure claims, enabling us to greatly increase the number of claims used to develop the APC payment weights. However, there remain several inherent features of multiple procedure claims that prevent us from using all of them to recalibrate the payment weights. We discussed these obstacles in detail in the August 9, 2002 proposed rule (67 FR 52092, 52108 through 52111), and the November 1, 2002 final rule (67 FR 66718, 66743 through 66746).

To enable us to use more claims in the creation of median costs upon which our payment weights and rates are based, we proposed several changes to how we use claims data for the CY 2004 OPPS. Specifically, we proposed to expand the number of HCPCS codes that we ''ignore'' for the purpose of creating pseudo single claims from claims that contain other separately payable HCPCS codes. We also looked at dates of service on packaged HCPCS codes and packaged revenue centers, and proposed where possible, to attribute the charges to major, separately payable HCPCS codes based on the codes' dates of service. We also considered creating combination APCs for procedures that have a significant device component. Our complete discussion of the use of data to set the weights for CY 2004 OPPS follows in section III.B of this preamble.

Expansion of the List of Codes To Be Ignored in Creation of Single Claims

For CY 2003 OPPS, we ignored the presence of HCPCS codes 93005, 71010, and 71020 to create pseudo-single claims where there was only one remaining separately paid, major HCPCS code on the claim. Ignoring these codes enabled us to attribute the costs of packaged HCPCS codes and packaged revenue centers to the remaining separately paid, major HCPCS codes and, thereby, create a useable psuedo single claim. We did this because we believed that the charges found in the packaged HCPCS or packaged revenue centers would be appropriately associated with the only other separately payable HCPCS that remained on the claim once the ignored codes were bypassed.

For CY 2004 OPPS, we proposed to expand the list of HCPCS codes to be ignored for purposes of creating pseudo-single claims. On claims that contain other separately payable HCPCS, we proposed to bypass the HCPCS codes in the APCs identified in Table 6. As with the previously ignored HCPCS codes 93005, 71010, and 71020, we believe that there are additional codes that are highly unlikely to have charges that are found in packaged HCPCS or in packaged revenue centers. Therefore, we believe that they also can be ignored for the purpose of creating pseudo-single claims from the remaining charges on the claim. We solicited comments on the proposed methodology to create pseudo-single claims, on the list of codes that we proposed to ignore (Table 6), and whether there are other low-cost services that we could ignore using this methodology. We also requested comments on whether we should use the charges for the codes in the APCs in Table 6 to create pseudo singles for these codes from these claims.

Use of Dates of Service To Create Single Claims

For CY 2004, we used dates of service on HCPCS codes and on packaged revenue centers to attribute charges to a major payable HCPCS code where the dates of service match. We could only use this approach where there are different dates of service for the separately payable major HCPCS codes. Where there are multiple major payable HCPCS codes on a claim with the same date, we could not use this approach because there was no way to tell to which major payable HCPCS code the charges from the packaged HCPCS or packaged revenue center belonged. Moreover, where the hospital did not provide dates for all packaged revenue centers, we could not attribute charges based on the date of service.

Use of Single Procedure Claims

Comment: Some commenters objected to the use of single procedure claims as the basis for setting weights for all APCs. The commenters are concerned that even with the changes we made to use more claims for 2004 OPPS, some of the APCs had medians based on less than 10 percent of their true claims volume. They believe that this methodology results in the use of claims only for simple, low-cost cases from small, relatively non-busy centers with low levels of technological complexity and inappropriately low costs and charges. They urged us to use external data, whether proprietary or not, in place of the claims-derived medians when the medians would otherwise be based on a small number of claims.

Some commenters urged us to ignore codes for procedures performed on the same day as procedures of interest to them and to package all revenue center charges and charges for packaged HCPCS codes into the code for which they were seeking a median. Some commenters gave us relatively elaborate strategies for creating pseduo-single claims out of multiple procedure claims for particular services or groups of services that were of interest to them. Some of these related to special packaging for chemotherapy services and nuclear medicine services. The commenters urged us to model our data for the 2005 OPPS according to the specifications they provided.

Response: We would certainly prefer to use all claims in the setting of weights for APCs, if it were possible to do so validly. However, we continue to be plagued by our inability to allocate revenue center charges when there are multiple major procedure codes for services performed on the same day. We are unable to determine how to accurately split some costs (for example, recovery room time) among the major procedures. We have received no comments that offer alternatives that would enable us to do so with confidence.

We did not accept the service-specific strategies for acquiring more single claims that were submitted in comments because none of them could be generalized to the entire claims population in such a way that we could be sure that they would not distort the relativity of all services. We set weights for hundreds of APCs in this system and we think it is important that the same rules governing creation of pseudo single claims from multiple procedure claims be applied across all services so that packaging occurs uniformly and the relativity of services is maintained. It is a practical impossibility to have different strategies for creating pseudo singles for each category of services.

We did not use the line items that were ignored in the calculation of medians for the APC into which they would fall because we lacked confidence that they would accurately represent the full cost of the service. We asked for comments on this in the proposed rule. Based on the comments that indicate that the data for these line items should be used in median setting, we expect to use these line items for median setting for the 2005 proposed rule.

APCs to be Ignored To Create More Single Claims

Comment: Commenters supported the expansion of the list of APCs that we ignored to create single procedure claims from multiple procedure claims to enable us to use more claims data in weight setting. A commenter asked that we confirm that the line items that were ignored to create pseudo-single claims (See Table 6) are used in the weight setting process. A commenter asked that we implement the combination APC approach as a way of using more claims data for multiple procedure claims. One commenter asked that we add evaluation and management codes to the list of codes ignored for purposes of creating pseudo-singles. Other commenters provided lists of additional codes that could be ignored to create more pseudo-single claims.

Commenters also supported the use of dates of service on lines with revenue code charges where they could be used to attribute charges to HCPCS codes for weight setting. Some commenters advised that we should use the date of service aggregation at the beginning of the pseudo-single claim creation to achieve the best effects. Some commenters asked that we require all hospitals to use dates of service on all lines (but not before July 1, 2004), even where only revenue codes are on the lines, so that more claims could be used in future years.

Several commenters asked that we eliminate the requirement for series bills for certain services if we require a date of service for each line because the claim will grow in size as charges for multiple dates of service that are now combined on a single line with no date of service will now have to be split into multiple lines to show the date of service. The commenters fear that the increase in the lines on the claim may result in errors on the claim and there may be cashflow problems if more claims are returned to the provider. The commenters indicated that delays in payment for series bills covering 30 days of service are significant.

Response: For the 2004 OPPS, we did make progress in using more claims by looking to the dates on revenue center charges, where they exist, to assign them to a single major procedure on the same date. We applied the date of service criteria before we ignored APCs to create single claims. Moreover, we were able to create more single procedure claims by ignoring procedures for which we thought no revenue center charges or packaged HCPCS charges would be appropriately assigned. We appreciate the information provided in comments and hope that the public will continue to furnish us with an expanded list of codes that they believe can be considered ''stand alone'' codes, which we could properly ignore in creating pseudo single claims from claims containing multiple major procedures. We did not add evaluation and management service codes to the list because we believe that drugs and supplies are often used during such services and that it would not be correct to assume that all of the supply and drug charges on the claim were for items and services used with the procedure that also is billed also on the same claim. We would like to further explore the issue of which claims to ignore for pseudo single creation with the APC Panel in its winter meeting and to seek the Panel's views on the specific code to be added to the list of codes to be ignored for this purpose.

While we did not apply the combination APC approach, we expect to continue to explore whether this would, upon further refinement, have value in establishing correct weights for procedures performed in combination with one another. We hope to improve both of these processes next year and to develop other methods of using multiple procedure claims.

We did not use the line items for the HCPCS codes we ignored in the calculation of medians for those HCPCS codes. We asked for public comment on the issue. In view of the public comments supporting the concept of ignoring certain codes for creation of pseudo singles and supporting the validity of using these line items in the median setting for these codes, we will propose to use them for median setting for the 2005 proposed rule.

Our requirement for series bills creates efficiencies in claims processing that enable us to provide better provider service. In view of the decision to not implement the drug administration option, which would have required coding of all drugs, and seemed to be the impetus for the comment, we do not expect to revise our series bill policy.

B. Description of Our Calculation of Weights for CY 2004

The methodology we followed to calculate the APC relative payment weights proposed for CY 2004 is as follows:

- We excluded from the data 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 end-stage renal disease (ESRD)).
- We eliminated claims from hospitals located in Maryland, Guam, and the U.S. Virgin Islands.
- 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 CY 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 287 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, a uniform charge applied to all services). Of these, 206 hospitals had claims data.
- We eliminated from our data claims for critical access hospitals that are not

paid under OPPS and whose claims are therefore not suitable for use in setting weights for services paid under OPPS.

• We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 56 hospitals whose total operating CCR deviated from the geometric mean by more than three standard deviations.

• We excluded from our data approximately 3.11 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.

• We matched revenue centers from the remaining universe of claims to hospital CCRs.

• We separated the remaining claims that we had matched with a cost report into the following three distinct groups: (1) Single-procedure claims; (2) multiple-procedure claims; and (3) claims on which we could not identify at least one OPPS covered service. Single-procedure claims are those that include 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 include more than one HCPCS code that could be mapped to an APC. Dividing the claims yielded approximately 24.43 million single-procedure claims and 16.86 million multiple-procedure claims.

We converted 9.833 million multiple-procedure claims to single-procedure claims using the following criteria: (1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim. (2) For multiple-procedure claims with a packaged HCPCS code (status indicator ''N'') on the claim, we ignored line items for preoperative procedures and for those services in the APCs identified in Table 6. These are services with payment amounts below $50 (under the CY 2003 OPPS) for which we believe the charge represents the totality of the charges associated with the service (that is, that there are no packaged HCPCS or packaged revenue centers attributable to the service). If only one procedure (other than HCPCS codes in Table 6) existed on the claim, we treated it as a single-procedure claim. (3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single-procedure claim if billed with single units. (4) If the claim had no packaged HCPCS codes but had packaged revenue centers for the procedure, we ignored the line item for codes in the APCs identified in Table 6. If only one HCPCS code remained, we treated the claim as a single-procedure claim.

TABLE 6.—APCS THAT WERE IGNORED TO CREATE PSEUDO SINGLE PROCEDURE CLAIMS

APC	APC Description	Status indicator
0001	Level I Photochemotherapy	S
0060	Manipulation Therapy	S
0077	Level I Pulmonary Treatment	S
0099	Electrocardiograms	S
0215	Level I Nerve and Muscle Tests	S
0215	Level I Nerve and Muscle Tests	S
0230	Level I Eye Tests & Treatments	S
0260	Level I Plain Film Except Teeth	X
0262	Plain Film of Teeth	X
0271	Mammography	S
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X
0342	Level I Pathology	X
0343	Level II Pathology	X
0344	Level III Pathology	X
0345	Level I Transfusion Laboratory Procedures	X
0364	Level I Audiometry	X
0367	Level I Pulmonary Test	X
0669	Digital Mammography	S
0690	Electronic Analysis of Pacemakers and other Cardiac Devices.	S
0706	New Technology—Level I ($0–$50)	S

In addition, we assessed the dates of service for HCPCS codes and packaged revenue centers on each claim that contained more than one major code. Where it was possible to attribute charges for packaged HCPCS and packaged revenue centers to HCPCS codes for major procedures by matching unique dates of service, we did this and created single claims by packaging charges into the charge for the major service on the same date. We were only able to do this if the multiple major procedures had different dates of service and if there were dates of service on all of the packaged revenue centers. Dates of service on revenue centers are not required and, therefore, only claims from hospitals that submitted dates of service on revenue centers in CY 2002 could be used in this process for maximizing the number of single-procedure claims to be used for weight setting.

• To calculate median costs for services within an APC, we used only single-procedure bills and those multiple-procedure bills that we converted into single claims. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.2 of this final rule, we did not use multiple-procedure claims that billed more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using multiple procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.

For APCs in Table 7, we required that there be a C code on the claim for the claim to be used. These APCs require the use of a device in the provision of the service. Moreover, in 2002, hospitals were required to bill the C code in order for the device to receive pass-through

payment for the device. Therefore, if no C code was billed on the claim, we presumed that the claim was incorrectly coded, and we did not use it. For some of these APCs, we further required that specific devices be on the claim.

TABLE 7.—APCS FOR WHICH A HCPCS FOR A DEVICE WAS REQUIRED TO BE ON A CLAIM USED FOR WEIGHT SETTING

APC	APC Description	Status
0032	Insertion of Central Venous/Arterial Catheter	T
0039	Implant Neurostim, One Array	S
0048	Arthroplasty with Prosthesis	T
0080	Diagnostic Cardiac Catheterization	T
0081	Non-Coronary Angioplasty or Atherectomy	T
0082	Coronary Atherectomy	T
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T
0085	Level II Electrophysiologic Evaluation	T
0086	Ablate Heart Dysrhythm Focus	T
0087	Cardiac Electrophysiologic Recording/Mapping	T
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T
0090	Insertion/Replacement of Pacemaker Pulse Generator	T
0104	Transcatheter Placement of Intracoronary Stents	T
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T
0107	Insertion of Cardioverter-Defibrillator	T
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T
0115	Cannula/Access Device Procedures	T
0119	Implantation of Devices	T
0122	Level II Tube Changes and Repositioning	T
0167	Level III Urethral Procedures	T
0202	Level VIII Female Reproductive Proc	T
0222	Implantation of Neurological Device	T
0225	Implantation of Neurostimulator Electrodes	S
0226	Implantation of Drug Infusion Reservoir	T
0227	Implantation of Drug Infusion Device	T
0229	Transcatheter Placement of Intravascular Shunts	T
0259	Level VI ENT Procedures	T
0313	Brachytherapy	S
0384	GI Procedures with Stents	T
0385	Level I Prosthetic Urological Procedures	T
0386	Level II Prosthetic Urological Procedures	T
0648	Breast Reconstruction with Prosthesis	T
0652	Insertion of Intraperitoneal Catheters	T
0653	Vascular Reconstruction/Fistula Repair with Device	T
0654	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	T
0655	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	T
0670	Intravenous and Intracardiac Ultrasound	S
0674	Prostate Cryoablation	T
0680	Insertion of Patient Activated Event Recorders	S
0681	Knee Arthroplasty	T

• 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. We used the most recent settled or submitted cost reports. Using the most recent ''submitted to settled ratio,'' we adjusted CCRs for the submitted cost reports but not the settled ones. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or used the hospital's overall CCR 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). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of ''N'').

• To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing services. Table 8 contains a list of the revenue centers that we packaged into major HCPCS codes when they appeared on the same claim. This is a change to the packaging of revenue centers by category of service that had been done since the inception of the OPPS in the April 7, 2000 final rule (65 FR 18457). In all prior years of the OPPS, we had specific subsets of revenue centers that we packaged into major HCPCS codes based on the type of service we assigned to the HCPCS code for this purpose. For example, we had a set of revenue centers that could be packaged into visit codes and a different, but overlapping, set of revenue centers that could be packaged into surgery codes. For 2004 OPPS, we converted these categories to a single set of revenue codes (see Table 8) that would be packaged into the major HCPCS code with which it appears on a claim. We believe that this will increase the likelihood that the total charge for the major HCPCS code will capture all of the costs attributed to the services furnished. Table 8 lists packaged services by revenue center that we are proposing to use to calculate per-service costs for outpatient services furnished in CY 2004.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE

Revenue code	Description
250	Pharmacy.
251	Generic.
252	Nongeneric.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
254	Pharmacy Incident to Other Diagnostic.
255	Pharmacy Incident to Radiology.
257	Nonprescription Drugs.
258	IV Solutions.
259	Other Pharmacy.
260	IV Therapy, General Class.
262	IV Therapy/Pharmacy Services.
263	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.
290	Durable Medical Equipment.
370	Anesthesia.
371	Anesthesia Incident to Radiology.
372	Anesthesia Incident to Other Diagnostic.
379	Other Anesthesia.
390	Blood Storage and Processing.
399	Other Blood Storage and Processing.
560	Medical Social Services.
569	Other Medical Social Services.
621	Supplies Incident to Radiology.
622	Supplies Incident to Other Diagnostic.
624	Investigational Device (IDE).
630	Drugs Requiring Specific Identification, General Class.
631	Single Source.
632	Multiple.
633	Restrictive Prescription.
637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic. COMA) .
700	Cast Room.
709	Other Cast Room.
710	Recovery Room.
719	Other Recovery Room.
720	Labor Room.
721	Labor.
762	Observation Room.
810	Organ Acquisition.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
819	Other Organ Acquisition.
942	Education/Training.

• 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 proposed FY 2004 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on May 9, 2002 (67 FR 31602). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. (*See* the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).

• 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 diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three 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.

• We calculated the median cost for each APC.

To develop the median cost for observation (APC 339, HCPCS code G0244), we selected claims containing HCPCS code G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours) that also showed one or more of the ICD–9 (International Classification of Diseases, Ninth Edition) diagnosis codes required for payment of APC 339. We ignored other separately payable codes so that the claims with G0244 would not be excluded for having multiple major procedures on a single claim. We packaged the costs of allowable revenue centers and HCPCS codes with status indicator ''N'' into the cost of G0244, and trimmed as was done for the calculation of the median costs for other APCs.

• Using the median APC costs, we calculated the relative payment weights for each APC. As in prior years, 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. 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. Using 2002 data, the median cost for APC 0601 is $58.78.

Section 1833(t)(9)(B) of the Act requires that APC revisions, relative payment weight revisions, and wage index and other adjustments be made in a manner that ensures that estimated aggregate payments under the OPPS for 2004 are neither greater than nor less than the estimated 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 2003 relative weights to aggregate payments using the CY 2004 proposed weights. Based on this comparison, we made an adjustment of 0.981635942 to the weights. The weights that we developed for 2004 OPPS, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B.

Impact of Allocation of Equipment and Capital Costs

Comment: Several commenters indicated that the weight setting methodology may have a disproportionately adverse effect on procedures performed in departments with higher medical equipment and capital costs such as radiology and nuclear medicine. The commenters indicated that the capital costs incurred by these departments are generally spread among all hospital departments on a square foot or other basis, rather than being specifically allocated to the departments that incur the costs involved. This would distort the cost to charge ratios for these departments, resulting in under-weighting of the APCs for the services they furnish. Commenters indicated that we recognized this in the preamble to the 2000 OPPS rule (65 FR 18485, April 7, 2002) but indicated that it did not have the data necessary to make the appropriate adjustment due to hospital reporting processes. The commenter indicated that it would be appropriate for us to re-evaluate mechanisms that could be used to ameliorate the distortion.

Response: We recognize that the allocation of capital and equipment costs to revenue centers that do not use the equipment could distort cost to charge ratios for the revenue centers that use the equipment (and presumably whose charges reflect those costs). It is not clear how cost to charge ratios could be adjusted for such allocations. However, for the 2005 OPPS, we hope to explore the effect and impact of basing relative weights on relative hospital charges, rather than costs. If weights are based on relative charges, then presumably, the charges for services with high cost equipment and capital expenses would reflect those costs relative to other services without such costs.

Dates of Service on Revenue Code Lines

Comment: Commenters supported requiring dates of service on lines with revenue code charges but asked that the requirement not be enforced until June 2004 to enable hospitals to have sufficient time to adjust their systems to provide this information.

Response: Subsequent to the proposed rule, we learned that the X 12N 837 standard transaction with which covered entities had to be in compliance on October 16, 2003, requires a date of service on each line item containing a charge.

Single Revenue Code List for Packaging

Comment: One commenter supported the use of a single revenue code list for packaging costs into separately paid HCPCS codes. The commenter indicated that this change would result in more accurately attributing costs to services. Another commenter objected to our proposed changes for packaging revenue centers. This commenter is concerned that the use of a single set of revenue codes for packaging into the major procedure on a claim may inappropriately allocate charges not associated with the major service on the claim. For example, the commenter stated that revenue code 254 and revenue code 255 should continue to map to a radiological APC, and charges in these revenue centers should not be assigned to a major non-radiological procedure.

Response: We proposed to combine the multiple lists of revenue codes into one because there was significant overlap in them and our physicians believed that the risk of not picking up appropriate charges was greater than the risk of picking up charges that were not appropriate. In the case cited by the commenter, we are depending on hospital billing and our reliance on single procedure claims to preclude us from packaging a charge for a radiological service into a HCPCS code for a non-radiological service. We have never had a complaint that we have packaged more costs than were appropriate into a HCPCS code, although we frequently are told that we neglected to pick up all related charges. For the final rule, we retained the single set of revenue codes for packaging into separately payable major HCPCS codes.

Need for Stability in Relative Weights

Comment: Commenters stated that significant changes in weights for services from year to year are difficult for hospitals because not all hospitals provide all services and if the APC rates fall for the particular service mix the hospital furnishes, this can mean significant shifts in total payment for outpatient services from Medicare from year to year. Commenters indicated that we should adjust medians derived from claims data to limit the amount of change that occurs from year to year. Commenters indicated that hospitals are limiting availability of services based on declining Medicare OPPS revenues and that once a service is curtailed or eliminated, it is not likely to be reintroduced again because the hospital will cease monitoring the costs of the device and equipment needed to offer the service once it is no longer provided in the hospital and, therefore, even if it would be cost effective to reintroduce the service, it is not likely to occur. Commenters indicated that the pattern of revenue changes is a factor in hospital decisions regarding whether to acquire state-of-the-art equipment. Therefore, reductions in payments for equipment-intense services discourage hospitals from acquiring the equipment necessary to provide state-of-the-art services to Medicare beneficiaries. Commenters also indicated that the cumulative effects of the reductions from 2002 payment rates, particularly for procedures to implant medical devices, have resulted in significant payment cuts for many of these procedures and will discourage acquisition of the items necessary to provide the highest quality care.

A commenter stated that we should stabilize the APC rate when a device comes off of pass-through status. Several commenters stated that the proposed rates reverse the progress that was made in 2002 by using the manufacturer prices in the setting of medians for 2002. Commenters indicated that we should adjust the medians from claims data to ensure that no APC's median falls more than 5 percent compared to the medians used for payment in 2003. A commenter suggested that we adjust the medians whenever there is more than a 20 percent reduction from one year to the next. Another commenter indicated that all APCs that decline more than 10 percent compared to 2003 adjusted medians should be adjusted in the same way that we proposed to adjust medians for drugs, biologicals and radiopharmaceuticals and that these adjustments also should apply to brachytherapy sources.

Another commenter asked that we let no median cost used in weight setting fall more than half the difference between the loss and 15 percent because this methodology offers a buffer for hospitals to minimize annual changes. Another commenter indicated that we should freeze the 2003 payment rates, particularly for brachytherapy services and should educate providers to show all of the charges for all of the ancillary services on the claim so that they will be included in the development of relative weights for future years.

Response: We are sympathetic with the concerns of hospitals that the OPPS should be sufficiently stable that hospitals would have the capacity to plan and budget for future years. We recognize that the early years of a payment system may result in shifts in payment across services. However, a prospective payment system is a system of averaging in which the payment to the hospital becomes an overall amount that the hospital has at its disposal to use in the way it finds to be most efficient and effective. The payments for individual services are the means by which the amount of money to be spent on OPPS is distributed among hospitals but the hospitals have the right to use that payment as they choose across all services they choose to furnish. The OPPS is a system that attempts to calibrate payments for a service or procedure to best approximate the costs that an efficient provider would incur in providing the service or procedure in order to give providers incentives for efficient procurement and service delivery.

As we indicated in the proposed rule, for 2004, some of the same services had significant declines in median costs compared to the 2003 adjusted median but not compared to the 2003 median before adjustment. We did not propose to adjust the 2004 medians for procedural APCs compared to the 2003 adjusted median. Instead, we indicated that we would consider using external data that could be made publicly available if we were convinced that the medians for 2004 would result in payment rates that were grossly aberrant in the context of the service.

After reviewing the comments, and our final claims data for 2004, we decided that we would not adjust the medians for procedural APCs but that we would adjust medians for certain APCs for which we were given external data that could be made public because we were convinced that the medians from our claims data resulted in median costs that were grossly variant. We adjusted the medians for the following APCs using external data: APC 0107 (insertion of cardioverter-defibrilator), APC 0108 (Insertion/replacement/repair of cardioverter defibrillator leads and insertion of pulse generator), APC 0222 (implantation of neurostimulator), APC 0039 (which was broken out of APC 0222) and APC 0674 (prostate cryoablation). For each of these APCs we calculated an adjusted device portion of the median by taking one part of the device cost from our data and one part of the device cost supplied by external data. We added the adjusted device median to the nondevice median from our data to acquire the adjusted median. In the case of APC 0108, we used the external device cost data that was used to set the median for the 2003 OPPS because we received no outside data for the 2004 OPPS for this APC and because the proposed median of $28,685.30 set forth in the proposed rule was considerably higher than the final rule data median of $23,944.80, which resulted when additional claims were used to calculate the median cost. In other cases, we found that corrections in the APC assignment or splitting an APC into two APCs resulted in more accurate median costs.

For 2004, we will adjust median costs for drugs, biologicals and radiopharmaceuticals as proposed for reasons discussed in section VI.B.3. We will freeze payments for blood and blood products at the 2003 rates for reasons discussed in section VI.B.8. We will pay single indication orphan drugs at 88 percent AWP for reasons discussed in section VI.B.6.

Comparison of Procedural APC Medians for the 2004 OPPS to Adjusted Medians for 2003 OPPS

Using the data available to us at the time we developed the proposed rule, we identified APCs that showed decreases in median cost of more than 10 percent compared to the adjusted medians on which their payments were based for 2003. We discussed specific APC medians to the extent that we understood the reason for the decreases or were particularly puzzled by the change. We requested comments on the medians and provided a set of criteria for external data that could be used to supplement the median costs derived from our claims data. The criteria we provided regarding the use of external data included a stipulation that the data must not be confidential because any data we use must be available to the public. We also provided a list of preferred (but not required) criteria that addressed our preferences for characteristics of the data. We indicated that to be of optimal use, the external data should represent a divergent group of hospitals by location and type, identify the number of devices billed to Medicare as well as rebates or reductions for bulk purchases, identify the HCPCS codes with which the devices would be used, identify the source of the data and include both charges and costs for each hospital by quarter for the last 3 quarters of 2002 (68 FR 47987). We did not propose to adjust the medians for procedural APCs in the manner that they were adjusted for the 2003 OPPS. For 2004 we did not apply a systematic adjustment to all medians that declined more than a specified percentage in comparison with the medians for 2003. Instead, as discussed previously, we adjusted the medians of 5 APCs based on external data where we thought it was necessary and we have split some APCs where we thought doing so would result in more accurate relative weights.

Use of External Data

Comment: Some commenters opposed the use of external data on the basis that they believe that they will result in unfair imbalances in payment. They recognized that the application of cost-to-charge ratios will not result in amounts that are equal to full acquisition costs but they believe that as long as the same standard methodology is used across all services, the relative payments will be correct. They indicated that in a system of averaging, it is not necessary or even expected that each item and service will be paid at acquisition cost. They encouraged us to remain faithful to the averaging process inherent in a prospective payment system and not to rely on external data. Some commenters opposed use of external data and supported the requirement that they be publicly disclosable. Other commenters stated that we should use our claims data to set weights because they accurately reflect the relative hospital costs of providing outpatient services. However, these commenters were concerned with how different rates for some services in the 2004 proposed rule are from the rates for the same services in 2003.

Some commenters said that we should use external data that are proprietary and maintain the confidentiality of such data. Several commenters indicated that the prices for medical devices are often covered by agreements that preclude the parties from disclosing the price of the device and that we should use the data to set prices, notwithstanding that they cannot be made available for inspection by the parties whose payments may be reduced by their use. Several commenters stated that we used external data that were proprietary for setting of 2002 weights, and for some 2003 weights and that we should do so again because data from manufacturer price lists and invoices more accurately reflect the costs attained by applying the cost-to-charge ratios for hospital departments to the charges for the devices to get costs to package into the APC medians. These commenters stated that external data should be used more widely than data based on the criteria that were used for the 2003 OPPS for the use of external data (that is, that the device-cost portion of the APC exceeded 80 percent of the total APC cost for external data to be used). These commenters stated that external data should be used for all APCs that show significant reductions since the 2002 OPPS. In particular, they cited the APC Panel recommendation that outside data be used to set the median cost for APC 107.

Some commenters had specific comments on the criteria we provided for use of external data. One commenter stated that its members did not have and could not easily acquire the data that would ensure that the data represent a diverse group of hospitals by location and type nor could they identify specific hospitals that used their devices. The commenter also stated that its members could not provide the information on discounts and rebates against their price lists that we requested. The commenter indicated that its members did not want to provide the HCPCS codes in which their products were used but instead, wanted us to require the typical applications that they feel are most appropriate. The commenters agreed that they could provide the source of the data. The commenters stated that its members could not provide data that corresponded with the same period of time being used to set the relative weights for all APCs.

Response: In the proposed rule, we indicated that external data should cover services furnished during the last 3 quarters of 2002 (68 FR 47987). We appreciate that manufacturers and wholesalers would not want to disclose negotiated prices for 2003 or 2004 for competitive reasons. However, we fail to

understand how they could be harmed by publicly disclosing prices that were applicable in 2002 but have now been obsolete for a year. Moreover, since upward adjustment of any median cost results in reduction of payments for all other items and services, we believe that, in a governmental payment program, the parties whose payments are reduced by the use of external data should be able to examine all elements of the payment system.

We do not believe that widespread use of external data to set median costs for selected APCs is appropriate in a system that relies on relativity to establish payment amounts. We are sympathetic with the concerns of some commenters that widespread use of external data will result in payment inequities rather than appropriate payments to hospitals based on the relative weights of the services they furnish. However, we are also concerned about circumstances in which we are convinced that the payment amounts that would result from the medians from our data will discourage hospitals to provide access to needed care. Therefore, in the case of several APCs as discussed elsewhere, we used external data to adjust the medians. In general, however, we continue to have confidence in the integrity of our claims data with respect to the procedural APCs. For the future, we prefer to seek ways to refine the methodologies that we apply to our own data, such as the use of a greater percentage of claims to set the weights for certain APCs.

Comment: Several commenters stated that we should work with them to set the methodology for the 2005 medians in view of the absence of device codes in the 2003 data and should pursue a study of the acquisition costs of devices in particular, so that there will be valid device related data for setting the 2005 OPPS.

Response: We are always interested in hearing the proposals of outside parties with regard to our methodology for setting OPPS weights. We recognize the concern that the absence of device codes for 2003 claims may lead to median costs that fail to fully incorporate the costs of the devices used in the applicable APCs and we are interested in all ideas for preventing this problem. Our proposed methodology will be presented in the proposed rule for the 2005 OPPS and will be open to public comment.

General Comments About Payment

Comment: A commenter asked that we base the relative weights on the geometric mean that we use for trimming the data. The commenter indicated that the use of the geometric mean is the industry standard for both trimming aberrant data, as we use it, and also for calculating relative weights when costs are not distributed symmetrically. The commenter stated that the use of the geometric mean is particularly useful in circumstances that mirror those of OPPS: the first years of a new system and with low-volume high-cost services. The commenter noted that we agreed to move forward with analyses to look at the use of a mean versus median cost for weight setting in the November 1, 2002 final rule published in the **Federal Register**, but believes that not much analysis is needed since the use of the geometric mean is an industry standard for setting relative weights.

Response: We appreciate the thoughtful comments on this issue and other suggestions on how we might improve our rate setting methodology. We will continue to explore these options in 2004. Our efforts in 2003 were limited to creating unscaled weights from the means used for the 2003 OPPS and comparing them to the unscaled weights for medians for 2003 OPPS. Our preliminary comparison revealed that there would be many swings in payments. Hence, for the 2004 OPPS, we continued our use of the median cost.

In preparation for 2005 OPPS, we hope to calculate OPPS amounts using the mean costs, and also mean and median charges (to circumvent the effects of cost-to-charge ratios), and the 2004 OPPS conversion factor. This should give us a more complete view of the impact of revising our methodology in this way.

Charge Compression and Cost Finding

Comment: A commenter indicated that the use of cost to charge ratios is consistent with the concept of averaging that underpins a prospective payment system and that the system should not seek to micro-cost individual items or services but rather should rely upon the hospital charging patterns irrespective of Medicare policy to base relativity. The commenter indicated that while some items have different markups than others, the use of a standardized methodology to establish relative weights for all services should result in appropriate relative payments. The commenter strongly objected to any additional burdens that would be imposed in order to fine tune the pass-through payment system or weights at the expense of all other APC payments. The commenter specifically objected to CMS overriding the claims data to alter the ratio for new technology devices because the commenter believes that such adjustments will make the OPPS unduly administratively complex and create unfair imbalances in payment.

Other commenters opposed the use of cost-to-charge ratios applied to charges to acquire cost data. They indicated that in many cases, we had to use overall hospital cost-to-charge ratios that had no relevance to the costs of the services being determined and therefore resulted in invalid representations of median costs. They also indicated that both the departmental and the hospital specific cost-to-charge ratios were derived in part from costs that are commingled between inpatient and outpatient services and therefore are not necessarily representative of a ratio that could be applied to outpatient services alone, as we do. Some commenters indicated that we ignore studies that demonstrate that charges are compressed, with low-cost services being marked up more than high-cost services, thus resulting in systematic underpayment of high-cost items and diminishing beneficiary access to high-cost services. A commenter suggested that, for drugs, biologicals and radiopharmaceuticals, we set a minimum payment based on the Federal Supply Schedule price plus a percentage markup to ensure that payment for drugs, biologicals, and radiopharmaceuticals was sufficient to make them available to Medicare beneficiaries who need them.

Several commenters indicated that the application of hospital specific cost-to-charge ratios at the department level where available, otherwise at the hospital level will always result in incorrect costs because hospitals do not have a consistent markup for all items and services within a department. They indicated that hospitals markup low-cost items more than high-cost items and that therefore, the application of a cost-to-charge ratio, even at the department level, will never result in the hospital acquisition cost for an item. They indicated that there is no easy adjustment to correct for charge compression and they urge us to explore using external data, developing surveys or doing studies to acquire hospital cost data that can be used in place of the median costs acquired from claims data.

Response: We recognize that the application of cost-to-charge ratios to charges for individual items as needed to develop median costs for APCs is imperfect. However, the only means at our disposal for determining costs from the charges on the claims was to calculate a cost-to-charge ratio using the cost report data that we believe is

applicable to the OPD (for example, excluding room and board). We acknowledge that this system for determining relative values is imperfect, but we believe that it continues to be preferable to total reliance for particular items on external data which could inappropriately inflate Medicare payments for those items to the detriment of general hospital services. As indicated above, we hope to explore use of mean costs, and mean and median charges in preparation for the 2005 OPPS to determine if such a change would result in better relative weights and less instability in OPPS payments for particular services from year to year. However for 2004, we based relative weights on median costs derived through the application of a cost-to-charge ratio to the charges for the services.

General Concerns About Decreases

Comment: We received many comments objecting to proposed decreases in the proposed payment rates for specific services. These commenters indicated that the service has become more expensive rather than less expensive over the year, or indicated that the payment for the service declined for 2003 and should not decline for 2004. In some cases, the comments indicated that the payment should remain at the 2003 rate so that hospitals will not consider discontinuing the service.

Response: The OPPS is a relative payment system based upon the relative median costs of services. We calculate the costs of services by applying a cost to charge ratio to the charges for the services and then packaging the costs together for major HCPCS codes. We then calculate the median of the array of costs across all claims for HCPCS codes in an APC. There are many factors that can affect whether the cost of services rises or falls from one year to the next. In general, for the 2004 OPPS, about half the APC median costs increased and about half decreased compared to the 2003 median costs. In most cases, the changes were modest and such changes from year to year are to be expected as hospitals find ways to reduce costs for some services and incur higher costs for others. Because we do not expect the mix of services furnished in hospitals to vary hugely from year to year across the universe of hospitals, we do not expect that the changes in relative costs to create enormous impacts either.

Disparity in Payments for Overhead Costs for the Same Service

Comment: A commenter indicated that OPPS provides disparate payment for the overhead costs associated with services that are furnished both in physician offices and in hospital outpatient departments. As an example, the commenter indicated that CMS attributes $25.36 in physician practice expense to CPT code 99213 (office or outpatient mid level evaluation and management service for an established patient) but pays a hospital $54.46 (the amount set forth in the proposed rule) for the overhead for the same service and indicated that for other services the OPPS payment is as much as 4 times the amount paid to physicians for practice expense for the same service. The commenter asked that CMS establish payment equity for the same service furnished in these respective settings.

Response: The method for calculating payment for physicians' practice expenses under the Medicare physician fee schedule is established by law, as is the method we use for the outpatient setting. The application of the different methodologies results in different payment amounts in the two settings.

Comments and responses on payment amounts for specific APCs are included in section II.B.

Source of Data for Weight Setting

Comment: One commenter stated that we should conduct a study to establish a source for cost data other than claims data on which to base APC weights. Another commenter strongly objected to use of survey data because the commenter did not believe that it could ever fully capture all hospital costs for services and that therefore, the survey data would be used only for items and would have to be integrated with claims data for services. The commenter did not believe that the two could be integrated in a way that would properly reflect the relative costs.

Response: We believe that relative weights should generally be based on claims data because, notwithstanding the weaknesses, claims data are the most complete and accurate source of information about all services furnished by all providers paid under OPPS. We believe that it would be unreasonably expensive to acquire survey data that would be representative of the entire population of Medicare hospitals and all OPPS services furnished in them. We do not support the idea of using only selected hospitals and/or selected services because we think data from a limited survey would not be representative of the whole population of Medicare hospitals and services and would not be accurate to reflect relative costs of all services.

Incomplete Hospital Bills

Comment: Commenters indicated that when OPPS was implemented, hospitals no longer had a payment incentive to ensure that all charges were shown on the claim because there was no longer a direct relationship between the amount of charges on the claim and the interim payment they would receive for services. Therefore they ceased to complete the claim as fully as when the charges were directly related to the Medicare interim payment. Several commenters indicated that in some cases, hospitals went as far as to remove items from the chargemaster so that a charge was no longer created when an item or service was used, particularly if the item or service were from a department other than the department billing the CPT code. A commenter said that in many cases, hospitals ceased to bill all charges for services if the completion of the claim with all charges would delay the submission of the claim to Medicare and therefore delay the Medicare payment to the hospital. Commenters indicated that hospitals did this particularly for services like brachytherapy in which the services were furnished from multiple departments of the hospital and the claim could be delayed significantly to accumulate all charges. Commenters indicated that the absence of all charges for services could result in poor data and instability in median costs from year to year, particularly when we use only single procedure claims.

Response: We encourage hospitals to report all charges for all services on claims for Medicare payment so that the data on which relative weights are set will fully reflect the relative costs of all services. However, where all charges are not included on the claim but the costs exist in the cost centers, the cost-to-charge ratios would increase and, to some extent, offset the effect of the absence of charges. Hence, while we would prefer that hospitals bill all charges for the services they furnish, where they do not do so, it does not necessarily mean that the costs derived from applying the hospital's cost-to-charge ratio to charges would result in improper relative weights for the services.

C. Discussion of Relative Weights for Specific Procedural APCs

New APC for Antepartum Care

We proposed rule to split APC 0199, Obstetrical Care Service, into two APCs.

For this final rule, new APC 0700, Antepartum Care Service, was created and 59412 (external cephalic version) was assigned to it. The two remaining HCPCS code 59409 (vaginal delivery only) and 59612 (vaginal delivery only, after previous cesarean delivery) will remain in APC 0199, Obstetrical Care Service. We received no comments about this APC and will finalize our proposal.

Implantation of Neurostimulators and Implantation of Neurostimulator Leads (APCs 0222 and 225)

Comment: Commenters encouraged us to use a ''dampening'' approach to increase the median costs for these APCs and to use external data to set the payment weights for APCs 0222 and 0225. Commenters indicated that the proposed payment amounts do not cover the cost of the device, much less the hospital services to furnish it. Commenters indicated that our policy of calculating median weights based on single claims or pseudo single claims disadvantages these services by resulting in the use of only the simplest and lowest cost services. A commenter indicated that these services have had relative weights that were too low since the inception of OPPS and that the cumulative effect of multiple years of payment reductions will cause hospitals to cease to provide these services to Medicare beneficiaries. A commenter suggested that we split these APCs to reflect the different resources used in implanting one device versus another device in the same APC. A commenter also asked that we establish a separate APC for the NeuroCybernetic Prosthesis System.

Response: We also are concerned that the median costs for these APCs appear to be so low relative to other OPPS median costs. Both of these APCs are ones for which we require that selected C codes be on the claims that are used in calculation of the median to increase the likelihood that we are using correctly coded claims for these services. We recognize that the need to use single procedure claims and the need to further select claims that appear to be correctly coded reduce the number of claims used in median calculation. However, if we did not require that selected C codes were on the claims used, the median costs would be even lower than those calculated. Hence, using more single procedure claims would, in this case, result in even lower median costs.

For 2004, we have made changes to both of these APCs. In the case of APC 0222, we removed HCPCS code 61885 from APC 0222 and we placed it in its own APC 0039 because the APC Panel recommended that its status indicator be changed from a ''T'' to an ''S'' in order to not apply the multiple procedure reduction when two devices are implanted, as is often the case. Moreover, for both APC 0222 and APC 0039, we accepted external data for the device cost and used one part external data and one part claims data for the device portion of the APC's median cost to which we added the nondevice portion of the median cost. This increased the median cost for APC 0222 from a final data median of $11,050.90 to an adjusted median cost of $13,383.79. This increased the median cost for APC 0039 from a final data median cost of $10,741.66 to an adjusted median cost of $13,555.80. We believe that this more accurately reflects the relative cost of these services to other OPPS services.

In the case of APC 0225, we split the APC into two APCs, (APC 0225) and (APC 0040). APC 0225 contains CPT codes 63655, 64553, 64573, 64580 and 64577 and for this final rule, has a median cost of $11,873.72. APC 0040 contains CPT codes 64560, 64555, 63650, 64561, 64575, 64581, and 64565 and, for this final rule, has a median cost of $3,002.98. Both APCs have a status indicator ''S'' (to which multiple procedure discounts do not apply).

We believe that these changes will result in more appropriate relative weights for these services in relation to other OPPS services.

Brachytherapy Issues

High Dose Rate Brachytherapy (APC 0313)

Comment: Commenters objected to the proposed payment amounts for this APC and indicated that the costs of the procedure could not be fully included in it. Commenters indicated that they did not believe that hospitals were billing for both the needles and the catheters. These commenters recommended that we use only claims that contain the primary procedure code, the HDR Iridium source code, and codes for catheters and needles. A commenter indicated that the direct costs for the practice expense in physician offices for the codes in this APC average $1,130.16 and that it is inconceivable to the commenter that hospital costs could be any less. The commenter believes that the faulty data are attributable to hospital billing errors and urged us to educate hospitals regarding how to bill the service properly. A commenter asked us to issue a program instruction requiring hospitals to report both the cost of the HDR source and the needles or catheters needed to administer the treatment by date of service to facilitate setting of a correct median cost. The commenter is concerned that the actual cost of brachytherapy needles and catheters has not been captured and is not incorporated into any of the related APCs. Commenters also indicated that the discussion of the APC in the August 12, 2003 proposed rule was confusing and did not fit the services furnished in this APC.

Response: Upon receipt of comments and after listening to the concerns of outside groups during the comment period, we explored the circumstances surrounding the development of the median cost for the APC that resulted in the weights and payments in the August 12, 2003 proposed rule. We found that, while the APC was on the list of APCs for which claims were required to contain C codes and although the criteria required that there be both a brachytherapy source (C1717) and either needles (C1715) or catheters (C1728), no claims that met all of those criteria were found among the single procedure claims for that APC. Therefore, the system defaulted to using all single procedure claims, for which there were no sources or needles/catheters on the claim. Hence, APC 0313 was erroneously included in Table 7 as an APC for which C codes were required. Moreover, our discussion of the median for the APC was in error to say that there had been sources packaged into the payment for 2002 and that this accounted for the reduction in proposed payment for 2003.

For the final rule, we acquired more single procedure claims but again, none of the single procedure claims contained both sources and needles or catheters. We then revised our criteria to require only that the claims must contain sources (C1717). This gave us 27 single procedure claims that we used to acquire a median cost of $936.52, a significant increase over the median for all claims of $795.83.

In the course of discussions regarding this APC, some parties suggested that we ignore other procedure codes, such as dosimetry codes, that are typically found on claims for these services because the commenters believe that no charges billed under packaged revenue codes or packaged HCPCS should be allocated to those other procedures. We plan to explore the expansion of the codes we ignore for selection of single procedure claims for the 2005 OPPS. However, we did not believe we had sufficient information or data to make such a change for the final rule for 2004. We again note that it is important for

hospitals to include charges for all services they furnish on the claim so that we can better ensure that the relative weights are based on the most accurate data possible.

Low Dose Rate Brachytherapy (APCs 312 and 651)

Comment: We received several comments regarding payment for low dose, non-prostate brachytherapy (APCs 312 and 651). Commenters cited the proposed reduction in payment for APC 0312 and expressed concern that our methodology that excludes a number of multiple procedure bills results in our use of data from atypical encounters such as those in small centers with minimal technological complexity and inappropriate costs and charges. Commenters indicated that typically other services would be furnished on the same day and that the presence of these services on the claim would likely result in the claim not being used. Commenters indicated that the resources used for the services in these APCs are highly variable depending on the part of the body being treated and the nature of the equipment involved. They indicated that some hospitals ceased billing charges for all of the services furnished when OPPS was implemented because showing the charges on the claim would no longer result in more payment but showing all charges on the claim was costly, burdensome, and slowed billing. Commenters indicated that we should educate providers in the correct way to bill for the catheters, needles, and sources used for this service and that in the absence of acceptable median costs, we should adjust the medians to result in reasonable payments for the service. Commenters indicated that we should select only claims that contain device costs and ignore claims that do not contain such costs, setting the median cost on the subset of selected claims.

Response: We used the medians from our final data to set the relative weights on which the payments will be based for 2004. We were not convinced by comments that the data did not reflect a median cost that was appropriate relative to the costs of other OPPS services. We recognize that our methodology excludes a large number of claims because there were multiple procedures on the claim and as we indicated in the discussion of multiple procedure claims, we are continuing to work on ways to use more claims data. We will closely examine expanding the list of CPT and HCPCS codes that could be ignored to create pseudo single claims for use in calculating median costs to set relative weights. For future years, we will consider whether to impose criteria for correctly coded claims, such as requiring that the claims contain either any C code or specified C codes for brachytherapy sources and needles or catheters that are necessary to insert the sources. We were not able to do this for the 2004 OPPS. For the 2005 OPPS, we will use the claims data from 2003, for which there is no coding of brachytherapy needles or catheters, although there is coding of sources that can be used to select correctly coded claims.

As we previously indicated, for the 2004 OPPS, we will pay for prostate brachytherapy using the CPT codes and the HCPCS codes for brachytherapy sources used. We expect that the majority of the CPT codes billed will be 77778 (APC 0651) and 55859 (APC 0163) and that the HCPCS codes billed will be C1718 (brachytherapy source, iodine 125) or C1720 (brachy source, palladium 103). When we calculate the total median cost on which the payment to the hospital for the services involved in prostate brachytherapy will be based, we determine that paying under APC 0651 and APC 0163 with separate payment for the sources (APC 1718 or APC 1720) will result in more payment than would be the case under the packaged payment we proposed. For example, if we assume that 100 sources are implanted during a prostate brachytherapy procedure, we would expect the hospital to bill 77778, 55859, and 100 units of either C1718 or C1720. The sum of the applicable medians will be $6,486.54 if using iodine sources and $7,261.54 if using palladium sources. This is a considerable increase over the payments in 2003, which were $5,154.34 with iodine sources and $5,998.24 with palladium sources. We believe that this circumstance will be the predominant use of APC 0651 and that the total median for the service will result in appropriate relative weights on which to set the payments.

APC 0312 was billed just over 850 times for the 9 months of data used in the final rule. Of the five CPT codes in this APC, four have median costs for the CPT code of less than $400 and one code, 77776, Interstitial radiation source application, simple has a median of $2,218.18. However, that code does not meet the test of being significant, which we define as having a frequency greater than 1,000 or a frequency lower than 99 and a percentage of larger than or equal to 2 percent. Therefore, we have not moved it from the APC.

Separate Payment for All Brachytherapy Sources

Comment: Commenters indicated that we should provide separate payment for all brachytherapy sources but that the current payment structure and amounts are inadequate. Commenters indicated that we should create two new permanent separate brachytherapy source APCs for high activity iodine 125 and high activity palladium 103 sources that should be paid on a per source, per patient basis in addition to the procedure code. Commenters indicated that the proposed rates for iodine 125 and palladium 103 sources do not capture the costs of loose low dose seeds, much less the costs of high activity sources, which typically cost in excess of $150 per source.

Response: For 2004, we will pay separately for implantable brachytherapy sources based on the median costs from our claims data. We were not convinced by comments that the relative weights that will result from these median costs are inappropriate.

Prostate Brachytherapy

Comment: Commenters indicated that the creation of the new G codes (G0256 and G0261) for prostate brachytherapy imposes an unneeded burden on hospitals and that it conflict with the reporting of the service by other payers. Additionally, commenters stated that the use of the codes will preclude us from capturing the costs of the service in the future. The commenters encouraged us to eliminate the G codes and pay using the CPT codes for the procedures and the HCPCS codes for the sources on a per source, per case basis. They indicated that this would allow us to capture the true costs of the procedures to set rates in the future and that this approach is consistent with the APC Panel recommendation to us. A commenter requested that we eliminate APC 0649 (Prostate Brachytherapy Palladium Seeds) and APC 0684 (Prostate Brachytherapy Iodine Seeds) and reinstate the previous policy that allowed hospitals to bill the prostate brachytherapy procedures with two separate APCs; one for urology CPT code 55859 and one for the radiation oncology CPT code 77778. The commenter stated that this elimination would be consistent with our decision to pay for the sources on an individual basis. The commenter believed that creation of the G codes has caused unnecessary confusion for hospitals. The procedure is now described with a single G code; however, only one revenue center can be selected, causing confusion since these APCs have both a

urology CPT code as well as a radiation oncology CPT code. The commenter requested that we eliminate these two APC groups and institute a system that would allow the two procedures to be reported in separate APC groups.

Response: We agree and have deleted the alphanumeric HCPCS codes for packaged prostate brachytherapy and will pay using CPT codes for the procedures and the HCPCS codes for the sources. We have deleted the G codes (G0256 and G0261) and APCs 0649 and 0684; and for 2004, we will pay prostate brachytherapy procedures under APCs 0163 and 0651. Brachytherapy sources used for prostate brachytherapy will be paid on a per source basis using APCs 1718 (iodine) and 1720 (palladium).

Cryoablation of the Prostate (APC 0674)

Comment: Commenters indicated that the proposed payment was too low to pay for both the hospital services and the cost of the probes used in the procedure. They indicated that 92 percent of the procedures use 6 or more probes (64 percent use 6 probes and 28 percent use more than 6 probes). They indicated that a kit of 6 probes costs $5,000 and asked that we set a payment amount no less than the minimum cost a hospital incurs to provide the service, which they stated is $6,750. Commenters indicated that charges for this new technology were not properly reported by hospitals and that therefore the data do not properly reflect the costs of the service.

Response: We recognize that with the device being paid as a pass-through for the first time effective April 1, 2001, it is likely that there are irregularities in the claims data regarding the number of units of the device that have probably led to a median cost that is not representative of the relative cost of the procedure with the device packaged. Therefore, for 2004, we used one part of the acquisition cost of 6 probes ($5,000 for 6 probes which are used in 64 percent of the procedures) and one part of the device cost from our claims data to create an adjusted device cost median to which we added the nondevice cost from our claims data to acquire an adjusted median of $6,915.08 on which we based the relative weight for the 2004 OPPS. This compares favorably to the median of $5,925.41 on which the August 12, 2003 proposed rule was based and also compares favorably to the final rule data median of $6,283.49 on which the payment weights would have been based had we not used external data to adjust the device portion of the median.

Payment for Cesium-131

A new brachytherapy source, Cesium-131, came to our attention during the latter part of this year, through the pass-through device application process. We reached a decision on this application after publication of the August 12, 2003 proposed rule. We determined that this source did not meet our criteria for creation of a new pass-through category for devices. However, we believe that separate payment for a substantially equivalent new brachytherapy source is warranted, since we pay separately for other sources. The indications presented to us for Cesium-131 were substantially the same as those for Palladium-103 and Iodine-125. As such, the reasons for separate payment of brachytherapy sources, for example, variation in the number of seeds or other source forms make packaging into a clinical APC an undesirable option. Therefore, we have decided to create a separate APC so that the costs of this new source may be tracked like those of other brachytherapy sources. The payment rate for this source is $44.67 per seed. This payment rate is close to the reported price of the Cesium-131 seed and equal to our payment rate based on claims for Palladium-103, a source that is used for similar clinical indications.

Cardiopulmonary Resuscitation

Comment: A commenter indicated that a 28 percent drop in payment for this service is unwarranted because of the number of people and the level of training needed when this service is furnished.

Response: We were not convinced that the relative weight that would result from the use of the median cost for this APC would be inappropriate in relation to other OPPS services. Therefore, we will use the median cost from the final rule data to set the weight for this APC.

Computer Aided Detection for Diagnostic Mammography

Comment: A commenter expressed concern about our proposal to reassign Computer-Aided Detection for Diagnostic Mammography from a New Technology APC to APC 0410. The commenter stated that the proposed reassignment is premature and would result in a reduced payment rate that would be approximately half of the payment rate for the technical component of procedures performed in other settings. The commenter recommended that we retain this procedure in New Technology APC 1501 until we have greater claims experience.

Response: The alphanumeric HCPCS code for this service (G0236) is being replaced by a CPT code for the same service for 2004 (CPT code 76082). We found over 43,000 claims for this service in the 2002 data on which we are basing the 2004 relative weights. We believe that this volume of services is sufficient to justify setting a relative weight based on cost information rather than keeping the service in a new technology APC. Moreover, the practice expense portion of payment for this service is not relevant to the setting of relative weights for OPPS services, in which the relativity is established within the context of services paid under OPPS and not with regard to the practice expense for services under the Medicare physician fee schedule.

Orthopedic Fracture Fixation Procedures

Comment: Commenters stated that APCs 0043, 0046, 0047, 0048, 0049, and 0050 are not clinically similar and they violate the 2 times rule. They asked that we separate out the more costly procedures that involve fracture fixation devices because they involve additional time, resources, and significant costs of fixation devices. They recommended that we either create two new APCs with corresponding HCPCS codes for upper (at a payment of approximately $2,000) and lower fracture fixation devices (at a payment of approximately $3,000) or create two code modifiers (for upper and lower fixation devices) and multiple new APCs.

Response: For the 2004 OPPS, services that require an external fixation device will continue to be paid in APCs that also provide payment for fractures that do not require external fixation devices. While we are sympathetic to the commenters' concerns, we are not able to identify CPT codes that always require use of an external fixation device or the extent to which such devices are required for other codes. Nor did the information we received from the commenters provide a convincing breakdown of the differences in costs for procedures using external fixation devices. To create new APCs or new APC relative weights to provide additional payment for external fixation devices where such APCs would also contain procedures that do not routinely require use of an external fixation device, would result in overpayment of those procedures. Moreover, since most services in these APCs do not require an external fixation device, it may be appropriate to continue to pay for them in these APCs to encourage hospitals to use them only when required. Furthermore, we would be reluctant to

impose an additional burden on hospitals by establishing ''G'' codes or modifiers to use in reporting procedures with or without external fixation devices. However, as we state elsewhere, we would support interested specialty societies' decisions to request the CPT to consider this coding issue.

APC 0680 Reveal ILR

Comment: A commenter indicated that the proposed payment rate is about 95 percent of the hospital acquisition cost of the device, leaving the hospital at an immediate loss if it implants this device. The commenter indicated that it is the only manufacturer of the device and therefore the only source of acquisition cost for the device. They indicated that in 2002, the cost was $3,495 and recommended that we re-evaluate and re-price the APC to provide sufficient payment that beneficiaries will have access to the device when needed. They indicated that the predominant site of service is in the hospital outpatient department and that if payment is below hospital cost, beneficiary access will eventually be limited.

Response: The final rule data for APC 0680 reveals a median cost of $3,691.15 for this APC, on which the relative weights for 2004 are based. We were not convinced by comments that this median cost would result in a relative weight that would be inappropriate relative to the payments for other services under OPPS.

Fractional Flow Reserve (FFR)

Comment: A commenter indicated that fractional flow reserve (CPT codes 93571, Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement * * * during coronary angiography, initial vessel and 93572, each additional vessel) should be paid separately in addition to the procedure with which they are performed, rather than being packaged into the payment for the primary procedure. The commenter indicated that FFR should be paid separately because it is an expensive service with higher device and equipment costs and takes more time and staff than if it is not used. They also indicated that we pay separately for Intravascular ultrasound (IVUS) which is also deployed via guidewires. They stated that the principal difference is that IVUS describes the anatomy of the vessels while FFR describes the blood flow through the vessels. They indicated that it is inequitable to treat them differently. Payment for IVUS but not FFR creates inappropriate financial incentives for hospitals in determining which procedures to provide.

Response: Currently, where FFR is provided, the costs for it are packaged with the principal service to which FFR is an addition, which we expect to be coronary angiography. If we were to pay separately for this service, we would need to remove the costs for this service from the cost for services with which it was packaged (that is, coronary arteriography), which would reduce the medians on which the payments for those services are based. This would reduce the median and therefore the payment for coronary angiography. We are concerned with the circumstances under which this service would be appropriately paid under Medicare and will consider development of a national coverage decision regarding when it is medically necessary to treat illness or injury. After such a coverage decision is made, we will reconsider whether it is appropriate to pay separately for the service.

Cataract Surgery With IOL Implantation (APC 0246)

Comment: A manufacturer of intraocular lenses was concerned that on claims for the procedures in APC 246, the median charge of claims for which no charge is reported using revenue code 276 (Intraocular lens) is one-third lower than the median charge of claims where a charge is reported using revenue code 276. The commenter believes that when charges are not listed in revenue center 0276, they are omitted from the claim altogether, rather than being placed in a different revenue center. The commenter recommended that we adopt a policy of using only claims for APC 0246 that report charges for revenue code 276, which would be consistent with our proposal to calculate relative weights for certain device-related APCs using only claims that included a separate and correctly coded charge for a device.

Response: For the 2004 OPPS, payment for cataract surgery with IOL insertion is based on the median cost for the procedure from the final data. A review of the 2002 claims for procedures in APC 246, which includes CPT code 66984, one of the highest volume outpatient surgical procedures paid under the OPPS, indicates that the vast majority are billed with revenue code 276. Long-standing instructions require hospitals to report the IOL charge under revenue code 276 when billing for a procedure in APC 246.

In our implementing instructions for the 2004 OPPS update, we will remind hospitals and the contractors who process OPPS claims that, in order to receive payment for a procedure in APC 246, hospitals are required to report the associated IOL charge under revenue code 276. We will also consider for the 2005 OPPS update the commenter's recommendation that we use only claims with revenue code 276 to recalibrate the relative payment weight for APC 246. Our data are extremely robust for this APC (with a frequency of nearly 520,000), and they indicate that the preponderance of the claims used to establish the 2004 median does include revenue code 276.

Transcatheter Placement of Intracoronary Drug-Eluting Stent Procedures (APC 0656)

Comment: One commenter supported our recognition of the new drug-eluting stent technology through the creation of two ''G'' codes (G0290 and G0291) and their placement in new APC 0656. However, the commenter questioned how we calculated the proposed payment rate for 2004. The commenter stated that some patients classically considered at higher risk for percutaneous interventions, including diabetics and patients with multi-vessel disease, are being referred for drug-eluting stent procedures. The commenter stated that the clinical disposition of these patients makes them more complex and more resource-intensive than the average patient. The commenter further noted that, while the reporting of a second main coronary vessel procedure would result in a second, reduced APC payment, that our payment for the single vessel should be based on an average of 1.7 stents per vessel. Finally, the commenter recommended that we add APC 0656 to the list of APCs for which a device was required to be on the claim for weight setting.

Response: For the 2004 OPPS, we will continue to base the payment for transcatheter placement of intracoronary drug eluting stents on the median for APC 0104, transcatheter placement of intracoronary stents. We increased the median for APC 0104 ($4,765.05) by $1,200 to acquire the median we used for APC 0656. We are using the same adjustment amount used for a single stent in the inpatient prospective payment system. We received no comments that are sufficiently compelling to convince us that more than one stent per vessel typically will be used when this service is furnished in the outpatient department or that the adjustment amount of $1,200 per stent is inappropriate. We will consider including this on the agenda for the next APC Panel meeting.

With respect to the comment that we should add APC 0656 to the list of APCs for which a device was required to be on the claim for weight setting, we believe it would be inappropriate to do so for the 2004 OPPS. This is because the drug-eluting stent was not approved by the FDA until 2003, and, therefore, it did not appear in the 2002 data. Moreover, since there are no device codes for coronary stents for use on claims in 2003, the 2003 data will not contain the device codes that would be needed to create a subset of stent device claims to use for the 2005 OPPS. However, in view of the reinstitution of device coding for 2004, we will consider this comment in our work to develop the 2006 OPPS. Moreover, as we indicated above, we based the payment for APC 0656 on the median for APC 0104, which was calculated from claims that contained C codes for stents.

Cardioverter Defibrillator (APC 0107)

Comment: Commenters indicated that the proposed payment for this APC was too low to pay for the device, much less the cost of the services to implant it. They indicated that the cost of the device in 2002 varied between $19,160 and $21,410 among major group purchasers, considerably more than the proposed payment of $15,773.28. They asked that we use the external data to set the device portion of the hospital cost.

Response: We reviewed the data for this APC and considered the comments of the APC Panel at its August 2003 meeting on the August 12, 2003 proposed rule. We were convinced that the median for this device is too low to be appropriate relative to other median costs. We used external data that had been presented to the APC Panel to calculate a mean external acquisition cost and used one part external cost to one part median cost from our claims data to acquire an adjusted cost for the device. We then added the nondevice median from our claims data to the adjusted device acquisition cost to acquire an adjusted median that we used to set the relative weight for this APC. Effective for October 1, 2003, we established codes to be used for reporting the services assigned to APCs 107 and 108. Specifically, CPT code 33240 (Insertion of cardioverter defibrillator) is no longer recognized as a valid code for OPPS. Instead, hospitals now report either G0297 (Insertion of single chamber pacing cardioverter defibrillator pulse generator) or G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator). Also effective for October 1, 2003, CPT code 33249 (Insertion/replacement/repair of cardioverter defibrillator and insertion of pulse generator) is no longer recognized as a valid code for OPPS. Instead, hospitals will report either G0299 (Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator) or G0300 (Insertion or repositioning of electrode lead for dual chamber pacing cardioverter defibrillator and insertion of pulse generator). These codes were created to capture differential costs related to single and dual chamber cardioverter defibrillators. Claims containing the CPT codes we no longer recognize for OPPS (CPT codes 33240 and 33249) are being returned to providers to be coded correctly and resubmitted.

Insertion of Pacemaker Dual Chamber (APC 0655) and Insertion of Pacemaker Single Chamber (APC 0089)

Comment: A commenter indicated that the proposed payment rates for these APCs are only slightly more than the lowest median hospital acquisition cost of the device leaving a hospital little or no payment for the services to implant it. They asked that we re-evaluate and price these APCs at a level that pays the full cost of the device and services.

Response: We carefully reviewed the data for these APCs. We were not convinced that there was a need to adjust the median for either of these APCs. The median cost for APC 0655 is about 12 percent higher than the adjusted median on which the 2003 payment weights were based (2003 adjusted median of $7,298.52 versus the final rule median of $8,225.23). The median cost for APC 0089 is slightly higher than the adjusted median on which the 2003 weights were based (2003 adjusted median of $6,686.16 versus the final rule median of $6,754.63). The comment was not convincing that these median costs were inappropriate in relation to the other median costs that will be used to set the relative weights. Moreover, since median costs for both APCs rose above the amounts achieved by upward adjustments for these APCs in 2003, we believe that the medians are appropriately relative to the costs for other services that will be used to set the relative weights.

Insertion of Pacemaker, Dual Chamber Generator Only (APC 0654)

Comment: A commenter indicated that the proposed payment rate is about 95 percent of the hospital acquisition cost of the device, leaving the hospital at an immediate loss if it implants this device. They asked that we re-evaluate and price these APCs at a level that pays the full cost of the device and services.

Response: The median cost for this APC is about 19 percent higher than the adjusted median on which the 2003 payment weight was based (2003 adjusted median of $5,456.63 versus the final rule median of $6,495.61). We saw no reason to further adjust the median on which the relative weights for 2004 are based. The comment was not convincing that these median costs were inappropriate in relation to the other median costs that will be used to set the relative weights. Moreover, since the median cost for the APC rose above the amounts achieved by upward adjustments for the APC in 2003, we believe that the median is appropriately relative to the costs for other services that will be used to set the relative weights.

INTEGRA Wound Products and Other Wound Products

Comment: We received a comment concerning INTEGRA Dermal Regeneration Template and INTEGRA Bilayer Wound Matrix in which the commenter stated that there is a payment disparity between the INTEGRA products and APLIGRAF, DERMAGRAFT and TRANSCYTE, which are eligible for separate payment as biologicals. The commenter noted that hospitals that use APLIGRAF, DERMAGRAFT, and TRANSCYTE receive an extra payment in the form of a pass-through or other separately paid APC payment in addition to the APC payment for the skin repair procedures (APC 0025), while users of the aforementioned INTEGRA products receive only the regular payment associated with skin repair CPT codes. The commenter stated that this payment differentiation provides a financial incentive to hospitals to use the other skin replacement products, and places INTEGRA at a competitive disadvantage. The commenter recommended that we create a product-specific APC for INTEGRA to provide comparable payment for ''this class of products.'' Alternatively, the commenter recommended that we establish a single APC that includes the cost of all or most skin replacement technologies. The manufacturer noted that hospitals using INTEGRA would receive only $340.41 under our proposed rate for APC 0025, while total payments for APC 0025 plus the product-specific codes for APLIGRAF, DERMAGRAFT, and TRANSCYTE would be between $770.86 and $1,072.86.

Response: TRANSCYTE was approved for transitional pass-through

payment as a biological as of July 1, 2003; DERMAGRAFT continues in pass-through status through 2004; and APLIGRAF is a former pass-through biological proposed to be paid separately as non-pass-through biological, that is, status indicator ''K.'' Since no party has yet applied for transitional pass-through payment for INTEGRA along with relevant documentation in order to evaluate Integra as a biological for pass-through payment, we have not been able to evaluate pass-through payment status as a biological for this product. We are sympathetic to the commenter's concern, and we find merit in the recommendation to group a class of skin replacement products into the same APC. However, we do not believe that we have sufficient information at present upon which to determine the appropriate payment rate for such an APC. Furthermore, we would want to allow the public an opportunity to provide input on such a proposal. Therefore, we will consider the recommendation of a common APC for skin repair using new skin replacement technologies for 2005. We will also consider referring this issue for consideration by the APC Panel at its next meeting. Meanwhile, we invite public comment on the concept of grouping payment for skin repair procedures using new skin repair technologies such as INTEGRA, DERMAGRAFT, and APLIGRAF into a common APC.

Stereotactic Radiosurgery

Comment: A commenter urged that we continue to consider stereotactic radiosurgery (SRS) to be a radiation procedure and that we not reopen the revenue code of surgery for SRS, stating that a radiation oncologist is a critical component to the delivery of SRS. The commenter expressed concern for unintended consequences that may result from unbundling of services associated with this procedure.

Response: We appreciate the commenter's concern for accurately capturing the costs of stereotactic radiosurgery. As a matter of policy, however, we do not generally mandate the reporting of services under specific revenue centers but leave that decision up to the hospitals.

Comment: We received several comments regarding stereotactic radiosurgery (SRS). Commenters were concerned that the current G code descriptors do not appropriately recognize the differences among the various forms of SRS. Commenters explained that there are two basic methods in which SRS can be delivered to patients, linear accelerator-based treatment (often referred to as ''Linac'') and multi-source photon-based treatment (often referred to as Cobalt 60). Advances in technology have further distinguished these treatment modalities. Linear accelerator-based treatment can be performed using various types of SRS systems, two of which include gantry-based systems and image-guided robotic SRS systems. Commenters stated that the existing G codes do not accurately describe the unique differences among these services and therefore do not accurately capture the costs involved in providing these services.

For example, several commenters expressed concern regarding the limitation imposed by the code descriptor for HCPCS code G0242, which restricts its use to planning for Cobalt 60-based treatment. While some commenters stated that planning costs for linear accelerator-based treatment and Cobalt 60-based treatment are identical, other commenters asserted that planning costs for these services differ significantly.

Commenters recommended the following options to resolve the issue:

(1) Create another G code to distinguish between linear accelerator-based SRS and Cobalt 60-based SRS, which would be consistent with the two G codes (G0173 for linear accelerator-based and G0243 for Cobalt 60-based) for SRS treatment delivery; or

(2) Modify the descriptor for HCPCS code G0242 to describe treatment planning for both linear accelerator-based and Cobalt 60-based SRS treatments. For clarification purposes, the current G codes for SRS treatment delivery services are as follows:

G codes for linear accelerator-based SRS treatment delivery:

HCPCS code G0173—Stereotactic radiosurgery, complete course of therapy in one session.

HCPCS code G0251—Linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.

G code for Cobalt 60-based SRS treatment delivery:

HCPCS code G0243—Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions. The current G code for Cobalt 60-based SRS treatment planning is as follows:

HCPCS code G0242—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.

Response: We agree with commenters that the current description for HCPCS code G0242 is limited to the planning of Cobalt 60-based SRS treatment and does not account for the planning of linear accelerator-based SRS treatment. To be consistent with the two G codes we created for treatment delivery, we will create a new G code (G0338) to distinguish linear accelerator-based SRS treatment planning from Cobalt 60-based SRS treatment planning. We will place G0338 in APC 1516 at a payment rate of $1,450. The new G code for linear accelerator-based SRS treatment planning will be as follows:

HCPCS code G0338—Linear-accelerator-based stereotactic radiosurgery 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.

Comment: Several commenters expressed concern that our current code descriptors for HCPCS codes G0173 and G0251 do not distinguish between the various types of linear accelerator-based SRS treatment. Currently, image-guided robotic linear accelerator-based SRS systems are grouped with other forms of linear accelerator-based SRS systems using HCPCS codes G0173 and G0251. Commenters requested that we modify the code descriptors to distinguish image-guided robotic systems from other forms of linear accelerator-based SRS systems to account for the wide cost variation in delivering these services.

Response: We agree with commenters that the descriptors for HCPCS codes G0173 and G0251 do not distinguish image-guided robotic SRS systems from other forms of linear accelerator-based SRS systems to account for the cost variation of delivering these services. To more accurately capture the true costs of these services, we will create two new G codes (G0339 and G0340) to describe complete and fractionated image-guided robotic linear accelerator-based SRS treatment. Please see response to below comment for code descriptors.

Comment: Commenters urged that we modify the code descriptor for the delivery of image-guided robotic SRS to include both complete and fractionated courses of therapy in one code, resulting in the same payment amount for both types of therapy. Commenters explained

that the per-session costs of delivering image-guided robotic linear accelerator-based SRS are the same, regardless of whether the patient's disease requires one treatment or multiple treatments.

Response: Our claims data do not support the assertion that the per-session costs of delivering image-guided robotic linear accelerator-based SRS is equal to the costs of delivering a complete course of image-guided robotic linear accelerator-based SRS treatment. However, we acknowledge the possibility that claims data for G0173 and G0251 may include both image-guided robotic linear accelerator-based SRS treatments as well as other forms of linear accelerator-based SRS treatments and, as a result, the median cost may not accurately reflect the true costs of delivering image-guided robotic linear accelerator-based SRS therapy. As stated in our response to the above comment, we will create two new G codes (G0339 and G0340) to distinguish complete and fractionated image-guided robotic linear accelerator-based SRS treatment from other forms of complete and fractionated linear accelerator-based SRS treatment. We will place HCPCS code G0339 (complete session) in APC 1528 at a payment rate of $5250. The APC placement of HCPCS code G0340 is discussed below.

While we recognize the costs to provide multi-session image-guided robotic SRS therapy may be greater than the current payment rate for HCPCS code G0251, we received no convincing cost data supporting commenters' claims that the costs of performing each additional session subsequent to the first session of a fractionated treatment is equivalent to the costs of performing a complete session. Rather, we believe that certain economies of scale are realized when performing each additional session subsequent to the first session of a fractionated treatment. That is, based on our understanding of the therapy, we do not believe that the same exact amount of hospital resources would be utilized for each subsequent session.

Statements provided by various interested parties indicate that the costs of providing each session of a fractionated treatment range from $2700 to $9000. However, we received no convincing data to substantiate these statements. We have estimated that approximately 75 percent of the costs of a complete session would be required to provide each additional session subsequent to the first session of a fractionated treatment. Therefore, we will place HCPCS code G0340 in new technology APC 1525, which covers procedures ranging from $3500 to $4000 in payment and which pays $3750. This new technology APC range pays approximately seventy-five percent of the payment for HCPCS code G0339. We will modify the descriptor for HCPCS code 0340 to describe additional sessions (second through fifth sessions) subsequent to the first session of a fractionated treatment. In addition, we will expand the descriptor for a complete session (HCPCS code G0339) to include the first session of a multi-session treatment. To further clarify, when providers perform multi-session image-guided robotic SRS therapy, they should bill using HCPCS code G0339 for the first session. For each additional session subsequent to the first session, providers should bill using only HCPCS code G0340 up to a maximum of five sessions.

Although we received no clinical data to substantiate the use of a single session versus multiple fractionations up to five sessions, a few commenters stated that a maximum of five sessions may be utilized to treat certain conditions; therefore, we will continue to pay for the delivery of multi-session therapy (HCPCS code G0340) up to a maximum of five sessions per course of treatment. When additional data is submitted, we may reconsider this payment decision.

As described above, we will create the following new G codes to identify image-guided robotic linear accelerator-based SRS treatment delivery:

HCPCS code G0339—Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment.

HCPCS code G0340—Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment.

SIRTeX Medical (RE: SIR-Spheres Brachytherapy Source)

Comment: The manufacturer of a brachytherapy source to treat liver cancer commented that our proposed payment of $8,870.88 for APC 2616 was inadequate to pay for its product, which it reported costs $14,000 per treatment dose. This commenter stated that there are only two products that would fit this APC, which is for Yttrium-90 brachytherapy source. Moreover, this party claimed that there were significant clinical differences between its product and another Yttrium-90 source, and that these differences necessitated the price differential between the two products. The commenter requested establishment of a separate alpha-numeric HCPCS code for its product, in order to account for the cost differences between the two Yttrium-90 products and to set more equitable payment rates for the two products.

Response: We appreciate the concerns of the commenter. We would first note that payment to APC 2616 has increased to $9,615.50 per dose compared to the 2003 payment of $6,485.37. The information provided in the comment did not convince us that the payment rate resulting from the 2002 claims data is inadequate to pay hospitals for the Yttrium-90 products. We are uncertain whether or not there are other Yttrium-90 sources in addition to the two discussed in this comment that would need to be considered in any analysis of the relative costs of the products. Therefore, until we have additional data, we believe that code C2616 and APC 2616 adequately describes and pays for Yttrium-90 brachytherapy sources.

Low Osmolar Contrast Media

Comment: A radiology specialty society expressed disappointment because we did not address payment for low osmolar contrast media (LOCM) in the proposed rule. The commenter believes that the variability in usage and Medicare's restricted coverage of LOCM warrant payment in a separate APC in the 2004 final rule. The commenter recommends that we increase the relative weights of APCs that include codes that involve the use of LOCM agents to reflect the additional costs of these agents if we do not establish a separate APC to pay for LOCM.

Response: We issued a program memorandum on November 22, 2002 (Transmittal A–02–120, Change Request 2185) in which we removed all requirements differentiating payment between high osmolar contrast material and LOCM as well as restrictions that would limit payment for LOCM only to patients with specific diagnoses. In that program memorandum, we instructed our contractors to discontinue any edits that would prohibit payment for LOCM if specific diagnoses were not reflected on the claim, effective for services furnished on or after January 1, 2003. We further directed contractors to instruct hospitals to include charges for LOCM in the charge for the diagnostic procedure or, if LOCM is billed as a separate charge, to use revenue code 254 or 255 as appropriate. These instructions applied only to hospitals subject to the OPPS.

We disagree with the commenter's recommendation that a separate APC

should be established to bill for LOCM for several reasons. Prior to issuance of Transmittal A–02–120, covered LOCM costs would have been reflected either in an appropriate revenue code or within the hospital's charge for a diagnostic procedure or in a charge with an appropriate HCPCS code (A4644, A4645, or A4646). To the extent that hospitals submitted covered charges for LOCM in 2002, those costs are packaged into the cost of the procedure with which the LOCM was used. We expect that claims for services involving the use of LOCM furnished during CY 2003 will reflect even more fully costs associated with LOCM in light of the instructions that were issued in Transmittal A–02–120. These costs will be reflected in the 2005 update of the OPPS. Finally, without verifiable information that demonstrates the actual market-based price that a broadly based national sample of hospitals are routinely required to pay in order to procure LOCM, we have no data upon which to base a determination that a separate APC for LOCM would be appropriate.

Prosthetic Urology

Comment: Several commenters supported the proposed restructuring of the prosthetic urology procedures into APCs 385 and 386. However, the commenters urged us to consider further refinements to increase the payment rates for these APCs. The commenters expressed concern about the use of a single departmental cost-to-charge ratio for devices and recommended for calendar year 2005 that we implement edits in our development of median costs to benchmark cost data for device procedures so that charges for expensive devices are not reduced below a designated point. The commenters also stated that hospitals charged for only one component of a prosthetic urology device for multi-component prosthetic urology devices. The commenters believe this resulted in under-reporting of charges for the entire procedure. The commenters recommended that we use external data to adjust the level of payment for multi-component devices and exclude claims with device costs less than $5,000 from the rate-setting database. Commenters stated that hospitals in the States of California, Colorado, Florida, Illinois, North Dakota, New York, and Oklahoma have closed their prosthetic urology programs because Medicare OPPS payments are too low.

Response: APCs 385 and 386 were created by splitting APC 0182 into two APCs for higher cost and lower cost devices (penile prostheses and urinary sphincters). The payment for these procedures in 2003 is $4,975.96. As a result of splitting former APC 0182 into two APCs, the payment amount for 2004 is $3,663.93 for APC 0385 and $6,342.07 for APC 0386. This is a relatively small reduction for APC 0385 with the lower cost devices and a very significant increase for APC 0386, with the higher cost devices. Moreover, as discussed in more detail elsewhere, we decided to change the status indicator for these APCs from ''T'' to an ''S'' so that the multiple procedure reduction will not apply to them (or other procedures with a ''T'' status indicator) on the same day. These changes together result in significantly more payment for these services in 2004 than in 2003. Therefore, we did not use external data to further adjust the median cost on which the payment was based.

Intensity Modulation Radiation Therapy

Comment: Commenters urged that we withdraw our proposal to move intensity modulation radiation therapy (IMRT) treatment planning (CPT code 77301) from new technology APC 1510 (previously APC 0712 in 2003) to APC 0413 and IMRT treatment delivery (CPT code 77418) from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412. Commenters indicated that the payments proposed for APCs 0412 and 0413 are too low to adequately compensate hospitals for the costs of the services. One commenter further explained that part of the problem behind the low median cost may be that, according to CMS PM A–02–26, hospitals are precluded from billing for all of the services involved in this treatment. The commenter indicated that hospitals should be able to bill and be paid for the simulations (CPT codes 77280–77295), dosimetry calculations (CPT code 77300), an isodose plan (CPT codes 77305–77315), special teletherapy port plan (CPT code 77321), continuing medical physics (CPT code 77336) and special medical physics (CPT code 77370). Commenters requested that CPT codes 77301 and 77418 be retained in their current new technology APCs (APCs 1510 and 1506, respectively) for another year to provide additional time for provider education about the proper coding of these services and to enable the data to mature.

Response: We agree with commenters that the payment rate for APC 0413 does not adequately cover the costs of providing IMRT treatment planning (CPT code 77301). As noted by one commenter, PM A–02–26 instructs that services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336, and 77370 are included in the APC payment for IMRT and SR planning. The low median for CPT code 77301 appears to be a result of miscoding. Therefore, we will retain CPT code 77301 in new technology APC 1510 to allow additional time for provider education and to enable the data to mature. We believe, however, that the significant volume of single claims (93 percent of total claims) used to set the payment rate for IMRT treatment delivery (CPT code 77418) accurately reflects the costs hospitals are reporting for this service. Based on this robust claims data, we will move CPT 77418 from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412 (IMRT Treatment Delivery).

Comment: One commenter requested that we allow the use of existing IMRT CPT codes 77301 and 77418 for compensator-based IMRT technology in the hospital outpatient setting. The commenter states that Medicare beneficiaries may be denied access to compensator-based IMRT as a result of inadequate payment for this service.

Response: We do not prohibit the use of existing IMRT CPT codes 77301 and 77418 to be billed for compensator-based IMRT technology in the hospital outpatient setting. Rather, we believe the confusion may pertain to billing instructions for CPT codes 77301 and 77334 billed on the same day. CMS PM A–02–26 instructs that ''payment for IMRT and SR planning does not include payment for services described by CPT codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301 and G0242.'' Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a 59 modifier to receive accurate payment.

Proton Beam Therapy

Comment: Several commenters indicated that proton beam therapy, intermediate and complex should be moved from APC 0650 to a new technology APC (as it appears in Addendum B). However, commenters stated that these two codes should not be placed in the same APC due to a significant difference in resource utilization. We received several other comments supporting our proposal to maintain simple proton beam therapy (CPT codes 77520 and 77522) in APC 0664 and intermediate and complex proton beam therapies (CPT codes 77523 and 77525, respectively) in APC 1511 (previously APC 0712 in 2003).

Response: We agree with commenters that codes for simple proton beam

radiation therapy (CPT codes 77520 and 77522) should be placed in a different APC than codes for intermediary (CPT code 77523) and complex (CPT code 77525) radiation therapy. As we stated in the correction notice of February 10, 2003 (68 FR 6636), we also agree with commenters that it would be inappropriate to return codes for simple proton beam therapy to a new technology APC due to having sufficient claims data to integrate these codes into the OPPS. We continue to believe that the placement of these codes in APC 0664 is appropriate based on having used 98 percent of total claims for simple proton beam therapy to set the 2004 median for APC 0664. Therefore, CPT codes 77520 and 77522 will remain in APC 0664.

The placement of intermediate (CPT code 77523) and complex (CPT code 77525) proton beam therapies in APC 650 in the November 1, 2002 final rule (67 FR 66718) for the 2003 OPPS was an error that was corrected in the correction notice of February 10, 2003 (68 FR 6636). We clarified in the correction notice that these CPT codes were placed in new technology APC 0712 for CY 2003 because they lacked sufficient cost data to confidently move these codes out of a new technology APC. We continue to lack sufficient cost data to move these codes into a clinical APC; therefore, we will crosswalk CPT codes 77523 and 77525 from new technology APC 0712 to the corresponding new technology APC 1511 for CY 2004. Once sufficient data is available, we will be able to determine whether intermediate and complex proton beam therapies should be placed in the same APC.

FDG PET Procedures

Comment: Several commenters commended us for our proposed rates for FDG PET procedures. They were pleased that the proposed 2004 rates for the FDG PET procedure and the radiopharmaceutical when combined are nearly identical to the rates for the combined procedure and radiopharmaceutical for 2003. Commenters stated that the retention of FDG PET procedures in a new technology APC will allow providers an additional year to improve their reporting practices, while providing us with another year of more accurate claims data.

Response: We agree with commenters that the retention of FDG PET procedures in a new technology APC for an additional year will allow providers a reasonable amount of time to improve their reporting practices, while providing us with another year of claims experience. Therefore, we will retain FDG PET procedures in new technology APC 1516.

Comment: One commenter expressed concern that HCPCS code G0296 did not appear in Addendum B of the August 12, 2003 proposed rule. The commenter urged us to place this new code in APC 1516 with other FDG PET procedures.

Response: We thank the commenter for bringing to our attention the absence of HCPCS code G0296 from addendum B of the proposed rule. We agree with the commenter's recommendation to place this code in the same APC as other FDG PET procedures. Therefore, we will place HCPCS code G0296 in new technology APC 1516.

Comment: One commenter recommended the establishment of a revenue code dedicated solely to PET procedures.

Response: Revenue codes exist for hospital accounting purposes and, in general we do not require that particular services be billed with particular revenue codes. We are not convinced that adding specific requirements for revenue coding or expanding the revenue codes to acquire more specific information will result in better data or that the end result would be cost effective in terms of its potential effect on hospital operations.

IV. Transitional Pass-Through and Related Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain medical devices, drugs, and biological agents. 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, Pub. L. 107–186; current drugs, biological agents, and brachytherapy devices used for the treatment of cancer; and current drugs and biological products.

For those drugs, biological agents, and devices referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), Pub. L. 106–554, enacted December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' medical devices, drugs, and biological 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 can be made for at least 2 years but not more than 3 years.

Section 1833(t)(6)(B)(i) of the Act required that we establish by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. Section 1833(t)(6)(B)(i)(II) of the Act explicitly authorized us to establish initial categories by program memorandum (PM). On March 22, 2001, we issued two PMs, Transmittals A–01–40 and A–01–41 that established the initial categories. We posted them on our Web site at: *http://www.hcfa.gov/pubforms/transmit/A0140.pdf* and *http://www.hcfa.gov/pubforms/transmit/A0141.pdf,* respectively.

Transmittal A–01–41 includes a list of the initial device categories, a crosswalk of all the item-specific codes for individual devices that were approved for transitional pass-through payments, and the initial category code by which the cross-walked individual device was to be billed beginning April 1, 2001. Items eligible for transitional pass-through payments are generally coded using a Level II HCPCS code with an alpha prefix of ''C.'' Pass-through device categories are identified by status indicator ''H'' and pass-through drugs and biological agents are identified by status indicator ''G.'' Subsequently, we added a number of additional categories, retired 95 categories effective January 1, 2003, and made clarifications to some of the categories' long descriptors found in various program transmittals. A list of current device category codes can be found below, in Table 10.

Section 1833(t)(6)(B)(ii) of the Act also requires us to establish, through rulemaking, criteria that will be used to create additional device categories for transitional pass-through payment. The criteria for new categories were the subject of a separate interim final rule with comment period published in the **Federal Register** on November 2, 2001 (66 FR 55850) and made final in the November 1, 2002 **Federal Register** (67 FR 66781) announcing the 2003 update to the OPPS.

Transitional pass-through categories are for devices only; they do not apply to drugs or biological agents. The regulations at § 419.64 governing transitional pass-through payments for eligible drugs and biological agents are unaffected by the creation of categories.

The process to apply for transitional pass-through payment for eligible drugs and biological agents or for additional device categories can be found on respective pages on our Web site at *http://www.cms.gov.* If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes for approval by the Office of Management and Budget (OMB) as required under the Paperwork Reduction Act (PRA). Notification of new drug, biological, or device category application processes is generally posted on the OPPS Web site at *http://www.cms.gov.*

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 Medicare and beneficiary payments under the hospital OPPS. For a year before 2004, the applicable percentage is 2.5 percent; for 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent. We proposed to set the percentage at 2.0 percent for the 2004 OPPS.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a 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. We make an estimate of pass-through spending to determine not only whether payment exceeds the applicable percentage but also to determine the appropriate reduction to the conversion factor.

In the August 12, 2003 proposed rule, we described in the detail the methodology we used to make an estimate of pass-through spending in 2004 (68 FR 47992). In general, we specified that after using the respective methodologies described in the proposed rule, to determine projected 2004 pass-through spending for the groups of devices, drugs, and biological agents, we would calculate total projected 2004 pass-through spending as a percentage of the total projected payments (Medicare and beneficiary payments) under OPPS to determine if the pro rata reduction would be required.

Table 9 shows our current estimate of 2004 pass-through spending for known pass-through drugs, biologicals, and devices based on information available at the time this table was developed. We specified in the proposed rule that we were uncertain whether estimated pass-through spending in 2004 would exceed $456 million (2.0 percent of total estimated OPPS spending) because we had not yet completed the estimate of pass-through spending for a number of drugs and devices. In particular, we did not have estimates for those drugs still under agency review for additional pass-through payments beginning October 2003 or the changes in pass-through spending that could result from quarterly rather than annual updates of AWP for pass-through drugs. Finally, we would incorporate an estimate of pass-through spending for items for which pass-through payment becomes effective later in 2004 (that is, April 1, 2004; July 1, 2004; and October 1, 2004) based on estimates of items that become eligible for pass-through payment on October 1, 2003 and January 1, 2004. Specifically, we would assume a proportionate amount of spending for items that become eligible later in the year while making an adjustment to account for the fact that items made eligible later in the year will not receive pass-through payments for the entire year. We invited comments on the methodology we proposed and the estimates for utilization that appeared in Table 12 of the August 12, 2003 proposed rule. We received several comments on this proposal, which are summarized below along with our responses.

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2004

HCPC	APC	Drug biological	2004 pass-through payment portion	2004 estimated utilization	2004 anticipated pass-through payments
		Existing Pass-through Drugs/biologicals			
J0583	9111	Injectin Bivalrudin, per 1 mg	$0.40	$5,278,000	$2,111,200
C9112	9112	Injection, Perflutren lipid microsphere, per 2 ml	37.44	67,000	2,508,480
C9113	9113	Injection, Pantoprazole sodium, per vial	6.34	20,000	126,800
J1335	9116	Injection, Ertapenum sodium, per 500 mg	6.00	14,400	86,400
J2505	9119	Injection, Pegfilgrastim, per 6 mg single dose vial	708.00	110,344	78,123,329
J9395	9120	Injection, Fluvestrant, per 25 mg	22.13	274,156	6,067,072
C9121	9121	Injection, Argatroban, per 5 mg	4.13	50,000	206,500
C9200	9200	Orcel, per 36 cm2	286.80	1,000	286,800
C9123	9123	Transcyte, per 247 sq cm	194.76	100	19,476
C9203	9203	Injection Perflexane lipid microspheres, per 10 ml vial	36.00	82,400	2,966,400
J2324	9114	Injection, Nesiritide, per 0.5 mg vial	38.30	60,000	2,298,000
J3315	9122	Injection, Triptorelin pamoate, per 3.75 mg	100.70	307,440	30,959,208
J3487	9115	Injection, Zoledronic acid, per 1 mg	54.93	539,000	29,607,270
J3486	9204	Injectionm Ziprasidone mesylate, per 10 mg	5.25	234,286	1,230,000
C9205	9205	Injection, Oxaliplatin, per 5 mg	23.86	280,756	6,698,845
C9208	9208	Injection, IV, Agalsidase beta, per 1 mg	31.27	194,533	6,083,040
C9201	9201	Dermagraft, per 37.5 square centimeters	145.92	9,264	1,351,803
C9209	9209	Injection, IV, Laronidase, per 2.9 mg	162.72	2,612	425,092
		Pass-through Drugs/Biologicals Effective January 2004			
C9207	9207	Injection, IV, Bortezomib, per 3.5 mg	262.66	102,680	26,970,000
C9210	9210	Injection, IV, Palonosetron HCI, per 0.25 mg (250 micrograms)	77.76	37,500	2,916,000
C9211	9211	Injection, alefacept, for intravenous use, per 7.5 mg	168.00	13,775	2,314,200
C9212	9212	Injection, alefacept, for intramuscular use, per 7.5 mg	119.40	27,550	3,289,470
		Existing Pass-through Devices			
C1783	1783	Ocular implant, aqueous drainage assist device		324	160,250
C1814	1814	Retinal tamponade device, silicone oil		35,173	13,675,262
C1884	1884	Embolization Protective System		25,000	38,601,544
C1888	1888	Catheter, ablation, non-cardiac, endovascular (implantable)		215	129,731

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2004—Continued

HCPC	APC	Drug biological	2004 pass-through payment portion	2004 estimated utilization	2004 anticipated pass-through payments
C1900	1900	Lead, left ventricular coronary venous system		2,095	2,819,912
C2614	2614	Probe, percutaneous lumbar discectomy		901	1,752,445
C2632	2632	Brachytherapy solution, iodine—125, per mCi		225	1,890,000
C1818	1818	Integrated keratoprosthesis		4	27,800
		Pass-through Devices Effective January 2004			
C1819	1819	Tissue localization-excision dev		9,858	1,823,730
		Other Items Expected To Be Determined Eligible for 2004			
		Spending for future approved drugs			22,466,959
		Spending for future approved devices			12,791,197
		Total Spending for Pass-through Drugs/biologicals, and devices 2004.			302,784,216

Comment: Several commenters objected to the methods used to project pass-through drug spending, especially those techniques used to estimate future products that are first eligible for pass-through payments beginning in April 2004 or later in the year. They are concerned that pass-through expenditures in 2004 will exceed the statutory cap and cause us to impose a pro rata reduction. Several hospital associations propose that we limit the funds allocated for the pass-through pool to one percent and use the remaining 1.0 percent to fund all other APCs. They suggest that we over-estimate pass-through spending, which results in the reduction of payment rates for other critical care services.

Response: Section 1833(t)(6)(E)(i) of the Act requires that the Secretary estimate the total pass-through payments to be made for the forthcoming year (which allows us to determine the amount of the conversion factor for the forthcoming year) and to the extent the estimate exceeds the statutory limit, reduce the amount of each pass-through payment. For 2004, the statutory limit is 2.0 percent of total estimated program payments. In the August 12, 2003 proposed rule, we provided our best estimate at that time of pass-through payments for the drugs and devices for which we expected to make pass-through payments in 2004, and we explained our methodology for determining the estimate for the final rule. We provided a list of the devices and drugs we either knew would be paid under pass-through next year or which we believed may be paid as pass-through items in 2004.

We finalized our estimate of 2004 pass-through spending and, for the reasons discussed below, we have determined that no pro rata reduction will be required in 2004. As discussed below the estimate falls under the statutory limit of 2.0 percent. Therefore, the conversion factor has been increased correspondingly from the proposed rule by 0.7 percent.

Pass-Through Devices Effective January 2004

Comment: One commenter recommended that we not impose a pro rata reduction on pass-through devices if the estimated pass-through expenditures increase appreciably. A device manufacturers' association was concerned that new drugs will take an increasing share of the pass-through pool. They suggested that the shift to more pass-through spending on drugs will increase under the easier qualifications for drug pass-through payments and encouraged us to reconsider the issue to determine how to ensure that devices maintain an ''adequate'' share of the pass-through pool.

Response: Section 1833(t)(6)(E)(iii) of the Act requires a prospective uniform reduction (pro rata) of the amount of each of the transitional pass-through payments made in that year, if it is expected that pass-through payments will exceed the cap set for OPPS pass-through expenditures. Therefore, if any pro rata reduction applies, we are required to apply it to pass-through devices as well as drugs and biological agents. For 2004, we do not expect the total payments for pass-through drugs and devices to exceed the statutory limit. Therefore, as discussed elsewhere, we will not impose a pro rata adjustment on any pass-through items in 2004.

V. Payment for Devices

A. Pass-Through Devices

Section 1833(t)(6)(B)(iii) of the Act requires that a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. We proposed that two device categories currently in effect would expire effective January 1, 2004. Our proposed payment methodology for devices that have been paid by means of pass-through categories, and for which pass-through status would expire effective January 1, 2004, is discussed in the section below.

Although the device category codes became effective April 1, 2001, most of the item-specific ''C'' codes for pass-through devices that were crosswalked to the new category codes were approved for pass-through payment in CY 2000 and as of January 1, 2001. (The crosswalk for item-specific ''C'' codes to category codes was issued in Transmittals A–01–41 and A–01–97). We based the expiration dates for the category codes listed in Table 10, on when a category was first created, or when the item-specific devices that are described by, and included in, the initial categories were first paid as pass-through devices, before the implementation of device categories. The device category expiration dates are listed in Table 10. We proposed to base the expiration date for a device category on the earliest effective date of pass-through payment status of the devices that populate that category. There are two categories for devices that will have been eligible for pass-through payments for more than 2½ years as of December 31, 2003, and we proposed that they would not be eligible for pass-through payments effective January 1, 2004. The two categories we proposed for expiration are C1765 and C2618, as indicated in Table 10. Each category includes devices for which pass-through payment was first made under OPPS in 2000 or 2001.

A comprehensive list of all currently effective pass-through device categories is displayed in Table 10. Also displayed

are the dates the devices described by the category were populated and their respective expiration dates. For devices continuing on pass-through status after 2003, expiration dates were set forth in the August 12, proposed rule and are finalized here. Newly added code C1819 is first announced in this final rule and is given a December 31, 2005 expiration date.

The methodology used to base expiration of a device category is the same as that used to determine the 95 initial categories that expired as of January 1, 2003. A list including those 95 categories that expired as of January 1, 2003 (as well as 5 categories that continued to be paid in 2003) is found in the November 1, 2002 final rule (67 FR 66761 through 66763).

TABLE 10.—LIST OF CURRENT PASS—THROUGH DEVICE CATEGORIES WITH EXPIRATION DATES

HCPCS codes	Category long descriptor	Date(s) populated	Expiration date
C1765	Adhesion Barrier	10/1/00–3/31/01; 7/1/01.	12/31/03
C2618	Probe, cryoblation	4/1/01	12/31/03
C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
C1900	Lead, left ventricular coronary venous system	7/1/02	12/31/04
C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
C1884	Embolization protective system	1/1/03	12/31/04
C2614	Probe, percutaneous lumbar discectomy	1/1/03	12/31/04
C2632	Brachytherapy solution, iodine-125, per mCi	1/1/03	12/31/04
C1814	Retinal tamponade device, silicone oil	4/1/03	12/31/05
C1818	Integrated keratoprosthesis	7/1/03	12/31/05
C1819	Tissue localization excision device	1/1/04	12/31/05

We received several comments on this proposal, which are summarized below along with our responses.

Comment: A few parties provided comments on our criteria for eligibility for a new device category for pass-through payment as published in the November 1, 2002 **Federal Register** (67 FR 66781).

Response: We made no proposal to modify our criteria for establishment of a new category for transitional pass-through payment, so the criteria were not subject to comment in this rulemaking period. However, we will take note of these comments as considerations in our ongoing evaluation of the new device category process.

New Technology Treatment for New Devices for Brachytherapy Catheters and Needles

Comment: A commenter asked that we consider pass-through payment or new technology payment for new devices of brachytherapy catheters and needles when they are approved by FDA for new indications and treatment protocols.

Response: We have a process for applying for pass-through new technology APC status. See *http://www.cms.hhs.gov* for instructions. If a provider or other party believes that an item or service meets the criteria for pass-through or new technology status, the interested party should submit an application, and we will then make a judgement based on the individual circumstances described in the application.

B. Expiration of Transitional Pass-Through Payments in CY 2004

In the November 1, 2002 final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). We stated that we would package the costs of the devices no longer eligible for pass-through payments in 2003 into the costs of the clinical APCs with which the devices were billed in 2001. There were very few exceptions to the policy (for example, brachytherapy sources for other than prostate brachytherapy), and we proposed to make no changes. Therefore, we proposed that payment for the devices that populate C1765 and C2618, which we proposed would cease to be eligible for pass-through payment on January 1, 2004, would be made as part of the payment for the APCs with which they are billed.

The methodology that we proposed to use to package expiring pass-through device costs is consistent with the packaging methodology that we describe in section II.B.5. For the codes in APCs displayed in Table 10 of the proposed rule, we proposed to use only those claims on which the hospital included the ''C'' code and to discard the claims on which no ''C'' code is billed. We proposed to limit our analysis to the claims with ''C'' codes because we are not confident that the claims for the relevant APCs include the charges for the devices unless the ''C'' codes are specifically billed.

To calculate the total cost for a service on a per-service basis, we included all charges billed with the service in a revenue center in addition to packaged HCPCS codes with status indicator ''N.'' We also packaged the costs of devices that we proposed would no longer be eligible for pass-through payment in 2004 into the HCPCS codes with which the devices were billed.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: A commenter supported packaging the cost of expiring pass-through codes C2618 and CC1765 into the payment for the procedure in which they are used because they believe that packaging minimizes payment incentive to use these devices over other appropriate devices. The commenter urged CMS to release the crosswalk it will use to assign pass-through device costs to specific APCs so that they can confirm the appropriateness of the assignment.

Response: There is no such crosswalk. Devices and packaged drugs (that is, those with a per day median cost of $50 or less) are packaged into the HCPCS code on the single procedure claim (natural single or pseudo single) with which they are billed. The packaging is controlled solely by what the hospital bills on the claim. To determine what drugs and devices were packaged into an APC, one would need to undertake an extensive analysis of all single and pseudo single claims used in weight setting. The only time that judgment was used to attribute a device to an APC was not for purposes of packaging charges into APCs but rather was in the setting of median costs for 5 APCs in which external data on acquisition costs was used in a one to one proportion

with claims data to set the device cost for an APC as discussed above.

C. Reinstitution of C Codes for Expired Device Categories

Comment: Some commenters strongly objected to reinstatement of the C codes for devices because of the burden that it would impose on hospitals without a corresponding benefit in immediate payment. They indicated that charges for devices are included in the revenue code charges for the services furnished and that using C codes will increase administrative costs significantly without any benefit to patient care or hospital revenues. They indicated that hospital staffs would not be able to differentiate between devices that should be reported and those that should not. One commenter said that widespread confusion over what device to code and what device to not code is the reason that the claims for services that require pass-through devices often do not show codes for the devices. The commenter indicates that most hospitals could not comply with this requirement by January 1, 2004 in any case because of extensive changes to chargemasters that would be needed. Moreover, given that many hospitals did not comply even when the use of the code would have resulted in separate payment is a strong indication that they would be unlikely to comply when no additional payment will result from coding devices. Commenters indicated that reintroducing C codes for devices will result in continuation of improper coding and will lead to a false sense of confidence in the data for procedures that require devices. A commenter said that if CMS decided to reintroduce C codes for devices, CMS should reinstate the same C codes that were used for device coding in 2002 because it would minimize confusion.

Other commenters said that CMS should reinstate the C codes for reporting of devices so that CMS and others can ensure that only correctly coded claims are used to set medians for APCs into which device costs are packaged. They said that coding for devices is needed so that CMS can be assured that the costs of the devices are packaged into the costs for the procedure when the medians for the procedure are set. They urged us to continue to use the presence of an appropriate device code as a criterion for claims used to set medians for devices.

Response: For 2004, we are reactivating the C codes for device categories as they existed on December 31, 2002. The use of the code is not required and will not be enforced. However, hospitals should understand that providing complete and accurate information on the claims about the services that were furnished and the charges for those services is fundamental to our establishment of relative weights on which the payment for their services is based.

Comment: Commenters that supported the reinstitution of C codes for devices said that CMS should continue to restrict the claims used for APCs with a device to claims that contain the charges for the devices used in the APC. In particular, a commenter said that the median for APC 0246 (Cataract removal with intraocular lens) should be based only on claims that contain charges under revenue center 0276 and that claims for APC 0246 that do not contain charges in revenue center 0276 should not be used to set the median. In the case of this APC, the commenter asked that we adopt the 2004 proposed payment at a minimum. Other commenters opposed the reinstitution of C codes for devices, which would preclude us from restricting claims used to set weights for device APCs to claims containing such codes.

Response: We restricted the claims used to set the medians for the APCs contained in Table 7 to claims for which there was a line item containing a device category code that was in use for services furnished on April 1, 2002 through and including December 31, 2002. We believed that restricting the claims used to set median costs to those that met this criterion resulted in median costs that more accurately reflected relative costs of these services. Moreover, for the APCs in Table 7 we required that the claim not only contain a device code that was valid during the period specified but we also required that the claim must have a particular device code or combination of device codes.

For APC 0313 (high dose rate brachytherapy), we attempted to require both brachytherapy sources HDR Iridium 192 (C1717) and either a catheter (C1728) or needle (C1715) but we found that no single procedure claims met those criteria. Hence, the median for APC 0313 that appeared in the 2003 OPPS final rule was the median for claims that did not meet the specified criteria and it was mistakenly included in Table 10 in the NPRM. For this final rule, we again began by applying the criteria including source and needle or catheter codes, but still no claims met the criteria. Therefore, we sought only single procedure claims that contained brachytherapy sources. We found 27 single procedure claims that met the revised criteria and we used the median cost of $936.52 that resulted from those claims.

D. Other Policy Issues Relating to Pass-Through Device Categories

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

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the 2002 OPPS update (April 1, 2002), we deduct from the pass-through payments for the identified devices an amount that offsets the portion of the APC payment amount that we determine is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 final rule, we published the applicable offset amounts for 2003 (67 FR 66801).

For the 2002 and 2003 OPPS updates, we estimated the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data from the period used for recalibration of the APC rates. Using these claims, we calculated a median cost for every APC without packaging the costs of associated C codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of associated device category C codes that were billed with the APC packaged into the median. Comparing the median APC cost minus device packaging to the median APC cost including device packaging enables us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to final APC rates, we determined the applicable offset amount. We included any APC on the offset list for which the device cost was at least 1 percent of the APC's cost.

As we discussed in our November 1, 2002 final rule (67 FR 66801), the listed offsets are those that may potentially be used because we do not know which procedures would be billed with newly created categories.

After publication of the November 1, 2002 final rule, we received a comment indicating that in some cases it may be inappropriate to apply an offset to a new device category because the device category is not replacing any device whose costs have been packaged into the APC. We agree with this comment

and proposed to modify our policy for applying offsets. Specifically, we proposed to apply an offset to a new device category only when we can determine that an APC contains costs associated with the device. We specified in the proposed rule that we would continue our existing methodology for determining the offset amount, described above. However, we solicited comments for alternative methodologies for determining the offset amounts that potentially could be applied to the payment amounts for new device categories.

We added that we could use this methodology to establish the device offset amounts for the 2004 OPPS because we are using 2002 claims on which device codes are reported. However, for the 2005 update to OPPS, we proposed to use 2003 claims that would not include device coding. Thus, for 2005, we are considering whether or not to use the charges from lines on the claim having no HCPCS code but have charges under revenue codes 272, 275, 276, 278, 279, 280, 289, and 624 as proxies for the device charges that would have been billed with HCPCS codes for these devices in previous years. We are also considering the reinstitution of the C codes for expired device categories and requiring hospitals to use one or more newly created C codes for identification of devices and costs on claims. *See* section VI.B of this final rule for further discussion.

We proposed to review each new device category on a case-by-case basis to determine whether device costs associated with the new category are packaged into the existing APC structure.

We reviewed the device categories eligible for continuing pass-through payment in 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. For the categories existing as of publication of the proposed rule, we determined that there are no close or identifiable costs associated with the devices in our data related to the respective APCs that are normally billed with those devices. Therefore, for these categories we proposed to set the offset to $0 for 2004.

If we create a new device category and determine that our data contain identifiable costs associated with the devices in any APC, we would apply an offset. We proposed, if any offsets apply, for new categories, to announce the offsets in a transmittal that announces the information regarding the new category.

We received several comments on the proposal, which are summarized below along with our responses.

Comment: Device manufacturers and associations generally supported our proposal to modify our policy in applying offsets to only those device categories where we can determine that an APC contains costs associated with the device category. One commenter also recommended that we not apply offsets to those categories that do not replace current devices found in the APC costs.

Response: We will apply an offset to a new device category only when we are able to determine that an APC contains costs associated with the new device. We will also continue our existing methodology for determining any offset amount, if we find that device costs associated with a new device category are packaged into the APCs. We will include information about any applicable offset in the transmittal we issue to announce information regarding the new category.

We also will publish the device percentages related to APCs on our web site. We believe this information is useful to the public even if we do not use the information to apply any particular offset to new device categories, because we use this information to apply the tests of ''not insignificant cost'' to a proposed new device category application. A transitional pass-through device category must have an average cost that is not insignificant in relation to the OPD fee schedule amount, according to section 1833(t)(6)(A)(iv)(II) of the Act.

2. Multiple Procedure Reduction for Devices

In our discussion in the proposed rule of recommendations of the Advisory Panel, we noted that the Panel asked us to analyze our data to determine if we may be underpaying for devices when the multiple procedure policy is applied (68 FR 47976). We made no proposal to change our policy regarding the multiple procedure reduction for device-related APCs, but we did receive a number of comments on the topic.

Comment: Commenters stated that we should change the status indicator (SI) from ''T'' to ''S'' for APCs with packaged device costs so that the multiple procedure discount will not adversely affect the payment for APCs that contain high cost devices. One commenter indicated that no APC for which the device percentage is 50 percent or more should be subjected to a multiple procedure reduction because any such reduction would reduce the Medicare payment below the hospital's cost for the device. The commenter offered to work with us to develop a list of device percentages of APC payments that would not be subject to the multiple procedure reduction. Another commenter suggested that we create a modifier that could be used to override the multiple procedure reduction for certain codes with SI ''T''. Some commenters said that any code that is not subject to the multiple procedure modifier under the Medicare physician fee schedule should be subjected to a multiple procedure modifier under OPPS.

Response: We are concerned that the application of the multiple procedure reduction has been a recurring theme among commenters with regard to APCs that contain significant device costs. We continue to believe that for most cases, including many cases with devices, the payment reductions for the second and subsequent payments are appropriate. This is particularly true given that there must be two procedures with SI=T for the reduction to occur. Hence, if a device procedure is performed with a non-device procedure, the non-device procedure will not be reduced if the device procedure has an SI=S, even if the non-device procedure is less costly because it was done at the same time as the device intense procedure. We are reluctant to change the SIs for device procedures because of the increase that will occur for non-device procedures. The shift in median costs will be picked up in the scaling of relative weights for budget neutrality and will result in some reduction for all services, shifting payment to procedures and away from other services types (for example, E&M, diagnostic tests).

Decisions regarding the application of the multiple procedure SIs are made independently for the Medicare physician fee schedule and the OPPS. The physician fee schedule decision is heavily dependent upon the work performed by the physician and the OPPS decision is made only with regard to the resources the hospital supplies for the service to be performed. There is no reason to believe that a decision to reduce or not reduce for multiple procedures in one system would necessarily justify that same decision in the other system.

For 2004 OPPS we have not changed the policy. However, as we did for 2003 OPPS, we have changed the SI for certain APCs for which we were convinced that the application of the multiple procedure reduction would result in inappropriate payment. For 2005, we hope to analyze the effects of a more systematic approach to determining when we should apply the

multiple procedure reduction to APCs with high device costs. We hope to develop these possible approaches and discuss them with the APC Panel at its winter meeting.

Prosthetic Urology (APCs 0385 and 0386)

Comment: Commenters said that APCs 0385 and 0386 should be changed from SI=S to SI=T and that the APC Panel agreed and recommended these changes in its August 22, 2003 meeting. The commenters indicated that when a penile prosthesis and a urinary sphincter are both implanted at the same time, while there is some cost efficiency (for example, OR time, recovery room time, drugs, supplies), the cost of the prostheses are such a large part of the cost of the APC that the reduction of the second APC by 50 percent results in less than cost being paid.

Response: For the 2004 OPPS, we have changed the SI for these APCs from T to S, so that when both the prosthesis and sphincter are implanted on the same date, the multiple procedure reduction will not apply to the second device. These APCs each contain a combination of penile prostheses and sphincters. Our data analysis shows that it is not a rare occurrence for both to be implanted on the same day and that each APC has a device percentage in excess of 60 percent. For these reasons, we have changed the SI for these APCs to ''S'' for 2004.

Electrophysiology APCs (APCs 0085, 0086 and 0087)

Comment: Commenters said that APCs 0085, 0086, and 0087 should not be subject to the multiple procedure reduction because the devices used in these procedures are not less costly when the second procedure is done on the same day. Commenters said that these procedures have become so advanced that they now are commonly done on the same day and that the multiple procedure reduction significantly reduces the payments below what they were paid when they were done on subsequent days. A commenter suggested that we should create a combination APC for APCs 0085, 0086 and 0087 or for APCs 0085 and 0086 since these are often performed on the same day and the commenter believes that the multiple procedure reduction improperly reduces payment for them.

Response: We have not changed the SI for these APCs because we do not believe that such a change is warranted. Although devices are integral to these APCs, the device portion of the median is not very significant. Each has a device percent lower than 35 percent (APC 0085 = 25.61 percent, APC 0086=34.77 percent, APC 0087= 30 percent). Moreover, we believe that there is efficiency in performing these procedures on the same day in the outpatient setting, which is why hospital practice has changed. Therefore, we are retaining these procedures as SI=T for 2004.

Implantation or Revision of Pain Management Catheter; Implantation of Drug Infusion Device (APCs 0223 and 0227)

Comment: A commenter indicated that the same rationale that applies to implantation of neurostimulators (discussed immediately preceding) applies to APCs 0223 and 0227 and that therefore, the multiple procedure reduction should not apply.

Response: We are not convinced by the comment that it would be appropriate to change the SI for APCs 0223 and 0227 from ''T'' to ''S''. We believe that there are economies of scale that cause these procedures to allow for appropriate payment when they are performed with other procedures.

Left Ventricular Leads (APCs 0105, 1547 and 1550)

Comment: A commenter indicated that placement of a Left ventricular lead (CPT code 33224, 33225, and 33226, APCs 0105, 1547 and 1550 respectively) should not be subjected to the multiple procedure reduction.

Response: We have reviewed the codes contained in these APCs and we are not convinced that it would be appropriate to change the SI for these APCs.

VI. Payment for Drugs, Biologicals, Radiopharmaceutical Agents, Blood, and Blood Products

A. Pass-Through Drugs and Biologicals

In the proposed rule, we expressed concern about the extent to which Medicare pays more for pass-through drugs than other payers and more than the market-based price of drugs. To address this problem of how to pay appropriately for drugs that are priced using the AWP, we are developing regulations that would revise the current payment methodology for Part B covered drugs paid under section 1842(o) of the Act. We proposed to adopt and apply the provisions of the final AWP rule to establish the AWP of pass-through drugs payable under the OPPS. If implementation of the AWP final rule necessitates mid-year changes in the 2004 OPPS payment rates for pass-through drugs, we proposed to make those changes on a prospective payment basis through our regular OPPS Transmittal process and PRICER quarterly updates. We further proposed to issue instructions by program memorandum regarding implementation of the provisions of the AWP final rule to set payment rates for pass-through drugs under the OPPS.

We stated that if the AWP final rule is not issued in time to permit us to apply its provisions to price pass-through drugs furnished on or after January 1, 2004, we proposed to use 95 percent of the AWP listed in the most recent quarterly update of the Single Drug Pricer (SDP). If a drug with pass-through status is not included in the SDP, we proposed to forward to the SDP contractor the AWP information submitted as part of the pass-through application for calculation of an allowed payment amount.

Because the January SDP would not be available in time, we proposed to announce the January 1, 2004 prices for pass-through drugs in our January 2004 OPPS implementing instructions to fiscal intermediaries and in the January 2004 OPPS PRICER rather than in the 2004 final rule, which is to be published in the **Federal Register** by November 1, 2003. We further proposed to update the AWP for pass-through drugs paid under the OPPS on a quarterly basis in accordance with the quarterly updates of the SDP. The updated rates for pass-through drugs and biologicals would also be issued through our quarterly OPPS program memoranda and PRICER updates.

Comment: A national hospital association supported our proposal to use the SDP to determine the payment amount for pass-through drugs and biologicals. However, the same commenter expressed concern about not having accurate 2004 information on AWP until after the 2004 OPPS is implemented, which would make it impossible to predict pass-through spending and not give hospitals enough time to update their billing systems. The commenter also opposed our proposal to update the AWP for pass-through drugs on a quarterly basis because it would result in increased confusion and burden on hospitals to make quarterly price changes and could result in CMS having to make quarterly adjustments to the pass-through pool to recalculate the relative payment weights for all APCs.

A provider expressed reservations about the impact of the AWP rule, which could precipitate a shift in care from physicians' offices to hospitals. This commenter recommended that we determine pass-through payment

amounts using market applications by drug manufacturers and acquisition data solicited from the hospital industry through group purchasing organizations and individual hospitals and systems. The same commenter encouraged us to delay changes in pass-through payments pending an assessment of the impact of the AWP rule on physician practices.

Response: We wish to clarify how our use of the SDP to price pass-through drugs will affect the OPPS in 2004. The payment rates for pass-through drugs and biologicals that are shown in Addendum B are based on the April 1, 2003 SDP, which was the update that was available when we recalibrated the relative payment weights for this final rule. We also used these payment rates as the basis for estimating pass-through spending in 2004, which is discussed in section IV of this preamble.

We have carefully considered the commenter's concern about the confusion that could result if we were to revise the payment amounts for pass-through drugs and biologicals by installing prices from the January 2004 update of the SDP in the OPPS PRICER for implementation beginning January 1, 2004. We agree with the commenter that, because of the timing, this proposal could create operational problems both for providers and for our claims processing systems. Therefore, we will retain the payment amounts published in this final rule as the payment amounts for pass-through drugs effective January 1, 2004.

Further, to keep quarterly changes to a minimum, we have decided not to implement at this time our proposal to update the AWP for pass-through drugs paid under the OPPS on a quarterly basis in accordance with quarterly SDP updates.

At this time, we are not implementing the AWP rule. Therefore, we are not making final the OPPS changes we proposed that would have resulted from the AWP rule.

Comment: Several commenters were concerned about the delay in processing pass-through applications and assigning c-codes for new drugs and biologicals. Commenters believed that the lack of immediate payment under OPPS for new FDA-approved drugs and biologicals may drive hospitals to discontinue providing innovative life-saving therapies to Medicare beneficiaries until pass-through payments are established. Another commenter suggested that CMS create and regularly update a central on-line listing of all current codes for pass-through drugs, biologicals, and devices. The Web site should also list all pass-through drug and device applications under review, and their status in the review process.

Response: We understand the concerns expressed by commenters about the impact of the time gap from FDA approval to our c-code assignment and payment for new pass-through items; however, our position on this issue remains the same as that described in the November 1, 2002 final rule (67 FR 66780–81).

B. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the OPPS, we currently pay for radiopharmaceuticals, drugs, and biologicals including blood, and blood products, which do not have pass-through status, in one of three ways: packaged payment, separate payment (individual APCs), and reasonable cost. As we explained in the April 7, 2000 final rule (65 FR 18450), we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, a Program Memorandum issued to Intermediaries on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services). As we explained in the November 1, 2002 final rule (67 FR 66757), we do not classify diagnostic and therapeutic radiopharmaceutical agents as drugs or biologicals as described in section 1861(t) of the Act.

Comment: Several trade associations and manufacturers urged CMS to revise its policy that radiopharmaceuticals are not drugs. They emphasized that radiopharmaceuticals go through the same FDA approval process as drugs, are approved for inclusion in the United States Pharmacopoeia Drug Indication, and have historically been considered drugs under OPPS. They indicated that Congress is considering a legislative clarification that under OPPS radiopharmaceuticals will continue to be treated and paid as drugs.

Response: We appreciate the comments on this issue. We do not intend, by our designation of radiopharmaceuticals for purposes of determining which items are eligible for pass-through status, to imply that radiopharmaceuticals are not considered drugs under the Food, Drug, and Cosmetic Act or that they are not subject to the same FDA approval process as those items that we have designated as drugs. However, we will continue to consider radiopharmaceuticals as neither a drug nor biological. Our reasons were set forth in the November 1, 2002 final rule (67 FR 66757). In that rule, we stated that a careful reading of the statutory language in section 1861(t)(1) convinces us that inclusion of an item in, for example, the USPDI, does not necessarily mean that the item is a drug or biological. Inclusion in such a reference (or approval by a hospital committee) is a necessary condition for us to call a product a drug or biological, but it is not enough. CMS must make its own determination that a product is a drug or biological for OPPS purposes under its governing statutes, and this determination is different from and does not affect FDA's determination that a product is a drug or biological under the Food, Drug, and Cosmetic Act.

While we have determined that radiopharmaceuticals are not drugs under the OPPS, we have chosen to establish separate payment for radiopharmaceuticals under the same packaging threshold policy that we apply to drugs and biologicals. We have also determined that we will apply the same adjustments to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

Payment for New Radionucliide Therapy for Certain Forms of Non-Hodgkins Lymphoma

Currently, payment for the radiopharmaceutical Zevalin (Ibritumomab Tiuxetan) is packaged into the payment for HCPCS codes G0273 (Pretx planning, non-Hodgkins) and G0274 (Radiopharm tx, non-Hodgkins). To ensure consistency with our payment policy for other radiopharmaceuticals (that is, making separate payment for radiopharmaceuticals whose costs are greater than $150 per episode of care), we proposed to make payment for Zevalin (ibritumomab tiuxetan) separately from payment for the procedures with which Zevalin (ibritumomab tiuxetan) is used.

We proposed to use HCPCS A9522 (Indium 111 ibritumomab tiuxetan) to report the use of In-111 Zevalin (In-111 Ibritumomab Tiuxetan) and HCPCS A9523 (Yttrium 90 ibritumomab tiuxetan) to report the use of Y90 Zevalin (Y90 Ibritumomab Tiuxetan). We proposed to place HCPCS A9522 in

APC 9118 with a payment amount of $2,084.55 and HCPCS A9523 in APC 9117 with a payment amount of $18,066.09. We note that payment rates for radiopharmaceuticals are not subject to wage index adjustments because no portion of the payment is attributed to labor-related costs.

Because we proposed that payment for G0273 and G0274 no longer include payment for Zevalin, we also proposed to place G0273 into newly created APC 0406 and G0274 into newly created APC 0408. These APCs include procedures that are similar clinically and in terms of resource consumption to G0274 and G0273, respectively.

Zevalin (ibritumomab tiuxetan) is a radioimmunotherapy that is used to treat patients with certain forms of non-Hodgkin's lymphoma (NHL). Medicare began payment under the OPPS for Zevalin services furnished on or after October 1, 2002.

On June 27, 2003, the FDA approved the manufacture and sale of Bexxar (tositumomab and Iodine I 131 tositumomab), which is another radioimmunotherapy used to treat patients with certain forms of non-Hodgkin's lymphoma. Both Zevalin and Bexxar are therapeutic regimens administered in two separate steps: The first step is diagnostic to determine radiopharmaceutical biodistribution of radiolabeled antibodies; the second step is the therapeutic administration of targeted radiolabeled antibodies.

On September 8, 2003, we issued a One Time Notification (Transmittal 1, Change Request 2914) to implement payment for Bexxar effective for services furnished on or after July 1, 2003. We instructed hospitals to bill for Bexxar using HCPCS codes G0273 (Pretx planning, non-Hodgkins), G0274 (Radiopharm tx, non-Hodgkins), and G3001 (Administration and supply of tositumomab, 450mg). Publication deadlines precluded our being able to address payment for Bexxar in the August 12, 2003 proposed rule.

Comment: A major hospital association, a nuclear medicine specialty organization, several providers that treat cancer patients, and two radiopharmaceutical manufacturers submitted comments regarding the changes we proposed to the coding and payment for Zevalin (ibritumomab tiuxetan) under the 2004 OPPS. The commenters agree with our proposal to separate payment for Zevalin from the payment for the procedure and to pay for Zevalin using HCPCS codes A9522 and A9523, which would not be subject to a wage index adjustment. One commenter noted that the HCPCS descriptors for A9522 and A9523 define the unit of service as ''per millicurie,'' but that the payment we proposed for these two codes appeared to be a total payment amount rather than a per millicurie rate. Several commenters recommended that the code descriptors for A9522 and A9523 be revised to read ''per dose'' rather than ''per millicurie.''

Response: We appreciate the commenters'' support of our proposal to pay for Zevalin separately from its administration. We also agree with the commenter who suggested that the payment rate proposed for A9522 and A9523 was incorrectly shown as a total payment amount rather than a per millicure rate, and we have made certain that the final payment amounts implemented in the 2004 update are consistent with the code descriptor for the service. We further agree with the recommendation of commenters that the HCPCS descriptors for Indium 111 ibritumomab tiuxetan and Yttrium 90 ibritumomab tiuxetan would be less confusing if expressed in terms of dose rather than millicuries. However, the descriptors for A9522 and A9523 were established by the HCPCS National Panel through the process described on our Web site at *http://www.cms.hhs.gov/medicare/hcpcs/,* and such a descriptor change could not be applied for in time for January 1, 2004 implementation of the OPPS. Therefore, we are establishing two temporary C-codes for hospitals to use to bill under the OPPS for Indium 111 ibritumomab tiuxetan and Yttrium 90 ibritumomab tiuxetan, for services furnished beginning January 1, 2004, as follows:

C1082, Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose

C1083, Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose

Comment: One commenter recommended that we create separate codes that parallel A9522 and A9523 to bill for Bexxar (tositumomab and I–131 tositumomab).

Response: We are establishing two temporary C-codes for hospitals to use to bill under the OPPS for I–131 tositumomab for services furnished beginning January 1, 2004, as follows:

C1080, Supply of radiopharmaceutical diagnostic imaging agent, I–131 tositumomab, per dose

C1081, Supply of radiopharmaceutical therapeutic imaging agent, I–131 tositumomab, per dose

Comment: Several commenters recommended that we discontinue use of HCPCS codes G0273 and G0274 to describe the administration of Zevalin and that, instead, we instruct hospitals to report new CPT code 78804, Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging, and new CPT code 79403, Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion. One commenter expressed concern about our proposal to assign G0273 for pre-treatment planning and administration of the diagnostic dose to APC 0406, Tumor/Infection Imaging because the payment rate proposed for APC 0406 ($258.10) is inadequate to pay for the cost of the scans required to measure the distribution of the radiopharmaceutical agent. The same commenter agreed with our proposal to assign G0274 for administration of the therapeutic dose to APC 0408, with a proposed payment rate of $217.16.

Response: We agree with the commenters' recommendations that we replace HCPCS codes G0273 and G0274 with CPT codes 78804 and 79403, respectively. We will direct our contractors to instruct hospitals to use CPT code 78804 to report administration of the diagnostic dose of ibritumomab tiuxetan and I–131 tositumomab and to report CPT code 79403 to report administration of the therapeutic dose of ibritumomab tiuxetan and I–131 tositumomab. We also agree with the concern of commenters that the payment amount for APC 0406 in the final rule is insufficient for administration of the diagnostic radiolabeled antibodies plus the imaging required to determine radiopharmaceutical localization of tumor(s) and distribution of the radiopharmaceutical agent. Therefore, we are assigning CPT code 78804 to New Technology APC 1508, which has a payment rate of $650. After we have had an opportunity to collect claims data that indicate hospital costs for this procedure, we will re-evaluate its APC assignment. Further, there are several additional expenses associated with these innovative radioimmunotherapies used to treat patients with certain forms of non-Hodgkin's lymphoma, which we discuss below. We are therefore assigning CPT code 70403 to New Technology APC 1507, until we have collected sufficient data to confirm the appropriate clinical APC for this service.

Comment: Several commenters expressed concern that our proposed payment for Zevalin ($2,084.55 for the diagnostic dose of indium and $18,066.09 for the therapeutic dose of

yttrium) would be approximately $2,000 less than what it costs a hospital to purchase Zevalin from a nuclear pharmacy, thereby jeopardizing beneficiary access to this therapy. One commenter submitted information from a nuclear pharmacy attesting that it has dispensed 2,068 patient-specific doses of Zevalin nationwide (1,071 Indium doses and 997 Yttrium doses) and that its current charges are $2,260 per dose of Indium-111 Zevalin and $19,565 per dose of Yttrium-90 Zevalin. The commenter stated that this represents nearly 80 percent of all Zevalin doses dispensed between product launch in April 2002 through June 30, 2003.

Another commenter expressed concern about the adverse impact that the proposed reduction in payments for Zevalin could have on payment for Bexxar in 2004. The commenter urged us not to base payment for Bexxar on what we proposed for Zevalin but, rather, on hospital acquisition costs for Bexxar, which approximate the wholesale acquisition cost (WAC) of $2,250 for the diagnostic dose and $19,500 for the therapeutic dose.

Response: Although we established a code to enable hospitals to bill for and receive separate payment for Zevalin effective October 1, 2002, hospitals could only report this code through December 31, 2002. (Effective January 1, 2003, we combined payment for Zevalin with its administration, using HCPCS codes G0273 and G0274.) Our 2002 claims data are insufficient to allow us to calculate a median cost for Zevalin. Because Bexxar was approved by the FDA in June 2003, it was not billed at all in 2002. Therefore, we cannot determine payment rates for either radiopharmaceutical based on the standard methodology that we use to calculate the other APC relative payment weights and rates. In instances where we lack adequate data upon which to base a payment rate, we have relied wholly or in part on external data as the basis for rate setting. For example, in the absence of claims data, we use data submitted in applications for new technology status to enable us to assign a service to an appropriate new technology APC. Elsewhere in this final rule, we discuss how we are using external data to set 2004 payment rates for certain other services and procedures.

We received information consistent with our request for verifiable data (68 FR 47998) that indicates the payment amounts we proposed for A9522 and A9523 in the proposed rule do not reflect the price for Zevalin that is widely available to the hospital market.

Therefore, we are making final the following payments, effective for services furnished on or after January 1, 2004:

For HCPCS code C1080 (APC 1080) the payment is $2,260;

For HCPCS code C1081 (APC 1081) the payment is $19,565; For HCPCS code C1082 (APC 9118) the payment is $2,260;

For HCPCS code C1083 (APC 9117) the payment is $19,565.

Comment: One commenter expressed concern about the inadequacy of the 2003 payment rate ($2,159) that we established for HCPCS code G3001, Administration and supply of tositumomab, 450mg. The commenter noted that the WAC for unlabeled tositumomab is $2,125, and that a payment amount of $2,159 is not sufficient to pay hospitals for both the acquisition of unlabeled tositumomab and its administration. The commenter was also concerned that packaging the unlabeled antibody tositumomab with its administration and assigning it to an APC that is subject to wage adjustment would result in large payment differences across the country. The commenter noted that the unlabeled antibody rituximab, which is used with Zevalin therapy, is a separately payable drug and therefore not subject to wage index adjustments. The commenter recommended that we either increase the payment rate for G3001 and exempt it from wage adjustment or that we create a new code for unlabeled tositumomab, assign a payment rate that reflects its acquisition cost, and pay separately for its administration using HCPCS code Q0084.

Response: After carefully reviewing the commenter's concerns, we have assigned HCPCS code G3001 to New Technology APC 1522, which has a payment rate of $2,250. Unlabeled tositumomab is not approved as either a drug or a radiopharmaceutical, but is a supply that is required as part of the Bexxar treatment regimen. Therefore, we do not agree with the commenter's recommendation that we assign a separate new code to unlabeled tositumomab. Moreover, administration of unlabeled tositumomab is a complete service that qualifies it for assignment to a New Technology APC. We believe that the increased payment resulting from assignment of G3001 to New Technology APC 1522 will be sufficient to enable hospitals to acquire and administer unlabeled tositumomab, notwithstanding application of a wage adjustment.

Comment: One commenter recommended that we modify the payment amounts for the existing codes used to bill for Bexxar or that we establish new codes to recognize the costs of patient evaluation, education, and clearance for radiation safety purposes as well as the costs of compounding Bexxar by radiopharmacies. The same commenter suggested that, as an alternative to establishing a new code for the costs associated with the procedures required for patient safety and education when Bexxar is used, we allow hospitals to report an appropriate Evaluation and Management code for patient evaluation, education, and clearance when receiving diagnostic or therapeutic services involving radioisotopes.

Response: We disagree with the commenter's recommendation that an additional code is needed to pay for radiopharmacy compounding costs or that an allowance of $1,000 should be added to the payment for the both diagnostic and therapeutic doses of Bexxar to offset these costs. We believe that the rates we are implementing in this final rule, as discussed above, provide sufficient payment for radiopharmacy compounding or delivery costs that hospitals may incur when using Bexxar or Zevalin. We have carefully considered the commenter's recommendation that hospitals be allowed to bill an appropriate evaluation and management code for patient evaluation, education, and clearance following procedures involving radioisotopes. We recognize that special requirements may have to be met before releasing a patient following exposure to a high dose of radiation. We would expect the patient's physician to provide, and bill for separately with appropriate documentation, a significant portion of the preparation and education needed by a patient being treated with Zevalin or Bexxar. However, to the extent that qualified hospital staff are required to provide additional face-to-face patient education and instructions before the patient's release following radioimmunotherapy, the hospital may bill an appropriate evaluation and management code as long as the medical record documents that the services are medically necessary and that they constitute a distinct, separately identifiable evaluation and management service that is consistent with the hospital's criteria for that service.

Drugs and Biologicals for Which Pass-Through Status Will Expire in 2004

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less

than 2 years nor any longer than 3 years. The drugs and biologicals that are due to expire on December 31, 2003 meet that criterion. Table 11 lists the drugs and biologicals for which pass-through status will expire on December 31, 2003.

TABLE 11.—LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES CY 2004

HCPCS	APC	Long descriptor	Trade name	Pass-through expiration date
C9202	9202	Injection, suspension of microspheres of human serum albumin with octafluoropropane, per 3ml.	Optison (single source)	12–31–03
J0587	9018	Injection, Botulinum toxin, type B, per 100 units	Myobloc (single source)	12–31–03
J0637	9019	Injection, Caspofungin acetate, 5 mg	Cancidas (single source)	12–31–03
J7517	9015	Mycophenolate mofetil, oral per 250 mg	CellCept (single source)	12–31–03
J9010	9110	Injection, Alemtuzumab, per 10 mg	Campath (single source)	12–31–03
J9017	9012	Injection, Arsenic trioxide, per 1 mg	Trisenox (single source)	12–31–03
J9219	7051	Implant, Leuprolide acetate, per 65 mg implant	Viadur (single source)	12–31–03

Comment: A commenter requested that we maintain transitional pass-through status for this biological through calendar year 2004. The commenter indicated that Dermagraft was approved as a pass-through device effective October 1, 2000 through March 31, 2001, by which time CMS had concluded that Dermagraft should be classified as a biological for payment purposes. Dermagraft later re-qualified for pass-through status as a biological effective April 1, 2002. The commenter stated that CMS should not count the time Dermagraft was on the pass-through list as a device to determine whether this product received a minimum of 2 years under pass-through status.

Response: We agree with the commenter and will retain Dermagraft in pass-through status through December 2004.

Comment: The manufacturer of an ultrasound contrast agent, Optison (APC 9202, C9202), expressed concern about our decision to retire their product from pass-through status on December 31, 2003. The manufacturer indicated that two of Optison's competitors, Definity (C9112) and Imagent (C9203) will remain pass-throughs in 2004 and receive higher payments, while payment for Optison will be based on median cost calculated from hospital claims data. The commenter was concerned about differential OPPS payments to hospitals for clinically similar products and recommended that we should either allow all of these agents to remain on pass-through status until December 31, 2004, or remove them and use claims data to establish a uniform payment rate for 2004.

Response: As stated above, section 1833(t)(6)(C)(i) of the Act specifies that transitional pass-through payments for drugs and biologicals must be made for at least for 2 years but not more than 3 years. Pass-through payment for Optison was established on April 1, 2001, while Definity and Imagent received pass-through status on April 1, 2002 and April 1, 2003, respectively. Since hospitals have been billing for and receiving pass-through payments for Optison for at least 2 years, we have the statutory authority to remove this item from pass-through status. Since pass-through payments for Definity and Imagent have not exceeded the minimum 2-year period yet, these products will retain their special status in 2004. In the absence of verifiable external data, the 2004 payment rate for Optison was calculated using hospital claims data from April through December 2002 and was eligible for dampening.

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

To the maximum extent possible, our intention is to package into the APC payment the costs of any items and supplies that are furnished with an outpatient procedure. For 2004, we proposed to continue with our policy of paying separately for drugs and radiopharmaceuticals whose median cost per day exceeds $150 and packaging the cost of drugs and radiopharmaceuticals with median cost per day of less than $150 into the procedures with which they are billed. In the proposed rule, we set forth the methodology we used to calculate the median cost per day for drugs, biologicals, and radiopharmaceuticals (68 FR 47996–47997).

We proposed to provide an exception in 2004 to the packaging rule for drugs and radiopharmaceuticals whose payment status would change as a result of using newer data. For 2004, we proposed that:

- Currently packaged drugs and radiopharmaceuticals with median costs per day at or above $150 would receive separate payment in 2004.
- Currently separately payable drugs and radiopharmaceuticals with median costs per day under $150 would continue to receive separate payment in CY 2004.
- Drugs whose pass-through status would expire on December 31, 2003, and whose median costs per day are under $150 would receive separate payment in 2004.
- Currently packaged drugs and radiopharmaceuticals with median costs per day below $150 would remain packaged in 2004.

We requested comments on the methodology we used to determine the median cost per day, on the threshold we proposed to use for packaging drugs and radiopharmaceuticals, and on the proposal to pay separately for drugs and radiopharmaceuticals whose payment status would change based on use of recent claims data and our proposed methodology. We also requested comments on alternatives to packaging.

We received many comments on our proposals, which are summarized below along with our responses.

Comment: We received many comments from patient advocates, individual clinicians, physician and nursing professional associations, individual hospitals, and manufacturers and their representatives that expressed significant concerns over our proposal to continue the 2003 policy under which we package the cost of most drugs, biologicals and radiopharmaceuticals that cost $150 or less. We also received several comments from major provider groups in support of the packaging proposal and recommending a higher threshold. One such organization recommends that we study this issue further to develop a more appropriate long-term solution.

Commenters who disagreed with the proposal to package drugs, biologicals and radiopharmaceuticals costing $150 or less believe that the proposed rates for the drug administration codes do not adequately address the costs of hospitals to administer these drugs. Several commenters conducted their own analyses of this issue in conjunction

with the proposals for drug administration discussed elsewhere in this final rule. For many of these commenters, the issues of packaging, drug payment rates and our discussion of drug administration in the proposed rule were intertwined. Some commenters that disagreed with our $150 packaging threshold asserted that most visits involve delivery of drugs that had been designated as packaged and that overpayment for visits with no packaged drugs is small compared to the overall underpayment of both packaged and separately payable drugs. Particular concern was expressed about the packaging of cancer chemotherapy drugs. One commenter stated that the dosages may vary significantly, and where given in high doses the cost for a single drug alone may exceed the total packaged payment. Also, commenters stated that several packaged drugs are often administered during a single infusion, and where the cost of a single packaged drug may be less than $150 the cost of multiple packaged drugs is often greater than $150.

Several commenters indicated that the methodology and cost data we used to calculate the median cost per day for drugs and radiopharmaceuticals were based on incorrectly coded claims where the wrong number of units were reported and a very limited number of single claims were captured which failed to portray the hospitals' charges appropriately. Therefore, certain high cost items fell below the $150 threshold.

Commenters expressed concern about patient access to effective but lower cost drugs and the disincentive we may create by paying separately for those over $150 per day. One organization stated that cancer centers have reported that they have taken or are considering steps to restrict patient access to those drugs that we have packaged. One hospital estimated that it would lose approximately $490 per visit for a patient receiving chemotherapy due to the $150 packaging rule and the proposed reductions in payments for certain drugs. While some commenters expressed general concerns about packaging the costs of any drugs, biologicals or radiopharmaceuticals, other commenters recommended that we apply a $50 threshold in lieu of the proposed $150 threshold in determining which items to pay for separately. Some of the commenters recommending a $50 threshold cited statutory changes under consideration by Congress that would mandate a $50 threshold.

Response: For 2004, we have established a $50 median cost per day threshold in determining whether drugs, biologicals and radiopharmaceuticals will be packaged. Those items that fall below the threshold will be packaged into the costs of the service or procedure with which they are billed; those items with median costs above the threshold will be paid for separately in 2004.

We analyzed our data in determining our final drug administration coding and payment policy, as discussed elsewhere in this final rule, and reviewed the median costs of all APCs under both a $150 and a $50 packaging rule. We concluded that there was not a sufficient difference in the median costs under those two scenarios, resulting in inadequate payment when drugs, biologicals and radiopharmaceuticals costing between $50 and $150 would be used by the hospital. Therefore, we agree with the majority of commenters that, for 2004, the appropriate threshold should be $50.

We also recognize, as several commenters did, that packaging creates incentives for hospital efficiencies and will continue to apply that concept to devices, most supplies and equipment associated with a procedural APC, and low cost drugs. However, we are convinced that under our current methodology for establishing relative weights, that packaging drugs, biologicals and radiopharmaceuticals costing in excess of the $50 threshold per patient per day would not provide adequate payment in 2004 and could adversely affect beneficiary access to important therapies. Nevertheless, our final decision for 2004 does not mean that a change in our methodology for establishing relative weights in the future could not cause us to revisit our packaging policy in the future. Since we have lowered the packaging threshold from $150 to $50, we will not adopt the proposal to provide an exception to the packaging rule for drugs and radiopharmaceuticals whose payment status would change from 2003 to 2004 as a result of using newer 2002 data.

However, we note several exceptions to our policy of packaging drugs, biologicals and radiopharmaceuticals for which the median per day cost is less than the $50 threshold. As discussed elsewhere in this final rule, we will allow separate payment under the OPPS for all blood and blood products and for single indication orphan drugs. We will also allow separate payment for hepatitis B vaccine under the OPPS. While the median per day costs for several hepatitis B vaccine codes fell below the $50 threshold using the final rule data, we believe that continued separate payment for these codes is warranted given the special, separate benefit category established by Congress. Separate payment for influenza and pneumococcal vaccines will continue to be made outside of the OPPS on a reasonable cost basis.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals That Are Not Packaged

In order to establish payment rates for separately payable drugs and radiopharmaceuticals for the 2004 OPPS, we first determined median cost for each drug and radiopharmaceutical per unit. When we compared the median cost per unit used for determining the 2003 payment rate (for example, the true or dampened median cost) for separately payable drugs and radiopharmaceuticals with their 2004 median cost per unit, we found fluctuations in costs from 2003 to 2004.

We solicited comments concerning the reasons for the fluctuations in median costs from 2003 to 2004. We stated our interest in determining whether these fluctuations reflect changes in the market prices of these drugs and radiopharmaceuticals or problems in the hospital claims data (for example, inaccurate coding, improper charges) that we use for setting payment rates.

In the proposed rule, we discussed in detail several options we considered to address the fluctuations in median costs for separately payable drugs and radiopharmaceuticals (68 FR 47997–47998). The option that we proposed for 2004 was a variation of the methodology used for the 2003 OPPS. For separately payable drugs and radiopharmaceuticals whose 2004 median costs decreased by more than 15 percent from the applicable 2003 median cost, we proposed to limit the reduction in median costs to one fourth of the difference between the value derived from claims data and a 15 percent reduction (for example, for a drug whose cost decreased by 35 percent from the applicable 2003 median cost, the allowed reduction from 2003 to 2004 would be 15 percent + (¼ times 35 − 15) percent = 20 percent). For separately payable drugs and radiopharmaceuticals whose median costs decreased by less than 15 percent from 2003 to 2004, we proposed to establish their payment rates using the median costs derived from the 2002 claims data. We stated that, based on more complete claims data we expected to have for the final rule and on the comments from the public, we would re-evaluate the appropriateness of adjusting median costs for drugs for which median costs would decline in 2004.

We also proposed a separate payment policy for drugs, biologicals, and radiopharmaceuticals for which generic alternatives have been approved by the Food and Drug Administration (FDA) between October 2001 and December 2002.

We solicited comment on both our proposed methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004. We requested that commenters who disagree with the proposed rate for a drug or radiopharmaceutical submit verifiable information to support their opinions that the proposed rate is inaccurate and does not reflect the price that is widely available to the hospital market.

We received a number of comments on our payment methodology options for separately payable drugs, biologicals, and radiopharmaceuticals. Those comments are summarized below along with our responses.

Comment: We received a number of comments noting disagreement with the proposed payment rates for separately paid drugs, biologicals and radiopharmaceuticals overall. Many of these comments were included in the comments on our packaging proposal, summarized above, and expressed some of the same concerns, such as restrictions to patient access, particularly to cancer chemotherapy drugs. One hospital commenting on the proposed rates stated that, as with most hospitals, they continually attempt to leverage buying power to reduce the costs of drugs but, like most hospitals, have been unable to do so for certain drugs. Commenters asked that we critically review the data used to establish the payment rates including consideration of the charge compression issue. Commenters stated that the proposed payments would not cover the direct acquisition costs of certain items.

A number of commenters objecting to our proposed payment rates stated that the hospital data that we use to calculate those rates are flawed and that the methodology we employ to convert hospital claims data to relative weights is problematic. Commenters attributed these concerns to issues such as hospital billing practices that result in inaccurate reporting of units or charges, HCPCS coding changes, and the use of cost-to-charge ratios across all products regardless of whether an item is high or low cost.

We received numerous comments on alternatives to our proposed policies for separately payable drugs and radiopharmaceuticals. One commenter suggested that we pay the amount of the hospital's acquisition cost plus an additional 25 percent to pay for costs of receiving, processing and storing the items. Other comments suggested that we limit the decreases for all separately paid drugs to a reduction of 10 percent in the payment rates, as we proposed for blood and blood products, instead of our proposed policy of limiting reductions in median costs for those separately paid items with median costs with reductions greater than 15 percent. Another suggestion was that we establish a payment rate floor for a product that could be raised if a manufacturer submitted information demonstrating that the rate should be higher than the floor.

Several commenters indicated that we should use only claims that have the appropriate administration or procedure code and the HCPCS code for a particular drug or radiopharmaceutical when determining the median cost for that drug or radiopharmaceutical. One commenter recommended that we pay for drugs and biologicals at 95% AWP to standardize payments for drugs and biologicals across different practice settings. Another commenter requested that we establish payment floors that are equal to those in the pending Congressional Medicare legislation (for example, certain sole source drugs would be paid at least 88 percent of AWP in 2004); whereas another drug manufacturer recommended that we use the Federal Supply Schedule price plus a certain percentage (for example, 12.5 percent) as an absolute minimum payment amount for drugs and radiopharmaceuticals.

In addition to the comments regarding our proposed payment rates for drugs, biologicals and radiopharmaceuticals overall, we received comments concerning the proposed rate for specific items. For a few of those items, we received external cost data that met the preferred criteria we set forth in our proposed rule (for example, non-proprietary data that demonstrates actual, market-based prices at which a broadly-based national sample of hospitals were able to procure the item). Several commenters suggested that we substitute external data on hospital acquisition cost for median costs calculated from our claims data when determining the payment rate for drugs and radiopharmaceuticals for which we have received such data. Others recommended that we use external data to benchmark payment for drugs and radiopharmaceuticals and make appropriate adjustments to the proposed 2004 payment levels. Even though most commenters supported the use of external data in place of hospital claims data, a national hospital association expressed concern about the use of external data in OPPS. The commenter indicated that if external data is used for rate setting in 2004, then we may have to continue to collect data on acquisition cost for future years to be able to continue to adjust the weights. Instead, the commenter was supportive of using claims data to set payment rates without the use of external data and urged us to remain committed to the averaging process inherent in the prospective payment system.

Response: We have decided to adopt the general principle proposed in our August 12, 2003 proposed rule limiting the reduction in median costs to one-fourth of the difference between the value derived from our claims data and a 15 percent reduction. For example, a drug whose median cost decreased by 35 percent from the median cost used to establish the separate payment rate for 2003 would be 15 percent + (¼ times 35–15) percent, or 20 percent. However, we will not apply this methodology to the medians of those drugs, biologicals and radiopharmaceuticals that are packaged in 2003 but for which we will allow separate payment in 2004. Payment for drugs, biologicals and radiopharmaceuticals that emerge from packaged status in 2004 because their median per day costs are greater than $50 per day will be based on the unadjusted median cost derived from our April–December 2002 claims data. Since these items are packaged in 2003, we did not calculate any adjusted medians on which to base their payments on for 2003. Thus, we are unable to determine the extent to which their median costs fluctuate from 2003 to 2004.

As discussed in our proposed rule and elsewhere in this final rule, we used a more complete set of claims for the April–December 2002 claims period and the most recently submitted cost report data to calculate median costs for all currently separately paid drugs, biologicals and radiopharmaceuticals. Our analysis of the later and more complete data revealed that a number of these items continued to experience a decline of more than 15% in median cost. We again considered several options to address the fluctuations in medians, which for some items would result in wide fluctuations in payments to hospitals. One option was to do nothing to adjust for the fluctuations; another option was to apply a more modest give-back (for example, 50 percent instead of 75 percent, after allowing for the 15 percent reduction.) We also considered the comments we received on drug payments in general and for specific items.

We did not adopt the options that would allow no adjustments for items separately paid in 2003 where the costs declined because we were convinced by the many commenters on this topic that such fluctuations create problems for the hospitals. We were also convinced by the commenters that a less generous give-back, such as 50 percent, would not adequately address the very real concerns about patient access to some of these drugs, particularly for cancer chemotherapy. We believe that, for the majority of items paid separately in 2003 for which the more recent hospital data indicates a reduction in excess of 15 percent, the adjustment methodology we proposed and that we are adopting for this final rule provides an adequate buffer for the hospitals against dramatic fluctuations in payment amounts while at the same time not significantly affecting the budget neutrality scalar applied to the relative weights for all services.

We believe that either the use of our unadjusted medians or, where applicable, a median adjusted to limit reductions greater than 15 percent methodology, will not adversely impact beneficiary access. However, we were convinced by the external data meeting our preferred criteria and the related comments that we received for several items, the payment rates resulting from our data alone could provide a disincentive for hospitals to provide these particular therapies. Therefore, we have determined that we will use this credible and relevant external data to establish a median cost for the following items listed in table 15. For these items, as with the few device-related APCs for which we are considering external data, we have calculated an adjusted median cost by blending the median cost derived from our dampening methodology with the cost data from the external sources on a one-to-one ratio.

TABLE 12.—LIST OF DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS FOR WHICH BLENDED DATA WERE USED TO DETERMINE 2004 PAYMENT RATES

APC	HCPCS	Short descriptor	2004 adjusted median cost	External acquisition cost	2004 1:1 Blended median cost
0909	J1825	Interferon beta-1a	$159.16	$231.25	$195.21
9022	Q3025	IM inj interferon beta-1a	53.05	77.08	65.07
0902	J0585	Botulinum toxin a	2.86	3.92	3.39
7000	J0207	Amifostine	241.95	369.49	305.72
1624	Q3007	Sodium phosphate p32	49.18	100.00	74.59
1625	Q3008	Indium 111-in pentetreotide	400.41	550.00	475.21
1305	C1305	Apligraf	659.55	1,077.57	868.56

We note that we also received external data for other items, which we did not use for rate setting. In those cases, we determined the data was not reliable because the data did not meet the preferred criteria set forth in the August 12, 2003 proposed rule.

Comment: One commenter raised a concern about our proposal to limit reductions in the median costs of non-pass-through drugs and biologicals to one-fourth of the difference between the actual decline and 15% less than the 2003 adjusted median. While expressing support for an initiative that reduces significant fluctuation in APC payment rates from one year to the next, the commenter expressed uncertainty about the size of the reduction limitation and suggested that CMS consider a less generous dampening approach since the budget-neutral dampening would negatively affect other APCs.

Response: While we believe that a general limitation on reductions in payments for certain drugs and biologicals is warranted for reasons discussed elsewhere in this final rule, we also recognize the commenter's concerns about the effect that such a policy would have on other APCs. We have decided to address the commenter's concern by placing an upper limit on adjustments to the median costs used to calculate the 2004 payment rates. We believe that it is reasonable to place such an upper limit on the dampening so that the resulting adjusted median is no greater than 95 percent of AWP or the 2004 unadjusted median. We reviewed the drugs, biologicals, and radiopharmaceuticals whose median costs decreased by more than 15 percent from 2003 to 2004. We then compared the adjusted median (after dampening) to 95 percent of AWP for each of the items. In cases where 95 percent of AWP was higher than the adjusted median, we capped the adjusted median at a value that was the higher of 95 percent of AWP or the 2004 unadjusted median. The 95 percent of AWPs for these drugs and radiopharmaceuticals were calculated using AWP values from the Redbook that were effective as of April 1, 2003. We reviewed the drugs, biologicals, and radiopharmaceuticals whose median costs decreased by more than 15 percent from 2003 to 2004. We then compared the adjusted median (after dampening) to 95 percent of AWP for each of the items. In cases where 95 percent of AWP was higher than the adjusted median, we capped the adjusted median at a value that was the higher of 95 percent of the AWP or the 2004 unadjusted median. The drugs, biologicals, and radiopharmaceuticals affected by this policy are listed in the table below.

TABLE 13.—ITEMS WHOSE 2004 ADJUSTED MEDIANS ARE CAPPED AT THE HIGHER OF 95 PERCENT OF AWP OR THEIR 2004 UNADJUSTED MEDIAN

APC	Description	2004 adjusted median	95% AWP	2004 unadjusted median
1095	Technetium TC 99m depreotide	$216.26	$40.00	$17.18
0820	Daunorubicin	89.80	78.14	65.81
0961	Albumin (human), 5%, 50 ml	41.86	15.31	16.15
0963	Albumin (human), 5%, 250 ml	204.03	58.00	62.83
0964	Albumin (human), 25%, 20 ml	46.10	15.31	21.86
0965	Albumin (human), 25%, 50 ml	114.36	30.63	51.12

4. Payment for Drug Administration

In order to facilitate accurate payments for drugs and drug administration, we considered whether to make several changes in our current payment policy with regard to payment for Q0081, Q0083, Q0084, and Q0085.

We proposed to continue our current policy of packaging drugs and radiopharmaceuticals that cost less than $150 per episode of care into the APC with which they are associated (for example, nuclear medicine scans, drug administration).

In the proposed rule, we presented data that showed that paying based on a median cost for the APC for each of the four current codes generally results in underpayment when packaged drugs are billed on the claim and overpayment when separately paid drugs are billed on the claim. In the proposed rule we discussed our data analysis in detail. We also discussed four alternatives to the current codes and APC payments in detail (68 FR 47999–48003). In summary, the 4 alternatives presented were:

1. Maintain the current codes and APCs with payments based on the median costs of all claims in the APC.

2. Eliminate the four current codes and create eight new codes to enable hospitals to report that they administered a packaged drug or a separately paid drug. We would pay a different APC amount for each of the eight new codes. The new code descriptors would parallel those of the current codes. This would retain the concept of using one code rather than two when both ''infusion'' and administration of chemotherapy by ''other than infusion'' occurred (as exists under the current codes). Coders would have to look up the drugs administered to know which code to bill.

3. Eliminate the four current codes and create six new codes to enable hospitals to report that they administered a packaged drug or separately paid drug and pay a different APC amount for each of the six new codes. In this option, no code equivalent to Q0085 would exist. Therefore, when administering chemotherapy by ''infusion'' or ''other than infusion,'' hospitals would report two codes, one for administration by ''infusion'' and one for administration by ''other than infusion.'' This would eliminate the need to use one code when both infusion and another method of administration of chemotherapy occurred. Coders would have to look up the drugs administered to know which code to bill.

4. Retain three of the current codes (Q0081, Q0083, and Q0084) but delete Q0085 (infusion and other administration of chemotherapy) and modify the OCE to use the drugs billed on the claim to assign an APC for packaged drugs or an APC for separately paid drugs. No drug administration code could be paid without a drug also being reported on the claim. We solicited comments on each of the options in the proposed rule.

For 2004 OPPS we will continue the use of Q0081, Q0083 and Q0084 to pay for drug administration, for both packaged drugs and separately paid drugs. These drug administration codes will continue to describe the administration of drugs per visit. As recommended by the APC Panel, we will cease to make payment under OPPS for Q0085 and will instead permit the services described by Q0085 to be billed using both Q0083 and Q0084. We believe that this will result in appropriate payment for drug administration because for 2004 OPPS we will pay separately for drugs for which the per day median cost is in excess of $50 per day.

Comment: Commenters stated that appropriate payment for drug administration is very important but the options provided for making changes would be extremely burdensome and cannot be done for 2004, if ever. They indicated that the risk of incorrect coding and the adverse consequences of incorrect coding for options 2, 3 or 4 are severe and that the payment changes do not justify the change in codes or policy. Commenters indicated that options 2–4 would increase operational costs that would eliminate any benefit from higher payments; decrease accuracy of coding for drug administration; increase improper payments due to decreased accuracy of coding; increase inaccuracies in claims data due to decreased accuracy of coding. The commenters indicated that they believe that there were many errors in the addenda (Addenda L, M, N, O, P, and Q) in the proposed rule that would be used for option 4 and that it would be virtually impossible to create mutually exclusive lists of drugs as would be required to implement option 4.

Commenters indicated that they believed the options as presented in the NPRM would violate the HIPAA requirements that the same service be coded the same way for all payers. They urged CMS to eliminate the Q codes for drug administration and in favor of use of the CPT codes to code drugs administration. Commenters asked that CMS engage the APC Panel in a discussion of the best way to code drug administration.

One of the commenters indicated that its analysis showed that options 2, 3 or 4 have considerable financial risk for Medicare. Specifically, the commenter indicated that its analysis revealed that option 2 would result in additional payments of $107.1 million for 2004. A commenter asked that CMS create a task force to study the most appropriate methodology for payment for drug administration and for setting payment rates. A commenter supported option 4, which would continue the current coding and map the combination of a drug administration code and drug codes to the appropriate APC. One commenter suggested that we continue the current coding for drug administration, set payment rates at the packaged drug rate for the APC but offset the payment by the difference if no appropriate drug is billed for the same date of service. The commenter indicated that this would simplify the coding and the payment for drug administration and should result in greater accuracy of payment. A commenter supported options 2 or 3 as the most accurate for payment of drugs furnished in the emergency department.

Response: For the reasons discussed earlier in this section, for 2004, CMS will continue use of Q0081, Q0083 and Q0084. Q0085 will not be recognized as a valid OPPS code for 2004. Instead, when a hospital furnishes chemotherapy infusion and chemotherapy via another route, the hospital will bill and be paid for both Q0083 and Q0084. Coding for drug administration is discussed in greater detail below in the context of other comments.

As discussed in elsewhere in this final rule, for 2004, CMS will pay separately for all drugs, biologicals and radiopharmaceuticals that have a per day median cost in excess of $50. Therefore, only drugs, biologicals and radiopharmaceuticals that have a per day median cost of $50 or less will be packaged into the payment for the services. Therefore, the payment for drug administration codes Q0081, Q0083 and Q0084 will be based on the median costs for drug administration with only drugs having a median per day cost of $50 or less packaged into the cost of the administration code. We believe that separate payment for drugs with a median cost in excess of $50 will result in the drug administration codes being paid more accurately and will result in more equitable payment for both the drugs and their administration.

Edits To Ensure Correct Billing for Drugs

Comment: A commenter asked that CMS create a series of edits in the OCE that would facilitate the collection of better data on drug costs and drug administration. Specifically, the commenter wants the OCE to edit out claims where a drug administration code is billed with no drug code on the claim; where a chemotherapy drug administration code is billed with a revenue code 25X and no specific HCPS code; and where multiple units of a drug administration code are billed on the same line.

Response: We will consider what edits may be appropriate for inclusion in the OCE with regard to drug administration to facilitate collection of better data. However, we are concerned that edits of the type requested by the commenter may both impose greater billing burden on hospitals and create complexities that could delay claims processing.

Discounting of Non-Chemotherapy Administration

Comment: Commenters indicated that no multiple procedure reduction should be applied to Q0081 (infusion of drugs other than chemotherapy) or its successor codes under any of the options. They indicated that payment is already too low to cover the cost of the infusion and that reducing it further when there are more costly procedures on the claim will only further under pay the service.

Response: We have retained the status indicator of ''T'' for Q0081. This status indicator means that the code will be reduced by 50 percent if it is the lower priced service on the same claim with another procedure with the status indicator ''T''. In most cases, we expect that this reduction would occur when there is a separate procedure performed on the same day as the infusion and that there will be significant efficiencies in administering an infusion. If the infusion is performed by itself or with a visit, or with a service with status code ''S'', the multiple procedure reduction will not apply.

Payment for Drug Administration on a Per Day Versus a Per Visit Basis

Comment: Commenters indicated that it would be incorrect to revise the definition of the drug administration codes to be per day instead of per visit, as they are currently defined. They referred to many cases in which it is necessary for a patient to have more than one administration of non-chemotherapy drugs in a day and that hospitals should be able to bill multiple units of the applicable code when that occurs. They noted that the APC Panel supported this view with regard to Q0081, infusion of non-chemotherapy drugs. They asked that CMS provide explicit instructions regarding billing for drug administration and ensure that fiscal intermediaries are bound to comply with the national instructions. One commenter asked that CMS create modifiers or specific HCPCS codes to reflect administration of multiple chemotherapy agents during a single session and that CMS permit payment for more than one chemotherapy administration on the same day of service, with a new modifier to reflect truly separate administrations.

Response: We acknowledge the commenters' concerns about our proposal to change the drug administration codes from a per visit basis to a per day basis and have not revised the definition of the drug administration codes from per day to per visit.

CPT Codes for Drug Administration

Comment: Many commenters suggested that CMS should delete the HCPCS alphanumeric codes for drug administration and should use existing CPT codes. They indicated that the APC Panel supports this change and that it would be less burdensome for providers than using the HCPCS alphanumeric codes. One commenter presented a crosswalk that could be used to pay under the current drug administration APCs while permitting hospitals to bill using CPT codes. A commenter indicated that hospitals already maintain start and stop times for infusion therapies and that, therefore, the use of CPT codes for infusion would not be more burdensome than the current HCPCS codes.

Response: For the reasons discussed earlier in this section, for 2004 OPPS, administration of infusion of non-chemotherapy drugs, infusion of chemotherapy drugs and administration of chemotherapy by other than infusion, will continue to be billed and paid based on Q0081, Q0083 and Q0084. However, we take seriously the requests of the commenters and the APC Panel that we should use the CPT codes to pay for drug administration. We will seriously consider the crosswalk submitted and will discuss it with the APC Panel at its winter meeting. We also will pursue a means by which the existing data from 2003 hospital claims, which exist only for the Q codes, which are per visit, can be used to pay for services billed under the CPT infusion codes, which are on a per hour basis.

Elimination of Q0085 Chemotherapy Administration by Both Infusion and Other Technique

Comment: Several commenters supported elimination of Q0085 and the continued use of Q0083 and Q0084 in place of Q0085.

Response: As indicated above, we will no longer recognize Q0085 for payment of drug administration services for 2004. The code could not be deleted from HCPCS because the 2004 HCPCS was complete before the NPRM comment period closed. Instead, hospitals will bill and be paid for both Q0083 and Q0084 when they furnish chemotherapy by both infusion and another route.

Charge Compression Reduction Through Revenue Code Requirements and Expansion of Revenue Codes

Comment: A commenter indicated that CMS could reduce charge compression effects by requiring hospitals to do detailed coding of drugs using the most specific categories of revenue codes. The commenter indicated that CMS would also need to create additional revenue codes to collect more specific information. The commenter indicated that collection of drug charge information at such detailed levels would both reduce charge compression and give CMS more information when determining which drugs to package to specific drug administration services.

Response: CMS will not require that specific revenue codes be used for drugs and will not ask the National Uniform Billing Committee to create additional revenue codes to collect more specific information. Revenue codes exist for hospital accounting purposes and, in general CMS does not require that particular services be billed with particular revenue codes. We are not convinced that adding specific requirements for revenue coding or expanding the revenue codes to acquire more specific information will result in better data or that the end result would be cost effective in terms of its potential effect on hospital operations. We believe that such requests to the NUBC should be generated by the provider community if it believes such changes would be in their overall best interest.

Request for Clarification of Instructions

Comment: Commenters said that CMS needs to develop and issue clear national instructions on how drug administration in the OPD should be billed and to ensure that fiscal intermediaries all comply uniformly with the instructions. They said that in the absence of national instructions,

fiscal intermediary medical directors have developed and enforced local medical review policies that vary considerably from one another, resulting in very different interpretations of how services should be billed and of the amount of payment for the same set of circumstances. They specifically recommend that we address issues including how often drug administration codes can be billed in a day, billing for piggyback infusions, how to bill units of service, billing for pain control pump services, double infusions, and use of chemotherapy administration codes for patients with non-cancer diagnoses. The commenter also asked for clarification of the use of 90782 (IM injection) and 90784 (IVP injection) when used for sedation before surgery, Q0081 when used to keep a vein open, and Q0083 with regard to whether it should be billed each time a chemotherapy drug is administered. A commenter also asked that CMS clarify whether HCCPS codes Q0081, Q0083, Q0084 and Q0085, CPT codes 90783, 90784 and 90788 may be billed more than once per visit. The commenter indicated that CMS previously said that CPT codes 90782–90788 may be billed separately for each injection and asked if this is a change to CMS policy in this regard.

Response: CMS will develop program instructions regarding how the drug administration codes should be used. We will attempt to address the specific questions identified in the comments in the course of developing those instructions. When the instructions are issued, they will be binding on all Medicare fiscal intermediaries under their contract with CMS. In the absence of national instructions, Medicare fiscal intermediaries have authority to develop local medical review policies governing billing, coverage and payment.

With regard to the issue of how often in a day Q0081, Q0083 and Q0084 may be billed, each of these codes is to be used to report all services in a single visit, regardless of the number of drugs administered during that visit. Therefore, if two chemotherapy drugs are administered by intravenous injection and 3 chemotherapy drugs are administered by infusion, the hospital would bill 1 unit of Q0083 and 1 unit of Q0084. A second unit of either code would only be billed if the patient left the OPD after completion of the first administration and then returned later for a separate encounter for administration of another chemotherapy drug. If the patient leaves the OPD and returns later in the day suffering from dehydration and requires infusion of fluids and infusion of antiemetics, the hospital would bill Q0081 for those services. If the patient returns later in the same day for another infusion of one or more chemotherapy drugs that could not be administered at the earlier infusion for medical reasons, the hospital may bill 2 units of Q0084.

CPT codes 90782–90788 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

As indicated above, drugs for which the median cost per day is greater than $50 are paid separately and are not packaged into the payment for the drug administration codes with which they are billed. *See* Addendum B for the 2004 OPPS payment amount for separately paid drugs, which are indicated with both payment amounts and status indicator ''K.''

Proposed Payment Rates for Drug Administration

Comment: Commenters indicated that the proposed payment rates for drug administration are too low to adequately compensate hospitals for the costs of packaged drugs. They indicated that there is some confusion over the resultant decrease in drug administration medians after low cost drugs ($50–$150) were packaged into the drug administration codes. The expectation was that the addition of the drug costs would result in increases. Moreover, they stated that the payment rates for drug administration services that include drugs that cost $50 to $150 per day, are so low that none of the rates are adequate to cover cases for which multiple drugs of $100 each are administered.

A commenter who is particularly concerned with immunosuppressive drugs that are needed by beneficiaries following organ transplants, indicated that in 2000, Congress directed the Secretary of HHS to prepare a report to Congress containing recommendations regarding a cost effective way of providing coverage for immunosuppressive drugs to promote the objectives of improving health outcomes by decreasing transplant rejection rates attributable to failure to comply with immunosuppressive drug therapy and to achieve Medicare cost savings by preventing the need for secondary transplants and other care related to post transplant complications (Pub. L. 106–113). The commenter believes that packaging transplant drugs into the payment for drug administration and the proposal of such a low amount of payment defeats Congress's stated intention in this case and will decrease beneficiary access to immunosuppressive drug therapy following transplant surgery.

Response: We believe that making separate payment for both the procedure and drugs for which there is a median per day cost in excess of $50, will result in appropriate payment for the procedure with which the drug is billed. In the case of the HCPCS codes for administration of drugs per visit (Q0081, Q0083 and Q0084), compared to the proposed payments published in the NPRM, payments for the procedures do not decline by much when calculated without packaged drugs that have medians of $50 to $150. Therefore, we believe that total payments will be more appropriate for these drugs in 2004.

With respect to post-transplant immunosuppressive drugs, we would note that take-home supplies of such drugs are billed to the Durable Medical Equipment Regional Carriers and paid for separately outside of the OPPS. To the extent that such drugs fall below the $50 median cost per day, we expect the frequency of administration in the hospital outpatient setting to be low.

Coding for Drugs

Comment: A trade association representing drug manufacturers supported our proposal to require hospitals to report individual codes for all drugs, including those that are packaged, on the grounds that it would improve the quality of our data. Most commenters representing hospitals and hospital associations opposed the proposal. They indicated that the operational impact on hospitals would be significant, if we were to implement such a requirement. It would take a year or more to update chargemasters and train staff, and many more codes would have to be established for drugs that are administered but not identified in the current HCPCS. Hospitals and hospital groups did not support detailed reporting of routine, low cost drugs and supplies that are currently reported only using a packaged revenue code. A commenter stated that if CMS were to choose to require drug and/or device coding, CMS should give hospitals at least a year to prepare to implement the requirement and work with hospitals to identify all drugs and devices that would require codes, develop HCPCS codes with dosage descriptions that match the administered or purchased dose, assign HCPS to all administered drugs, clarify reporting of self-administered drugs and drugs considered integral to a procedure under OPPS, and identify applicable drugs and devices in hospital

chargemasters. Commenters indicated that the use of ''unclassified drugs'' and ''unclassified biologicals'' would increase if hospitals are required to bill all drugs and that such a requirement would result in less reliable data for CMS at great cost to hospitals, with no measurable benefit. Some commenters indicated that the use of unclassified codes would create significantly more work for hospital staff and Medicare contractors. One commenter was concerned that this requirement would force hospitals to contort internal ordering and billing systems in order to match HCPCS codes to unrelated packaged dosage amounts, thereby significantly increasing the potential for error in the administration of drugs and putting patient safety at risk.

Response: Because we are not implementing any of the new drug administration coding requirements that we proposed, the need for more detailed drug coding is removed. Therefore, we are not requiring hospitals to report with a HCPCS code every drug that is administered to a patient. However, in order to receive payment for a drug for which a separate payment is provided, hospitals will have to continue to bill for the drug using revenue code 636, ''Drugs requiring detail coding,'' and report the appropriate HCPCS code for the drug. Drugs for which separate payment is allowed are designated by status indicator ''K'' in Addendum B. Hospitals should continue to bill for packaged drugs, which are assigned status indicator ''N,'' using any of the drug revenue codes that are packaged revenue codes under the OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633. Hospitals are not required to use HCPCS codes when billing for packaged drugs, unless revenue code 636 is used. Although we are not requiring hospitals to report HCPCS codes for packaged drugs, it is essential that hospitals continue to bill charges for packaged drugs by including the charge for packaged drugs in the charge for the procedure or service with which the drug is used, or as a separate drug charge (whether or not it is separately payable). Reporting charges for packaged drugs is critical because packaged drug costs are used for calculating outlier payments and are also identified when we calculate hospital costs for the procedures and services with which the drugs are used in the course of the annual OPPS updates.

Comment: Several commenters recommended that CMS establish a unique revenue code for radiopharmaceuticals that hospitals would be required to use when reporting all radiopharmaceuticals, whether packaged or separately payable. They indicated that establishing a unique revenue code would assist CMS in tracking costs for the radiopharmaceuticals and contribute to more accurate cost data collection.

Response: We do not establish revenue codes. Rather, the National Uniform Billing Committee (NUBC) receives and considers such requests from multiple sources, including providers and other members of the public. While we continue to examine cost-to-charge and cost compression issues, we will consider whether such an approach would assist CMS in refining our methods of establishing relative weights. We would also note that the commenters and other interested parties may also request that the NUBC consider the creation of new revenue codes.

Comment: Several commenters expressed concern about the frequent coding changes implemented for radiopharmaceuticals over the past two years. They recommended that CMS revise the HCPCS coding descriptors for products that do not currently have ''per dose'' or ''per study'' descriptors to reflect the products as they are administered to the patient. They emphasized that creating these new descriptors and corresponding payment rates will improve data collection and help to ensure equitable payment to hospitals.

Response: We recognize the concerns expressed by these commenters. However, we are striving to achieve stability in descriptor changes, and we believe that in changing descriptors to ''per dose'', we will lose specificity with respect to the data we will receive from hospitals. We are not convinced that there is a programmatic need to change the radiopharmaceutical code descriptors to ''per dose'' and that our claims data are problematic for setting payment rates for these products; however, we will continue to work with industry representatives to ensure that the current HCPCS descriptors are appropriate and review this issue in the future, if needed. Furthermore, we stress the importance of proper coding by providers so that we can get accurate data for future rate setting.

Comment: One drug manufacturer urged CMS to advise hospitals that it is appropriate for them to set charges for drugs submitted to Medicare for OPPS services so that the charges reflect actual product costs when charges are multiplied by hospital and cost-center-specific ratios of cost-to-charges. The commenter also requested CMS to not rely on data obtained in the absence of such advice. A comment from a national hospital organization, however, advised CMS to permit hospitals to continue to establish their charge structures and mark-up policies separate and apart from CMS's payment policies. The commenter indicated that only in this manner would prospective payments appropriately reflect general trends in charges and mark-ups across all hospitals.

Response: We do not regulate what hospitals charge for hospital services and will not advise hospitals regarding how to determine the charge for an item or service. Hospital charges have fundamental uses and the use of charges to determine relative costs for OPPS should not be the determining factor in how a hospital sets its charge for any item or service. The OPPS is a system based upon the relative costs of services and these costs are developed by applying the hospital's most recent cost to charge ratio to the charges of the hospital for the item. While we recognize that the system is imperfect, we believe that on average, it results in appropriate relative weights. However we recognize that on occasion, this is not true and therefore, as discussed elsewhere, we have used external data where we believe that the median derived from claims data does not appropriately reflect the relative cost of the item or service.

Comment: One commenter requested that we change the status indicator for HCPCS code J7599 (Immunosuppressive drug, not otherwise classified) from ''E'' to ''N'' so that new immunosuppresives can be identified on claims forms as a separate line item until a unique pass-through ''C'' code can be assigned to the product.

Response: We agree that the status indicator for J7599 should be ''N'' and have made that change for CY 2004. As for other new drugs and biologicals, interested parties may submit an application for pass-through status for new immunosuppressives.

Coding for Drugs Billed as Supplies

Comment: Commenters said that CMS significantly complicated the issue of billing for drugs when it indicated that drugs that are an integral part of the procedure should be billed as supplies (revenue code 270) rather than as pharmaceuticals (revenue code 250).

Response: We did not issue instructions to require that drugs that are an integral part of a surgical procedure be billed using revenue code 270 (supplies) rather than revenue code 250 (pharmaceuticals). Rather, we instructed hospitals to report drugs that are treated as supplies because they are

an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs. (See section XXIV.D of Transmittal A–02–129, issued on January 3, 2003.)

In general, supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code. The charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

Correct Coding Initiative Edits

5. Generic Drugs, and Radiopharmaceuticals

In general, hospital acquisition costs for drugs, biologicals, and radiopharmaceutical agents with generic competitors are lower than the acquisition costs for sole source or multi-source drugs. In order to ensure that Medicare recognizes these lower costs in a timely manner, we proposed a new method of calculating payment amounts for drugs, biologicals, and radiopharmaceuticals that are separately paid under the OPPS and for which the Food and Drug Administration (FDA) has recently approved generic alternatives.

Because many hospitals have long term purchasing arrangements for drugs and radiopharmaceuticals, we believe that there is generally a 12-month lag between the time that generic items are made available and when our claims data will accurately reflect the costs associated with the availability of the generic alternative. Therefore, during the interval between FDA approval of a generic item and the time when we would reasonably expect claims data to reflect the cost of generic alternatives, we proposed to adopt the following methodology to price the affected drugs, biologicals, and radiopharmaceuticals under the OPPS.

We proposed to identify items approved for generic availability by the FDA during the 6 months before the first day of the claims period we use as the basis for an annual OPPS update. Where we determine that our claims data do not reflect the costs of generic alternatives for a separately payable drug, biological, or radiopharmaceutical, we proposed to base our payment rate on 43 percent of the AWP for the drug, biological, or radiopharmaceutical.

To apply this payment methodology to the 2004 OPPS update, we reviewed FDA approvals for generic drugs, biologicals, and radiopharmaceuticals issued between October 2001 and December 2002. We found six drugs, which we proposed to be separately paid under the 2004 OPPS that had generic alternatives approved during that time. These drugs are: Daunorubicin, Bleomycin, Pamidronate, Paclitaxel, Ifosfomide, and Idarubicin. Table 21 shows the dates when the FDA approved generic alternatives for these drugs.

We solicited comments on this proposed method of calculating payment for drugs, biologicals, and radiopharmaceuticals for which generic alternatives have recently been approved. Specifically, we were interested in comments concerning our proposed methodology for identifying these items, whether we properly identified all the items, and whether our proposed payment policy for these generic alternatives is appropriate.

We received many comments on our proposal regarding generic drugs and radiopharmaceuticals, which are summarized below along with our responses.

Comment: One commenter applauded CMS's efforts to lower payment for generic products to an amount more closely aligned with hospital acquisition cost. However, the commenter indicated that payment for generic cancer products would continue to be excessive and contribute to an environment where hospitals may offer treatments using less effective chemotherapy products. Alternatively, comments from a national hospital association and numerous manufacturers stated that the presence of generic alternatives in the market does not necessarily result in cost savings for hospitals. They indicated that established multi-year contracts may prevent providers from switching immediately to generic alternatives. As a result, providers would not realize any cost savings from buying the generic products until the conclusion of their existing contract, which in some cases may be a few years after the generics are available in the market. Commenters also indicated that it is quite common for shortages of generic equivalents to occur when they first appear in the market. Thus, there is no guarantee that sufficient quantities of generic alternatives will be available in the marketplace for all providers to purchase them. Furthermore, adoption of generic drugs by hospitals is also affected by whether the providers determine they are safe to use in comparison to the brand name products. One commenter recommended that CMS continue to use its 2002 claims data to set the payment rated for these drugs.

Response: We appreciate these insightful comments and agree with the commenters that the time it takes for hospitals to realize cost savings (or price decreases) from purchasing generic products is longer than we initially expected because of the various reasons described by the commenters. Further research on this issue also shows that cost savings due to competition between generic and name brand drugs can vary. One reason is that in some cases regulations allow the first generic marketed to compete with a name brand drug to have a period of exclusivity during which time no other generics may come on the market. This period of exclusivity may mean that cost savings during this period of exclusivity are less than cost savings that occur once more than one generic is put on the market. For 2004, we believe that calculating payment rates for generics according to the methodology discussed above would not sufficiently take into consideration the true costs incurred by hospitals for purchasing generic products. Therefore, we believe that it is appropriate to calculate the payment rates for generics according to the same methodology used for other separately payable drugs and radiopharmaceuticals.

6. Orphan Drugs

In the proposed rule we stated that we no longer believe that paying for orphan drugs at reasonable cost, outside of OPPS is appropriate, and we proposed the following payment policy:

- We proposed to continue using the same criteria to identify single indication orphan drugs (67 FR 66772).
- We proposed to discontinue retrospective cost payments and to make prospective payments under the OPPS for those identified single indication orphan drugs.
- We proposed to base payments on the same methodology we use to pay for other drugs including any limitation on payment reductions (as described above).
- We proposed to make separate payment for the single indication orphan drugs and place them in APCs.

The 11 single indication orphan drugs that would be affected by our proposal are: (J0205 Injection, alglucerase, per 10 units; J0256 Injection, alpha 1-proteinase inhibitor, 10 mg; J9300 Gemtuzumab ozogamicin, 5 mg; and J1785 Injection, imiglucerase, per unit); J2355 Injection, oprelvekin, 5 mg; J3240 Injection, thyrotropin alpha, 0.9 mg;

J7513 Daclizumab parenteral, 25 mg; J9015 Aldesleukin, per vial; J9160 Denileukin diftitox, 300 mcg; J9216 Interferon, gamma 1–b, 3 million units; and Q2019 Injection, basiliximab, 20 mg.

We solicited comments on these proposals and requested that commenters submit information meeting the same criteria as comments for other drugs (as discussed above). We received numerous comments, all of which were in opposition to our proposals regarding payment for orphan drugs.

Comment: Every commenter who commented on the changes we proposed regarding payments for single indication orphan drugs opposed our proposal to discontinue payment for orphan drugs on a reasonable cost basis and to instead use the same methodology to set payment amounts for the single indication orphan drugs that we use to set rates for other drugs. Commenters stated that doing so would create serious access problems for patients who rely on an orphan drug for treatment of a rare disease because hospitals would no longer be able to afford to treat them. A number of commenters were particularly concerned by the decreased payment rate proposed for alpha-1-proteinase inhibitor. Some pointed out that the data we used to calculate payments for orphan drugs are especially flawed because of the low volume, high cost characteristics of orphan drugs, complicated by errors in the way hospitals bill for drugs generally. Recommendations from commenters included: applying the dampening rule to limit decreases to 10% of reasonable cost payments in 2003; establishing a payment floor; and, continuing to pay for orphan drugs on a reasonable cost basis.

Response: We carefully reviewed commenters' concerns about the impact our proposal would have on patient access to orphan drugs. We do not dispute that orphan drugs used solely to treat an orphan condition are generally expensive and, by definition, are rarely used. We also recognize that coding changes may have resulted in questionable billing data. However, we believe that it is important to balance these concerns with maintaining a consistent payment system for hospital outpatient department services overall, and to limit to the maximum possible extent payment for services or items outside the OPPS. We also discussed in the August 12 proposed rule our concerns about the increased number of drugs that meet our criteria for special payment status as single indication orphan drugs and the resulting increase in the number of hospital outpatient services that would be paid outside the OPPS were we to continue to pay for these drugs on a reasonable cost basis. It was in light of these factors that we proposed to discontinue payment for single indication orphan drugs on a reasonable cost basis outside the OPPS and to use our claims data as the basis for setting payment rates for those drugs that we have identified as meeting our criteria for special payment status as single indication orphan drugs. We also proposed to pay separately for the single indication orphan drugs and to assign each of them to an APC.

Having weighed the concerns raised by commenters and our concerns about the increasing number of outpatient services that would be paid outside the OPPS were we to continue the current policy of paying for single indication orphan drugs on a reasonable cost basis, we have decided that beneficiaries, hospitals, and the Medicare program will be best served over the long term by our making payment for the single indication orphan drugs under the OPPS at 88 percent of the AWP. We arrived at 88 percent based on our analysis of claims data, and our intent that payment be sufficient to ensure that all beneficiaries have access to needed drugs. Among the 11 orphan drugs, the highest median cost in the claims data was approximately 78 percent of the AWP. After considering comments we received on the proposed rule, we were concerned that merely adopting the existing highest percentage of the AWP may not ensure that a sufficient payment amount is established in all cases prospectively. We therefore have provided for an additional margin of ten percentage points to account for possible future increases, and ensure sufficient payment. This results in the percentage of 88 percent that we have adopted in this final rule.

However, we received information consistent with our request for verifiable data (68 FR 47998) that indicates the payment amounts we proposed for alpha-1 proteinase inhibitor, for imiglucerase, and for alglucerase do not reflect the price at which these drugs are widely available to the hospital market. This information, combined with the concerns expressed by commenters generally that the payment amounts we proposed for the 11 drugs that meet our criteria for special payment as single indication orphan drugs are too low and may threaten beneficiary access to the drugs, have persuaded us to make final one modification to the method we proposed for setting payment rates for drugs that are paid as single indication orphan drugs under the OPPS. That is, rather than using claims data to calculate payment rates for single indication orphan drugs that meet our criteria for special payment under the OPPS, we are setting payment for all but two of these drugs at 88 percent of their AWP as established in the April 1, 2003 single drug pricer (SDP). As discussed above, we received information about the widely available market price for imiglucerase and alglucerase, and, based on that information, we have priced these two drugs at 94 percent of their AWP.

We believe that this policy is a reasonable compromise. It enables us to set a prospective payment amount under the OPPS for qualified single indication orphan drugs. But, by increasing payment levels for these low volume drugs, we minimize the risk of compromising beneficiary access to treatment for life-threatening, rare diseases.

Therefore, we have set payment rates for single indication orphan drugs in accordance with the following policy, effective January 1, 2004:

- We are using the same criteria that we implemented in CY 2003 to identify single indication orphan drugs used solely for an orphan condition for special payment under the OPPS;
- We are discontinuing payment on a reasonable cost basis for single indication orphan drugs furnished in the outpatient department of hospital that is subject to the OPPS;
- We are making separate payment for single indication orphan drugs and assigning them to APCs;
- We are setting payment under the 2004 OPPS for single indication orphan drugs at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer unless we are presented with verifiable information that shows that our payment rate does not reflect the price that is widely available to the hospital market.

Comment: Several commenters objected to our special treatment for only 11 orphan drugs, rather than including all of the drugs that the FDA designates as having orphan status. A few commenters recommended that we set the criteria for special treatment based on claims volume instead of our current criteria. That is, CMS would set a criterion for ''high volume'' drugs based on a threshold of 30,000 or more claims per year. Then, any FDA-designated orphan drug with less than the threshold volume of claims would be subject to special payment under the OPPS as an orphan drug.

Response: Using the statutory authority at section 1833(t)(1)(B)(i) of

the Act, which gives the Secretary broad authority to designate covered OPD services under the OPPS, we have established criteria which distinguish these 11 drugs from other drugs designated as orphan drugs by the FDA under the Orphan Drug Act. Our determination under this authority to provide special payment for a subset of FDA-designated orphan drugs does not affect FDA's classification of drugs under the Orphan Drug Act. Because these 11 drugs have a low volume of patient use, lack other indications, and have no other source of payment, we allow special treatment of them so beneficiaries can continue to have access to them. Because these 11 drugs are used solely to treat an orphan condition that affects a relatively low number of beneficiaries, hospitals receive payment for a low volume of cases by definition, and the cost of the drug is not spread across other uses. We are concerned that if we were to adopt the commenter's recommendation that we qualify all FDA-designated orphan drugs under a particular volume threshold for special payment under the OPPS, we could be expanding this special payment provision, which is meant to target the small number of orphan drugs that are used solely to treat rare diseases, to drugs that are used for other conditions and indications, for which hospitals would also be receiving payment. Therefore, we are not adding a volume threshold to our criteria for identifying orphan drugs that receive special payment under the OPPS in 2004.

7. Vaccines

Outpatient hospital departments administer large amounts of the vaccines for influenza (flu) and pneumococcal pneumonia (PPV), typically by participating in immunization programs. In recent years, the availability and cost of some vaccines (particularly the flu vaccine) have fluctuated considerably. As discussed in the November 1, 2002 final rule (67 FR 66718), we were advised by providers that OPPS payment was insufficient to cover the costs of the flu vaccine and that access of Medicare beneficiaries to flu vaccines might be limited. They cited the timing of updates to OPPS rates as a major concern. They said that our update methodology, which uses 2-year-old claims data to recalibrate payment rates would never be able to take into account yearly fluctuations in the cost of the flu vaccine. We agreed and decided to pay hospitals for influenza and pneumococcal pneumonia vaccines based on a reasonable cost methodology. As a result of this change, hospitals, home health agencies (HHAs), and hospices were paid at reasonable cost for these vaccines in 2003. We are aware that access concerns continue to exist for these vaccines; therefore, we proposed to continue paying for influenza and pneumococcal pneumonia vaccines under reasonable cost methodology.

We received no comments regarding our payment proposal for vaccines, and finalize our proposal in this rule.

8. Blood and Blood Products

Since the OPPS was first implemented in August 2000, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. We proposed to continue to pay separately for blood and blood products.

The list of APCs containing blood and blood products can be found in the November 1, 2002 final rule (67 FR 66750). We note that the APCs for these products are intended to make payment for the costs of the products. Costs for storage and other administrative expenses are packaged into the APCs for the procedures with which the products are used.

As described in the November 1, 2002 final rule (67 FR 66773), we applied a special dampening option to blood and blood products that had significant reductions in payment rates from 2002 to 2003. For 2003, we limited the decrease in payment rates for blood and blood products to approximately 15 percent.

After careful comparison of the 2003 dampened medians with the 2004 medians from our claims data, we determined that establishing payment rates based on the 2004 median costs would, for many blood and blood products, result in payments that are significantly lower than hospital acquisition costs. In order to mitigate any significant payment reductions and to minimize any compromise in access of beneficiaries to these products, we proposed a 10 percent limit to decreases in payment rates for blood and blood products from 2003 to 2004.

We solicited comment on this proposal, especially from hospitals. Specifically, we solicited comments that include verifiable information about the widely available acquisition cost of commonly used blood and blood products.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: Several hospital groups supported the recommendation made by the APC Panel at its August 22, 2003 meeting and urged us to consider freezing 2004 payment rates for blood and blood products at the 2003 levels. A few commenters recommended that CMS use data provided by suppliers of blood and blood products to help set payment rates for 2004. Two commenters stated that major blood organizations are prepared to share the data for verification with CMS. Another commenter recommended that CMS base payments on either reasonable cost or external data.

Response: After carefully reviewing the concerns expressed by commenters and analyzing the further reductions in payment that would result from using our 2002 claims data, even with the 10 percent limit on payment decreases that we proposed, we are convinced that our payments would be considerably lower than what it costs hospitals to acquire blood and blood products. Further, we are mindful of the increasing number of tests required to ensure the safety of the nation's blood supply, which is adding to the cost of processing blood and blood products. Therefore, in order to ensure that our beneficiaries have uninterrupted access to safe blood and blood products, we agree with the recommendation of commenters and the APC Panel that we freeze payments for blood and blood products in 2004 at 2003 payment levels rather than implement our proposal to limit payment decreases to 10 percent. This will enable us to undertake further study of the issues raised by commenters and by presenters at the August APC Panel meeting, without putting beneficiary access to blood and blood products at risk. Therefore, effective for services furnished on or after January 1, 2004, the payment rates for blood and blood products will not change from their 2003 levels.

Comment: One commenter was concerned that while autologous blood and directed donor blood do not have separate CPT codes, hospitals' costs to obtain them are different. Hospitals can only report charges for the autologous blood unit if the patient receives it; otherwise, hospitals must absorb the cost of the autologous donation. The same commenter also suggested that CMS research the issue of whether providing blood to patients with special needs would increase hospital costs. The commenter stated that hospitals do not receive additional payment when conducting national searches to meet special blood needs. Another commenter was concerned that drugs and biologicals were dampened to a

lesser extent than blood and blood products. The commenter requested that CMS discontinue the differential dampening and apply the dampening rule equally.

Response: The commenter's concerns about rules governing payment for autologous blood and the costs associated with procuring blood for patients with special needs fall outside the scope of our proposed rule. These questions require further analysis and study, which we cannot undertake in time for implementation of the 2004 update of the OPPS. However, as we examine the current policies that affect payment for blood and blood products under the OPPS, we will consider both of the commenter's concerns.

As for the comment regarding adoption of a uniform dampening policy for both separately payable drugs as well as blood and blood products, this concern is no longer an issue because of our decision to freeze payment rates for blood and blood products at their 2003 levels for 2004.

Comment: Several commenters requested that CMS provide and promote guidance on correct coding and billing for blood and blood products to hospitals and other providers.

Response: We acknowledge the need for comprehensive billing and coding guidelines for hospitals and other providers. This is an area we expect to address in the near future.

9. Intravenous Immune Globulin

In the proposed rule, we discussed public comments suggesting that we reclassify intravenous immune globulin (IVIG) as a blood and blood product. We stated that after a review of claims data, we believe that payment for these products is appropriate using the methodology we proposed to implement for other drugs and biologicals. Therefore, we proposed to continue to classify IVIG as a biologic. We solicited comments on this proposal.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: Several trade associations, manufacturers, patient organizations and individual commenters urged CMS to classify intravenous immune globulin (IVIG) under the ''blood and blood product category.'' They indicated that IVIG is derived from plasma fractionation similar to other products categorized as a blood and blood product by CMS; and, furthermore, IVIG falls within the FDA's definition of ''blood and blood product.'' Some of the commenters expressed concern about the potential negative impact on patient access as a result of our proposed payment policy. Another commenter requested that we consider all plasma-derived products and their recombinant analogs as blood products.

Response: We appreciate these comments. However, we continue to believe that IVIG and other plasma-derived therapies and their recombinant analogs are comparable to other drugs and biologicals, and they do not have the same access concerns as other blood and blood products. Our policy regarding IVIG and plasma therapies were described in the November 1, 2002 final rule (67 FR 66774). For 2004, IVIG will be a separately payable item, and its payment rate will be based on approximately 26,500 claims for approximately 1.5 million services. As mentioned in the August 12, 2003 proposed rule (68 FR 48005), analysis of the claims data indicated that hospital costs and billing practices for IVIG have been consistent over the past two years. Therefore, we believe that the 2002 claims data contain a sufficiently robust set of claims for IVIG on which to base the payment rate for this item using the methodology that will be used for other separately payable non-pass-through drugs, biologicals, and radiopharmaceuticals.

10. Payment for Split Unit of Blood

Since implementation of the OPPS, we have assigned status indicator ''E'' to HCPCS code P9011, blood (split unit). Status indicator ''E'' designates services for which payment is not allowed under the OPPS or services that are not covered by Medicare. P9011 was created to identify situations where one unit of red blood cells or whole blood, for example, is split and half of the unit is transfused to one patient and the other half to another patient. Because use of split units is not uncommon, we proposed to change the status indicator for P9011 from ''E'' to ''K'' and assign it to a blood and blood product APC that pays approximately 50 percent of the payment for the whole unit of blood. We proposed to assign P9011 to APC 0957 (Platelet concentrate) with a payment rate of $37.30. We invited comments on this proposed change in the status indicator and payment amount for P9011.

We received a few comments on this proposal, which are summarized below along with our responses.

Comment: Commenters pointed out that there was a typographical error in the proposed rule in which we referred to the split unit of blood as P9010 rather than P9011.

Response: We agree this was an error and have corrected it in this preamble and are making final our proposal to assign P9011 to APC 0957 (platelet concentrate).

11. Other Issues

We proposed to continue our payment policy for Procrit and Aranesp for calendar year 2004. As explained in detail in the November 1, 2002 final rule (67 FR 66758), Aranesp and Procrit are in separate APCs, and are paid at equivalent rates with the application of a ratio to convert the dosage units of Aranesp into units of Procrit. We indicated that we might refine the conversion ratio as soon as feasible based on information not available at the time we established the current conversion ratio.

We have continued to gather information regarding an appropriate conversion ratio by reviewing recent published studies and data from alternative sources. In the proposed rule, we stated that we remain open to establishing a different conversion ratio in the final rule if we conclude that a change is warranted based on public comments and information submitted during the public comment period and/or any other information we consider in developing the final rule. Therefore, we proposed to continue with the current policy regarding payment for Procrit and Aranesp, including the current conversion ratio. We solicited comments on this issue and we stated that we would base any changes to our current payment policy for these two drugs only on data that we could make available to the public.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: We received several comments concerning payment under the OPPS for erythropoietin and an erythropoietin-like product. Specifically, the comments pertained to payment for Aranesp™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech) under the OPPS and the decision we made for 2003 with respect to an appropriate conversion ratio to ensure that these products, which use the same biological mechanism to produce the same results, are paid at the same rate .

Response: Erythropoietin, a protein produced by the kidney, stimulates the bone marrow to produce red blood cells. In severe kidney disease, the kidney is not able to produce normal amounts of erythropoietin and this leads to the anemia. Additionally, certain chemotherapeutic agents used in the treatment of some cancers suppress the bone marrow and cause anemia. Treatment with exogenous erythropoietin can increase red blood

cell production in these patients and thus treat their anemia.

In the late 1980's, scientists used recombinant DNA technology to produce an erythropoietin-like protein called epoetin alfa. Epoetin alfa has exactly the same amino acid structure as the erythropoietin humans produce naturally and, when given to patients with anemia, stimulates red blood cell production.

Two commercial epoetin-alfa products are currently marketed in the United States: Epogen™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech). These products are exactly the same but are marketed under two different trade names. Both Epogen™ and Procrit™ are approved by the FDA for marketing for the following conditions: (1) Treatment of anemia related to chronic renal failure (including patients on and not on dialysis), (2) treatment of Zidovudine-related anemia in HIV patients, (3) treatment of anemia in cancer patients on chemotherapy, and (4) treatment of anemia related to allogenic blood transfusions in surgery patients. Both products are given either intravenously or subcutaneously up to three times a week.

Amgen developed a new erythropoietin-like product, darbepoetin alfa, which it markets as Aranesp™. Also produced by recombinant DNA technology, darbepoetin alfa differs from epoetin alfa by the addition of two carbohydrate chains. The addition of these two carbohydrate chains affects the biologic half-life of the compound. This change, in turn, affects how often the biological can be administered, which yields a decreased dosing schedule for darbepoetin alfa by comparison to epoetin alfa. Amgen has received FDA approval to market Aranesp™ for treatment of anemia related to chronic renal failure (including patients on and not on dialysis) and for treatment of chemotherapy-related anemia in cancer patients.

Because darbepoetin alfa has two additional carbohydrate side-chains, it is not structurally identical to epoetin alfa. However, the two products use the same biological mechanism to produce the same clinical results—stimulation of the bone marrow to produce red blood cells.

These biologicals are dosed in different units. Epoetin alfa is dosed in Units per kilogram (U/kg) of patient weight and darbepoetin alfa in micrograms per kilogram (mcg/kg). The difference in dosing metric is due to changes in the accepted convention at the time of each product's development. At the time epoetin alfa was developed, biologicals (such as those developed through recombinant DNA) were typically dosed in International Units (IU or Units for short), a measure of the product's biologic activity. They were not dosed by weight (for example, micrograms) because of a concern that weight might not accurately reflect their standard biologic activity. The biologic activity of such products can now be accurately predicted by weight, however, and manufacturers have begun specifying the doses of such biologicals by weight. No standard formula exists for converting amounts of a biologic dosed in Units to amounts of a drug dosed by weight.

In the clinical management of individual patients, CMS recognizes that no precise method of converting an epoetin alfa dose to a darbepoetin alfa dose has yet been established for any of the approved clinical uses. There are general guidelines for conversion and clinicians modify the dose based on the patient's hematopoietic response after the start of treatment with the new biological. For the purpose of developing a payment policy, however, it is feasible to establish a method of converting the dose of each of these drugs to the other. This payment methodology is intended to reflect average dosing requirements for the entire Medicare target population, and is not intended to serve as a guide for dosing individual patients.

As part of the process to define and further refine a payment conversion ratio between these biologicals, CMS held a series of meetings with representatives from both Amgen and Ortho Biotech. Both companies provided substantial new data, both published and unpublished. We also reviewed the Food and Drug Administration labeling for each product (EpogenTM, ProcritTM, and AranespTM), hired an independent contractor to review the available clinical evidence, and performed an internal review of this evidence as well. CMS took into consideration both published and unpublished studies as well as abstracts, conference reports, clinical guidelines, marketing material, and other reports and materials provided by Amgen and Ortho Biotech.

As noted in the OPPS final rule for 2003, CMS was interested in having a ''head-to-head'' comparison of epoetin alfa to darbepoetin alfa either in patients with chronic kidney disease or in cancer patients with chemotherapy-induced anemia, and in which appropriate outcome measures were used. Because no head-to-head study has yet been completed, CMS also considered clinical studies that either compared both products to each other or that linked the dose of a particular product with an appropriate health outcome measure. For the 2003 OPPS, we held a series of meetings with both Amgen and Ortho Biotech. We examined the written and published information provided by both companies, reviewed the FDA labeling for each product, hired an independent contractor to review available clinical evidence and performed an internal review of the evidence as well. In our review, we placed the greatest emphasis on published, high quality clinical studies and looked for the best possible estimates based on an evaluation of the dosing of each product that, on average, produced the same clinical response. Based on our own review of the evidence, our consultation with the independent contractor who also reviewed the evidence, and our discussions with each company, we established a conversion ratio for purposes of payment in 2003 of 260 International Units of epoetin alfa to one microgram of darbepoetin alfa (260:1).

Since publication of the OPPS final rule for 2003, we have continued to review and refine our analysis of the appropriate conversion ratio between these biologicals. In order to facilitate analysis of the non-peer reviewed materials submitted by Amgen and Ortho Biotech, we initiated a process in July 2003, in which each company shared with CMS, our contractor, and each other, a detailed description of the methods used in each of their unpublished clinical studies. Each company was then asked to submit to us their comments as well as the responses to questions raised by the other company's review. Finally, based on our analysis of this information, CMS submitted questions to each company to clarify their views. The final payment conversion ratio is based on our analysis of the information submitted during the process described above, as well as claims analysis, and other publicly available information.

Chemotherapy-induced anemia: The articles submitted by the manufacturers regarding treatment of chemotherapy-induced anemia (CIA) were all observational, retrospective, cohort studies. Several of these studies were conducted with a high degree of attention to minimizing avoidable bias and maximizing data integrity. Observational studies are, however, unavoidably subject to patient selection bias since study subjects are not randomly assigned to the groups being compared. It is not possible to eliminate the possibility that the choice of

erythropoetic agent was somehow systematically linked to characteristics of the patients treated. Similarities or differences in clinical response may reflect either baseline patient characteristics or the effects of the therapy being studied.

Another major limitation of observational studies is that the researcher typically has no control over the manner in which the intervention under study has been delivered. In this instance, an additional difficulty with using observational studies to assess the equivalence of dosages of epoetin alfa and darbepoetin alfa in chemotherapy-induced anemia in cancer patients is that the response to these drugs may be disease-driven, dosage-driven, or both (depending for example, among other factors, on the individual cancer patient's level of endogenous erythropoietin). A large range of dosages of both epoetin alfa and darbepoetin alfa may show similar effects in any given patient and higher than necessary dosages may not be reflected in greater elevations of hemoglobin. More generally, the populations in the reported studies may show different results due to differences in demographics, health status, types of cancer, and cancer treatments.

Beyond these methodological concerns, the question of what constitutes the best indicator of drug effect remains unsettled. Studies in the literature have used one or more of the following end-points to analyze the effects of erythropoietic drugs:

1. Hemoglobin response—an increase from baseline of >2 g/dL (usually in the absence of transfusion in the preceding 28 days)
2. Hematopoietic response—Hemoglobin increase of >2g/dL from baseline or a hemoglobin >12g/dL
3. Mean change in hemoglobin ''the mean increase in hemoglobin from baseline (usually in the absence of transfusion in the preceding 28 days)
4. Transfusions of red blood cells ''the number (percent) of patients requiring transfusion measured at various time intervals.

Studies submitted by one of the manufacturers proposed additional measures such as ''early hemoglobin response'' (the hemoglobin rise from baseline at 4 or 5 weeks) and the ''area under the curve'' defined by hemoglobin increases from baseline. The FDA has not used these measures as criteria for registration (i.e., market approval) and they do not appear to be regularly used in the peer reviewed literature of erythropoietic drugs and their use either in kidney disease or in oncology. Therefore, their clinical significance is unclear at this time. They do, however, raise the question of how hemoglobin response patterns affect symptoms that matter most to patients. Both companies are conducting additional clinical studies to address further the potential importance of front-loaded regimens that provide high initial doses of erythropoietic drugs in order to stimulate a more rapid clinical response.

During the process of exchanging and critiquing study methods, Amgen and Ortho-Biotech each raised significant methodological concerns about the study designs used to obtain new data. In addition to the overall concern about the observational methodology and selection of the outcome chosen for purposes of comparison, the following concerns were raised:

—the use of survival curves to analyze clinical data in this context
—the possible effect of patient functional status on erythropoietic response
—the technique for calculating mean values for drug dosages (arithmetic vs geometric means)
—the strategy for deciding how to handle data from patients who received transfusions
—the significance of an early rise in hemoglobin, and/or the significance of measures of hemoglobin response over the entire 12–16 week treatment interval

Each company provided extensive and compelling discussions of these and other issues, highlighting the fact that conclusions regarding the relative potency of these products are inherently limited by the nature and quality of the clinical data that currently exist. Despite the limitations of the available studies, CMS believes that it has sufficient data to establish a reasonable conversion ratio for payment purposes.

Amgen submitted several observational studies, including one community-based study and three medication use evaluations (MUE). While interim results from two of these studies have been published in peer-reviewed journals, final results have not yet been subjected to full peer review. In one study (Vadhan-Raj, 2003), patients were started on darbepoetin at 3 mcg/kg every other week (QOW). The patients received up to 8 doses (16 weeks). The patients had hemoglobin (Hgb) responses comparable to that seen with epoetin 40,000–60,000 IU per week. The protocol allowed a dose increase and 43 percent of participants had their darbepoetin dose increased to 5 mcg/kg/QOW per the protocol. Virtually all of the Amgen studies produced results that suggested a conversion ratio of 400:1.

Ortho Biotech submitted early unpublished results from a multicenter head-to-head trial of 40,000 IU of epoetin weekly compared to 200 mcg of darbepoetin every other week. The primary end-point is the change in Hgb from baseline at week 5, and initial results show significantly greater increase in Hgb for patients treated with epoetin. Ortho Biotech also submitted data from several retrospective analyses of medical charts and electronic medial records, totaling several thousand patients. None of these studies have yet been peer-reviewed or published. All of the Ortho-sponsored studies provide results suggesting that the appropriate conversion ratio is 260:1 or less.

In the observational studies that directly compare Aranesp and Procrit for the treatment of CIA, and report total dose per patient per episode of both epoetin and darbepoetin, the ratio of mean total doses is 341:1 and the ratio of median total doses is 352:1. However, selection bias may affect the validity of these studies. CMS therefore believes that the above-mentioned ratios may still overestimate, at least modestly, the potency of darbepoetin alfa relative to epoetin alfa. An analysis of Medicare claims data from 2002 and 2003 determined that the ratio of utilization of Procrit to Aranesp in Medicare patients was 330:1 (units:mcg).

As noted above, a conversion ratio between the dosages of these two products is not meant to guide what should be done for individual patients in clinical practice. In addition, by using a conversion ratio CMS is not attempting to establish a lower or upper limit on the amount of either biological a physician can prescribe to a patient. CMS expects that physicians will continue to prescribe these biologicals based on their own clinical judgment of the needs of individual patients.

Based on our own review of the evidence, our consultation with the independent contactor who also reviewed the evidence, and our discussions with Amgen and Ortho Biotech, CMS concludes that an appropriate conversion ratio for the purposes of a payment policy is 330 International Units of epoetin alfa to one microgram of darbepoetin alfa (330:1) for the purpose of treating chemotherapy-induced anemia.

Chronic Kidney Disease without dialysis: It is well established that as a patient progresses through the stages of chronic kidney disease (CKD), erythropoietin levels decline and anemia tends to develop. Furthermore,

CKD patients are a very heterogeneous population, and it is likely that they will need varying doses of erythropoietic drugs as their CKD progresses to ESRD. At the present time there are no head-to-head randomized controlled clinical trials that look at erythropoietic drug needs across the spectrum of CKD.

Amgen presented studies that examined the effect of darbepoetin on hemoglobin in this population. Two studies showed a dose conversion ratio (DCR) range between 215–330. These were observational studies similarly affected by the methodological weaknesses of this study design previously discussed for chemotherapy-induced anemia. A third study submitted by Amgen showed a DCR of 168:1 and is the only study that prospectively looked at darbepoetin and epoetin.

We estimate that no more than 10 percent of the Medicare patients who receive darbepoetin in the hospital outpatient setting receive it solely because of CKD. As a result, at this time, we believe that it could be confusing and burdensome for hospitals as well as the Medicare claims processing systems to use different HCPCS codes assigned to different APCs in order to distinguish and pay different amounts for darbepoetin used by patients with CIA from darbepoetin used by patients with CKD. Therefore, given the heterogeneity of the population, the general paucity of scientific evidence on CKD, the estimated low incidence of CKD-only indications in the OPPS population, and the potential burden on providers of requiring different codes for different indications, we are not establishing a different payment rate for darbepoetin for CKD at this time. However, CMS invites the submission of peer reviewed clinical data to further illuminate the issue. Therefore, we are going to use a 330:1 conversion ratio for CKD also and, therefore, a single APC payment rate for darbepoetin alfa, in 2004.

VII. Wage Index Changes for CY 2004

Section 1833(t)(2)(D) of the Act requires that we 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 proposed Federal fiscal year (FY) 2004 hospital inpatient PPS wage index to make wage adjustments in determining the proposed payment rates set forth in the proposed rule. We also proposed to use the final FY 2004 hospital inpatient wage index to calculate the final CY 2004 payment rates and coinsurance amounts for OPPS. Therefore, we have used the corrected final FY 2004 hospital inpatient wage index to make wage adjustments in determining the final payments rates set forth in this final rule. The corrected final FY 2004 hospital inpatient wage index published as Tables 4A, 4B, and 4C in the October 6, 2003 **Federal Register** (68 FR 57732 through 57758) 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. We used the corrected final FY 2004 hospital inpatient wage index to calculate the payment rates and coinsurance amounts published in this final rule to implement the OPPS for CY 2004. We note however, that from time to time, there are mid-year corrections to these wage indices and that our contractors will adopt and implement the mid-year changes for OPPS in the same manner that they make mid-year changes for inpatient hospital prospective payment.

We received several comments on how we apply the wage index in setting rates.

Comment: Commenters stated that we should exempt the device portion of the median cost from wage adjustment. They indicated that the wage index reflects the variation in wages and that applying it to 60 percent of an APC payment where part of that payment is for devices, to which the wage index is not applicable, results in inappropriately low payments in rural areas and discourages the expansion of state of the art technologies to rural hospitals. A commenter indicated that we should work with the commenter to calculate and publish a list of the device percentages for each APC and that the wage index adjustment should not be applied to that portion of the APC.

Response: To apply the wage index only to the non-device portion of the APC payment will mean a significant revision to the methodology used to calculate the relative weights and the conversion factor as well as changes to the system that applies the wage index on individual claims. When we calculate median costs, we divide 60 percent of the cost by the wage index for the hospital to neutralize the cost for the effects of the wage index. In addition, when we determine the conversion factor, we calculate a wage adjustment scalar to adjust for any increase or decrease that may occur to total payments from changes in the wage index. Moreover, it cannot be assumed that not applying the wage index to the device portion of the APC payment will result in increased payment for APCs that require devices. In localities that have high wage indices, this change could result in reductions in payments for device APCs. For example, if the wage index is 1.5 and the national APC payment is $10,000, the wage index applied to 60 percent of the APC increases the payment to the high wage index hospital to $13,000. If the wage index is 0.9, the wage index applied to 60 percent of the APC decreases the payment to the hospital to $9,400. However, if the wage index is applied only to 20 percent of the APC payment because 80 percent of the cost of the APC is for the device, the hospital in the high wage index area will now get $11,000 (a $2,000 loss) and the hospital in the low wage index area will now get $9,800 (a $400 gain).

Also, because the wage index is used to neutralize costs derived from charges and is a factor in the conversion factor, the $10,000 payment in the example may change. To gauge the full impact of such a change, we would have to undertake significant statistical analysis. We will continue to apply the wage index to 60 percent of the APC for 2004. However, we recognize the need to reassess whether this percentage is correct in view of the packaging of high cost devices into APCs and will make every effort to do a reassessment for 2005 OPPS proposed rule. If we determine that a change to the percentage might be appropriate, we will propose it in the 2005 OPPS NPRM.

VIII. Copayment for CY 2004

In the November 30, 2001 final rule (66 FR 59887), we adopted a methodology that applied five rules for calculating APC copayment amounts when payments for APC groups change because the APCs' relative weights are recalibrated or when individual services are reclassified from one APC group to another. In calculating the unadjusted copayment amounts for 2004, we encountered circumstances that the methodology in the November 30, 2001 final rule either did not address or whose applicability was ambiguous. Therefore, we proposed to revise and clarify the methodology we would follow to calculate unadjusted copayment amounts, including situations in which recalibration of the relative payment weight of an existing APC results in a change in the APC payment; situations in which reclassification of HCPCS codes from an existing APC to another APC results in a change in the APC payment; and situations in which newly created APCs are comprised of HCPCS codes from existing APCs.

As we stated in the August 12, 2003 proposed rule, as a general rule, we would seek to lower the coinsurance rate for the services in an APC from the prior year. This principle is consistent with section 1833(t)(8)(C)(ii) of the Act, which accelerates the reduction in the national unadjusted coinsurance rate so that beneficiary liability will eventually equal 20 percent of the OPPS payment rate for all OPPS services and with section 1833(t)(3)(B), which indicates the congressional goal of achieving 20 percent coinsurance when fully phased in and gives the Secretary the authority to set rules for determining copayment amounts to new services. However, in no event is the proposed 2004 unadjusted coinsurance amount for an APC group lower than 20 percent or greater than 50 percent of the payment rate.

We proposed to determine copayment amounts in 2004 and subsequent years in accordance with the following rules.

1. When an APC group consists solely of HCPCS codes that were not paid under the OPPS the prior year because they were packaged or excluded or are new codes, the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If a new APC that did not exist during the prior year is created and consists of HCPCS codes previously assigned to other APCs, the copayment amount is calculated as the product of the APC payment rate and the lowest coinsurance percentage of the codes comprising the new APC.

3. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is equal to or *greater than* the prior year's rate, the copayment amount remains constant (unless the resulting coinsurance percentage is less than 20 percent).

4. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is *less than* the prior year's rate, the copayment amount is calculated as the product of the new payment rate and the prior year's coinsurance percentage.

5. If HCPCS codes are added to or deleted from an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in a decrease in the coinsurance percentage for the reconfigured APC, the copayment amount would not change (unless retaining the copayment amount would result in a coinsurance rate less than 20 percent).

6. If HCPCS codes are added to an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in an increase in the coinsurance percentage for the reconfigured APC, the copayment amount would be calculated as the product of the payment rate of the reconfigured APC and the lowest coinsurance percentage of the codes being added to the reconfigured APC.

We stated in the proposed rule that this methodology would, in general, reduce the beneficiary coinsurance rate and copayment amount for APCs for which the payment rate changes as the result of the reconfiguration of APCs and/or the recalibration of relative payment weights. We received no comments from the public on our proposal for the calculation of beneficiary copayment amounts.

The unadjusted copayment amounts for services payable under the OPPS effective January 1, 2004 are shown in Addendum A and Addendum B.

IX. Conversion Factor Update for CY 2004

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis.

Section 1833(t)(3)(C)(iv) of the Act provides that for 2004, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2004 published in the inpatient PPS proposed rule on May 19, 2003 was 3.5 percent. To set the proposed OPPS conversion factor for 2004, we increased the 2003 conversion factor of $52.151 (the figure from the November 1, 2002 final rule (67 FR 66788) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for 2004 to ensure that the revisions we proposed to update by means of the wage index are made on a budget-neutral basis. We calculated a budget neutrality factor of 1.003 for wage index changes by comparing total payments from our simulation model using the proposed FY 2004 hospital inpatient PPS wage index values to those payments using the current (FY 2003) wage index values. In addition, for CY 2004, allowed pass-through payments have decreased to 2 percent of total OPPS payments, down from 2.3 percent in CY 2003. The 0.3 percent was also used to adjust the conversion factor.

The proposed market basket increase factor of 3.5 percent for 2004, the required wage index budget neutrality adjustment of approximately 1.003, and the 0.3 percent adjustment to the pass-through estimate, resulted in a proposed conversion factor for 2004 of $54.289.

For purposes of updating the CY 2003 conversion factor to determine a final conversion factor for CY 2004 we applied an update factor based on the final hospital inpatient market basket increase for FY 2004 of 3.4 percent, as published in the final rule for IPPS on August 1, 2003. We further adjusted the conversion factor by applying a budget neutrality factor of 1.001 for wage index changes based on final FY 2004 hospital inpatient PPS wage index values as published in a correction notice to the IPPS final rule on October 6, 2003. In addition, for CY 2004, estimated pass-through payments have decreased to 1.3 percent of total OPPS payments, down from 2.3 percent in CY 2003. The conversion factor was further adjusted by the difference in estimated pass-through payments of 1.0 percent.

The increase factor of 3.4 percent for 2004, the required wage index budget neutrality adjustment of slightly more than 1.001 and the 1.0 percent adjustment to the pass-through estimate, result in a final conversion factor for 2004 of $54.561.

We received several comments concerning the conversion factor update for 2004, which are summarized below.

Comment: Several commenters stated that the OPPS has been underfunded since its inception. One commenter stated that the OPPS conversion factor has increased by less than the full market basket increase and urged that we work with Congress to enact an annual outpatient update for 2005 that corrects for the funding gap. Other commenters, noting the preliminary estimate of pass-through spending in our proposed rule of August 12 of 1.0 percent of total OPPS payments, strongly urged us to return the remaining 1.0 percent to the conversion factor to help fund all other APCs.

Response: As described elsewhere in this final rule, we have completed our estimate of pass-through spending for 2004. By statute, we are authorized to spend only 2.0 percent of total estimated OPPS payments on pass-through spending for 2004. According to the best information available to us at this time, we estimate the total pass-through spending to be 1.3 percent of total OPPS spending for 2004. For 2003, we estimated the total pass-through spending to be 2.3 percent of total. Thus, we have returned the additional 1.0 percent to the conversion factor.

X. Outlier Policy and Elimination of Transitional Corridor Payments for CY 2004

A. Outlier Policy for CY 2004

For OPPS services furnished between August 1, 2000 and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we would calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

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. For purposes of simulating payments to calculate outlier thresholds, we proposed to continue to set the target for outlier payments at 2.0 percent. For 2003, the outlier threshold is met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the current outlier payment percentage is 45 percent of the amount of costs in excess of the threshold.

For the reasons discussed in detail in section XI.E of this preamble, we proposed to establish two separate outlier thresholds, one for community mental health centers (CMHCs) and one for hospitals. For CY 2004, we proposed to continue to set the target for outlier payments at 2.0 percent of total OPPS payments (a portion of that 2.0 percent, 0.36 percent, would be allocated to CMHCs for PHP services). Based on our simulations for 2004, we proposed to set the hospital threshold for 2004 at 2.75 times the APC payment amount, and the proposed 2004 payment percentage applicable to costs over the threshold at 50 percent. We proposed to set the threshold for CMHCs for 2004 at 11.75 times the APC payment amount and the 2004 outlier payment percentage applicable to costs over the threshold at 50 percent. In this final rule, we are setting the target amount for outlier payments at 2.6 times the APC payment for hospitals and 3.65 times the APC payment for CMHCs. For 2004, the hospital outlier threshold is met when costs of furnishing a service or procedure exceed 2.6 times the APC payment amount and the outlier payment percentage is 50 percent of the amount of costs in excess of the threshold. Similarly, for CMHCs the threshold is met when costs of furnishing a service or procedure exceed 3.65 times the APC payment amount and the outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

We received several comments concerning our proposal to establish two separate outlier pools, one for hospitals and another for CMHCs, and to determine eligibility for outlier payments by applying an outlier threshold of 2.75 times the APC payment for hospitals and 11.75 times the APC payment for CMHCs. The comments we received concerning that proposal are summarized in section XI E.3 along with our responses. Comments we received pertaining to other aspects of our proposal for outlier payments are summarized below:

Comment: One hospital association contended that outpatient services that qualify for outlier payments should receive 80 percent of their costs above the threshold, rather than the proposed level of 50 percent. The association stated that an increased payment level would help to ameliorate the level of losses incurred by hospitals, such as teaching hospitals, that provide complex outpatient services and would make OPPS policy consistent with the policy under the IPPS. The association also pointed out that because we apply an outlier threshold that is a multiple of the APC payment, rather than a fixed dollar amount, hospitals that provide certain costlier services must absorb significantly more costs before even qualifying for outlier payments, making it even more important to increase the outlier payment percentage. The association recognized that increasing the payment percentage would require additional funds and recommended that we seriously consider increasing the outlier payment pool from its current level of 2.0 percent of total OPPS payments to 3.0 percent, the maximum allowed by law for 2004 and beyond.

Response: Although we acknowledge the importance of outlier payments to providers, those payments are intended to ensure that the Medicare program shares, to some extent, in the extraordinarily high costs a provider may incur in caring for specific patients in unusual circumstances. Outlier payments are not intended to be paid on a routine or regular basis for treating the majority of Medicare beneficiaries. The APC payments are developed to be reasonable and adequate payment for all but the most extraordinary cases. At this time, we do not believe that it would be appropriate to shift additional funds from APC payments in order to increase the outlier payment percentage. Increasing the outlier pool would result in reduced payments for the majority of services providers furnish in order to make increased payments for the rare, extraordinarily high cost cases a provider may treat.

Comment: A hospital association commented that we have furnished very little data on actual outlier payments under the OPPS, so hospitals have no way of knowing whether actual payments were higher or lower than estimated outlier payments and are unable to comment on the proper outlier threshold for OPPS. The association pointed out that we have historically furnished data on actual outlier payments in the IPPS rule and recommended that we furnish data on OPPS outlier payments so that hospitals may be able to make informed comments on the proper threshold.

Response: Based on hospital and CMHC claims submitted for the period April 1, 2002 through December 31, 2002, outlier payments for that period amounted to 1.78 percent of total OPPS payments. The outlier target we were trying to achieve for that period was 1.5 percent of total OPPS payments. Outlier payments to hospitals alone amounted to 1.54 percent of total OPPS payments to hospitals, while outlier payments to CMHCs amounted to 49.8 percent of their total OPPS payments.

B. Elimination of Transitional Corridor Payments for CY 2004

Since the inception of the OPPS, providers have been eligible to receive additional transitional payments if the payments they received under the OPPS were less than the payments they would have received for the same services under the payment system in effect before the OPPS. Under 1833(t)(7) of the Act, most hospitals that realize lower payments under the OPPS received transitional corridor payments based on a percent of the decrease in payments. However, rural hospitals having 100 or fewer beds, as well as cancer hospitals and children's hospitals described in section 1886(d)(1)(B)(iii) and (v) of the Act, were held harmless under this provision and paid the full amount of the decrease in payments under the OPPS.

Transitional corridor payments were intended to be temporary payments to ease providers' transition from the prior cost-based payment system to the prospective payment system. Beginning January 1, 2004, in accordance with section 1833(t)(7) of the Act, transitional corridor payments will no longer be paid to providers other than cancer hospitals and children's hospitals. Cancer hospitals and children's hospitals are held harmless permanently

under the transitional corridor provisions of the statute.

Since small rural hospitals may not be able to achieve the same level of operating efficiencies as larger rural hospitals and urban hospitals, we were concerned that the possible decrease in payments to these hospitals resulting from the elimination of the transitional corridor payments could result in these hospitals having to decrease or altogether cease to provide certain outpatient services. A reduction of services could have consequences for Medicare beneficiaries and their continued access to care in rural areas. In light of these concerns, we stated in the August 12, 2003 proposed rule that one thing we could do is to provide increased APC payments for clinic and emergency room visits furnished by rural hospitals having 100 or fewer beds. Any adjustment to payments for these hospitals would be made under the authority granted to the Secretary under section 1833(t)(2)(E) of the Act, to establish in a budget neutral manner adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals. In the August 12, 2003 proposed rule, we invited comments on whether we should provide an adjustment, such as the one described above, for small rural hospitals.

We received a few comments regarding the elimination of transitional corridor payments, which are summarized below along with our responses.

Comment: Two commenters stated that the loss of transitional corridor payments would dramatically affect revenues for rural hospitals; therefore, they supported increased payments to rural hospitals for clinic and emergency room visits. One hospital association recommended that we provide appropriate payment protections for small rural hospitals that provide emergency services to safeguard them from any adverse consequences stemming from the elimination of transitional corridor payments and to avoid life-threatening consequences by protecting beneficiaries' timely access to emergency services. Two additional commenters contended that our proposal would be inadequate and that to avoid curtailing services to Medicare beneficiaries relief is needed for small rural hospitals, sole community hospitals, and rural referral centers. They recommended that we continue transitional corridor payments using the authority we have to make adjustments under section 1833(t)(2)(E) of the Act. One commenter stated that our proposal failed to address other outpatient services that will be underpaid and suggested that transitional corridor payments be continued for a year while a more broad based payment methodology is developed for small rural hospitals. Another commenter recommended a rural APC add-on adjustment for all APCs paid to rural hospitals to acknowledge that these hospitals cannot achieve the same level of operating efficiencies as larger rural and urban hospitals. Another commenter argued that termination of transitional corridor payments was detrimental to all hospitals and recommended retaining transitional corridor payments for all hospitals.

One commenter opposed shifting payments from larger hospitals in order to increase payments to small rural hospitals. The commenter stated that all hospitals, regardless of size and location, struggle with gaining operating efficiencies under the OPPS. One hospital association indicated that transitional corridor payments have been a critical source of financial support for many teaching hospitals and payments to these hospitals deserve further analyses by us, which would likely result in the conclusion that a teaching hospital adjustment is warranted. Several hospital associations expressed concern about our proposal to create differential payment rates between urban and rural hospitals for clinic and emergency room visits, and one questioned our legal authority to pay differently for the same service. One of the associations added that as a preferred alternative, it is urging the Congress to allocate additional resources to extend the transitional corridor and hold harmless provisions to all providers as well as urging the Congress to increase payments for clinic and emergency room visits for all hospitals. Another of the hospital associations stated that it does not support a budget neutral, redistributive adjustment through regulation, but is instead urging the Congress to allocate additional resources to assist rural hospitals by increasing payment rates for clinic and emergency room visits for all hospitals.

The Medicare Payment Advisory Commission (MedPAC) commented that the August 12, 2003 proposed rule failed to provide a rationale for proposing increased payments for emergency room and clinic visits as a means of supporting small rural hospitals and recognized that only limited cost report data are available to assess the performance of small rural hospitals under the OPPS. MedPAC stated that we should consider other regulatory options to ensure access to care for rural beneficiaries, such as a low-volume adjustment and pointed out that any payment adjustment should be accompanied by an analysis of how small rural hospitals have fared under the OPPS, the impact of any payment adjustment, and the impact of other policies that affect rural hospitals such as conversion to critical access status. MedPAC also stated that legislative remedies could include extending the hold harmless policy or providing a transition from hold harmless status.

Response: Although we expressed concerns in the August 12, 2003 proposed rule that the sunsetting of transitional corridor payments might significantly impact small rural hospitals and we invited comments about whether we should provide for some type of adjustment to payments for these hospitals, we did not receive a large number of comments and the comments we did receive are mixed on the issue. Although some commenters called for an extension of hold harmless transitional corridor payments for small rural hospitals, we do not believe that is a viable option because any adjustment we would make under the authority of section 1833(t) of the Act would have to be made on a budget neutral basis and would result in decreased APC payments for all providers. Because we did not receive a strong response in favor of increased visit payments to small rural hospitals or compelling evidence that clearly supported the position that an adjustment for small rural hospitals is necessary to ensure access to hospital outpatient services in areas served by small rural hospitals, we will not adopt a payment adjustment for small rural hospitals. We will continue to seek information related to specific situations that demonstrate that access to care is a problem for Medicare beneficiaries.

XI. Other Policy Decisions and Changes

A. Hospital Coding for Evaluation and Management (E/M) Services

Facilities code clinic and emergency department visits using the same [Physicians'] Current Procedural Terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are currently five levels of care. Because these codes were defined to reflect only the activities of physicians, they are inadequate to describe the range and mix of services provided to patients in the clinic and emergency department settings (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

In the April 7, 2000 final rule (65 FR 18434), we stated that in order to ensure proper payment to hospitals, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. Commenters recommended that we keep the current E/M coding system until facility-specific E/M codes for emergency department and clinic visits, along with national coding guidelines, were established. Commenters also recommended that we convene a panel of experts to develop codes and guidelines that are simple to understand, implement, and that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

Outcome of January 2002 APC Panel Meeting

During its January 2002 meeting, the APC Panel made several recommendations regarding coding for evaluation and management services. After careful review and consideration of written comments, oral testimony, and the APC Panel's recommendations, we proposed the following in the August 9, 2002 proposed rule (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services:

GXXX1—Level 1 Facility Emergency Services;

GXXX2—Level 2 Facility Emergency Services;

GXXX3—Level 3 Facility Emergency Services;

GXXX4—Level 4 Facility Emergency Services; and

GXXX5—Level 5 Facility Emergency Services.

2. To develop five G codes to describe clinic services:

GXXX6—Level 1 Facility Clinic Services;

GXXX7—Level 2 Facility Clinic Services;

GXXX8—Level 3 Facility Clinic Services;

GXXX9—Level 4 Facility Clinic Services; and

GXXX10—Level 5 Facility Clinic Services.

3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.

4. To establish separate documentation guidelines for emergency visits and clinic visits.

In our November 1, 2002 final rule (67 FR 66792), we stated that the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that would make recommendations to us. In light of the expertise of organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), we felt that these organizations were particularly well equipped to make recommendations to us and to provide ongoing education to providers.

On their own initiative, the AHA and the AHIMA convened an independent expert panel of individuals from various organizations to develop code descriptions and guidelines for hospital emergency department and clinic visits and to make recommendations to us.

The panel recommended the following to us.

1. We should make payment for emergency and clinic visits based on four levels of care.

2. We should create HCPCS codes to describe these levels of care as follows:

GXXX1—Level 1 Emergency Visit.

GXXX2—Level 2 Emergency Visit.

GXXX3—Level 3 Emergency Visit.

GXXX4—Critical Care provided in the emergency department.

GXXX5—Level 1 Clinic Visit.

GXXX6—Level 2 Clinic Visit.

GXXX7—Level 3 Clinic Visit.

GXXX8—Critical Care provided in the clinic.

3. We should replace all the HCPCS currently in APCs 600, 601, 602, 610, 611, 612, and 620 with GXXX1 through GXXX8.

4. Based on the above recommendations, we would crosswalk payments as follows: GXXX1 to APC 610, GXXX2 to APC 611, GXXX3 to APC 612, GXXX4 to APC 620, GXXX5 to APC600, GXXX6 to APC 601, GXXX7 to APC 602, and GXXX8 to APC 620. These crosswalks and code descriptions are listed in Table 14 below.

TABLE 14.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES

2003 HCPCS description	2004 G code description	2003 HCPCS	2004 Proposed G codes	APC	Payment amount
Emergency department visit	Level 1 Emergency Visit	99281 99282	GXXX1	0610	$74.70
Emergency department visit	Level 2 Emergency Visit	99283	GXXX2	0611	130.77
Emergency department visit	Level 3 Emergency Visit	99284 99285	GXXX3	0612	226.30
Critical care	Level 4 Critical Care provided in the emergency department.	99291 99292	GXXX4	0620	491.01
Office/outpatient visit, new	Level 1 Clinic Visit	99201 99202	GXXX5	0600	50.62
Office/outpatient visit, new	Level 2 Clinic Visit	99203	GXXX6	0601	53.56
Office/outpatient visit, new	Level 3 Clinic Visit	99204 99205	GXXX7	0602	82.07
Office/outpatient visit, established	Level 1 Clinic Visit	99211 99212	GXXX5	0600	50.62
Office/outpatient visit, established	Level 2 Clinic Visit	99213	GXXX6	0601	53.56
Office/outpatient visit, established	Level 3 Clinic Visit	99214 99215	GXXX7	0602	82.07
Office consultation	Level 1 Clinic Visit	99241 99242	GXXX5	0600	50.62
Office consultation	Level 2 Clinic Visit	99243	GXXX6	0601	53.56
Office consultation	Level 3 Clinic Visit	99244 99245	GXXX7	0602	82.07

TABLE 14.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES—Continued

2003 HCPCS description	2004 G code description	2003 HCPCS	2004 Proposed G codes	APC	Payment amount
Critical care	Level 4 Critical Care provided in the clinic.	99291 99292	GXXX8	0620	491.01

The independent panel convened by the AHA and AHIMA recommended these levels in anticipation of the development of national coding guidelines for emergency and clinic visits that meet the following criteria we announced in the August 9, 2002 proposed rule (67 FR 52131):

1. Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, rather than physician resource use.

2. Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and comply with HIPAA.

3. Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably, coding guidelines should be based on current hospital documentation requirements.

4. Coding guidelines should not create incentives for inappropriate coding (for example, up-coding).

We have received recommendations for a set of coding guidelines from the independent E/M panel comprised of members of the AHA and AHIMA. We proposed to implement new evaluation and management codes only when we are also ready to implement guidelines for their use, after allowing ample opportunity for public comment, systems change, and provider education. We also proposed to use cost data from the current HCPCS codes in these APCs to determine the relative weights of these APCs until cost data from GXXX1 through GXXX8 are available to set relative weights. We note that this proposal requires discontinuing the use of all HCPCS codes in these APCs and would not allow us to collect cost data for the five levels of emergency and clinic visits that are currently described by CPT codes. We further note that we would no longer be able to distinguish among the costs for visits by new patients, established patients, consultation patients, or patients being seen for more specialized care (for example, pelvic screening exams and glaucoma screening exams).

We would be using claims data from current HCPCS codes and crosswalking those data to the new codes in the same APCs; therefore, there would be no change in payment for any of these services as a result of these coding changes. Once cost data become available from the new HCPCS codes, we would use those data to set the relative weights, and, therefore, there should be no budgetary impact.

We are currently considering the set of proposed national coding guidelines for emergency and clinic visits recommended by the independent panel. We plan to make any proposed guidelines available to the public for comment on the OPPS web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. With regard to the development of these guidelines, our primary concerns are—

1. To make appropriate payment for medically necessary care;

2. To minimize the information collection and reporting burden on facilities;

3. To minimize any incentives to provide unnecessary or low quality care;

4. To minimize the extent to which separately billable services are counted as E/M services;

5. To develop coding guidelines that are consistent with facility resource use; and

6. To develop coding guidelines that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. Before adoption and implementation of any coding changes or coding guidelines, ample time will be provided for the public to comment on our proposal and, following announcement of any final decisions, for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines. In the proposed rule, we requested comments on the amount of time hospitals believe would be adequate to implement these new codes and guidelines. We stated that we remain committed to working with appropriate organizations and stakeholders in our continuing development of a standard set of codes and national guidelines for facility coding of emergency and clinic visits.

We received comments on our proposal, which are summarized below with our responses.

Comment: Several physician societies objected to the creation of new G codes to replace existing CPT codes for facility coding of emergency and clinic visits. These commenters stated that new G codes for these services would add an unnecessary layer of complexity and confusion to the system, and that the existing CPT codes adequately and appropriately describe the services provided in the emergency and clinic settings. One physician society supported the creation of new G codes for facility coding of emergency and clinic visits, agreeing that CPT codes fail to accurately describe facility resources used to provide E/M services, but expressed concern that payers or auditors might refer to crosswalks made in establishing facility E/M code levels to determine appropriate level of coding for physician E/M services. This commenter urged CMS to clarify that the levels of visits for facility E/M services should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

Several commenters, including a hospital association and federation, commended CMS for proposing new G codes for facility coding of emergency and clinic visits, stating that existing CPT codes for E/M services correspond to different levels of physician effort and fail to adequately describe non-physician resources. These commenters stated that the proposed new G codes would appropriately capture facility resources, minimize confusion relative to physician versus facility E/M services, and adequately meet hospitals' need to comply with HIPAA regulations.

Response: We agree with those commenters who believe that CPT codes for E/M services describe different levels of physician effort, and therefore, fail to accurately describe facility resources used to provide E/M services. In the November 1, 2002 final rule (67 FR 66718), we explained that the development of new HCPCS codes for facility visits was necessary to address potential HIPAA compliance issues. We also agree with comments that the

proposed new G codes would appropriately capture facility resources and minimize confusion relative to physician versus facility E/M services. Therefore, we will continue to develop coding guidelines for facility E/M codes that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. For clarification purposes, levels of visits for facility E/M services should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

Comment: We received a number of comments regarding our proposal of three levels of care (plus critical care) for clinic and emergency department visits. Several commenters stated that variation in cost per visit warrants five levels of service mapping to five separate APCs to maintain reasonable steps in payment as treatment costs increase. These commenters expressed concern that the agency will no longer have the ability to collect cost data for the five levels of emergency and clinic visits currently described by CPT codes, and that an averaging of charges over only three levels of service will result in adverse effects (that is, overpayments and underpayments) at the low and high end of visit codes. Furthermore, these commenters stated that private payers require a five tiered system and may not recognize the new G codes for payment. In contrast, we received several comments supporting our proposal of three levels of care (plus critical care) for clinic and emergency department visits. These commenters stated that three levels would help reduce the coding complexity and would be a more appropriate and accurate mechanism for reporting emergency and clinic visits.

Response: We appreciate the commenters' concerns while at the same time recognizing merits in the independent expert panel's recommendation to create three levels of care (plus critical care) for clinic and emergency visits. Given the level of interest in this issue and the importance to Medicare and to hospitals of establishing the appropriate codes and payment levels for these services, we will continue to study the issue. Prior to implementation of new facility E/M codes we will carefully consider all commenters' concerns related to variation in visit costs and recognition of a three tiered system by private payers. We will also consider placing this issue on the agenda for the 2004 APC Panel meeting.

Comment: Several physician societies expressed concern about potential discrepancies in payment for the same services furnished in clinic and emergency departments versus physician offices. One commenter stated that the proposal lacked physician input. While acknowledging statutory requirements that dictate the structure of the payment system for non-physician resources required to support physician services and the payment system for outpatient facility resources, commenters stated that we should avoid adopting policies that further increase the inequity in Medicare's payment systems. These commenters urged us to establish payment equity for the same services furnished in these respective settings.

Response: As stated elsewhere, the statute contains different provisions for how payments are established under the physician fee schedule and how payments are established under the OPPS. With respect to the absence of physician input on the proposal, we welcome comments from all interested parties as we continue to develop our policy.

Comment: We received numerous and detailed comments in reference to the model guidelines proposed by the independent expert panel convened by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA).

Response: We are appreciative of the detailed comments we received in reference to the model guidelines proposed by the independent expert panel convened by the AHA and AHIMA. While we will carefully consider these comments in our continued review of the independent panel's proposed guidelines, we will not be responding to such comments in this rule since CMS did not propose these coding guidelines in the August 12, 2003 proposed rule.

Comment: Several commenters supported our decision to delay implementation of new E/M codes for clinic and emergency department visits until we have established defined and uniform coding guidelines.

Response: To minimize confusion, we continue to believe that a national set of defined coding guidelines must be established and implemented in conjunction with any new E/M codes for clinic and emergency department visits.

Comment: Several commenters encouraged CMS to make any proposed guidelines for billing hospital emergency room and clinic visits publicly available with opportunity to comment as soon as they are complete.

Response: We plan to make any coding guidelines that we are considering available to the public for comment on the OPPS Web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. As stated elsewhere, we will provide ample opportunity for the public to comment on the proposal.

Comment: Several commenters requested that CMS provide adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate new evaluation and management (E/M) codes and guidelines. While two commenters requested a minimum notice of three months prior to implementation, the majority of commenters requested a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines.

Response: We will continue to be considerate of the time necessary to educate clinicians and coders and for hospitals to modify their systems to accommodate new codes and guidelines. Based on comments received, we will provide a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines. We do not expect to implement these new codes and guidelines any earlier than January 2005.

B. Status Indicators and Issues Related to OCE Editing

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate whether a service represented by an HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. We are providing our status indicator (SI) assignments for APCs in Addendum A, HCPCS codes in Addendum B, definitions of the status indicators in Addendum D1, and definitions of code condition indicators in Addendum D2.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the

OPPS, we must be able to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through a system of payment status indicators with specific meanings.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services.

In the August 12, 2003 proposed rule, we listed the OPPS status indicators and described how we proposed to use them in the 2004 OPPS. We also solicited comments on the appropriateness of the status indicator that we proposed to assign to each APC in Addendum A and each HCPCS code in Addendum B. Because the assignment of a status indicator designates how a particular outpatient service will be paid, either under the OPPS or under another payment system, or why payment is not made for a code, the comments that we received regarding the status indicator assigned to a particular APC or HCPCS code are discussed elsewhere in this final rule, within the context of the payment policy or rule that affect how payment is determined for the APC or HCPCS code.

Since publication of the August 12 proposed rule, we have been preparing specifications for the January 1, 2004 outpatient code editor (OCE) and PRICER, which are pivotal in determining how hospital claims for outpatient services are processed and paid. In the course of discussions with the contractors and systems maintainers with whom we work to ensure that claims are processed appropriately and in accordance with the policies and changes that we are implementing in this final OPPS rule for 2004, several issues related to status indicator definitions and claims processing edits and dispositions have arisen. As a result of these discussions, we have determined that claims would be processed more accurately if we established two additional payment status indicators to designate with greater specificity the appropriate disposition of certain codes for which payment is not made under the OPPS. Therefore, we are adding two status indicators, status indicator ''B'' and status indicator ''Y,'' to Addendum D1, which lists all of the status indicators established as part of the OPPS and describes what they signify. We have also revised and refined the status indicator definitions and clarified the explanation of what each status indicator means. None of these changes affect how services are paid under the OPPS. Rather, the changes are intended to clarify how the status indicators relate to existing payment policy and rules and to assist hospitals and our contractors in determining the disposition of individual HCPCS codes when they are billed to Medicare.

In 2004, we are adding a new Status Indicator ''Y'' to designate codes for non-implantable Durable Medical Equipment (DME) to assist hospitals in identifying codes that they must bill directly to the Durable Medical Equipment Regional Carrier (DMERC) rather than to the fiscal intermediary. Codes assigned Status Indicator ''Y'' are listed in Addendum B.

Historically, we have used Status Indicator ''E'' to identify certain HCPCS codes that are recognized by Medicare but that are not payable under the OPPS when they are submitted on an outpatient hospital Part B bill type (bill type 12x, 13x, or 14x). Beginning with implementation of the 2004 final rule, we are assigning Status Indicator ''B'' to HCPCS codes that are not payable under OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x), but that may be payable by intermediaries to other provider types when submitted on an appropriate bill type, such as bill type 75x submitted by a CORF. In some cases, another code may be submitted by hospitals on an outpatient hospital Part B bill type (12x, 13x, and 14x) to receive payment for a service or code that is assigned status indicator ''B'' in Addendum B. Because we did not include these status indicator changes in the August 12, 2003 proposed rule, we invite comments on their addition to Addendum D1, and on the revised definitions and explanations that we included in Addendum D1.

Addendum D2 shows the indicators that we use to designate codes that are new in 2004 for which comments may be submitted as well as codes that are deleted in 2004 either with or without a grace period.

C. Observation Services

In the November 1, 2002 update to the OPPS (67 FR 66794), we summarized and clarified previously published guidance (Transmittal A–02–026) regarding payment requirements for HCPCS code G0244, Observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum of 8 hours, maximum 48 hours. We also implemented HCPCS codes G0263 and G0264 to identify patients directly admitted to observation. In January 2003, we published Transmittal A–02–129, which provides further instructions regarding billing for observation services. In the proposed rule, we did not propose anything new with regard to observation services, nor did we seek public comment on observation issues. We stated that we would update by Program Memorandum any changes in the list of ICD–9–CM codes required for payment of HCPCS code G0244 resulting from the October 1 annual update of ICD–9–CM. We also stated in the proposed rule that we would include any changes in the 2004 final OPPS rule and allow the public an opportunity to comment.

We have had an opportunity to review the October 1, 2003 update of the ICD–9–CM and we have determined that there are not changes that affect the list of diagnosis codes required for payment of HCPCS code G0244. Therefore, we are not implementing any changes in the way we pay for observation services under the 2004 OPPS.

D. Procedures That Will Be Paid Only as Inpatient Procedures

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to be provided only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

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

discussed in the April 7, 2000 and the November 30, 2001 final rules, we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule, we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ambulatory surgical center (ASC) procedures or proposed by us for addition to the ASC list.

At its January 2003 meeting, the APC Panel did not make recommendations regarding procedures on the inpatient list, and in the proposed rule, we did not propose to make any of the procedures that are currently on the inpatient list in Addendum E payable under the OPPS in 2004. We solicited comments on whether any procedures in Addendum E should be paid under the OPPS. We asked commenters recommending reclassification of a procedure to an APC to include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and effective manner. We also solicited comments on the appropriate APC assignment for the procedure in the event that we determine in the final rule, based on comments, that the procedure would be payable under the OPPS in 2004.

Following our review of any comments that we receive about the procedures in Addendum E, we indicated in the proposed rule that we would propose either to assign a CPT code to an APC for payment under the OPPS or, if the comments did not provide sufficient information and data to enable us to make a decision, to present the comments to the APC Panel at its 2004 meeting.

Procedures on the inpatient list can be found in Addendum E. CPT codes that are new in 2004 and that we believe are appropriately assigned status indicator ''C'' to designate that they are on the inpatient list can be found in Addendum B with condition code ''NI''. We invite comment on assignment of these codes to the inpatient list.

We received a few comments regarding the inpatient list, which are summarized below with our responses.

Comment: A group of providers representing 18 health care systems around the country requested that CMS clarify the intent of the inpatient list. The commenter expressed concern that some independent medical review criteria appear to equate codes with APC payments as procedures that CMS has determined must be outpatient services both because they are payable under the OPPS and because they are not included on the inpatient list. The commenter is concerned that hospitals will interpret these criteria to mean that any procedure or service not on the inpatient list must be furnished on an outpatient basis, regardless of the needs of the patient.

Response: We wish to clarify that assignment of an APC payment to a service or procedure does not mean that Medicare covers the service or procedure or that it may only be payable when furnished in an outpatient setting. In the November 1, 2002 final rule (67 FR 66739) as well as the April 7, 2000 and the November 30, 2001 final rules, we explain in detail our rationale for the inpatient list. Assignment of an APC payment to a service or procedure does not prohibit hospitals from providing these services on an inpatient basis when it is reasonable and necessary to admit the patient based on the patient's medical condition.

Comment: The same commenter repeated objections that have been submitted in comments to OPPS rules in prior years, that it is unfair to deny payment to hospitals for procedures on the inpatient list, but to pay physicians when they perform procedures on the inpatient list in a hospital outpatient setting. The commenter asserts that physicians are not responsive to hospital efforts to educate them regarding Medicare payment for procedures on the inpatient list performed on a patient who has not been admitted as an inpatient because the location that the physician chooses to perform a procedure has no impact on Medicare payment for the physician's professional services. Moreover, the commenter asserts that physicians disagree with assignment of procedures to the inpatient list because new technology or surgical advances allow the procedure to be appropriately performed on an outpatient basis. The commenter urged us to release the inpatient list as part of the physician's fee schedule in order to align hospital and physician incentives.

Response: In the November 1, 2002 final rule (67 FR 66740) we responded to similar comments regarding hospitals' concerns about physicians being paid for procedures on the inpatient list that are performed on an outpatient basis even though payment is denied to hospitals for those procedures. As we state above, the basis for the inpatient list is rooted in section 1833(t)(1)(B)(i) of the Act, which gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. The authority in this section of the Act does not extend to services that are covered and paid for under the Medicare physician fee schedule, which is a separate benefit and payment system. However, we believe that as hospitals and physicians continue to gain experience and become more knowledgeable about how Medicare pays for services under the OPPS, problems associated with the existence of the inpatient list will continue to diminish.

Moreover, we welcome at any time recommendations from hospitals and/or physicians regarding procedures currently on the inpatient list that are being safely and appropriately performed on an outpatient basis. Requests for review of a code or group of codes on the inpatient list should be sent to the Director, Division of Outpatient Care, Centers for Medicare & Medicaid Services, Mailstop C4–05–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Such requests should include supporting information and data to demonstrate that the code meets the five criteria for payment under the OPPS that are listed above, and that are also discussed in the November 1, 2002 final rule (67 FR 66739). In addition, we ask that evidence be submitted, including operative reports of actual cases and peer-reviewed medical literature, to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals.

Comment: The same commenter recommended that we change our policy for OPPS payment of inpatient services when the patient is transferred to another hospital. They state that the current requirement creates unnecessary administrative burden when a hospital, in order to receive payment, must admit a patient simply to stabilize them prior to transfer. The commenter

recommended that, when procedures on the inpatient list are provided to patients in order to stabilize the patient immediately prior to transfer, we ignore the payment status indicator of ''C'' assigned to the procedure on a claim and allow the claim to be paid under the OPPS.

Response: Procedures on the inpatient list performed on patients whose status is that of outpatient are not payable under the OPPS. However, we recognize that there are occasions when a procedure on the inpatient list may have to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient. We also recognize that, once stabilized, such a patient may subsequently require transfer to another facility in order to receive appropriate care. As we explain in the November 1, 2002 final rule (67 FR 66798), when a physician performs a procedure on the inpatient list to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient, we expect the physician to order that the patient be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient hospital bed. Or, the physician may order that the patient be admitted and then determine that the patient should be transferred to another provider. In the latter instance, Medicare allows payment for services furnished to a patient who is transferred to another provider. However, in order for the discharging hospital to receive payment in cases where it is determined that appropriate care for the patient necessitates transfer to another provider, long-standing Medicare rules provide that the patient has to have been admitted to the discharging hospital. Further, as we discuss in the November 1, 2002 final rule, it is important that the particular circumstances necessitating performance of a procedure on the inpatient list when the patient's status is that of an outpatient be thoroughly documented in the medical record. For these reasons, we disagree with and are not implementing the commenter's recommendation that we modify the outpatient code editor (OCE) to allow payment under the OPPS for services furnished to resuscitate or stabilize an outpatient with an emergent, life-threatening condition who is transferred to another facility following a procedure on the inpatient list.

Comment: One hospital requested that we remove CPT 37182, Insertion of transvenous intrahepatic protosystemic shunts(s) (TIPS), from the inpatient list. One health system requested that we remove CPT 20660, Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure) and CPT 49061, Drainage of retroperitoneal abscess; percutaneous, from the inpatient list.

Response: Our medical officers reviewed these recommendations and determined that these codes do not meet the criteria for removing a procedure from the inpatient list and assignment to an APC. We would expect patients whose medical condition requires these procedures to be admitted as inpatients in order to have these procedures performed. Our data indicate that these procedures are performed predominantly in the inpatient setting. Therefore, in the absence of evidence demonstrating that these procedures are being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals and that the criteria for removing a procedure from the inpatient list are met, we are retaining these codes on the inpatient list.

Comment: A provider group requested that we change the status indicator of the following codes from ''N'' to ''C,'' because these are add-on codes for procedures already on the inpatient list: CPT 61316, Incision and subcutaneous placement of cranial bone graft; CPT 61517, Implantation of brain intracavitary chemotherapy agent; CPT 62148, Incision and retrieval of subcutaneous cranial bone graft for cranioplasty; and, CPT 62160, Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage.

Response: We thank the commenter for bringing these codes to our attention and we agree that the status indicator for these codes should be changed from ''N'' to ''C.''

New APC To Pay for Services Furnished on Same Date as Service With Modifier -CA:

In the 2003 update of the OPPS, we implemented a new modifier -CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. In section VI of Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of modifier -CA when submitting a claim on bill type 13x for a procedure that is on the inpatient list and that is assigned payment SI ''C.'' (Transmittal A–02–129 can be found on our web site at *cms.hhs.gov*.) We also implemented in the November 1, 2002 final rule (67 FR 66799) a new payment policy to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as the HCPCS code billed with modifier -CA. A single payment for outpatient services on the claim, other than those coded with SI ''C'' and modifier -CA, is currently made under APC 0977.

We reviewed this policy and determined that assigning payment for these services to APC 0977, which is a New Technology APC, is problematic because payment under New Technology APCs is a fixed amount that does not have a relative payment weight and is, therefore, not subject to recalibration based on hospital costs. We proposed to establish a new APC for which payment would be made under certain conditions for otherwise payable outpatient services furnished on the same date of service that a procedure with SI ''C'' is performed emergently on an outpatient who dies before admission to the hospital as an inpatient. Beginning in 2004, hospitals would be paid under APC 0375 instead of APC 0977 for services furnished on the same date of service that a procedure with SI ''C'' and modifier -CA is billed. We proposed at the outset to set the payment rate for APC 0375 in the amount of $1,150, which is the payment amount for the newly structured New Technology APC that would replace APC 0977. When the APC weights are recalibrated in 2005, we would use charge data from CY 2003 claims for line items that have the same date of service as the line with modifier -CA and that show a HCPCS code with status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' or ''K'' to calculate a median cost and relative payment weight for APC 375. Once we have claims data, we would be able to determine whether it is appropriate to calculate a relative payment weight based on median costs from our claims data or to continue a fixed payment rate for these special cases. In the proposed rule, we invited comments on these proposed changes.

Comment: One commenter was concerned with the methodology for calculation of APC 375, Ancillary Outpatient Services when Patient Expires. The commenter stated that items such as pass-through devices and drugs and packaged items reported without HCPCS should be included in the calculation.

Response: It is conceivable that a pass-through drug or device could be furnished to a patient during the same encounter when a procedure billed with modifier -CA is performed. If that were the case, we would expect the hospital to include these services on the claim submitted for the encounter. Although

we would not pay separately for the pass-through items, we agree with the commenter that we should consider taking these costs into account when evaluating how best to establish the payment rate for APC 375 in future updates of the OPPS. We also agree that charges reported with a revenue code but without a HCPCS code should be considered as well.

E. Partial Hospitalization Payment Methodology

1. Background

As we discussed in the April 7, 2000 OPPS final rule (65 FR 18452), partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in place of inpatient psychiatric care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000.

The analysis of hospital partial hospitalization claims resulted in a per diem payment of $202.19, effective August 1, 2000. This amount was updated effective January 1, 2001 and April 1, 2002 to $206.82 and $212.27, respectively.

Effective January 1, 2003, the PHP APC amount was $240.03, of which $48.17 is the beneficiary's coinsurance. In the proposed rule, we described the methodology we followed in developing the 2003 PHP payment rate.

2. PHP APC Update for CY 2004

For CY 2004, we analyzed hospital and CMHC PHP claims for services furnished between April 1, 2002 and December 31, 2002. We intended to propose to use the same methodology for computing median costs per day for CY 2004 that was used to compute the CY 2003 PHP median cost per day. However, when we applied the methodology to the CMHC claims, the CMHC median cost per day was determined to be significantly higher than the median cost per day for hospital outpatient departments to provide the same benefit. In addition, the difference in median costs per day was significantly larger than last year.

As a result, we proposed a per diem rate for PHP services furnished during CY 2004 based solely on hospital PHP data. The proposed PHP APC 0033 amount, after scaling, was determined to be $208.95, of which $41.69 is the beneficiary's coinsurance.

However, a Program Memorandum issued on January 17, 2003, directed the FIs to recalculate hospital and CMHC cost-to-charge ratios. We anticipated receipt of the updated ratios this summer, and indicated that if the updated cost-to-charge ratios resulted in a more reasonable median per diem rate, we would use the CMHC data in developing the final rate for CY 2004.

We received 42 public comments in response to this proposal. A summary of the comments is provided below along with our responses.

Comment: In general, the commenters expressed concern that a reduction in the PHP rate of this magnitude would lead to the closure of many PHPs and that limited access to this crucial service would result in more costly inpatient hospital care as the ony alternative. A hospital association commented that basing the rate on only hospital data is inconsistent with other prospective payment systems and recommended that we find an alternative method to secure reliable CMHC data. CMHCs commented that their costs are higher than hospitals', with most in the $300 to $400 range. One commenter provided summary information on the average per day costs for seven CMHCs. Although the average per day cost for these seven providers was $390, the costs for individual providers ranged from $216 to $725. Unfortunately, the commenter did not provide a breakdown of these costs. Another commenter indicated that a per day rate of $300 to $350 was more appropriate than our proposed amount.

Another commenter stated that our inability to process the data timely does not constitute an appropriate basis for excluding all CMHC data from the per diem calculations. The commenters suggested alternatives such as including prior years' CMHC data trended forward based on medical inflation or maintaining the CY 2003 payment rate for PHP services furnished in CY 2004. One commenter questioned why the median cost per day for hospitals was reported as $225 but the proposed rate was reduced to $208.95.

Response: As we stated in the August 12, 2003 proposed rule, we intended to review the PHP data using the updated cost-to-charge ratios to compute the final CY 2004 PHP APC. As expected, the updated ratios reduced the median cost per day for CMHCs. The revised medians are $440 for CMHCs and $206 for hospitals. Combining these files results in a median per diem PHP cost of $303. As with all APCs in the OPPS, the median cost for each APC is scaled to be relative to a mid-level office visit and the conversion factor is applied. The resulting APC amount for CY 2004 is $286.82 of which $57.36 is the beneficiary's coinsurance.

Comment: With respect to the methodology used to establish the PHP APC amount, commenters expressed concern that data from settled cost reports fails to include costs reversed on appeal and that there are inherent problems in using claims data from a different time period like available cost-to-charge ratios on settled cost reports.

Response: We used the best available data in computing the APCs. The January 17, 2003 Program Memorandum directed FIs to update the cost-to-charge ratios on an ongoing basis whenever a more recent full year cost report is available. In this way, we hope to minimize the time lag between the cost-to-charge ratios and claims data.

Comment: One commenter provided links to certain data files that were used to establish the APC rates. Since APC 0033 and certain HCPCS codes that are only paid under OPPS when they are furnished as part of a PHP were not included in these data files, the commenter believed that the data used to establish the PHP APC amount is incomplete.

Response: These data files are provided so that interested parties can study the costs associated with the HCPCS codes that comprise each APC and other analyses. We are required to include the HCPCS codes within each APC that are similar in resource use. This is not the case with the PHP APC (0033) in which the day of care is the unit that defines the structure and scheduling of PHPs and the composition of the PHP APC consists of the cost of all services provided each day. Although we require that each PHP day include a psychotherapy service, we do not specify the specific mix of other services provided and have focused our analysis on the cost per day rather than the cost of each service furnished within the day. As a result, we will add APC 0033 to the file that displays the APC median costs, but not the PHP data that show medians by HCPCS codes. We will continue to analyze the PHP data and will reconsider this position in the future.

Comment: One commenter related that administrative costs for CMHCs continue to be a major impediment to operating PHPs for Medicare beneficiaries. Medicare does not cover transportation to and from programs and does not cover meals. Almost all programs offer transportation because in

most cases Medicare beneficiaries with serious mental illnesses would not be able to access these programs without the transportation. They also commented about the current Medicare bad debt policy, which is beyond the scope of the August 12, 2003 proposed rule.

Response: The services that are covered as part of a PHP are specified in section 1861(ff) of the Act. Meals and transportation are specifically excluded under section 1861(ff)(2)(I) of the Act.

Comment: Several commenters summed the median cost figures for various combinations of HCPCS codes 90853 (group psychotherapy), 90818 (individual psychotherapy, 45–50 minutes), and 90847 (family psychotherapy, with patient present) and concluded that the per diem amount is considerably less than the combined cost of these services.

Response: We believe that the figures cited by the commenters were taken from a file that shows the median cost for single bills, for example, where group psychotherapy was the only service furnished. We do not believe that this is an appropriate comparison. These amounts are provided to enable the public to identify the median cost of services before scaling. It is important to note that these services are not PHP services, but rather single outpatient therapeutic sessions. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a program of services where savings can be realized by hospitals and CMHCs over delivering individual psychotherapy services.

Comment: Several commenters compared the proposed per diem amount to the cost of the minimum services mandated by us or by the local medical review policies (LMRP) used by their FIs.

Response: We have not specified the specific daily components of a PHP. However, there is an edit in our claims processing system to identify claims that do not have at least three services, with at least one psychotherapy service (individual, group, or family therapy) for each day of PHP care. We have implemented this edit to ensure that PHPs meet the statutory requirement that they be intensive treatment programs provided in lieu of inpatient psychiatric hospital services. Claims with fewer than three services per day undergo medical review by the FIs to ensure that the patient is receiving intensive treatment. There may be legitimate reasons for a day on a claim to have fewer services, for example, where the patient leaves the program early to receive medical care. Medical review of these claims verifies that the patient requires and is receiving a PHP level of care.

Comment: The commenters also questioned our requirement that psychotherapy services be conducted by a Master's level practitioner. One commenter questioned how a hospital could comply with the three services per day requirement when licensed clinical social worker (CSW) services are bundled into the per diem payment.

Response: We do not require that a Master's prepared practitioner furnish psychotherapy services in a PHP. However, in accordance with section 1861(ff)(2)(A) of the Act, we require that practitioners who furnish psychotherapy services are authorized to do so by their States, through licensure, certification, or other official State processes. When a service is furnished by a practitioner who is not authorized by the State to furnish psychotherapy services, the service would not be recognized as a PHP service.

With respect to billing by CSWs, the professional component of services furnished by CSWs to PHP patients is bundled into the per diem payment amount and no billing to the Part B carrier is permitted. The rationale for this policy was explained in the interim final regulation with comment period we published on February 11, 1994 (59 FR 6570).

The OPPS is intended to pay PHP providers for the resources associated with sponsoring a PHP, for example, building maintenance, utilities, and support staff, including the cost of CSWs. Thus, where a PHP provider utilizes CSWs for psychotherapy services to PHP patients, payment for the professional costs of the CSW is made through the OPPS per diem payment. However, if a PHP utilizes psychiatrists, clinical psychologists, nurse practitioners, physician assistants, or clinical nurse specialists to furnish therapeutic services to PHP patients, the physician or practitioner may bill the Part B carrier for payment under the physician fee schedule for their professional services. When this occurs, the PHP provider may bill the FI under the OPPS for the facility resources associated with the psychotherapy service.

We note that a physician or any of the practitioners specified in 42 CFR 410.43(b) (including CSWs) may bill the Part B carrier for their professional services furnished to hospital outpatients who are *not* in a PHP. In this case, the hospital would bill the FI under the OPPS for the facility resources associated with the service furnished.

Comment: Several commenters suggested alternative methodologies for paying PHP providers, such as linking per diem and outlier payments to the units of service furnished each day or paying providers the average of all PHP costs plus 40 percent, subject to final settlement based on the provider's cost.

Response: We plan further analysis of the PHP data and may propose changes to the payment methodology for CY 2005. We note that OPPS is a prospective system and a methodology with interim payments subject to cost settlement would not be allowable under the statute.

Comment: One commenter believes the sample used to determine the rates is skewed and represents a subset of the provider community that provides PHP services.

Response: We do not agree that the sample is skewed. All facilities that submit claims for PHP services have been included in the development of the final rate.

3. Outlier Payments for PHPs

In a related matter, the use of historical cost-to-charge ratios applied to current charges has resulted in an excessive amount of outlier payments being made to CMHCs. As a result of more in-depth analysis of the 2001 data files that were used to compute the CY 2003 PHP per diem amount, we discovered a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP.

In the August 12, 2003 proposed rule, we stated that given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Therefore, we proposed to designate a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2004, excluding outlier payments. Since CMHCs were projected to receive 0.36 percent of total OPPS payments in CY 2004, excluding outlier payments, we proposed to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we proposed to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We proposed to apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we

proposed to pay 50 percent of CMHC and hospital per diem costs over the threshold.

Comment: Several commenters representing CMHCs suggested that in developing our proposed outlier policy, we made generalizations and overreacted to a few aberrant providers. Also, these commenters believe the per diem amount is insufficient and that outlier payments would provide the additional amounts they needed to stay in business until more representative data could be obtained and analyzed.

Response: Based on our analysis of PHP claims data, nearly half of the CMHCs billing for PHP services in 2002 received outlier payments. The total dollar amount of outlier payments received by these CMHCs was nearly equal to the total amount all CMHCs received in per diem payments. Of those CMHCs that received outlier payments, 56 percent received an average of more than $200 per day in outlier payments, 30 percent received more than $300 per day in outlier payments, 21 percent received more than $400 per day in outlier payments, and 11 percent received more than $500 per day in outlier payments.

The outlier policy is intended to compensate providers for treating exceptionally resource-intensive patients. Outlier payments were never intended to be made for all patients and used as a supplement to the per diem payment amount. Our analysis showed that the CMHC average charge per day increased by 31 percent from CY 2001 to CY 2002. We do not believe this increase in charges correlates to an equivalent increase in CMHC costs. Rather, our analysis indicates that the increase in charges was made in order to qualify for outlier payments to cover CMHC operating expenses, not for patients who are exceptionally resource-intensive. We are concerned that if CMHCs continue this pattern of escalating charges, CMHCs will receive a disproportionate share of outlier payments compared to non-CMHCs that do not artificially inflate their charges, thereby limiting outlier money for truly deserving cases.

Comment: Although one commenter supported our proposed outlier policy, most commenters, including major hospital associations, did not believe it was sound policy to create separate outlier thresholds based on site of service.

Response: Applying the updated cost-to-charge ratios reduced the CMHC charges to better reflect their costs. We are concerned, however, that the impact of updated cost-to-charge ratios may be mitigated by future increases in charges. We proposed an outlier policy in consideration of the charges on the claims, the cost report data available, and the payments made to CMHCs. Our analysis indicates that CMHCs have dramatically increased their charges between CY 2001 and CY 2002. Between CYs 2001 to 2002, CMHC average per diem charges increased by 31 percent. We believe that in most cases, these increases in charges were not related to a corresponding increase in costs, but rather were designed to enhance outlier payments. We believe the data may indicate a pattern of artificially inflated charges by CMHCs that needs to be addressed. Although we agree that establishing site of service differences is not generally the preferred approach, we continue to believe that establishing two separate outlier percentages is the most appropriate way to address the problem to account for the disparity between hospital and CMHC PHP per diem charges.

For these reasons, for CY 2004, we are establishing a separate CMHC threshold. The threshold is based on the proportion of total OPPS payments CMHCs are estimated to receive in CY 2004. As stated earlier in this section, our analysis indicated that CMHCs were projected to receive 0.36 percent of total OPPS payments in CY 2004, excluding outlier payments. Therefore, we proposed to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we proposed to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We have updated our simulations using the final CY 2004 PHP per diem rate. CMHCs are now projected to receive approximately 0.5 percent of estimated total OPPS payments in CY 2004, excluding outlier payments. We have calculated the CMHC outlier threshold to achieve that level of payment. The resulting threshold for CY 2004 is 3.65 percent times the APC 0033 payment amount. We will apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we will pay 50 percent of the difference between CMHC per diem costs and the CMHC outlier threshold amount. We intend to analyze whether a separate CMHC outlier threshold will continue to be appropriate in future updates.

XII. General Data, Billing, and Coding Issues

We received a number of general comments about OPPS data and related issues to which we respond below. Not all coding questions are addressed, however. We do not believe that the final rule is the appropriate venue in which to address specific inquiries about billing.

OPPS Data

Comment: A commenter indicated that it was difficult to model the August 12, 2003 proposed rule after its release and urged us to provide timely responses to questions about data, data files, and the specifics of the methodology used to generate relative weights, either by having data meetings or by clarifying the language in the final rule and median cost files. The commenter asked that we create a web-site to post responses to questions on data so that the information will be available for all to use. The commenter also asked that a number of data elements be added to the median cost file and the limited data set of claims that is available for public purchase.

Response: We have tried to respond to questions on data related issues on a flow basis. However, staff limitations and the need to develop the final rule greatly restrict the amount of time that our staff can devote to replying to these questions. Moreover, creation and maintenance of a web-site to post answers to questions from a few people with special interests is not a good use of our limited staff resources. We would encourage interested parties who have suggestions for improving our data file clarity to contact us with those specifics.

Creation of a National Outpatient Coding Governing Body

Comment: A commenter indicated that we should create an outpatient coding governing body that would educate providers regarding the correct use of codes, maintain a web-site on which all guidance on coding would be maintained, and oversee the Medicare fiscal intermediary interpretation of codes to ensure national uniformity across fiscal intermediaries.

Response: The HCPCS codes most often used for payment under OPPS are CPT codes, which are created and owned by the American Medical Association (AMA). Providers should look to the many resources available from the AMA for education regarding the correct use of CPT codes. The alphanumeric HCPCS codes are created and owned by us but they form a very limited portion of the services payable under OPPS and, as providers have frequently asked, we attempt to eliminate alphanumeric codes whenever possible and to work with the AMA to create CPT codes for use in both the physician fee schedule and the OPPS.

We attempt to provide coding guidance on alphanumeric codes, which are usually created only when there is a coverage or payment decision and when there is no CPT code that describes the service being covered or paid. However, providers must look to the AMA for education and support in the use of the CPT codes that form the bulk of OPPS.

Comment: We received one comment requesting that we publish updated addenda each quarter.

Response: The addenda that are published annually online are an official public record that cannot be changed without going through the **Federal Register**. We provide the Addenda in Excel format for the convenience of users since it is difficult to manipulate data in pdf format.

We also received a number of comments that were not relevant to the proposals made in the August 12, 2003 proposed rule. The commenters requested specific coding changes and requested clarification or guidance regarding certain billing requirements. Although we will provide answers to the questions raised, the final rule is not the appropriate venue for that guidance. We will consider the requests and suggestions provided, and will continue our ongoing efforts to formulate and publish billing instructions. Similarly, we will consult with our clinical experts regarding the suggestions made regarding coding of outpatient department procedures and other services.

Revenue Code Edits

Comment: A commenter asked whether we permit fiscal intermediaries to impose CPT to revenue code edits. The commenter believes that CMS has said that providers may choose the revenue code that applies to the item or service being billed but that some fiscal intermediaries have imposed revenue code to CPT edits that prevent hospitals from billing the service under the revenue code that they believe is appropriate and that cause unnecessary and unfair payment denials.

Response: We have issued some instructions that require that specific revenue codes be billed with certain HCPCS codes, such as specific revenues codes that must be used when billing for devices that qualify for pass-through payments. Where explicit instructions have not been issued, we instructed intermediaries to advise hospitals to report charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. However, we have not explicitly prohibited intermediaries from installing the revenue code to HCPCS code edits, so it is possible that certain edits are applied by some intermediaries and not others. The commenter did not provide examples of the edits that are causing what the commenter considers to be unnecessary and unfair payment denials.

New CPT Venous Access Codes

Comment: A commenter indicated that CPT had revised its venous access codes and encouraged us to use external information to determine hospital acquisition costs for devices used in these procedures.

Response: We carefully reviewed the new CPT codes for insertion of venous access devices and we assigned the new CPT codes to APCs based on our clinicians' view of the relative amount of hospital resources that the services, as described by the new codes, would use. We note that the new CPT codes represent longstanding services, albeit with new code descriptions and code numbers. Since these are new CPT codes (albeit for existing services), the APC and status indicator assignments are interim and subject to comment.

New ''NI'' Drug Codes

There are several new HCPCS codes for drugs, biologicals, and radiopharmaceuticals that are new for 2004. Since these codes were not subject to public comment in the August 12, 2003 proposed rule, they have been assigned to code condition ''NI'' and are subject to public comments following the publication of this rule. Some of these new codes for drugs and radiopharmaceuticals are replacements for codes for which we have hospital cost data. In these cases, we cross-walked the data for the expired codes to the new codes to determine their packaging status and payment rates. For codes that did not have a predecessor, we had no means to determine associated hospital costs; therefore, we assigned the codes to packaged status for 2004. We reinforce the importance of billing for packaged codes with appropriate charges so that we can collect cost data on these codes to use for future rate setting. We invite comments on the status indicators that have been assigned to these codes. Commenters who would like us to consider their cost data for these codes may submit verifiable external information according to the criteria set forth in the August 12, 2003 proposed rule.

Status Indicator Changes for Services Currently Packaged

Comment: A commenter asked us to pay separately for the following services for which payment is currently packaged into payment for other services. Commenters asked that we change the SI for CPT code 36540, collection of blood from an implanted access device, to a payable SI because otherwise hospitals would be forced to bill an E&M code when this is the only service provided. Commenters asked that we change the SI for 36600, withdrawal of arterial blood, from an ''N'' to a ''T'' since it requires more effort and risk than a simple venipuncture (which is paid separately under the clinical laboratory fee schedule). Commenters asked that we change the SI for 90471 and 90472, vaccine administration and each subsequent administration, from N to X since patients may present only to receive the vaccine because otherwise hospitals must bill an E&M to receive any payment. Commenters asked that we change the SI for CPT codes 94760, 94761, and 94762, Pulse oximetry, multiple and continuous, from ''N'' to ''X'' because these may be the only services the patient receives and, in the case of CPT code 94762, the service continues for a long period of time. Commenters also asked that we change the SI for the following services from ''N'' to ''C'' since they are add-ons to services that are inpatient only: 61316, 61517, 62148, and 62160.

Response: We will carefully consider the status indicator changes for the currently packaged services for which the commenter wants separate payment for 2005 OPPS. The commenters did not provide enough information or empirical evidence to convince us of the need for these changes and so we would like to have the opportunity to receive input about this from the APC Panel. We have revised the SI for the following codes from ''N'' to a ''C'' in recognition that if there are charges for these codes which are add-ons to inpatient only procedures, they are billing errors and should not be packaged into the median costs for other procedures on the claim that can be paid in the outpatient department: 61316, 61517, 62148, and 62160.

XIII. Provisions of the Final Rule With Comment Period for 2004

A. Changes Required By Statute

We made the following changes to implement statutory requirements:

- Added APCs, deleted APCs, and modified the composition of some existing APCs.

• Recalibrated the relative payment weights of the APCs.

• Updated the conversion factor and the wage index.

• Revised the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.

• Ceased transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.

• Ceased transitional outpatient payments (TOPS payments) for all hospitals paid under OPPS except for cancer hospitals and children's hospitals.

B. Additional Changes

We made the following additional changes to the OPPS:

• Adjusted payment to moderate the effects of decreased median costs for non-pass-through drugs, biologicals, and radiopharmaceuticals.

• Changed status indicators for HCPCS codes.

• Listed midyear and proposed HCPCS codes that are paid under OPPS.

• Allocated a portion of the outlier percentage target amount to CMHCs and created a separate threshold for outlier payments for partial hospitalization services.

• Created methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004.

• Changed the status indicator and payment amount for P901 by assigning it to APC 0957 (Platelet concentrate) with a payment rate of $37.30.

C. Major Changes From the Proposed Rule

• We will apply a $50 threshold in lieu of the proposed $150 threshold in determining which drugs to pay for separately.

• We will set payment for all except two orphan drugs that meet our criteria for special payment under the OPPS at 88 percent of their AWP as established in the April 2003 single drug pricer (SDP). Based on widely available market prices for two orphan drugs, we will set the payment for these two orphan drugs at 94 percent of their AWP.

• We will set payment rates for 2004 for blood and blood products at 2003 payment rates.

XIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The OPPS provisions set forth in this final rule do not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XV. Response to Public Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to comments in the preamble to that document.

XVI. 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), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that will be implemented by this final rule will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in the final rule as well as enrollment, utilization, and case mix changes) in expenditures under the OPPS for CY 2004 compared to CY 2003 to be approximately $0.607 billion. Therefore, this final rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

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 $6 million to $29 million in any 1 year (*see* 65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals will be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that will be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (*see* the standards Web site at *http://www.sba.gov/regulations/siccodes/*). 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 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital 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. We believe that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule will have a significant impact on a substantial number of small entities.

Unfunded Mandates

Section 202 of the Unfunded Mandates 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 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not mandate any requirements for State, local, or tribal governments. This final rule will not impose unfunded mandates on the private sector of more than $110 million dollars.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a 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 an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (*see* Table 15) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 4.9 percent under the final rule.

B. Changes 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)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2004 as we discuss in sections IX and VII, respectively, of this final rule. We are also revising the relative APC payment weights based on claims data from April 1, 2002 through December 31, 2002. Finally, we are removing two devices and eight drugs and biological agents from pass-through payment status. Alternatives to the changes we proposed and why we did not accept them are discussed throughout this final rule. In particular, see section V.B with regard to the expiration of pass-through payment for devices; see section VI.B with regard to the expiration of pass-through payment for drugs and biological agents.

Under this final rule, the change to the conversion factor as provided by statute will increase total OPPS payments by 4.5 percent in 2004. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for many drugs and devices) will not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes will change the distribution of payments within the budget neutral system as shown in Table 15 and described in more detail in this section. The overall 4.5 percent increase does not take into account the expiration of transitional corridor payments or the end of the hold harmless provisions for small rural hospitals.

A. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options we have are discussed throughout this final rule. Some of the major issues discussed in this rule and the sections in which they are discussed follow:

Issue	Preamble section
Drug packaging threshold	VI.B.2.
Drug administration	VI.B.4.
Adjustment of median costs	II.B.
Outlier policy	X.A.
Device coding	V.C.
Payment adjustment for small rural hospitals.	X.B.
Payment for orphan drugs, generic drugs and blood.	VI.B.
APC changes	II.A and III.C.

Conclusion

It is clear that the changes in this final rule will 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.

The OPPS rates for CY 2004 will have, overall, a positive effect for every category of hospital. These changes in the OPPS for 2004 will result in an overall 4.5 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments. We also noted that both the overall 4.5 percent increase and the percent changes to individual classes of hospitals depicted in Table 15 are exclusive of any impacts to those hospitals that would result from the expiration of the transitional corridor payments or the end of the hold harmless provision for small rural hospitals. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the relative weights to ensure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. We also note that both the overall 4.5 percent increase and the percent changes to individual classes of hospitals depicted in Table 15 are exclusive of any impacts to those hospitals that would result from the expiration of the transitional corridor payments or the end of the hold harmless provision for small rural hospitals. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 15.

The overall projected increase in payments for urban hospitals is slightly lower (4.3 percent) than the average increase for all hospitals (4.5 percent) while the increase for rural hospitals is slightly greater (4.9 percent) than the average increase. Again, as noted above, these numbers do not include the effect of the expiration of the transitional hold harmless payments to small rural hospitals. The introduction of a new wage index combined with changes to the APC structure will result in small distributional changes for all categories of hospitals. Rural hospitals will gain 0.2 percent from the wage index change and another 0.2 percent as a result of APC changes. Large urban hospitals will lose 0.2 percent from the APC change, whereas ''other'' urban hospitals show an increase of 0.1 percent from the APC changes. A discussion of the distribution of outlier payments that we project under this final rule can be found under section XV.E below. Table 16 presents the outlier distribution that we expect to see under this 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 2004, 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.

D. Estimated Impacts of This Final Rule on Hospitals

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistribution of hospital payments among providers as a result of a new wage index and APC structure. In some cases, under this final rule, hospitals will receive more total payment than in 2003 while in other cases they will receive less total payment than they received in 2003. The impact of this final rule will depend on a number of factors, most significant of which are the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services will change) and the impact of the wage index changes on the hospital.

Column 4 in Table 15 represents the full impact on each hospital group of all the changes for 2004. Columns 2 and 3 in the table reflect the independent effects of the final change in the wage index and the APC reclassification and recalibration changes, respectively. We excluded critical access hospitals (CAHs) from the analysis of the impact of the final 2004 OPPS rates that is summarized in Table 15. For that reason, the total number of hospitals included in Table 15 (4,378) is lower than in previous years. CAHs are excluded from the OPPS.

To a very limited extent, wage index changes favor rural hospital categories. Large urban hospitals with greater than 500 beds show the largest percent decrease (−3.0) attributable to wage index changes. Rural hospitals show modest increases of 0.2 percent for most bed sizes but show the largest gains for categories with fewer than 50 beds or 150 to 199 beds where the wage index change results in a 0.4 percent increase. Rural hospitals located in Puerto Rico show the largest negative impact (−2.5 percent) due to changes in the wage index. Hospitals located in the Middle Atlantic region also experience a large negative impact −0.6 percent due to wage index changes regardless of urban or rural designation. However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals with the exception of rural hospitals with 200 or more beds that show a negative effect (−0.8 percent). Conversely, urban hospitals with greater than 199 beds show a decrease attributed to APC recalibration. Urban hospitals in excess of 500 beds show a 0.5 percent decrease as a result of APC recalibration. In general, APC changes are small and result in very few distributional changes among hospital categories.

In both urban and rural areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with volumes between 5,000 and 20,999 are projected to experience increases larger than 5.0 percent. Urban hospitals that provide low-volume services show similar rates of increases (5.0 percent). Conversely, urban and rural hospitals providing more than 21,000 services are projected to experience a rate of increase in the 4.0 to 4.7 percent range.

Major teaching hospitals are projected to experience a smaller increase in payments (3.7 percent) than the aggregate for all hospitals (4.5 percent) due to negative impacts from both the wage index (−0.4 percent) and APC recalibration (−0.4 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (4.5 percent) that is equal to the average for all hospitals. There is little difference in impact among hospitals that serve low-income patients where increases in payments range from 4.3 to 4.7 percent higher than in 2003.

Psychiatric hospitals and long term care facilities show the largest increase in payment rates among all categories of hospital providers. Psychiatric hospitals show an increase of 18.2 percent as a result of an increase in payment rates for partial hospitalization programs and for other services such as psychotherapy. Also, payments made to psychiatric facilities represent a small portion of total spending for OPPS, approximately 60.6 million dollars for 2004. Long-term care facilities show a growth rate of 7.5 percent over payments made in 2003. We believe this is the result of a policy change that removes payments made for therapy services from the physician fee schedule to the hospital outpatient prospective payment system. Payments made for long-term care account for a small amount of OPPS payments, approximately 14.5 million for 2004.

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of hospitals (1)	New Wage index (2)	APC changes (3)	All CY 2004 changes (4)
ALL HOSPITALS	4,378	0	0	4.5
NON-TEFRA HOSPITALS	3,854	0	−0.1	4.4
URBAN HOSPS	2,383	−0.1	−0.1	4.3
LARGE URBAN (GT 1 MILL.)	1,377	0	−0.2	4.2
OTHER URBAN (LE 1 MILL.)	1,006	−0.1	0.1	4.4
RURAL HOSPS	1,471	0.2	0.2	4.9
BEDS (URBAN)				
0–99 BEDS	538	0.1	0.6	5.2
100–199 BEDS	878	−0.1	0.3	4.8
200–299 BEDS	454	−0.1	−0.1	4.3
300–499 BEDS	363	0.1	−0.4	4.2
500 + BEDS	150	−0.3	−0.5	3.7
BEDS (RURAL)				
0–49 BEDS	699	0.4	0.6	5.6

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of hospitals (1)	New Wage index (2)	APC changes (3)	All CY 2004 changes (4)
50–99 BEDS	454	0.2	0.6	5.3
100–149 BEDS	190	0.2	0	4.7
150–199 BEDS	66	0.4	0.1	4.9
200 + BEDS	62	0.1	−0.8	3.7
VOLUME (URBAN)				
LT 5,000 Lines	186	0.1	1	5.6
5,000–10,999 Lines	350	0	0.9	5.4
11,000–20,999 Lines	499	−0.1	0.7	5.1
21,000–42,999 Lines	720	0.1	0.1	4.6
GT 42,999 Lines	628	−0.1	−0.4	4
VOLUME (RURAL)				
LT 5,000 Lines	364	0.3	0	4.8
5,000–10,999 Lines	466	0.3	0.5	5.3
11,000–20,999 Lines	346	0.2	0.7	5.4
21,000–42,999 Lines	234	0.3	0	4.7
GT 42,999 Lines	61	0.1	−0.4	4.2
REGION (URBAN)				
NEW ENGLAND	128	−0.3	−0.3	3.9
MIDDLE ATLANTIC	369	−0.6	−0.5	3.4
SOUTH ATLANTIC	353	0	0	4.5
EAST NORTH CENT.	400	−0.2	−0.2	4
EAST SOUTH CENT.	149	0.3	0.2	5
WEST NORTH CENT.	163	0.2	0.5	5.1
WEST SOUTH CENT.	295	0.1	0.1	4.7
MOUNTAIN	122	0.8	0	5.3
PACIFIC	364	0.3	−0.2	4.6
PUERTO RICO	40	0	4.8	9.5
REGION (RURAL)				
NEW ENGLAND	36	0.4	1.7	6.7
MIDDLE ATLANTIC	65	−0.6	0.9	4.9
SOUTH ATLANTIC	216	0.1	0	4.6
EAST NORTH CENT.	193	0.2	0	4.7
EAST SOUTH CENT.	227	0.2	−0.2	4.5
WEST NORTH CENT.	247	0.8	0.5	5.8
WEST SOUTH CENT.	269	0.4	0.2	5.2
MOUNTAIN	123	0.2	−0.1	4.6
PACIFIC	90	0.4	−0.9	3.9
PUERTO RICO	5	−2.5	0.3	2.2
TEACHING STATUS				
NON-TEACHING	2,805	0.1	0.1	4.7
MINOR	761	0.1	−0.1	4.5
MAJOR	288	−0.4	−0.4	3.7
DSH PATIENT (PERCENT)				
0	10	3	3.8	11.6
GT 0–0.10	897	0	−0.2	4.3
0.10–0.16	837	−0.1	0	4.4
0.16–0.23	787	0.1	−0.2	4.3
0.23–0.35	744	0	0.1	4.5
GE 0.35	579	−0.1	0.2	4.7
URBAN IME/DSH				
IME & DSH	965	−0.1	−0.2	4.1
IME/NO DSH	1	−0.1	8.5	13.3
NO IME/DSH	1,409	0	0.1	4.6
NO IME/NO DSH	8	3	3.7	11.6
RURAL HOSP. TYPES				
NO SPECIAL STATUS	469	0.1	0.2	4.9
RRC	161	0.3	−0.5	4.3
SCH/EACH	489	0.3	0.5	5.4
MDH	250	0.3	1.6	6.5
SCH AND RRC	75	0.1	−0.3	4.3
TYPE OF OWNERSHIP				
VOLUNTARY	2,370	−0.1	−0.2	4.2
PROPRIETARY	696	0.2	0.5	5.2
GOVERNMENT	788	0.2	0.3	4.9
SPECIALTY HOSPITALS				
EYE AND EAR	13	−0.6	1.8	5.7
CANCER	11	0	−1.2	3.2
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES)				
REHAB	155	0.5	−1.1	3.9

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of hospitals (1)	New Wage index (2)	APC changes (3)	All CY 2004 changes (4)
PSYCH	175	0.8	12.2	18.2
LTC	150	1.6	1.2	7.5
CHILDREN	44	0	0.5	4.9

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 by applying the FY 2004 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The appropriate hospital inpatient wage index appears in a correction notice published in the FEDERAL REGISTER on October 6, 2003 68FR 57732.
3. This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2002 hospital claims data.
4. This column shows changes in total payment from CY 2003 to CY 2004, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2 and 3. In addition, it shows the impact of the FY 2004 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.
5. Volume is expressed in terms of the number of lines that appear on a claim.

E. Projected Distribution of Outlier Payments

As stated elsewhere in this preamble, we have allocated 2 percent of the estimated 2004 expenditures to outlier payments. Table 16 below illustrates the percentage of outlier payments relative to the total projected payments for the categories of hospitals that we show in the impact table.

We project, based on the mix of services for the hospitals that will be paid under the OPPS in 2004, that approximately 95 percent of hospitals will receive outlier payments. For the majority of provider groups, the table shows outlier payments as a percent of total payments in the 1.5 to 3.5 percent range. Two categories, Rehabilitation and Children's hospitals are the exception with outlier to total payment ratios of 6.7 and 11.9 percent respectively. We would point out that these hospital types represent a small number of providers with a low volume of services. The anticipated outlier payments for urban hospitals can be expected to ameliorate the impact of the wage index and APC changes on payments to urban hospitals.

TABLE 16.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT

	Number of hospitals	Percent of total hospitals	Number of hospitals with outliers	Outlier payments as a percent of total payments (percent)
ALL HOSPITALS	4,378	100	4,144	2.0
NON-TEFRA HOSPITALS	3,854	88	3,841	2.0
URBAN HOSPS	2,383	54.4	2,372	2.1
LARGE URBAN (GT 1 MILL.)	1,377	31.4	1,371	2.3
OTHER URBAN (LE 1 MILL.)	1,006	23	1,001	1.8
RURAL HOSPS	1,471	33.6	1,469	1.7
BEDS (URBAN)				
0–99 BEDS	538	12.2	529	2.5
100–199 BEDS	878	20	877	1.8
200–299 BEDS	454	10.4	453	1.9
300–499 BEDS	363	8.2	363	2.1
500 + BEDS	150	3.4	150	2.6
BEDS (RURAL)				
0–49 BEDS	699	16	698	2.3
50–99 BEDS	454	10.4	453	1.9
100–149 BEDS	190	4.4	190	1.4
150–199 BEDS	66	1.6	66	1.7
200 + BEDS	62	1.4	62	1.4
VOLUME (URBAN)				
LT 5,000	186	4.2	175	3.2
5,000–10,999	350	8	350	3.0
11,000–20,999	499	11.4	499	2.1
21,000–42,999	720	16.4	720	2.0
GT 42,999	628	14.4	628	2.1
VOLUME (RURAL)				
LT 5,000	364	8.4	362	3.1
5,000–10,999	466	10.6	466	2.2
11,000–20,999	346	8	346	1.8
21,000–42,999	234	5.4	234	1.5
GT 42,999	61	1.4	61	1.5
REGION (URBAN)				
NEW ENGLAND	128	3	127	1.8

TABLE 16.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT—Continued

	Number of hospitals	Percent of total hospitals	Number of hospitals with outliers	Outlier payments as a percent of total payments (percent)
MIDDLE ATLANTIC	369	8.4	369	3.1
SOUTH ATLANTIC	353	8	353	1.9
EAST NORTH CENT.	400	9.2	396	1.9
EAST SOUTH CENT.	149	3.4	148	1.4
WEST NORTH CENT.	163	3.8	163	1.6
WEST SOUTH CENT.	295	6.8	295	2.4
MOUNTAIN	122	2.8	120	1.9
PACIFIC	364	8.4	361	2.0
PUERTO RICO	40	1	40	0.6
REGION (RURAL)				
NEW ENGLAND	36	0.8	36	2.2
MIDDLE ATLANTIC	65	1.4	65	1.6
SOUTH ATLANTIC	216	5	215	1.6
EAST NORTH CENT.	193	4.4	193	1.6
EAST SOUTH CENT.	227	5.2	227	1.2
WEST NORTH CENT.	247	5.6	246	1.8
WEST SOUTH CENT.	269	6.2	269	1.8
MOUNTAIN	123	2.8	123	2.8
PACIFIC	90	2	90	2.4
PUERTO RICO	5	0.2	5	1.0
TEACHING STATUS				
NON-TEACHING	2,805	64	2,793	1.8
MINOR	761	17.4	760	1.7
MAJOR	288	6.6	288	3.0
DSH PATIENT (PERCENT)				
0	10	0.2	8	3.5
GT 0–0.10	897	20.4	892	1.9
0.10–0.16	837	19.2	837	1.8
0.16–0.23	787	18	787	1.7
0.23–0.35	744	17	741	2.3
GE 0.35	579	13.2	576	2.9
URBAN IME/DSH				
IME & DSH	965	22	965	2.3
IME/NO DSH	1	0	0	0.0
NO IME/DSH	1,409	32.2	1,400	1.8
NO IME/NO DSH	8	0.2	7	3.5
RURAL HOSP. TYPES				
NO SPECIAL STATUS	469	10.8	467	1.8
RRC	161	3.6	161	1.4
SCH/EACH	489	11.2	489	2.1
MDH	250	5.8	250	2.0
SCH AND RRC	75	1.8	75	1.5
TYPE OF OWNERSHIP				
VOLUNTARY	2,370	54.2	2,366	1.9
PROPRIETARY	696	15.8	689	2.0
GOVERNMENT	788	18	786	2.5
SPECIALTY HOSPITALS				
EYE AND EAR	13	0.2	13	2.7
CANCER	11	0.2	11	3.9
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES)				
REHAB	155	3.6	103	6.7
PSYCH	175	4	59	0.5
LTC	150	3.4	98	2.5
CHILDREN	44	1	43	11.9

F. Estimated Impacts of This Final Rule on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example, for a mid-level office visit (APC 0601), the minimum unadjusted co-payment in 2003 was $10.11; under this final rule, the minimum unadjusted co-payment for APC 601 will be $10.71 because the OPPS payment for the service will increase under this final rule. For some services (those services for which a national unadjusted co-payment amount is shown in Addendum B) the beneficiary co-payment is frozen based on historic data and will not change, and will therefore present no potential impact on beneficiaries.

However, in all cases, the statute limits beneficiary liability for co-payment for a service to the inpatient hospital deductible for the applicable year. This amount is $876 for 2004. In general, the impact of this final rule on beneficiaries will vary based on the service the beneficiary receives and whether the co-payment for the service is one that is frozen under the OPPS.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 27, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2003.

Tommy G. Thompson,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.4237	$23.12	$7.09	$4.62
0002	Level I Fine Needle Biopsy/Aspiration	T	0.8083	$44.10		$8.82
0003	Bone Marrow Biopsy/Aspiration	T	2.3229	$126.74		$25.35
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.5882	$86.65	$22.36	$17.33
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.2698	$178.40	$71.59	$35.68
0006	Level I Incision & Drainage	T	1.6527	$90.17	$23.26	$18.03
0007	Level II Incision & Drainage	T	11.8633	$647.27		$129.45
0008	Level III Incision and Drainage	T	19.4831	$1,063.02		$212.60
0009	Nail Procedures	T	0.6652	$36.29	$8.34	$7.26
0010	Level I Destruction of Lesion	T	0.6480	$35.36	$10.08	$7.07
0011	Level II Destruction of Lesion	T	2.2217	$121.22	$27.88	$24.24
0012	Level I Debridement & Destruction	T	0.7694	$41.98	$11.18	$8.40
0013	Level II Debridement & Destruction	T	1.1272	$61.50	$14.20	$12.30
0015	Level III Debridement & Destruction	T	1.5968	$87.12	$20.35	$17.42
0016	Level IV Debridement & Destruction	T	2.5724	$140.35	$57.31	$28.07
0017	Level VI Debridement & Destruction	T	16.3697	$893.15	$227.84	$178.63
0018	Biopsy of Skin/Puncture of Lesion	T	0.9178	$50.08	$16.04	$10.02
0019	Level I Excision/ Biopsy	T	3.9493	$215.48	$71.87	$43.10
0020	Level II Excision/ Biopsy	T	7.0842	$386.52	$113.25	$77.30
0021	Level III Excision/ Biopsy	T	14.3594	$783.46	$219.48	$156.69
0022	Level IV Excision/ Biopsy	T	18.7932	$1,025.38	$354.45	$205.08
0023	Exploration Penetrating Wound	T	2.8141	$153.54	$40.37	$30.71
0024	Level I Skin Repair	T	1.6850	$91.94	$33.10	$18.39
0025	Level II Skin Repair	T	5.1912	$283.24	$107.00	$56.65
0027	Level IV Skin Repair	T	15.8990	$867.47	$329.72	$173.49
0028	Level I Breast Surgery	T	17.6584	$963.46	$303.74	$192.69
0029	Level II Breast Surgery	T	30.1167	$1,643.20	$632.64	$328.64
0030	Level III Breast Surgery	T	37.3083	$2,035.58	$763.55	$407.12
0032	Insertion of Central Venous/Arterial Catheter	T	11.4907	$626.94		$125.39
0033	Partial Hospitalization	P	5.2569	$286.82		$57.36
0035	Placement of Arterial or Central Venous Catheter	T	0.1691	$9.23	$2.79	$1.85
0036	Level II Fine Needle Biopsy/Aspiration	T	1.5170	$82.77		$16.55
0037	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.8921	$539.72	$237.45	$107.94
0039	Implantation of Neurostimulator	S	235.1866	$12,832.02		$2,566.40
0040	Level II Implantation of Neurostimulator Electrodes	S	52.1002	$2,842.64		$568.53
0041	Level I Arthroscopy	T	27.3819	$1,493.98		$298.80
0042	Level II Arthroscopy	T	43.0808	$2,350.53	$804.74	$470.11
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.9074	$104.07		$20.81
0045	Bone/Joint Manipulation Under Anesthesia	T	13.5889	$741.42	$268.47	$148.28
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	32.5581	$1,776.40	$535.76	$355.28
0047	Arthroplasty without Prosthesis	T	29.9582	$1,634.55	$537.03	$326.91
0048	Arthroplasty with Prosthesis	T	51.4609	$2,807.76	$695.60	$561.55
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	19.6046	$1,069.65		$213.93
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	24.8651	$1,356.66		$271.33
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	34.5144	$1,883.14		$376.63
0052	Level IV Musculoskeletal Procedures Except Hand and Foot.	T	42.7126	$2,330.44		$466.09
0053	Level I Hand Musculoskeletal Procedures	T	14.8831	$812.04	$253.49	$162.41
0054	Level II Hand Musculoskeletal Procedures	T	24.2456	$1,322.86		$264.57
0055	Level I Foot Musculoskeletal Procedures	T	18.7205	$1,021.41	$355.34	$204.28
0056	Level II Foot Musculoskeletal Procedures	T	25.3930	$1,385.47	$405.81	$277.09
0057	Bunion Procedures	T	25.5035	$1,391.50	$475.91	$278.30
0058	Level I Strapping and Cast Application	S	1.0931	$59.64		$11.93
0060	Manipulation Therapy	S	0.2788	$15.21		$3.04
0068	CPAP Initiation	S	1.0807	$58.96	$29.48	$11.79
0069	Thoracoscopy	T	28.9392	$1,578.95	$591.64	$315.79
0070	Thoracentesis/Lavage Procedures	T	3.0717	$167.60		$33.52
0071	Level I Endoscopy Upper Airway	T	0.8799	$48.01	$12.89	$9.60

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0072	Level II Endoscopy Upper Airway	T	1.7613	$96.10	$26.68	$19.22
0073	Level III Endoscopy Upper Airway	T	3.4541	$188.46	$73.38	$37.69
0074	Level IV Endoscopy Upper Airway	T	13.9480	$761.02	$295.70	$152.20
0075	Level V Endoscopy Upper Airway	T	20.3815	$1,112.04	$445.92	$222.41
0076	Level I Endoscopy Lower Airway	T	9.2346	$503.85	$189.82	$100.77
0077	Level I Pulmonary Treatment	S	0.2837	$15.48	$7.74	$3.10
0078	Level II Pulmonary Treatment	S	0.7917	$43.20	$14.55	$8.64
0079	Ventilation Initiation and Management	S	2.1494	$117.27		$23.45
0080	Diagnostic Cardiac Catheterization	T	36.0160	$1,965.07	$838.92	$393.01
0081	Non-Coronary Angioplasty or Atherectomy	T	35.0285	$1,911.19		$382.24
0082	Coronary Atherectomy	T	110.2196	$6,013.69	$1,293.59	$1,202.74
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	59.2047	$3,230.27		$646.05
0084	Level I Electrophysiologic Evaluation	S	10.5226	$574.12		$114.82
0085	Level II Electrophysiologic Evaluation	T	35.4126	$1,932.15	$426.25	$386.43
0086	Ablate Heart Dysrhythm Focus	T	44.9389	$2,451.91	$833.33	$490.38
0087	Cardiac Electrophysiologic Recording/Mapping	T	39.8161	$2,172.41		$434.48
0088	Thrombectomy	T	34.6942	$1,892.95	$655.22	$378.59
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	117.1896	$6,393.98	$1,722.59	$1,278.80
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	96.8284	$5,283.05	$1,651.45	$1,056.61
0091	Level II Vascular Ligation	T	28.8326	$1,573.14	$348.23	$314.63
0092	Level I Vascular Ligation	T	25.0959	$1,369.26	$505.37	$273.85
0093	Vascular Reconstruction/Fistula Repair without Device	T	21.3104	$1,162.72	$277.34	$232.54
0094	Level I Resuscitation and Cardioversion	S	2.6345	$143.74	$48.58	$28.75
0095	Cardiac Rehabilitation	S	0.5994	$32.70	$16.35	$6.54
0096	Non-Invasive Vascular Studies	S	1.7176	$93.71	$46.85	$18.74
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0635	$58.03	$23.80	$11.61
0098	Injection of Sclerosing Solution	T	1.0729	$58.54	$14.06	$11.71
0099	Electrocardiograms	S	0.3703	$20.20		$4.04
0100	Cardiac Stress Tests	X	1.5862	$86.54	$41.44	$17.31
0101	Tilt Table Evaluation	S	4.4040	$240.29	$105.27	$48.06
0103	Miscellaneous Vascular Procedures	T	11.6202	$634.01	$223.63	$126.80
0104	Transcatheter Placement of Intracoronary Stents	T	82.6713	$4,510.63		$902.13
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	19.1898	$1,047.01	$370.40	$209.40
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	T	58.9719	$3,217.57		$643.51
0107	Insertion of Cardioverter-Defibrillator	T	337.1304	$18,394.17	$3,699.14	$3,678.83
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	433.2998	$23,641.27		$4,728.25
0109	Removal of Implanted Devices	T	7.4705	$407.60	$131.49	$81.52
0110	Transfusion	S	3.6718	$200.34		$40.07
0111	Blood Product Exchange	S	13.1719	$718.67	$200.18	$143.73
0112	Apheresis, Photopheresis, and Plasmapheresis	S	37.5832	$2,050.58	$612.47	$410.12
0113	Excision Lymphatic System	T	19.9322	$1,087.52		$217.50
0114	Thyroid/Lymphadenectomy Procedures	T	37.5963	$2,051.29	$485.91	$410.26
0115	Cannula/Access Device Procedures	T	25.6437	$1,399.15	$459.35	$279.83
0116	Chemotherapy Administration by Other Technique Except Infusion.	S	0.7996	$43.63		$8.73
0117	Chemotherapy Administration by Infusion Only	S	3.0360	$165.65	$42.54	$33.13
0119	Implantation of Infusion Pump	T	134.7194	$7,350.43		$1,470.09
0120	Infusion Therapy Except Chemotherapy	T	1.9114	$104.29	$28.21	$20.86
0121	Level I Tube changes and Repositioning	T	2.1189	$115.61	$43.80	$23.12
0122	Level II Tube changes and Repositioning	T	8.8621	$483.53	$99.16	$96.71
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	5.2882	$288.53		$57.71
0124	Revision of Implanted Infusion Pump	T	23.8050	$1,298.82		$259.76
0125	Refilling of Infusion Pump	T	2.1606	$117.88		$23.58
0130	Level I Laparoscopy	T	32.7724	$1,788.09	$659.53	$357.62
0131	Level II Laparoscopy	T	40.8064	$2,226.44	$1,001.89	$445.29
0132	Level III Laparoscopy	T	57.2045	$3,121.13	$1,239.22	$624.23
0140	Esophageal Dilation without Endoscopy	T	6.4525	$352.05	$107.24	$70.41
0141	Upper GI Procedures	T	7.8206	$426.70	$143.38	$85.34
0142	Small Intestine Endoscopy	T	8.7959	$479.91	$152.78	$95.98
0143	Lower GI Endoscopy	T	8.2957	$452.62	$186.06	$90.52
0146	Level I Sigmoidoscopy	T	3.9826	$217.29	$64.40	$43.46
0147	Level II Sigmoidoscopy	T	7.6808	$419.07		$83.81
0148	Level I Anal/Rectal Procedure	T	3.8320	$209.08	$63.38	$41.82
0149	Level III Anal/Rectal Procedure	T	17.1425	$935.31	$293.06	$187.06
0150	Level IV Anal/Rectal Procedure	T	22.1919	$1,210.81	$437.12	$242.16

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP).	T	17.9462	$979.16	$245.46	$195.83
0152	Percutaneous Abdominal and Biliary Procedures	T	9.1474	$499.09	$125.28	$99.82
0153	Peritoneal and Abdominal Procedures	T	20.8723	$1,138.81	$410.87	$227.76
0154	Hernia/Hydrocele Procedures	T	26.9636	$1,471.16	$464.85	$294.23
0155	Level II Anal/Rectal Procedure	T	10.0809	$550.02	$188.89	$110.00
0156	Level II Urinary and Anal Procedures	T	2.4747	$135.02	$40.52	$27.00
0157	Colorectal Cancer Screening: Barium Enema	S	2.5693	$140.18		$28.04
0158	Colorectal Cancer Screening: Colonoscopy	T	7.4244	$405.08		$101.27
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.7823	$151.81		$37.95
0160	Level I Cystourethroscopy and other Genitourinary Procedures.	T	6.8801	$375.39	$105.06	$75.08
0161	Level II Cystourethroscopy and other Genitourinary Procedures.	T	16.8407	$918.85	$249.36	$183.77
0162	Level III Cystourethroscopy and other Genitourinary Procedures.	T	21.9098	$1,195.42		$239.08
0163	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	33.8805	$1,848.55		$369.71
0164	Level I Urinary and Anal Procedures	T	1.2021	$65.59	$17.59	$13.12
0165	Level III Urinary and Anal Procedures	T	14.6838	$801.16		$160.23
0166	Level I Urethral Procedures	T	16.7918	$916.18	$218.73	$183.24
0167	Level III Urethral Procedures	T	30.0186	$1,637.84	$555.84	$327.57
0168	Level II Urethral Procedures	T	30.0147	$1,637.63	$405.60	$327.53
0169	Lithotripsy	T	45.1150	$2,461.52	$1,115.69	$492.30
0170	Dialysis	S	5.9678	$325.61		$65.12
0180	Circumcision	T	18.6176	$1,015.79	$304.87	$203.16
0181	Penile Procedures	T	29.4217	$1,605.28	$621.82	$321.06
0183	Testes/Epididymis Procedures	T	21.6724	$1,182.47		$236.49
0184	Prostate Biopsy	T	3.8995	$212.76	$96.27	$42.55
0187	Miscellaneous Placement/Repositioning	X	4.4288	$241.64	$90.71	$48.33
0188	Level II Female Reproductive Proc	T	1.1365	$62.01		$12.40
0189	Level III Female Reproductive Proc	T	1.4232	$77.65	$18.09	$15.53
0190	Level I Hysteroscopy	T	19.6922	$1,074.43	$424.28	$214.89
0191	Level I Female Reproductive Proc	T	0.1853	$10.11	$2.93	$2.02
0192	Level IV Female Reproductive Proc	T	2.7121	$147.97	$39.11	$29.59
0193	Level V Female Reproductive Proc	T	15.0453	$820.89	$171.13	$164.18
0194	Level VIII Female Reproductive Proc	T	18.4286	$1,005.48	$397.84	$201.10
0195	Level IX Female Reproductive Proc	T	25.6950	$1,401.94	$483.80	$280.39
0196	Dilation and Curettage	T	16.1219	$879.63	$338.23	$175.93
0197	Infertility Procedures	T	4.8280	$263.42		$52.68
0198	Pregnancy and Neonatal Care Procedures	T	1.3578	$74.08	$32.19	$14.82
0199	Obstetrical Care Service	T	17.2831	$942.98		$188.60
0200	Level VII Female Reproductive Proc	T	17.9920	$981.66	$307.83	$196.33
0201	Level VI Female Reproductive Proc	T	16.8660	$920.23	$329.65	$184.05
0202	Level X Female Reproductive Proc	T	38.9821	$2,126.90	$1,042.18	$425.38
0203	Level IV Nerve Injections	T	11.5969	$632.74	$276.76	$126.55
0204	Level I Nerve Injections	T	2.1711	$118.46	$40.13	$23.69
0206	Level II Nerve Injections	T	5.2875	$288.49	$75.55	$57.70
0207	Level III Nerve Injections	T	6.4554	$352.21	$123.69	$70.44
0208	Laminotomies and Laminectomies	T	40.2830	$2,197.88		$439.58
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.5435	$629.82	$280.58	$125.96
0212	Nervous System Injections	T	2.9739	$162.26	$74.67	$32.45
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.9055	$158.53	$65.74	$31.71
0214	Electroencephalogram	S	2.2176	$120.99	$58.12	$24.20
0215	Level I Nerve and Muscle Tests	S	0.6457	$35.23	$15.76	$7.05
0216	Level III Nerve and Muscle Tests	S	2.8535	$155.69	$67.98	$31.14
0218	Level II Nerve and Muscle Tests	S	1.1404	$62.22		$12.44
0220	Level I Nerve Procedures	T	16.5554	$903.28		$180.66
0221	Level II Nerve Procedures	T	24.8875	$1,357.89	$463.62	$271.58
0222	Implantation of Neurological Device	T	232.2024	$12,669.20		$2,533.84
0223	Implantation or Revision of Pain Management Catheter	T	26.7610	$1,460.11		$292.02
0224	Implantation of Reservoir/Pump/Shunt	T	34.1770	$1,864.73	$453.41	$372.95
0225	Level I Implementation of Neurostimulator Electrodes	S	206.0034	$11,239.75		$2,247.95
0226	Implantation of Drug Infusion Reservoir	T	136.2989	$7,436.60		$1,487.32
0227	Implantation of Drug Infusion Device	T	160.8363	$8,775.39		$1,755.08
0228	Creation of Lumbar Subarachnoid Shunt	T	52.2880	$2,852.89	$639.03	$570.58
0229	Transcatherter Placement of Intravascular Shunts	T	61.9895	$3,382.21	$771.23	$676.44
0230	Level I Eye Tests & Treatments	S	0.7619	$41.57	$14.97	$8.31
0231	Level III Eye Tests & Treatments	S	2.1883	$119.40	$50.94	$23.88

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0232	Level I Anterior Segment Eye Procedures	T	4.9206	$268.47	$103.17	$53.69
0233	Level II Anterior Segment Eye Procedures	T	14.4205	$786.80	$266.33	$157.36
0234	Level III Anterior Segment Eye Procedures	T	21.4631	$1,171.05	$511.31	$234.21
0235	Level I Posterior Segment Eye Procedures	T	5.0749	$276.89	$72.04	$55.38
0236	Level II Posterior Segment Eye Procedures	T	18.6701	$1,018.66		$203.73
0237	Level III Posterior Segment Eye Procedures	T	34.1784	$1,864.81	$818.54	$372.96
0238	Level I Repair and Plastic Eye Procedures	T	3.1954	$174.34	$58.96	$34.87
0239	Level II Repair and Plastic Eye Procedures	T	6.1331	$334.63		$66.93
0240	Level III Repair and Plastic Eye Procedures	T	17.4535	$952.28	$315.31	$190.46
0241	Level IV Repair and Plastic Eye Procedures	T	22.1969	$1,211.09	$384.47	$242.22
0242	Level V Repair and Plastic Eye Procedures	T	29.4294	$1,605.70	$597.36	$321.14
0243	Strabismus/Muscle Procedures	T	21.7323	$1,185.74	$431.39	$237.15
0244	Corneal Transplant	T	37.6284	$2,053.04	$803.26	$410.61
0245	Level I Cataract Procedures without IOL Insert	T	12.2973	$670.95	$222.22	$134.19
0246	Cataract Procedures with IOL Insert	T	22.9755	$1,253.57	$495.96	$250.71
0247	Laser Eye Procedures Except Retinal	T	4.9482	$269.98	$104.31	$54.00
0248	Laser Retinal Procedures	T	4.8223	$263.11	$95.08	$52.62
0249	Level II Cataract Procedures without IOL Insert	T	27.7406	$1,513.55	$524.67	$302.71
0250	Nasal Cauterization/Packing	T	1.4697	$80.19	$28.07	$16.04
0251	Level I ENT Procedures	T	1.7880	$97.56		$19.51
0252	Level II ENT Procedures	T	6.4469	$351.75	$113.41	$70.35
0253	Level III ENT Procedures	T	15.2249	$830.69	$282.29	$166.14
0254	Level IV ENT Procedures	T	21.8901	$1,194.35	$321.35	$238.87
0256	Level V ENT Procedures	T	35.1548	$1,918.08		$383.62
0258	Tonsil and Adenoid Procedures	T	20.6265	$1,125.40	$437.25	$225.08
0259	Level VI ENT Procedures	T	392.8622	$21,434.95	$9,394.83	$4,286.99
0260	Level I Plain Film Except Teeth	X	0.7802	$42.57	$21.28	$8.51
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.3176	$71.89		$14.38
0262	Plain Film of Teeth	X	0.7540	$41.14	$9.82	$8.23
0263	Level I Miscellaneous Radiology Procedures	X	2.1883	$119.40	$43.58	$23.88
0264	Level II Miscellaneous Radiology Procedures	X	3.0287	$165.25	$79.41	$33.05
0265	Level I Diagnostic Ultrasound Except Vascular	S	1.0289	$56.14	$28.07	$11.23
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.6117	$87.94	$43.97	$17.59
0267	Level III Diagnostic Ultrasound Except Vascular	S	2.4586	$134.14	$65.52	$26.83
0268	Ultrasound Guidance Procedures	S	1.3081	$71.37		$14.27
0269	Level III Echocardiogram Except Transesophageal	S	3.2309	$176.28	$87.24	$35.26
0270	Transesophageal Echocardiogram	S	5.8546	$319.43	$146.79	$63.89
0271	Mammography	S	0.6499	$35.46	$16.80	$7.09
0272	Level I Fluoroscopy	X	1.4166	$77.29	$38.36	$15.46
0274	Myelography	S	3.5931	$196.04	$93.63	$39.21
0275	Arthrography	S	3.2775	$178.82	$69.09	$35.76
0276	Level I Digestive Radiology	S	1.5906	$86.78	$41.72	$17.36
0277	Level II Digestive Radiology	S	2.4444	$133.37	$60.47	$26.67
0278	Diagnostic Urography	S	2.7012	$147.38	$66.07	$29.48
0279	Level II Angiography and Venography except Extremity	S	10.7073	$584.20	$174.57	$116.84
0280	Level III Angiography and Venography except Extremity	S	19.1015	$1,042.20	$353.85	$208.44
0281	Venography of Extremity	S	6.6031	$360.27	$115.16	$72.05
0282	Miscellaneous Computerized Axial Tomography	S	1.6834	$91.85	$44.51	$18.37
0283	Computerized Axial Tomography with Contrast Material	S	4.6543	$253.94	$126.27	$50.79
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras.	S	7.1165	$388.28	$194.13	$77.66
0285	Myocardial Positron Emission Tomography (PET)	S	14.1508	$772.08	$334.45	$154.42
0287	Complex Venography	S	6.4923	$354.23	$111.33	$70.85
0288	Bone Density:Axial Skeleton	S	1.2726	$69.43		$13.89
0289	Needle Localization for Breast Biopsy	X	3.4900	$190.42	$44.80	$38.08
0296	Level I Therapeutic Radiologic Procedures	S	2.8635	$156.24	$69.20	$31.25
0297	Level II Therapeutic Radiologic Procedures	S	7.7145	$420.91	$172.51	$84.18
0299	Miscellaneous Radiation Treatment	S	5.7618	$314.37		$62.87
0300	Level I Radiation Therapy	S	1.4912	$81.36		$16.27
0301	Level II Radiation Therapy	S	2.1340	$116.43		$23.29
0302	Level III Radiation Therapy	S	6.3268	$345.20	$130.77	$69.04
0303	Treatment Device Construction	X	2.8835	$157.33	$66.95	$31.47
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6742	$91.35	$41.52	$18.27
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.6767	$200.60	$91.38	$40.12
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.7165	$748.39	$325.27	$149.68
0312	Radioelement Applications	S	3.6637	$199.90		$39.98
0313	Brachytherapy	S	16.2481	$886.51		$177.30
0314	Hyperthermic Therapies	S	4.6041	$251.20	$101.77	$50.24

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0320	Electroconvulsive Therapy	S	5.3785	$293.46	$80.06	$58.69
0321	Biofeedback and Other Training	S	1.2387	$67.58	$21.78	$13.52
0322	Brief Individual Psychotherapy	S	1.2802	$69.85		$13.97
0323	Extended Individual Psychotherapy	S	1.8689	$101.97	$21.26	$20.39
0324	Family Psychotherapy	S	2.4473	$133.53		$26.71
0325	Group Psychotherapy	S	1.4865	$81.10	$18.27	$16.22
0330	Dental Procedures	S	0.5745	$31.35		$6.27
0332	Computerized Axial Tomography and Computerized Angiography without Contras.	S	3.3936	$185.16	$91.27	$37.03
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material.	S	5.4241	$295.94	$146.98	$59.19
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.3499	$346.46	$151.46	$69.29
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont.	S	6.3897	$348.63	$174.31	$69.73
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed.	S	9.2075	$502.37	$240.77	$100.47
0339	Observation	S	3.8356	$209.27		$41.85
0340	Minor Ancillary Procedures	X	0.6314	$34.45		$6.89
0341	Skin Tests	X	0.1365	$7.45	$3.03	$1.49
0342	Level I Pathology	X	0.2162	$11.80	$5.88	$2.36
0343	Level II Pathology	X	0.4617	$25.19	$12.55	$5.04
0344	Level III Pathology	X	0.6291	$34.32	$17.16	$6.86
0345	Level I Transfusion Laboratory Procedures	X	0.2550	$13.91	$3.10	$2.78
0346	Level II Transfusion Laboratory Procedures	X	0.3866	$21.09	$5.32	$4.22
0347	Level III Transfusion Laboratory Procedures	X	0.9610	$52.43	$13.20	$10.49
0348	Fertility Laboratory Procedures	X	0.8194	$44.71		$8.94
0352	Level I Injections	X	0.1230	$6.71		$1.34
0353	Level II Allergy Injections	X	0.3982	$21.73		$4.35
0355	Level III Immunizations	K	0.2749	$15.00		$3.00
0356	Level IV Immunizations	K	0.7698	$42.00		$8.40
0359	Level II Injections	X	0.8000	$43.65		$8.73
0360	Level I Alimentary Tests	X	1.7313	$94.46	$42.45	$18.89
0361	Level II Alimentary Tests	X	3.5510	$193.75	$83.23	$38.75
0362	Level III Otorhinolaryngologic Function Tests	X	2.6984	$147.23		$29.45
0363	Level I Otorhinolaryngologic Function Tests	X	0.8641	$47.15	$17.44	$9.43
0364	Level I Audiometry	X	0.4459	$24.33	$9.06	$4.87
0365	Level II Audiometry	X	1.2132	$66.19	$18.95	$13.24
0367	Level I Pulmonary Test	X	0.5887	$32.12	$15.16	$6.42
0368	Level II Pulmonary Tests	X	0.9319	$50.85	$25.42	$10.17
0369	Level III Pulmonary Tests	X	2.4984	$136.32	$44.18	$27.26
0370	Allergy Tests	X	0.9185	$50.11	$11.58	$10.02
0371	Level I Allergy Injections	X	0.4105	$22.40		$4.48
0372	Therapeutic Phlebotomy	X	0.5607	$30.59	$10.09	$6.12
0373	Neuropsychological Testing	X	2.0899	$114.03		$22.81
0374	Monitoring Psychiatric Drugs	X	1.1252	$61.39		$12.28
0375	Ancillary Outpatient Services When Patient Expires	T		$1,150.00		$230.00
0376	Level II Cardiac Imaging	S	4.4510	$242.85	$121.42	$48.57
0377	Level III Cardiac Imaging	S	6.8830	$375.54	$187.76	$75.11
0378	Level II Pulmonary Imaging	S	5.4852	$299.28	$149.63	$59.86
0379	Injection adenosine 6 MG	K	0.2078	$11.34		$2.27
0380	Dipyridamole injection	K	0.2525	$13.78		$2.76
0384	GI Procedures with Stents	T	20.6602	$1,127.24	$244.83	$225.45
0385	Level I Prosthetic Urological Procedures	S	67.1530	$3,663.93		$732.79
0386	Level II Prosthetic Urological Procedures	S	116.2382	$6,342.07		$1,268.41
0387	Level II Hysteroscopy	T	28.1480	$1,535.78	$655.55	$307.16
0388	Discography	S	11.6347	$634.80	$303.19	$126.96
0389	Non-imaging Nuclear Medicine	S	1.6328	$89.09	$44.54	$17.82
0390	Level I Endocrine Imaging	S	2.7907	$152.26	$76.13	$30.45
0391	Level II Endocrine Imaging	S	3.1956	$174.36	$87.18	$34.87
0393	Red Cell/Plasma Studies	S	4.4354	$242.00	$121.00	$48.40
0394	Hepatobiliary Imaging	S	4.3714	$238.51	$119.25	$47.70
0395	GI Tract Imaging	S	3.9536	$215.71	$107.85	$43.14
0396	Bone Imaging	S	4.1883	$228.52	$114.26	$45.70
0397	Vascular Imaging	S	2.2183	$121.03	$60.51	$24.21
0398	Level I Cardiac Imaging	S	4.5091	$246.02	$123.01	$49.20
0399	Nuclear Medicine Add-on Imaging	S	1.5273	$83.33	$41.66	$16.67
0400	Hematopoietic Imaging	S	3.8242	$208.65	$104.32	$41.73
0401	Level I Pulmonary Imaging	S	3.3736	$184.07	$92.03	$36.81
0402	Brain Imaging	S	5.4063	$294.97	$147.48	$58.99

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0403	CSF Imaging	S	3.8402	$209.53	$104.76	$41.91
0404	Renal and Genitourinary Studies Level I	S	3.7303	$203.53	$101.76	$40.71
0405	Renal and Genitourinary Studies Level II	S	4.3432	$236.97	$118.48	$47.39
0406	Tumor/Infection Imaging	S	4.3955	$239.82	$119.91	$47.96 W≤
0407	Radionuclide Therapy	S	3.5841	$195.55	$97.77	$39.11
0409	Red Blood Cell Tests	X	0.1390	$7.58	$2.32	$1.52
0410	Mammogram Add On	S	0.1523	$8.31		$1.66
0411	Respiratory Procedures	S	0.4367	$23.83		$4.77
0412	IMRT Treatment Delivery	S	5.3904	$294.11		$58.82
0413	IMRT Treatment Plan	S	7.4469	$406.31		$81.26
0415	Level II Endoscopy Lower Airway	T	20.7348	$1,131.31	$459.92	$226.26
0600	Low Level Clinic Visits	V	0.9278	$50.62		$10.12
0601	Mid Level Clinic Visits	V	0.9816	$53.56		$10.71
0602	High Level Clinic Visits	V	1.5041	$82.07		$16.41
0610	Low Level Emergency Visits	V	1.3691	$74.70	$19.57	$14.94
0611	Mid Level Emergency Visits	V	2.3967	$130.77	$36.16	$26.15
0612	High Level Emergency Visits	V	4.1476	$226.30	$54.12	$45.26
0620	Critical Care	S	8.9992	$491.01	$142.30	$98.20
0648	Breast Reconstruction with Prosthesis	T	54.0165	$2,947.19		$589.44
0651	Complex Interstitial Radiation Source Application	S	10.2314	$558.24		$111.65
0652	Insertion of Intraperitoneal Catheters	T	27.0364	$1,475.13		$295.03
0653	Vascular Reconstruction/Fistula Repair with Device	T	30.0334	$1,638.65		$327.73
0654	Insertion/Replacement of a permanent dual chamber pacemaker.	T	112.6957	$6,148.79		$1,229.76
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	142.7039	$7,786.07		$1,557.21
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents.	T	103.4907	$5,646.56		$1,129.31
0657	Placement of Tissue Clips	S	1.5102	$82.40		$16.48
0658	Percutaneous Breast Biopsies	T	5.5779	$304.34		$60.87
0659	Hyperbaric Oxygen	S	3.0228	$164.93		$32.99
0660	Level II Otorhinolaryngologic Function Tests	X	1.7353	$94.68	$30.66	$18.94
0661	Level IV Pathology	X	3.2576	$177.74	$88.87	$35.55
0662	CT Angiography	S	5.8775	$320.68	$156.47	$64.14
0664	Proton Beam Radiation Therapy	S	9.7295	$530.85		$106.17
0665	Bone Density:AppendicularSkeleton	S	0.7257	$39.59		$7.92
0668	Level I Angiography and Venography except Extremity	S	10.2660	$560.12	$237.76	$112.02
0669	Digital Mammography	S	0.9009	$49.15		$9.83
0670	Intravenous and Intracardiac Ultrasound	S	27.4483	$1,497.61	$542.37	$299.52
0671	Level II Echocardiogram Except Transesophageal	S	1.6384	$89.39	$44.69	$17.88
0672	Level IV Posterior Segment Procedures	T	38.9476	$2,125.02	$988.43	$425.00
0673	Level IV Anterior Segment Eye Procedures	T	26.8390	$1,464.36	$649.56	$292.87
0674	Prostate Cryoablation	T	119.9733	$6,545.86		$1,309.17
0675	Prostatic Thermotherapy	T	49.3452	$2,692.32		$538.46
0676	Level II Transcatheter Thrombolysis	T	2.7315	$149.03	$40.30	$29.81
0677	Level I Transcatheter Thrombolysis	T	2.1805	$118.97		$23.79
0678	External Counterpulsation	T	2.0659	$112.72		$22.54
0679	Level II Resuscitation and Cardioversion	S	5.4887	$299.47	$95.30	$59.89
0680	Insertion of Patient Activated Event Recorders	S	62.8252	$3,427.81		$685.56
0681	Knee Arthroplasty	T	98.1613	$5,355.78	$2,131.36	$1,071.16
0682	Level V Debridement & Destruction	T	8.0790	$440.80	$174.57	$88.16
0683	Level II Photochemotherapy	S	1.5489	$84.51	$30.42	$16.90
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	4.8100	$262.44	$115.47	$52.49
0686	Level III Skin Repair	T	7.9247	$432.38	$198.89	$86.48
0687	Revision/Removal of Neurostimulator Electrodes	T	20.4416	$1,115.31	$513.05	$223.06
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.	T	46.7347	$2,549.89	$1,249.45	$509.98
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5533	$30.19		$6.04
0690	Electronic Analysis of Pacemakers and other Cardiac Devices.	S	0.4074	$22.23	$10.63	$4.45
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.8066	$153.13	$76.56	$30.63
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	1.1057	$60.33	$30.16	$12.07
0693	Level II Breast Reconstruction	T	39.0111	$2,128.48	$798.17	$425.70
0694	Mohs Surgery	T	2.9752	$162.33	$64.93	$32.47
0695	Level VII Debridement & Destruction	T	19.1849	$1,046.75	$266.59	$209.35
0697	Level I Echocardiogram Except Transesophageal	S	1.4415	$78.65	$39.32	$15.73
0698	Level II Eye Tests & Treatments	S	0.9599	$52.37	$18.72	$10.47
0699	Level IV Eye Tests & Treatments	T	2.2303	$121.69	$47.46	$24.34
0700	Antepartum Manipulation	T	2.4306	$132.62	$37.13	$26.52

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0701	SR 89 chloride, per mCi	K	7.3835	$402.85		$80.57
0702	SM 153 lexidronam, 50 mCi	K	16.0268	$874.44		$174.89
0704	IN 111 Satumomab pendetide per dose	K	2.2811	$124.46		$24.89
0705	Technetium TC99M tetrofosmin	K	1.0642	$58.06		$11.61
0726	Dexrazoxane hcl injection, 250 mg	K	2.0616	$112.48		$22.50
0728	Filgrastim 300 mcg injection	K	2.2631	$123.48		$24.70
0730	Pamidronate disodium , 30 mg	K	3.1949	$174.32		$34.86
0731	Sargramostim injection	K	0.2991	$16.32		$3.26
0732	Mesna injection 200 mg	K	0.5211	$28.43		$5.69
0733	Non esrd epoetin alpha inj, 1000 u	K	0.1802	$9.83		$1.97
0734	Injection, darbepoetin alfa (for non-ESRD), per 1 mcg	K		$3.24		$0.65
0763	Dolasetron mesylate oral	K	0.7514	$41.00		$8.20
0764	Granisetron HCl injection	K	0.1044	$5.70		$1.14
0765	Granisetron HCl 1 mg oral	K	0.6322	$34.49		$6.90
0800	Leuprolide acetate, 3.75 mg	K	3.3525	$182.92		$36.58
0802	Etoposide oral 50 mg	K	0.5016	$27.37		$5.47
0807	Aldesleukin/single use vial	K		$680.35		$136.07
0809	Bcg live intravesical vac	K	1.9015	$103.75		$20.75
0810	Goserelin acetate implant 3.6 mg	K	5.2265	$285.16		$57.03
0811	Carboplatin injection 50 mg	K	1.5849	$86.47		$17.29
0813	Cisplatin 10 mg injection	K	0.3985	$21.74		$4.35
0814	Asparaginase injection	K	0.2957	$16.13		$3.23
0815	Cyclophosphamide 100 MG inj	K	0.0868	$4.74		$0.95
0816	Cyclophosphamide lyophilized	K	0.0825	$4.50		$0.90
0817	Cytarabine hcl 100 MG inj	K	0.0930	$5.07		$1.01
0819	Dacarbazine 100 mg inj	K	0.0974	$5.31		$1.06
0820	Daunorubicin 10 mg	K	1.3557	$73.97		$14.79
0821	Daunorubicin citrate liposom 10 mg	K	2.9976	$163.55		$32.71
0823	Docetaxel, 20 mg	K	4.0499	$220.97		$44.19
0824	Etoposide 10 MG inj	K	0.0836	$4.56		$0.91
0827	Floxuridine injection 500 mg	K	2.0928	$114.19		$22.84
0828	Gemcitabine HCL 200 mg	K	1.4742	$80.43		$16.09
0830	Irinotecan injection 20 mg	K	1.8428	$100.55		$20.11
0831	Ifosfomide injection 1 gm	K	1.9435	$106.04		$21.21
0832	Idarubicin hcl injection 5 mg	K	3.2663	$178.21		$35.64
0834	Interferon alfa-2a inj	K	0.3777	$20.61		$4.12
0836	Interferon alfa-2b inj recombinant, 1 million	K	0.2003	$10.93		$2.19
0838	Interferon gamma 1-b inj, 3 million u	K		$180.15		$36.03
0840	Melphalan hydrochl 50 mg	K	4.6719	$254.90		$50.98
0842	Fludarabine phosphate inj 50 mg	K	3.7708	$205.74		$41.15
0844	Pentostatin injection, 10 mg	K	17.7045	$965.98		$193.20
0847	Doxorubic hcl 10 MG vl chemo	K	0.1212	$6.61		$1.32
0849	Rituximab, 100 mg	K	5.6158	$306.40		$61.28
0850	Streptozocin injection, 1 gm	K	1.1948	$65.19		$13.04
0851	Thiotepa injection	K	1.0984	$59.93		$11.99
0852	Topotecan, 4 mg	K	7.9435	$433.41		$86.68
0855	Vinorelbine tartrate, 10 mg	K	1.1874	$64.79		$12.96
0856	Porfimer sodium, 75 mg	K	29.2205	$1,594.30		$318.86
0857	Bleomycin sulfate injection 15 u	K	2.9427	$160.56		$32.11
0858	Cladribine, 1mg	K	0.6931	$37.82		$7.56
0860	Plicamycin (mithramycin) inj	K	0.2826	$15.42		$3.08
0861	Leuprolide acetate injection 1 mg	K	0.7991	$43.60		$8.72
0862	Mitomycin 5 mg inj	K	0.9719	$53.03		$10.61
0863	Paclitaxel injection, 30 mg	K	2.0553	$112.14		$22.43
0864	Mitoxantrone hcl, 5 mg	K	3.1832	$173.68		$34.74
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K	1.4598	$79.65		$15.93
0884	Rho d immune globulin inj, 1 dose pkg	K	0.1863	$10.16		$2.03
0888	Cyclosporine oral 100 mg	K	0.0470	$2.56		$0.51
0890	Lymphocyte immune globulin 250 mg	K	2.3439	$127.89		$25.58
0891	Tacrolimus oral per 1 mg	K	0.0246	$1.34		$0.27
0900	Alglucerase injection, per 10 u	K		$37.13		$7.43
0901	Alpha 1 proteinase inhibitor, 10 mg	K		$3.43		$0.69
0902	Botulinum toxin a, per unit	K	0.0588	$3.21		$0.64
0903	Cytomegalovirus imm IV/vial	K	5.3368	$291.18		$58.24
0905	Immune globulin, 1g	K	0.8057	$43.96		$8.79
0906	RSV-ivig, 50 mg	K	0.8910	$48.61		$9.72
0907	Ganciclovir sodium injection	K	0.5918	$32.29		$6.46
0909	Interferon beta-1a, 33 mcg	K	3.3868	$184.79		$36.96
0910	Interferon beta-1b /0.25 mg	K	1.8421	$100.51		$20.10

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0911	Streptokinase per 250,000 iu	K	1.5733	$85.84		$17.17
0913	Ganciclovir long act implant	K	1.5861	$86.54		$17.31
0916	Imiglucerase injection/unit	K		$3.71		$0.74
0917	Adenosine injection	K	1.0393	$56.71		$11.34
0925	Factor viii per iu	K		$0.51		$0.10
0926	Factor VIII (porcine) per iu	K		$1.52		$0.30
0927	Factor viii recombinant per iu	K		$1.01		$0.20
0928	Factor ix complex per iu	K		$0.51		$0.10
0929	Anti-inhibitor per iu	K		$1.01		$0.20
0931	Factor IX non-recombinant, per iu	K		$0.51		$0.10
0932	Factor IX recombinant, per iu	K		$1.01		$0.20
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K		$124.31		$24.86
0950	Blood (Whole) For Transfusion	K		$87.93		$17.59
0952	Cryoprecipitate	K		$29.31		$5.86
0954	RBC leukocytes reduced	K		$119.26		$23.85
0955	Plasma, Fresh Frozen	K		$95.00		$19.00
0956	Plasma Protein Fraction	K		$92.98		$18.60
0957	Platelet Concentrate	K		$41.44		$8.29
0958	Platelet Rich Plasma	K		$53.56		$10.71
0959	Red Blood Cells	K		$86.41		$17.28
0960	Washed Red Blood Cells	K		$160.69		$32.14
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.2802	$15.29		$3.06
0963	Albumin (human), 5%, 250 ml	K	1.0901	$59.48		$11.90
0964	Albumin (human), 25%, 20 ml	K	0.3741	$20.41		$4.08
0965	Albumin (human), 25%, 50ml	K	0.8869	$48.39		$9.68
0966	Plasmaprotein fract,5%,250ml	K		$464.90		$92.98
1009	Cryoprecip reduced plasma	K		$37.39		$7.48
1010	Blood, L/R, CMV-neg	K		$121.78		$24.36
1011	Platelets, HLA-m, L/R, unit	K		$499.77		$99.95
1013	Platelet concentrate, L/R, unit	K		$49.52		$9.90
1016	Blood, L/R, froz/deglycerol/washed	K		$301.68		$60.34
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K		$393.15		$78.63
1018	Blood, L/R, irradiated	K		$132.40		$26.48
1019	Platelets, aph/pher, L/R, irradiated, unit	K		$406.28		$81.26
1020	Pit, pher,L/R,CMV,irrad	K		$495.22		$99.04
1021	RBC, frz/deg/wsh, L/R, irrad	K		$336.04		$67.21
1022	RBC, L/R, CMV neg, irrad	K		$201.12		$40.22
1045	Iobenguane sulfate I-131per 0.5 mCi	K	3.0392	$165.82		$33.16
1064	I-131 sodium iodide capsule	K	0.1004	$5.48		$1.10
1065	I-131 sodium iodide solution	K	0.1189	$6.49		$1.30
1079	CO 57/58 per 0.5 uCi	K	1.2556	$68.51		$13.70
1080	I-131 tositumomab, dx	K		$2,260.00		$452.00
1081	I-131 tositumomab, tx	K		$19,565.00		$3,913.00
1084	Denileukin diftitox, 300 MCG	K		$1,232.88		$246.58
1086	Temozolomide,oral 5 mg	K	0.0690	$3.76		$0.75
1089	Cyanocobalamin cobalt co57	K	1.0460	$57.07		$11.41
1091	IN 111 Oxyquinoline, per .5 mCi	K	4.1151	$224.52		$44.90
1092	IN 111 Pentetate, per 0.5 mCi	K	3.9855	$217.45		$43.49
1095	Technetium TC 99M Depreotide	K	0.6940	$37.87		$7.57
1096	TC 99M Exametazime, per dose	K	3.8609	$210.65		$42.13
1122	TC 99M arcitumomab, per vial	K	9.8014	$534.77		$106.95
1166	Cytarabine liposome	K	5.1134	$278.99		$55.80
1167	Epirubicin hcl, 2 mg	K	0.3744	$20.43		$4.09
1178	Busulfan IV, 6 mg	K	5.4930	$299.70		$59.94
1200	TC 99M Sodium Glucoheptonat	K	0.5550	$30.28		$6.06
1201	TC 99M SUCCIMER, PER Vial	K	1.4706	$80.24		$16.05
1203	Verteporfin for injection	K	16.4439	$897.20		$179.44
1207	Octreotide injection, depot	K	1.2049	$65.74		$13.15
1305	Apligraf	K	15.0691	$822.19		$164.44
1409	Factor viia recombinant, per 1.2 mg	K		$1,083.93		$216.79
1501	New Technology—Level I ($0–$50)	S		$25.00		$5.00
1502	New Technology—Level II ($50–$100)	S		$75.00		$15.00
1503	New Technology—Level III ($100–$200)	S		$150.00		$30.00
1504	New Technology—Level IV ($200–$300)	S		$250.00		$50.00
1505	New Technology—Level V ($300–$400)	S		$350.00		$70.00
1506	New Technology—Level VI ($400–$500)	S		$450.00		$90.00
1507	New Technology—Level VII ($500–$600)	S		$550.00		$110.00
1508	New Technology—Level VIII ($600–$700)	S		$650.00		$130.00
1509	New Technology—Level IX ($700–$800)	S		$750.00		$150.00

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1510	New Technology—Level X ($800–$900)	S		$850.00		$170.00
1511	New Technology—Level XI ($900–$1000)	S		$950.00		$190.00
1512	New Technology—Level XII ($1000–$1100)	S		$1,050.00		$210.00
1513	New Technology—Level XIII ($1100–$1200)	S		$1,150.00		$230.00
1514	New Technology-Level XIV ($1200- $1300)	S		$1,250.00		$250.00
1515	New Technology—Level XV ($1300–$1400)	S		$1,350.00		$270.00
1516	New Technology—Level XVI ($1400–$1500)	S		$1,450.00		$290.00
1517	New Technology—Level XVII ($1500-$1600)	S		$1,550.00		$310.00
1518	New Technology—Level XVIII ($1600-$1700)	S		$1,650.00		$330.00
1519	New Technology—Level IXX ($1700-$1800)	S		$1,750.00		$350.00
1520	New Technology—Level XX ($1800-$1900)	S		$1,850.00		$370.00
1521	New Technology—Level XXI ($1900-$2000)	S		$1,950.00		$390.00
1522	New Technology—Level XXII ($2000-$2500)	S		$2,250.00		$450.00
1523	New Technology—Level XXIII ($2500-$3000)	S		$2,750.00		$550.00
1524	New Technology—Level XIV ($3000-$3500)	S		$3,250.00		$650.00
1525	New Technology—Level XXV ($3500-$4000)	S		$3,750.00		$750.00
1526	New Technology—Level XXVI ($4000-$4500)	S		$4,250.00		$850.00
1527	New Technology—Level XXVII ($4500-$5000)	S		$4,750.00		$950.00
1528	New Technology—Level XXVIII ($5000-$5500)	S		$5,250.00		$1,050.00
1529	New Technology—Level XXIX ($5500-$6000)	S		$5,750.00		$1,150.00
1530	New Technology—Level XXX ($6000-$6500)	S		$6,250.00		$1,250.00
1531	New Technology—Level XXXI ($6500-$7000)	S		$6,750.00		$1,350.00
1532	New Technology—Level XXXII ($7000-$7500)	S		$7,250.00		$1,450.00
1533	New Technology—Level XXXIII ($7500-$8000)	S		$7,750.00		$1,550.00
1534	New Technology—Level XXXIV ($8000-$8500)	S		$8,250.00		$1,650.00
1535	New Technology—Level XXXV ($8500-$9000)	S		$8,750.00		$1,750.00
1536	New Technology—Level XXXVI ($9000-$9500)	S		$9,250.00		$1,850.00
1537	New Technology—Level XXXVII ($9500-$10000)	S		$9,750.00		$1,950.00
1538	New Technology—Level I ($0–$50)	T		$25.00		$5.00
1539	New Technology—Level II ($50–$100)	T		$75.00		$15.00
1540	New Technology—Level III ($100–$200)	T		$150.00		$30.00
1541	New Technology—Level IV ($200–$300)	T		$250.00		$50.00
1542	New Technology—Level V ($300–$400)	T		$350.00		$70.00
1543	New Technology—Level VI ($400–$500)	T		$450.00		$90.00
1544	New Technology—Level VII ($500–$600)	T		$550.00		$110.00
1545	New Technology—Level VIII ($600–$700)	T		$650.00		$130.00
1546	New Technology—Level IX ($700–$800)	T		$750.00		$150.00
1547	New Technology—Level X ($800–$900)	T		$850.00		$170.00
1548	New Technology—Level XI ($900–$1000)	T		$950.00		$190.00
1549	New Technology—Level XII ($1000–$1100)	T		$1,050.00		$210.00
1550	New Technology—Level XIII ($1100–$1200)	T		$1,150.00		$230.00
1551	New Technology-Level XIV ($1200- $1300)	T		$1,250.00		$250.00
1552	New Technology—Level XV ($1300–$1400)	T		$1,350.00		$270.00
1553	New Technology—Level XVI ($1400–$1500)	T		$1,450.00		$290.00
1554	New Technology—Level XVII ($1500-$1600)	T		$1,550.00		$310.00
1555	New Technology—Level XVIII ($1600-$1700)	T		$1,650.00		$330.00
1556	New Technology—Level XIX ($1700-$1800)	T		$1,750.00		$350.00
1557	New Technology—Level XX ($1800-$1900)	T		$1,850.00		$370.00
1558	New Technology—Level XXI ($1900-$2000)	T		$1,950.00		$390.00
1559	New Technology—Level XXII ($2000-$2500)	T		$2,250.00		$450.00
1560	New Technology—Level XXIII ($2500-$3000)	T		$2,750.00		$550.00
1561	New Technology—Level XXIV ($3000-$3500)	T		$3,250.00		$650.00
1562	New Technology—Level XXV ($3500-$4000)	T		$3,750.00		$750.00
1563	New Technology—Level XXVI ($4000-$4500)	T		$4,250.00		$850.00
1564	New Technology—Level XXVII ($4500-$5000)	T		$4,750.00		$950.00
1565	New Technology—Level XXVIII ($5000-$5500)	T		$5,250.00		$1,050.00
1566	New Technology—Level XXIX ($5500-$6000)	T		$5,750.00		$1,150.00
1567	New Technology—Level XXX ($6000-$6500)	T		$6,250.00		$1,250.00
1568	New Technology—Level XXXI ($6500-$7000)	T		$6,750.00		$1,350.00
1569	New Technology—Level XXXII ($7000-$7500)	T		$7,250.00		$1,450.00
1570	New Technology—Level XXXIII ($7500-$8000)	T		$7,750.00		$1,550.00
1571	New Technology—Level XXXIV ($8000-$8500)	T		$8,250.00		$1,650.00
1572	New Technology—Level XXXV ($8500-$9000)	T		$8,750.00		$1,750.00
1573	New Technology—Level XXXVI ($9000-$9500)	T		$9,250.00		$1,850.00
1574	New Technology—Level XXXVII ($9500-$10000)	T		$9,750.00		$1,950.00
1600	Technetium TC 99m sestamibi	K	1.1782	$64.28		$12.86
1603	Thallous chloride TL 201/mci	K	0.3645	$19.89		$3.98
1604	IN 111 capromab pendetide, per dose	K	12.6045	$687.71		$137.54
1605	Abciximab injection, 10 mg	K	5.3048	$289.44		$57.89

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1606	Anistreplase, 30 u	K	27.7939	$1,516.46		$303.29
1607	Eptifibatide injection, 5mg	K	0.1465	$7.99		$1.60
1608	Etanercept injection	K	1.8762	$102.37		$20.47
1609	Rho(D) immune globulin h, sd, 100 iu	K	0.1789	$9.76		$1.95
1611	Hylan G-F 20 injection, 16 mg	K	2.2628	$123.46		$24.69
1612	Daclizumab, parenteral, 25 mg	K		$393.78		$78.76
1613	Trastuzumab, 10 mg	K	0.7434	$40.56		$8.11
1614	Valrubicin, 200 mg	K	8.4635	$461.78		$92.36
1615	Basiliximab, 20 mg	K		$1,425.06		$285.01
1618	Vonwillebrandfactrcmplx, per iu	K		$1.01		$0.20
1619	Gallium ga 67	K	0.2056	$11.22		$2.24
1620	Technetium tc99m bicisate	K	3.3666	$183.69		$36.74
1622	Technetium tc99m mertiatide	K	0.3782	$20.63		$4.13
1624	Sodium phosphate p32	K	1.2941	$70.61		$14.12
1625	Indium 111-in pentetreotide	K	8.2447	$449.84		$89.97
1628	Chromic phosphate p32	K	1.8057	$98.52		$19.70
1716	Brachytx source, Gold 198	K	1.3811	$75.35		$15.07
1718	Brachytx source, Iodine 125	K	0.6843	$37.34		$7.47
1719	Brachytx source,Non-HDR Ir-192	K	0.3187	$17.39		$3.48
1720	Brachytx source, Palladium 103	K	0.8187	$44.67		$8.93
1775	FDG, per dose (4-40 mCi/ml)	K	5.9471	$324.48		$64.90
1783	Ocular implant, aqueous drain device	H				$0.00
1814	Retinal Tamp, silicone oil	H				$-.00
1818	Integrated keratoprosthesis	H				$0.00
1819	Tissue localization-excision dev	H				$0.00
1884	Embolization Protect syst	H				$0.00
1888	Catheter, ablation, non-cardiac, endovascular (implantable)	H				$0.00
1900	Lead coronary venous	H				$0.00
2614	Probe, percutaneous lumbar disc	H				$0.00
2616	Brachytx source, Yttrium-90	K	176.2339	$9,615.50		$1,923.10
2632	Brachytx sol, I-125, per mCi	H				$0.00
2633	Brachytx source, Cesium-131	K	0.8187	$44.67		$8.93
7000	Amifostine, 500 mg	K	5.3041	$289.40		$57.88
7007	Inj milrinone lactate, per 5 mg	K	0.2129	$11.62		$2.32
7011	Oprelvekin injection, 5 mg	K		$248.16		$49.63
7015	Busulfan, oral, 2 mg	K	0.0288	$1.57		$0.31
7019	Aprotinin, 10,000 kiu	K	0.0215	$1.17		$0.23
7024	Corticorelin ovine triflutat	K	4.1221	$224.91		$44.98
7025	Digoxin immune FAB (ovine)	K	4.9694	$271.14		$54.23
7026	Ethanolamine oleate 100 mg	K	0.5099	$27.82		$5.56
7027	Fomepizole, 15mg	K	0.1325	$7.23		$1.45
7028	Fosphenytoin, 50 mg	K	0.0895	$4.88		$0.98
7030	Hemin, per 1 mg	K	0.0118	$0.64		$0.13
7031	Octreotide acetate injection	K	0.0264	$1.44		$0.29
7034	Somatropin injection	K	0.7547	$41.18		$8.24
7035	Teniposide, 50 mg	K	2.5185	$137.41		$27.48
7036	Urokinase 250,000 iu inj	K	3.7855	$206.54		$41.31
7037	Urofollitropin, 75 iu	K	1.1634	$63.48		$12.70
7038	Muromonab-CD3, 5 mg	K	5.8803	$320.84		$64.17
7040	Pentastarch 10% solution	K	0.4838	$26.40		$5.28
7041	Tirofiban hydrochloride 12.5 mg	K	4.176	$227.85		$45.57
7042	Capecitabine, oral, 150 mg	K	0.0302	$1.65		$0.33
7043	Infliximab injection 10 mg	K	0.7122	$38.86		$7.77
7045	Trimetrexate glucoronate	K	1.1246	$61.36		$12.27
7046	Doxorubicin hcl liposome inj 10 mg	K	4.6982	$256.34		$51.27
7048	Alteplase recombinant	K	0.2856	$15.58		$3.12
7049	Filgrastim 480 mcg injection	K	3.2251	$175.96		$35.19
7051	Leuprolide acetate implant, 65 mg	K	67.2039	$3,666.71		$733.34
7316	Sodium hyaluronate injection	K	2.5436	$138.78		$27.76
9001	Linezolid injection	K	0.2771	$15.12		$3.02
9002	Tenecteplase, 50mg/vial	K	23.7669	$1,296.75		$259.35
9003	Palivizumab, per 50mg	K	6.3077	$344.15		$68.83
9004	Gemtuzumab ozogamicin inj,5mg	K		$2,022.90		$404.58
9005	Reteplase injection	K	10.4165	$568.33		$113.67
9006	Tacrolimus injection	K	0.1048	$5.72		$1.14
9008	Baclofen Refill Kit-500mcg	K	0.1264	$6.90		$1.38
9009	Baclofen refill kit—per 2000 mcg	K	0.7499	$40.92		$8.18
9010	Baclofen refill kit—per 4000 mcg	K	0.7739	$42.22		$8.44
9012	Arsenic Trioxide	K	0.4933	$26.91		$5.38

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9013	Co 57 cobaltous chloride	K	1.0386	$56.67		$11.33
9015	Mycophenolate mofetil oral 250 mg	K	0.0374	$2.04		$0.41
9018	Botulinum toxin B, per 100 u	K	0.1279	$6.98		$1.40
9019	Caspofungin acetate, 5 mg	K	0.5432	$29.64		$5.93
9020	Sirolimus tablet, 1 mg	K	0.0529	$2.89		$0.58
9021	Immune globulin 10 mg	K	0.0080	$0.44		$0.09
9022	IM inj interferon beta 1-a	K	1.1290	$61.60		$12.32
9023	Rho d immune globulin 50 mcg	K	0.0310	$1.69		$0.34
9024	Amphotericin B, lipid formulation	K	0.3823	$20.86		$4.17
9025	Radiopharms Used to Image Perfusion of Heart	K	2.6372	$143.89		$28.78
9100	Iodinated I-131albumin, per 5 uci	K	0.0066	$0.36		$0.07
9104	Anti-thymocycte globulin rabbit	K	2.9978	$163.56		$32.71
9105	Hep B imm glob, per 1 ml	K	1.3074	$71.33		$14.27
9108	Thyrotropin alfa, per 1.1 mg	K		$572.00		$114.40
9109	Tirofliban hcl, per 6.25 mg	K	2.1737	$118.60		$23.72
9110	Alemtuzumab, per 10 mg	K	7.7873	$424.88		$84.98
9111	Inj, bivalirudin, per 250 mg vial	G		$1.60		$0.24
9112	Perflutren lipid micro, per 2ml	G		$148.20		$22.15
9113	Inj, pantoprazole sodium, vial	G		$25.08		$3.75
9114	Nesiritide, per 0.5 mg vial	G		$151.62		$22.66
9115	Inj, zoledronic acid, per 1 mg	G		$217.43		$32.50
9116	Inj, Ertapenem sodium, per 1 gm vial	G		$23.74		$3.55
9117	Yttrium 90 ibritumomab tiuxetan	K		$19,565.00		$3,913.00
9118	In-111 ibritumomab tiuxetan	K		$2,260.00		$452.00
9119	Pegfilgrastim, per 1 mg	G		$2,802.50		$418.90
9120	Inj, Fulvestrant, per 50 mg	G		$87.58		$13.09
9121	Inj, Argatroban, per 5 mg	G		$16.35		$2.44
9122	Inj, Triptorelin pamoate, per 3.75 mg	G		$398.62		$59.58
9123	Transcyte, per 247 sq cm	G		$770.93		$115.23
9200	Orcel, per 36 cm2	G		$1,135.25		$169.69
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$86.34
9202	Octafluoropropane	K	2.1737	$118.60		$23.72
9203	Perflexane lipid micro	G		$142.50		$21.30
9204	Ziprasidone mesylate	G		$20.79		$3.11
9205	Oxaliplatin	G		$94.46		$14.12
9207	Injection, bortezomib	G		$1,039.68		$155.40
9208	Injection, agalsidase beta	G		$123.78		$18.50
9209	Injection, laronidase	G		$644.10		$96.28
9210	Injection, palonosetron HCL	G		$307.80		$46.01
9211	Inj, alefacept, IV	G		$665.00		$99.40
9212	Inj, alefacept, IM	G		$472.63		$70.65
9217	Leuprolide acetate suspnsion, 7.5 mg	K	5.7252	$312.37		$62.47
9500	Platelets, irradiated	K		$74.79		$14.96
9501	Platelets, pheresis	K		$408.81		$81.76
9502	Platelet pheresis irradiated	K		$443.68		$88.74
9503	Fresh frozen plasma, ea unit	K		$69.74		$13.95
9504	RBC deglycerolized	K		$183.44		$36.69
9505	RBC irradiated	K		$108.65		$21.73
9506	Granulocytes, pheresis	K		$1,248.66		$249.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001F	E	NI	Blood pressure, measured					
0001T	C		Endovas repr abdo ao aneurys					
0002F	E	NI	Tobacco use, smoking, assess					
0002T	C	DG	Endovas repr abdo ao aneurys					
0003F	E	NI	Tobacco use, non-smoking					
0003T	S		Cervicography	1501		$25.00		$5.00
0004F	E	NI	Tobacco use txmnt counseling					
0005F	E	NI	Tobacco use txmnt, pharmacol					
0005T	C		Perc cath stent/brain cv art					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0006F	E	NI	Statin therapy, prescribed					
0006T	C		Perc cath stent/brain cv art					
0007F	E	NI	Beta-blocker thx prescribed					
0007T	C		Perc cath stent/brain cv art					
0008F	E	NI	Ace inhibitor thx prescribed					
0008T	E		Upper gi endoscopy w/suture					
0009F	E	NI	Assess anginal symptom/level					
0009T	T		Endometrial cryoablation	1557		$1,850.00		$370.00
00100	N		Anesth, salivary gland					
00102	N		Anesth, repair of cleft lip					
00103	N		Anesth, blepharoplasty					
00104	N		Anesth, electroshock					
0010F	E	NI	Assess anginal symptom/level					
0010T	A		Tb test, gamma interferon					
0011F	E	NI	Oral antiplat thx prescribed					
00120	N		Anesth, ear surgery					
00124	N		Anesth, ear exam					
00126	N		Anesth, tympanotomy					
0012T	T		Osteochondral knee autograft	0041	27.3819	$1,493.98		$298.80
0013T	T		Osteochondral knee allograft	0041	27.3819	$1,493.98		$298.80
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	27.3819	$1,493.98		$298.80
00160	N		Anesth, nose/sinus surgery					
00162	N		Anesth, nose/sinus surgery					
00164	N		Anesth, biopsy of nose					
0016T	T		Thermotx choroid vasc lesion	0235	5.0749	$276.89	$72.04	$55.38
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	0.6457	$35.23	$15.76	$7.05
00190	N		Anesth, face/skull bone surg					
00192	C		Anesth, facial bone surgery					
0019T	E		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, intrcrn nerve					
00222	N		Anesth, head nerve surgery					
0023T	A		Phenotype drug test, hiv 1					
0024T	C		Transcath cardiac reduction					
0025T	S	DG	Ultrasonic pachymetry	0230	0.7619	$41.57	$14.97	$8.31
0026T	A		Measure remnant lipoproteins					
0027T	T		Endoscopic epidural lysis	1547		$850.00		$170.00
0028T	N		Dexa body composition study					
0029T	A		Magnetic tx for incontinence					
00300	N		Anesth, head/neck/ptrunk					
0030T	A		Antiprothrombin antibody					
0031T	N		Speculoscopy					
00320	N		Anesth, neck organ, 1 & over					
00322	N		Anesth, biopsy of thyroid					
00326	N		Anesth, larynx/trach, < 1 yr					
0032T	N		Speculoscopy w/direct sample					
0033T	C		Endovasc taa repr incl subcl					
0034T	C		Endovasc taa repr w/o subcl					
00350	N		Anesth, neck vessel surgery					
00352	N		Anesth, neck vessel surgery					
0035T	C		Insert endovasc prosth, taa					
0036T	C		Endovasc prosth, taa, add-on					
0037T	C		Artery transpose/endovas taa					
0038T	C		Rad endovasc taa rpr w/cover					
0039T	C		Rad s/i, endovasc taa repair					
00400	N		Anesth, skin, ext/per/atrunk					
00402	N		Anesth, surgery of breast					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00404	C		Anesth, surgery of breast					
00406	C		Anesth, surgery of breast					
0040T	C		Rad s/i, endovasc taa prosth					
00410	N		Anesth, correct heart rhythm					
0041T	A		Detect ur infect agnt w/cpas					
0042T	N		Ct perfusion w/contrast, cbf					
0043T	A		Co expired gas analysis					
0044T	N		Whole body photography					
00450	N		Anesth, surgery of shoulder					
00452	C		Anesth, surgery of shoulder					
00454	N		Anesth, collar bone biopsy					
0045T	N	NI	Whole body photography					
0046T	T	NI	Cath lavage, mammary duct(s)	0018	0.9178	$50.08	$16.04	$10.02
00470	N		Anesth, removal of rib					
00472	N		Anesth, chest wall repair					
00474	C		Anesth, surgery of rib(s)					
0047T	T	NI	Cath lavage, mammary duct(s)	0018	0.9178	$50.08	$16.04	$10.02
0048T	C	NI	Implant ventricular device					
0049T	C	NI	External circulation assist					
00500	N		Anesth, esophageal surgery					
0050T	C	NI	Removal circulation assist					
0051T	C	NI	Implant total heart system					
00520	N		Anesth, chest procedure					
00522	N		Anesth, chest lining biopsy					
00524	C		Anesth, chest drainage					
00528	N		Anesth, chest partition view					
00529	N	NI	Anesth, chest partition view					
0052T	C	NI	Replace component heart syst					
00530	N		Anesth, pacemaker insertion					
00532	N		Anesth, vascular access					
00534	N		Anesth, cardioverter/defib					
00537	N		Anesth, cardiac electrophys					
00539	N		Anesth, trach-bronch reconst					
0053T	C	NI	Replace component heart syst					
00540	C		Anesth, chest surgery					
00541	N		Anesth, one lung ventilation					
00542	C		Anesth, release of lung					
00544	C	DG	Anesth, chest lining removal					
00546	C	DG	Anesth, lung,chest wall surg					
00548	N	DG	Anesth, trachea,bronchi surg					
0054T	E	NI	Bone surgery using computer					
00550	N	DG	Anesth, sternal debridement					
0055T	E	NI	Bone surgery using computer					
00560	C	DG	Anesth, open heart surgery					
00562	C	DG	Anesth, open heart surgery					
00563	N	DG	Anesth, heart proc w/pump					
00566	N	DG	Anesth, cabg w/o pump					
0056T	E	NI	Bone surgery using computer					
0057T	E	NI	Uppr gi scope w/ thrml txmnt					
00580	C		Anesth, heart/lung transplnt					
0058T	X	NI	Cryopreservation, ovary tiss	0348	0.8194	$44.71		$8.94
0059T	X	NI	Cryopreservation, oocyte	0348	0.8194	$44.71		$8.94
00600	N		Anesth, spine, cord surgery					
00604	C		Anesth, sitting procedure					
0060T	E	NI	Electrical impedance scan					
0061T	E	NI	Destruction of tumor, breast					
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					
00640	N		Anesth, spine manipulation					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
00834	N		Anesth, hernia repair< 1 yr					
00836	N		Anesth hernia repair preemie					
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					
00851	N		Anesth, tubal ligation					
00860	N		Anesth, surgery of abdomen					
00862	N		Anesth, kidney/ureter surg					
00864	C		Anesth, removal of bladder					
00865	C		Anesth, removal of prostate					
00866	C		Anesth, removal of adrenal					
00868	C		Anesth, kidney transplant					
00870	N		Anesth, bladder stone surg					
00872	N		Anesth kidney stone destruct					
00873	N		Anesth kidney stone destruct					
00880	N		Anesth, abdomen vessel surg					
00882	C		Anesth, major vein ligation					
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					
00921	N		Anesth, vasectomy					
00922	N		Anesth, sperm duct surgery					
00924	N		Anesth, testis exploration					
00926	N		Anesth, removal of testis					
00928	C		Anesth, removal of testis					
00930	N		Anesth, testis suspension					
00932	C		Anesth, amputation of penis					
00934	C		Anesth, penis, nodes removal					
00936	C		Anesth, penis, nodes removal					
00938	N		Anesth, insert penis device					
00940	N		Anesth, vaginal procedures					
00942	N		Anesth, surg on vag/urethral					
00944	C		Anesth, vaginal hysterectomy					
00948	N		Anesth, repair of cervix					
00950	N		Anesth, vaginal endoscopy					
00952	N		Anesth, hysteroscope/graph					
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					
01173	N	NI	Anesth, fx repair, pelvis					
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, hip arthroplasty					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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, dx knee arthroscopy					
01390	N		Anesth, knee area procedure					
01392	N		Anesth, knee area surgery					
01400	N		Anesth, knee joint surgery					
01402	C		Anesth, knee arthroplasty					
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/ft 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		Anes dx shoulder arthroscopy					
01630	N		Anesth, surgery of shoulder					
01632	C		Anesth, surgery of shoulder					
01634	C		Anesth, shoulder joint amput					
01636	C		Anesth, forequarter amput					
01638	C		Anesth, shoulder replacement					
01650	N		Anesth, shoulder artery surg					
01652	C		Anesth, shoulder vessel surg					
01654	C		Anesth, shoulder vessel surg					
01656	C		Anesth, arm-leg vessel surg					
01670	N		Anesth, shoulder vein surg					
01680	N		Anesth, shoulder casting					
01682	N		Anesth, airplane cast					
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, dx 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					
01829	N		Anesth, dx wrist arthroscopy					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01860	N		Anesth, lower arm casting					
01905	N		Anes, spine inject, x-ray/re					
01916	N		Anesth, dx arteriography					
01920	N		Anesth, catheterize heart					
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 4 percent					
01952	N		Anesth, burn, 4-9 percent					
01953	N		Anesth, burn, each 9 percent					
01958	N	NI	Anesth, antepartum manipul					
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					
01991	N		Anesth, nerve block/inj					
01992	N		Anesth, n block/inj, prone					
01995	N		Regional anesthesia limb					
01996	N		Hosp manage cont drug admin					
01999	N		Unlisted anesth procedure					
10021	T		Fna w/o image	0002	0.8083	$44.10		$8.82
10022	T		Fna w/image	0036	1.5170	$82.77		$16.55
10040	T		Acne surgery	0010	0.6480	$35.36	$10.08	$7.07
10060	T		Drainage of skin abscess	0006	1.6527	$90.17	$23.26	$18.03
10061	T		Drainage of skin abscess	0006	1.6527	$90.17	$23.26	$18.03
10080	T		Drainage of pilonidal cyst	0006	1.6527	$90.17	$23.26	$18.03
10081	T		Drainage of pilonidal cyst	0007	11.8633	$647.27		$129.45
10120	T		Remove foreign body	0006	1.6527	$90.17	$23.26	$18.03
10121	T		Remove foreign body	0021	14.3594	$783.46	$219.48	$156.69
10140	T		Drainage of hematoma/fluid	0007	11.8633	$647.27		$129.45
10160	T		Puncture drainage of lesion	0018	0.9178	$50.08	$16.04	$10.02
10180	T		Complex drainage, wound	0007	11.8633	$647.27		$129.45
11000	T		Debride infected skin	0015	1.5968	$87.12	$20.35	$17.42
11001	T		Debride infected skin add-on	0012	0.7694	$41.98	$11.18	$8.40
11010	T		Debride skin, fx	0019	3.9493	$215.48	$71.87	$43.10
11011	T		Debride skin/muscle, fx	0019	3.9493	$215.48	$71.87	$43.10
11012	T		Debride skin/muscle/bone, fx	0019	3.9493	$215.48	$71.87	$43.10
11040	T		Debride skin, partial	0015	1.5968	$87.12	$20.35	$17.42
11041	T		Debride skin, full	0015	1.5968	$87.12	$20.35	$17.42
11042	T		Debride skin/tissue	0016	2.5724	$140.35	$57.31	$28.07
11043	T		Debride tissue/muscle	0016	2.5724	$140.35	$57.31	$28.07
11044	T		Debride tissue/muscle/bone	0682	8.0790	$440.80	$174.57	$88.16
11055	T		Trim skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11056	T		Trim skin lesions, 2 to 4	0012	0.7694	$41.98	$11.18	$8.40
11057	T		Trim skin lesions, over 4	0013	1.1272	$61.50	$14.20	$12.30
11100	T		Biopsy, skin lesion	0018	0.9178	$50.08	$16.04	$10.02
11101	T		Biopsy, skin add-on	0018	0.9178	$50.08	$16.04	$10.02
11200	T		Removal of skin tags	0013	1.1272	$61.50	$14.20	$12.30
11201	T		Remove skin tags add-on	0015	1.5968	$87.12	$20.35	$17.42
11300	T		Shave skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11301	T		Shave skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11302	T		Shave skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11303	T		Shave skin lesion	0015	1.5968	$87.12	$20.35	$17.42
11305	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11306	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11307	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11308	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11310	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11311	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11312	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11313	T		Shave skin lesion	0016	2.5724	$140.35	$57.31	$28.07
11400	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11401	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11402	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11403	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11404	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11406	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11420	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11421	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11422	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11423	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11424	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11426	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11440	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11441	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11442	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11443	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11444	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11446	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11450	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11451	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11462	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11463	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11470	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11471	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11600	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11601	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11602	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11603	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11604	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11606	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11620	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11621	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11622	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11623	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11624	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11626	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11640	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11641	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11642	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11643	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11644	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11646	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11719	T		Trim nail(s)	0009	0.6652	$36.29	$8.34	$7.26
11720	T		Debride nail, 1-5	0009	0.6652	$36.29	$8.34	$7.26
11721	T		Debride nail, 6 or more	0009	0.6652	$36.29	$8.34	$7.26
11730	T		Removal of nail plate	0013	1.1272	$61.50	$14.20	$12.30
11732	T		Remove nail plate, add-on	0012	0.7694	$41.98	$11.18	$8.40
11740	T		Drain blood from under nail	0009	0.6652	$36.29	$8.34	$7.26
11750	T		Removal of nail bed	0019	3.9493	$215.48	$71.87	$43.10
11752	T		Remove nail bed/finger tip	0022	18.7932	$1,025.38	$354.45	$205.08
11755	T		Biopsy, nail unit	0019	3.9493	$215.48	$71.87	$43.10
11760	T		Repair of nail bed	0024	1.6850	$91.94	$33.10	$18.39
11762	T		Reconstruction of nail bed	0024	1.6850	$91.94	$33.10	$18.39
11765	T		Excision of nail fold, toe	0015	1.5968	$87.12	$20.35	$17.42
11770	T		Removal of pilonidal lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11771	T		Removal of pilonidal lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11772	T		Removal of pilonidal lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11900	T		Injection into skin lesions	0012	0.7694	$41.98	$11.18	$8.40
11901	T		Added skin lesions injection	0012	0.7694	$41.98	$11.18	$8.40
11920	T		Correct skin color defects	0024	1.6850	$91.94	$33.10	$18.39
11921	T		Correct skin color defects	0024	1.6850	$91.94	$33.10	$18.39
11922	T		Correct skin color defects	0024	1.6850	$91.94	$33.10	$18.39
11950	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11951	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11952	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11954	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11960	T		Insert tissue expander(s)	0027	15.8990	$867.47	$329.72	$173.49
11970	T		Replace tissue expander	0027	15.8990	$867.47	$329.72	$173.49
11971	T		Remove tissue expander(s)	0022	18.7932	$1,025.38	$354.45	$205.08
11975	E		Insert contraceptive cap					
11976	T		Removal of contraceptive cap	0019	3.9493	$215.48	$71.87	$43.10
11977	E		Removal/reinsert contra cap					
11980	X		Implant hormone pellet(s)	0340	0.6314	$34.45		$6.89
11981	X		Insert drug implant device	0340	0.6314	$34.45		$6.89
11982	X		Remove drug implant device	0340	0.6314	$34.45		$6.89
11983	X		Remove/insert drug implant	0340	0.6314	$34.45		$6.89
12001	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12002	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12004	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12005	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12006	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12007	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12011	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12013	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12014	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12015	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12016	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12017	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12018	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12020	T		Closure of split wound	0024	1.6850	$91.94	$33.10	$18.39
12021	T		Closure of split wound	0024	1.6850	$91.94	$33.10	$18.39
12031	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12032	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12034	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12035	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12036	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12037	T		Layer closure of wound(s)	0025	5.1912	$283.24	$107.00	$56.65
12041	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12042	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12044	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12045	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12046	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12047	T		Layer closure of wound(s)	0025	5.1912	$283.24	$107.00	$56.65
12051	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12052	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12053	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12054	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12055	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12056	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12057	T		Layer closure of wound(s)	0025	5.1912	$283.24	$107.00	$56.65
13100	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13101	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13102	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13120	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13121	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13122	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13131	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13132	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13133	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13150	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13151	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13152	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13153	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13160	T		Late closure of wound	0027	15.8990	$867.47	$329.72	$173.49
14000	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14001	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14020	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14021	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14040	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14041	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14060	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14061	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14300	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14350	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
15000	T		Skin graft	0025	5.1912	$283.24	$107.00	$56.65
15001	T		Skin graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15050	T		Skin pinch graft	0025	5.1912	$283.24	$107.00	$56.65
15100	T		Skin split graft	0027	15.8990	$867.47	$329.72	$173.49
15101	T		Skin split graft add-on	0027	15.8990	$867.47	$329.72	$173.49
15120	T		Skin split graft	0027	15.8990	$867.47	$329.72	$173.49
15121	T		Skin split graft add-on	0027	15.8990	$867.47	$329.72	$173.49
15200	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15201	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15220	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15221	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15240	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15241	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15260	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15261	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15342	T		Cultured skin graft, 25 cm	0024	1.6850	$91.94	$33.10	$18.39
15343	T		Culture skn graft addl 25 cm	0024	1.6850	$91.94	$33.10	$18.39
15350	T		Skin homograft	0686	7.9247	$432.38	$198.89	$86.48
15351	T		Skin homograft add-on	0027	15.8990	$867.47	$329.72	$173.49
15400	T		Skin heterograft	0025	5.1912	$283.24	$107.00	$56.65

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15401	T		Skin heterograft add-on	0025	5.1912	$283.24	$107.00	$56.65
15570	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15572	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15574	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15576	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15600	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15610	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15620	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15630	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15650	T		Transfer skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15732	T		Muscle-skin graft, head/neck	0027	15.8990	$867.47	$329.72	$173.49
15734	T		Muscle-skin graft, trunk	0027	15.8990	$867.47	$329.72	$173.49
15736	T		Muscle-skin graft, arm	0027	15.8990	$867.47	$329.72	$173.49
15738	T		Muscle-skin graft, leg	0027	15.8990	$867.47	$329.72	$173.49
15740	T		Island pedicle flap graft	0027	15.8990	$867.47	$329.72	$173.49
15750	T		Neurovascular pedicle graft	0027	15.8990	$867.47	$329.72	$173.49
15756	C		Free muscle flap, microvasc					
15757	C		Free skin flap, microvasc					
15758	C		Free fascial flap, microvasc					
15760	T		Composite skin graft	0027	15.8990	$867.47	$329.72	$173.49
15770	T		Derma-fat-fascia graft	0027	15.8990	$867.47	$329.72	$173.49
15775	T		Hair transplant punch grafts	0025	5.1912	$283.24	$107.00	$56.65
15776	T		Hair transplant punch grafts	0025	5.1912	$283.24	$107.00	$56.65
15780	T		Abrasion treatment of skin	0022	18.7932	$1,025.38	$354.45	$205.08
15781	T		Abrasion treatment of skin	0019	3.9493	$215.48	$71.87	$43.10
15782	T		Dressing change not for burn	0019	3.9493	$215.48	$71.87	$43.10
15783	T		Abrasion treatment of skin	0016	2.5724	$140.35	$57.31	$28.07
15786	T		Abrasion, lesion, single	0012	0.7694	$41.98	$11.18	$8.40
15787	T		Abrasion, lesions, add-on	0013	1.1272	$61.50	$14.20	$12.30
15788	T		Chemical peel, face, epiderm	0012	0.7694	$41.98	$11.18	$8.40
15789	T		Chemical peel, face, dermal	0015	1.5968	$87.12	$20.35	$17.42
15792	T		Chemical peel, nonfacial	0012	0.7694	$41.98	$11.18	$8.40
15793	T		Chemical peel, nonfacial	0012	0.7694	$41.98	$11.18	$8.40
15810	T		Salabrasion	0016	2.5724	$140.35	$57.31	$28.07
15811	T		Salabrasion	0016	2.5724	$140.35	$57.31	$28.07
15819	T		Plastic surgery, neck	0025	5.1912	$283.24	$107.00	$56.65
15820	T		Revision of lower eyelid	0027	15.8990	$867.47	$329.72	$173.49
15821	T		Revision of lower eyelid	0027	15.8990	$867.47	$329.72	$173.49
15822	T		Revision of upper eyelid	0027	15.8990	$867.47	$329.72	$173.49
15823	T		Revision of upper eyelid	0027	15.8990	$867.47	$329.72	$173.49
15824	T		Removal of forehead wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15825	T		Removal of neck wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15826	T		Removal of brow wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15828	T		Removal of face wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15829	T		Removal of skin wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15831	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15832	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15833	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15834	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15835	T		Excise excessive skin tissue	0025	5.1912	$283.24	$107.00	$56.65
15836	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15837	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15838	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15839	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15840	T		Graft for face nerve palsy	0027	15.8990	$867.47	$329.72	$173.49
15841	T		Graft for face nerve palsy	0027	15.8990	$867.47	$329.72	$173.49
15842	T		Flap for face nerve palsy	0027	15.8990	$867.47	$329.72	$173.49
15845	T		Skin and muscle repair, face	0027	15.8990	$867.47	$329.72	$173.49
15850	T		Removal of sutures	0016	2.5724	$140.35	$57.31	$28.07
15851	T		Removal of sutures	0016	2.5724	$140.35	$57.31	$28.07
15852	X		Dressing change,not for burn	0340	0.6314	$34.45		$6.89
15860	S		Test for blood flow in graft	1501		$25.00		$5.00
15876	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15877	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15878	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15879	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15920	T		Removal of tail bone ulcer	0019	3.9493	$215.48	$71.87	$43.10
15922	T		Removal of tail bone ulcer	0027	15.8990	$867.47	$329.72	$173.49
15931	T		Remove sacrum pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15933	T		Remove sacrum pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15934	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15935	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15936	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15937	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15940	T		Remove hip pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15941	T		Remove hip pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15944	T		Remove hip pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15945	T		Remove hip pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15946	T		Remove hip pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15950	T		Remove thigh pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15951	T		Remove thigh pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15952	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15953	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15956	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15958	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15999	T		Removal of pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
16000	T		Initial treatment of burn(s)	0012	0.7694	$41.98	$11.18	$8.40
16010	T		Treatment of burn(s)	0016	2.5724	$140.35	$57.31	$28.07
16015	T		Treatment of burn(s)	0017	16.3697	$893.15	$227.84	$178.63
16020	T		Treatment of burn(s)	0013	1.1272	$61.50	$14.20	$12.30
16025	T		Treatment of burn(s)	0012	0.7694	$41.98	$11.18	$8.40
16030	T		Treatment of burn(s)	0015	1.5968	$87.12	$20.35	$17.42
16035	C		Incision of burn scab, initi					
16036	C		Escharotomy; add'l incision					
17000	T		Destroy benign/premlg lesion	0010	0.6480	$35.36	$10.08	$7.07
17003	T		Destroy lesions, 2-14	0010	0.6480	$35.36	$10.08	$7.07
17004	T		Destroy lesions, 15 or more	0011	2.2217	$121.22	$27.88	$24.24
17106	T		Destruction of skin lesions	0011	2.2217	$121.22	$27.88	$24.24
17107	T		Destruction of skin lesions	0011	2.2217	$121.22	$27.88	$24.24
17108	T		Destruction of skin lesions	0011	2.2217	$121.22	$27.88	$24.24
17110	T		Destruct lesion, 1-14	0010	0.6480	$35.36	$10.08	$7.07
17111	T		Destruct lesion, 15 or more	0010	0.6480	$35.36	$10.08	$7.07
17250	T		Chemical cautery, tissue	0013	1.1272	$61.50	$14.20	$12.30
17260	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17261	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17262	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17263	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17264	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17266	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17270	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17271	T		Destruction of skin lesions	0013	1.1272	$61.50	$14.20	$12.30
17272	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17273	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17274	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17276	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17280	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17281	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17282	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17283	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17284	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17286	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17304	T		Chemosurgery of skin lesion	0694	2.9752	$162.33	$64.93	$32.47
17305	T		2 stage mohs, up to 5 spec	0694	2.9752	$162.33	$64.93	$32.47
17306	T		3 stage mohs, up to 5 spec	0694	2.9752	$162.33	$64.93	$32.47
17307	T		Mohs addl stage up to 5 spec	0694	2.9752	$162.33	$64.93	$32.47
17310	T		Extensive skin chemosurgery	0694	2.9752	$162.33	$64.93	$32.47
17340	T		Cryotherapy of skin	0012	0.7694	$41.98	$11.18	$8.40
17360	T		Skin peel therapy	0012	0.7694	$41.98	$11.18	$8.40
17380	T		Hair removal by electrolysis	0012	0.7694	$41.98	$11.18	$8.40
17999	T		Skin tissue procedure	0006	1.6527	$90.17	$23.26	$18.03
19000	T		Drainage of breast lesion	0004	1.5882	$86.65	$22.36	$17.33
19001	T		Drain breast lesion add-on	0004	1.5882	$86.65	$22.36	$17.33
19020	T		Incision of breast lesion	0007	11.8633	$647.27		$129.45
19030	N		Injection for breast x-ray					
19100	T		Bx breast percut w/o image	0005	3.2698	$178.40	$71.59	$35.68
19101	T		Biopsy of breast, open	0028	17.6584	$963.46	$303.74	$192.69
19102	T		Bx breast percut w/image	0005	3.2698	$178.40	$71.59	$35.68
19103	T		Bx breast percut w/device	0658	5.5779	$304.34		$60.87
19110	T		nipple exploration	0028	17.6584	$963.46	$303.74	$192.69
19112	T		Excise breast duct fistula	0028	17.6584	$963.46	$303.74	$192.69
19120	T		Removal of breast lesion	0028	17.6584	$963.46	$303.74	$192.69
19125	T		Excision, breast lesion	0028	17.6584	$963.46	$303.74	$192.69
19126	T		Excision, addl breast lesion	0028	17.6584	$963.46	$303.74	$192.69
19140	T		Removal of breast tissue	0028	17.6584	$963.46	$303.74	$192.69
19160	T		Removal of breast tissue	0028	17.6584	$963.46	$303.74	$192.69
19162	T		Remove breast tissue, nodes	0693	39.0111	$2,128.48	$798.17	$425.70
19180	T		Removal of breast	0029	30.1167	$1,643.20	$632.64	$328.64
19182	T		Removal of breast	0029	30.1167	$1,643.20	$632.64	$328.64
19200	C		Removal of breast					
19220	C		Removal of breast					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19240	T		Removal of breast	0030	37.3083	$2,035.58	$763.55	$407.12
19260	T		Removal of chest wall lesion	0021	14.3594	$783.46	$219.48	$156.69
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	S		Place breast clip, percut	0657	1.5102	$82.40		$16.48
19316	T		Suspension of breast	0029	30.1167	$1,643.20	$632.64	$328.64
19318	T		Reduction of large breast	0693	39.0111	$2,128.48	$798.17	$425.70
19324	T		Enlarge breast	0693	39.0111	$2,128.48	$798.17	$425.70
19325	T		Enlarge breast with implant	0648	54.0165	$2,947.19		$589.44
19328	T		Removal of breast implant	0029	30.1167	$1,643.20	$632.64	$328.64
19330	T		Removal of implant material	0029	30.1167	$1,643.20	$632.64	$328.64
19340	T		Immediate breast prosthesis	0030	37.3083	$2,035.58	$763.55	$407.12
19342	T		Delayed breast prosthesis	0648	54.0165	$2,947.19		$589.44
19350	T		Breast reconstruction	0028	17.6584	$963.46	$303.74	$192.69
19355	T		Correct inverted nipple(s)	0029	30.1167	$1,643.20	$632.64	$328.64
19357	T		Breast reconstruction	0648	54.0165	$2,947.19		$589.44
19361	C		Breast reconstruction					
19364	C		Breast reconstruction					
19366	T		Breast reconstruction	0029	30.1167	$1,643.20	$632.64	$328.64
19367	C		Breast reconstruction					
19368	C		Breast reconstruction					
19369	C		Breast reconstruction					
19370	T		Surgery of breast capsule	0029	30.1167	$1,643.20	$632.64	$328.64
19371	T		Removal of breast capsule	0029	30.1167	$1,643.20	$632.64	$328.64
19380	T		Revise breast reconstruction	0030	37.3083	$2,035.58	$763.55	$407.12
19396	T		Design custom breast implant	0029	30.1167	$1,643.20	$632.64	$328.64
19499	T		Breast surgery procedure	0028	17.6584	$963.46	$303.74	$192.69
20000	T		Incision of abscess	0006	1.6527	$90.17	$23.26	$18.03
20005	T		Incision of deep abscess	0049	19.6046	$1,069.65		$213.93
20100	T		Explore wound, neck	0023	2.8141	$153.54	$40.37	$30.71
20101	T		Explore wound, chest	0027	15.8990	$867.47	$329.72	$173.49
20102	T		Explore wound, abdomen	0027	15.8990	$867.47	$329.72	$173.49
20103	T		Explore wound, extremity	0023	2.8141	$153.54	$40.37	$30.71
20150	T		Excise epiphyseal bar	0051	34.5144	$1,883.14		$376.63
20200	T		Muscle biopsy	0021	14.3594	$783.46	$219.48	$156.69
20205	T		Deep muscle biopsy	0021	14.3594	$783.46	$219.48	$156.69
20206	T		Needle biopsy, muscle	0005	3.2698	$178.40	$71.59	$35.68
20220	T		Bone biopsy, trocar/needle	0019	3.9493	$215.48	$71.87	$43.10
20225	T		Bone biopsy, trocar/needle	0020	7.0842	$386.52	$113.25	$77.30
20240	T		Bone biopsy, excisional	0022	18.7932	$1,025.38	$354.45	$205.08
20245	T		Bone biopsy, excisional	0022	18.7932	$1,025.38	$354.45	$205.08
20250	T		Open bone biopsy	0049	19.6046	$1,069.65		$213.93
20251	T		Open bone biopsy	0049	19.6046	$1,069.65		$213.93
20500	T		Injection of sinus tract	0251	1.7880	$97.56		$19.51
20501	N		Inject sinus tract for x-ray					
20520	T		Removal of foreign body	0019	3.9493	$215.48	$71.87	$43.10
20525	T		Removal of foreign body	0022	18.7932	$1,025.38	$354.45	$205.08
20526	T		Ther injection, carp tunnel	0204	2.1711	$118.46	$40.13	$23.69
20550	T		Inject tendon/ligament/cyst	0204	2.1711	$118.46	$40.13	$23.69
20551	T		Inj tendon origin/insertion	0204	2.1711	$118.46	$40.13	$23.69
20552	T		Inj trigger point, 1/2 muscl	0204	2.1711	$118.46	$40.13	$23.69
20553	T		Inject trigger points, > 3	0204	2.1711	$118.46	$40.13	$23.69
20600	T		Drain/inject, joint/bursa	0204	2.1711	$118.46	$40.13	$23.69
20605	T		Drain/inject, joint/bursa	0204	2.1711	$118.46	$40.13	$23.69
20610	T		Drain/inject, joint/bursa	0204	2.1711	$118.46	$40.13	$23.69
20612	T		Aspirate/inj ganglion cyst	0204	2.1711	$118.46	$40.13	$23.69
20615	T		Treatment of bone cyst	0004	1.5882	$86.65	$22.36	$17.33
20650	T		Insert and remove bone pin	0049	19.6046	$1,069.65		$213.93
20660	C		Apply, rem 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	X		Removal of fixation device	0340	0.6314	$34.45		$6.89
20670	T		Removal of support implant	0021	14.3594	$783.46	$219.48	$156.69
20680	T		Removal of support implant	0022	18.7932	$1,025.38	$354.45	$205.08
20690	T		Apply bone fixation device	0050	24.8651	$1,356.66		$271.33
20692	T		Apply bone fixation device	0050	24.8651	$1,356.66		$271.33
20693	T		Adjust bone fixation device	0049	19.6046	$1,069.65		$213.93
20694	T		Remove bone fixation device	0049	19.6046	$1,069.65		$213.93
20802	C		Replantation, arm, complete					
20805	C		Replant forearm, complete					
20808	C		Replantation hand, complete					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	24.8651	$1,356.66		$271.33
20902	T		Removal of bone for graft	0050	24.8651	$1,356.66		$271.33
20910	T		Remove cartilage for graft	0027	15.8990	$867.47	$329.72	$173.49
20912	T		Remove cartilage for graft	0027	15.8990	$867.47	$329.72	$173.49
20920	T		Removal of fascia for graft	0027	15.8990	$867.47	$329.72	$173.49
20922	T		Removal of fascia for graft	0027	15.8990	$867.47	$329.72	$173.49
20924	T		Removal of tendon for graft	0050	24.8651	$1,356.66		$271.33
20926	T		Removal of tissue for graft	0027	15.8990	$867.47	$329.72	$173.49
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	1.6527	$90.17	$23.26	$18.03
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	19.6046	$1,069.65		$213.93
20979	A		Us bone stimulation					
20982	T	NI	Ablate, bone tumor(s) perq	1557		$1,850.00		$370.00
20999	T		Musculoskeletal surgery	0049	19.6046	$1,069.65		$213.93
21010	T		Incision of jaw joint	0254	21.8901	$1,194.35	$321.35	$238.87
21015	T		Resection of facial tumor	0253	15.2249	$830.69	$282.29	$166.14
21025	T		Excision of bone, lower jaw	0256	35.1548	$1,918.08		$383.62
21026	T		Excision of facial bone(s)	0256	35.1548	$1,918.08		$383.62
21029	T		Contour of face bone lesion	0256	35.1548	$1,918.08		$383.62
21030	T		Removal of face bone lesion	0254	21.8901	$1,194.35	$321.35	$238.87
21031	T		Remove exostosis, mandible	0254	21.8901	$1,194.35	$321.35	$238.87
21032	T		Remove exostosis, maxilla	0254	21.8901	$1,194.35	$321.35	$238.87
21034	T		Removal of face bone lesion	0256	35.1548	$1,918.08		$383.62
21040	T		Removal of jaw bone lesion	0254	21.8901	$1,194.35	$321.35	$238.87
21044	T		Removal of jaw bone lesion	0256	35.1548	$1,918.08		$383.62
21045	C		Extensive jaw surgery					
21046	T		Remove mandible cyst complex	0256	35.1548	$1,918.08		$383.62
21047	T		Excise lwr jaw cyst w/repair	0256	35.1548	$1,918.08		$383.62
21048	T		Remove maxilla cyst complex	0256	35.1548	$1,918.08		$383.62
21049	T		Excis uppr jaw cyst w/repair	0256	35.1548	$1,918.08		$383.62
21050	T		Removal of jaw joint	0256	35.1548	$1,918.08		$383.62
21060	T		Remove jaw joint cartilage	0256	35.1548	$1,918.08		$383.62
21070	T		Remove coronoid process	0256	35.1548	$1,918.08		$383.62
21076	T		Prepare face/oral prosthesis	0254	21.8901	$1,194.35	$321.35	$238.87
21077	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21079	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21080	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21081	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21082	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21083	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21084	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21085	T		Prepare face/oral prosthesis	0253	15.2249	$830.69	$282.29	$166.14
21086	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21087	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21088	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21089	T		Prepare face/oral prosthesis	0253	15.2249	$830.69	$282.29	$166.14
21100	T		Maxillofacial fixation	0256	35.1548	$1,918.08		$383.62
21110	T		Interdental fixation	0252	6.4469	$351.75	$113.41	$70.35
21116	N		Injection, jaw joint x-ray					
21120	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21121	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21122	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21123	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21125	T		Augmentation, lower jaw bone	0254	21.8901	$1,194.35	$321.35	$238.87
21127	T		Augmentation, lower jaw bone	0256	35.1548	$1,918.08		$383.62
21137	T		Reduction of forehead	0254	21.8901	$1,194.35	$321.35	$238.87
21138	T		Reduction of forehead	0256	35.1548	$1,918.08		$383.62

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21139	T		Reduction of forehead	0256	35.1548	$1,918.08		$383.62
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	21.8901	$1,194.35	$321.35	$238.87
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	35.1548	$1,918.08		$383.62
21199	T		Reconstr lwr jaw w/advance	0256	35.1548	$1,918.08		$383.62
21206	T		Reconstruct upper jaw bone	0256	35.1548	$1,918.08		$383.62
21208	T		Augmentation of facial bones	0256	35.1548	$1,918.08		$383.62
21209	T		Reduction of facial bones	0256	35.1548	$1,918.08		$383.62
21210	T		Face bone graft	0256	35.1548	$1,918.08		$383.62
21215	T		Lower jaw bone graft	0256	35.1548	$1,918.08		$383.62
21230	T		Rib cartilage graft	0256	35.1548	$1,918.08		$383.62
21235	T		Ear cartilage graft	0254	21.8901	$1,194.35	$321.35	$238.87
21240	T		Reconstruction of jaw joint	0256	35.1548	$1,918.08		$383.62
21242	T		Reconstruction of jaw joint	0256	35.1548	$1,918.08		$383.62
21243	T		Reconstruction of jaw joint	0256	35.1548	$1,918.08		$383.62
21244	T		Reconstruction of lower jaw	0256	35.1548	$1,918.08		$383.62
21245	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21246	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21249	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21261	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21263	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21267	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	35.1548	$1,918.08		$383.62
21275	T		Revision, orbitofacial bones	0256	35.1548	$1,918.08		$383.62
21280	T		Revision of eyelid	0256	35.1548	$1,918.08		$383.62
21282	T		Revision of eyelid	0253	15.2249	$830.69	$282.29	$166.14
21295	T		Revision of jaw muscle/bone	0252	6.4469	$351.75	$113.41	$70.35
21296	T		Revision of jaw muscle/bone	0254	21.8901	$1,194.35	$321.35	$238.87
21299	T		Cranio/maxillofacial surgery	0253	15.2249	$830.69	$282.29	$166.14
21300	T		Treatment of skull fracture	0253	15.2249	$830.69	$282.29	$166.14
21310	X		Treatment of nose fracture	0340	0.6314	$34.45		$6.89
21315	X		Treatment of nose fracture	0340	0.6314	$34.45		$6.89
21320	X		Treatment of nose fracture	0340	0.6314	$34.45		$6.89
21325	T		Treatment of nose fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21330	T		Treatment of nose fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21335	T		Treatment of nose fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21336	T		Treat nasal septal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
21337	T		Treat nasal septal fracture	0253	15.2249	$830.69	$282.29	$166.14
21338	T		Treat nasoethmoid fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21339	T		Treat nasoethmoid fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21340	T		Treatment of nose fracture	0256	35.1548	$1,918.08		$383.62
21343	C		Treatment of sinus fracture					
21344	C		Treatment of sinus fracture					
21345	T		Treat nose/jaw fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21346	C		Treat nose/jaw fracture					
21347	C		Treat nose/jaw fracture					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21348	C		Treat nose/jaw fracture					
21355	T		Treat cheek bone fracture	0256	35.1548	$1,918.08		$383.62
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	T		Treat eye socket fracture	0256	35.1548	$1,918.08		$383.62
21395	C		Treat eye socket fracture					
21400	T		Treat eye socket fracture	0252	6.4469	$351.75	$113.41	$70.35
21401	T		Treat eye socket fracture	0253	15.2249	$830.69	$282.29	$166.14
21406	T		Treat eye socket fracture	0256	35.1548	$1,918.08		$383.62
21407	T		Treat eye socket fracture	0256	35.1548	$1,918.08		$383.62
21408	C		Treat eye socket fracture					
21421	T		Treat mouth roof fracture	0254	21.8901	$1,194.35	$321.35	$238.87
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	21.8901	$1,194.35	$321.35	$238.87
21445	T		Treat dental ridge fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21450	T		Treat lower jaw fracture	0251	1.7880	$97.56		$19.51
21451	T		Treat lower jaw fracture	0252	6.4469	$351.75	$113.41	$70.35
21452	T		Treat lower jaw fracture	0253	15.2249	$830.69	$282.29	$166.14
21453	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21454	T		Treat lower jaw fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21461	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21462	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21465	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21470	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21480	T		Reset dislocated jaw	0251	1.7880	$97.56		$19.51
21485	T		Reset dislocated jaw	0253	15.2249	$830.69	$282.29	$166.14
21490	T		Repair dislocated jaw	0256	35.1548	$1,918.08		$383.62
21493	T		Treat hyoid bone fracture	0252	6.4469	$351.75	$113.41	$70.35
21494	T		Treat hyoid bone fracture	0252	6.4469	$351.75	$113.41	$70.35
21495	C		Treat hyoid bone fracture					
21497	T		Interdental wiring	0253	15.2249	$830.69	$282.29	$166.14
21499	T		Head surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
21501	T		Drain neck/chest lesion	0008	19.4831	$1,063.02		$212.60
21502	T		Drain chest lesion	0049	19.6046	$1,069.65		$213.93
21510	C		Drainage of bone lesion					
21550	T		Biopsy of neck/chest	0021	14.3594	$783.46	$219.48	$156.69
21555	T		Remove lesion, neck/chest	0022	18.7932	$1,025.38	$354.45	$205.08
21556	T		Remove lesion, neck/chest	0022	18.7932	$1,025.38	$354.45	$205.08
21557	C		Remove tumor, neck/chest					
21600	T		Partial removal of rib	0050	24.8651	$1,356.66		$271.33
21610	T		Partial removal of rib	0050	24.8651	$1,356.66		$271.33
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					
21685	T	NI	Hyoid myotomy & suspension	0252	6.4469	$351.75	$113.41	$70.35
21700	T		Revision of neck muscle	0049	19.6046	$1,069.65		$213.93
21705	C		Revision of neck muscle/rib					
21720	T		Revision of neck muscle	0049	19.6046	$1,069.65		$213.93
21725	T		Revision of neck muscle	0006	1.6527	$90.17	$23.26	$18.03
21740	C		Reconstruction of sternum					
21742	T		Repair stern/nuss w/o scope	0051	34.5144	$1,883.14		$376.63
21743	T		Repair sternum/nuss w/scope	0051	34.5144	$1,883.14		$376.63
21750	C		Repair of sternum separation					
21800	T		Treatment of rib fracture	0043	1.9074	$104.07		$20.81
21805	T		Treatment of rib fracture	0046	32.5581	$1,776.40	$535.76	$355.28
21810	C		Treatment of rib fracture(s)					
21820	T		Treat sternum fracture	0043	1.9074	$104.07		$20.81
21825	C		Treat sternum fracture					
21899	T		Neck/chest surgery procedure	0252	6.4469	$351.75	$113.41	$70.35
21920	T		Biopsy soft tissue of back	0020	7.0842	$386.52	$113.25	$77.30
21925	T		Biopsy soft tissue of back	0022	18.7932	$1,025.38	$354.45	$205.08

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21930	T		Remove lesion, back or flank	0022	18.7932	$1,025.38	$354.45	$205.08
21935	T		Remove tumor, back	0022	18.7932	$1,025.38	$354.45	$205.08
22100	T		Remove part of neck vertebra	0208	40.2830	$2,197.88		$439.58
22101	T		Remove part, thorax vertebra	0208	40.2830	$2,197.88		$439.58
22102	T		Remove part, lumbar vertebra	0208	40.2830	$2,197.88		$439.58
22103	T		Remove extra spine segment	0208	40.2830	$2,197.88		$439.58
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	1.9074	$104.07		$20.81
22310	T		Treat spine fracture	0043	1.9074	$104.07		$20.81
22315	T		Treat spine fracture	0043	1.9074	$104.07		$20.81
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	13.5889	$741.42	$268.47	$148.28
22520	T		Percut vertebroplasty thor	0050	24.8651	$1,356.66		$271.33
22521	T		Percut vertebroplasty lumb	0050	24.8651	$1,356.66		$271.33
22522	T		Percut vertebroplasty add'l	0050	24.8651	$1,356.66		$271.33
22532	C	NI	Lat thorax spine fusion					
22533	C	NI	Lat lumbar spine fusion					
22534	C	NI	Lat thor/lumb, add'l seg					
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	T		Lumbar spine fusion	0208	40.2830	$2,197.88		$439.58
22614	T		Spine fusion, extra segment	0208	40.2830	$2,197.88		$439.58
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					
22899	T		Spine surgery procedure	0043	1.9074	$104.07		$20.81
22900	T		Remove abdominal wall lesion	0022	18.7932	$1,025.38	$354.45	$205.08
22999	T		Abdomen surgery procedure	0022	18.7932	$1,025.38	$354.45	$205.08
23000	T		Removal of calcium deposits	0021	14.3594	$783.46	$219.48	$156.69
23020	T		Release shoulder joint	0051	34.5144	$1,883.14		$376.63

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23030	T		Drain shoulder lesion	0008	19.4831	$1,063.02		$212.60
23031	T		Drain shoulder bursa	0008	19.4831	$1,063.02		$212.60
23035	T		Drain shoulder bone lesion	0049	19.6046	$1,069.65		$213.93
23040	T		Exploratory shoulder surgery	0050	24.8651	$1,356.66		$271.33
23044	T		Exploratory shoulder surgery	0050	24.8651	$1,356.66		$271.33
23065	T		Biopsy shoulder tissues	0021	14.3594	$783.46	$219.48	$156.69
23066	T		Biopsy shoulder tissues	0022	18.7932	$1,025.38	$354.45	$205.08
23075	T		Removal of shoulder lesion	0021	14.3594	$783.46	$219.48	$156.69
23076	T		Removal of shoulder lesion	0022	18.7932	$1,025.38	$354.45	$205.08
23077	T		Remove tumor of shoulder	0022	18.7932	$1,025.38	$354.45	$205.08
23100	T		Biopsy of shoulder joint	0049	19.6046	$1,069.65		$213.93
23101	T		Shoulder joint surgery	0050	24.8651	$1,356.66		$271.33
23105	T		Remove shoulder joint lining	0050	24.8651	$1,356.66		$271.33
23106	T		Incision of collarbone joint	0050	24.8651	$1,356.66		$271.33
23107	T		Explore treat shoulder joint	0050	24.8651	$1,356.66		$271.33
23120	T		Partial removal, collar bone	0051	34.5144	$1,883.14		$376.63
23125	T		Removal of collar bone	0051	34.5144	$1,883.14		$376.63
23130	T		Remove shoulder bone, part	0051	34.5144	$1,883.14		$376.63
23140	T		Removal of bone lesion	0049	19.6046	$1,069.65		$213.93
23145	T		Removal of bone lesion	0050	24.8651	$1,356.66		$271.33
23146	T		Removal of bone lesion	0050	24.8651	$1,356.66		$271.33
23150	T		Removal of humerus lesion	0050	24.8651	$1,356.66		$271.33
23155	T		Removal of humerus lesion	0050	24.8651	$1,356.66		$271.33
23156	T		Removal of humerus lesion	0050	24.8651	$1,356.66		$271.33
23170	T		Remove collar bone lesion	0050	24.8651	$1,356.66		$271.33
23172	T		Remove shoulder blade lesion	0050	24.8651	$1,356.66		$271.33
23174	T		Remove humerus lesion	0050	24.8651	$1,356.66		$271.33
23180	T		Remove collar bone lesion	0050	24.8651	$1,356.66		$271.33
23182	T		Remove shoulder blade lesion	0050	24.8651	$1,356.66		$271.33
23184	T		Remove humerus lesion	0050	24.8651	$1,356.66		$271.33
23190	T		Partial removal of scapula	0050	24.8651	$1,356.66		$271.33
23195	T		Removal of head of humerus	0050	24.8651	$1,356.66		$271.33
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	0020	7.0842	$386.52	$113.25	$77.30
23331	T		Remove shoulder foreign body	0022	18.7932	$1,025.38	$354.45	$205.08
23332	C		Remove shoulder foreign body					
23350	N		Injection for shoulder x-ray					
23395	T		Muscle transfer,shoulder/arm	0051	34.5144	$1,883.14		$376.63
23397	T		Muscle transfers	0052	42.7126	$2,330.44		$466.09
23400	T		Fixation of shoulder blade	0050	24.8651	$1,356.66		$271.33
23405	T		Incision of tendon & muscle	0050	24.8651	$1,356.66		$271.33
23406	T		Incise tendon(s) & muscle(s)	0050	24.8651	$1,356.66		$271.33
23410	T		Repair of tendon(s)	0052	42.7126	$2,330.44		$466.09
23412	T		Repair rotator cuff, chronic	0052	42.7126	$2,330.44		$466.09
23415	T		Release of shoulder ligament	0051	34.5144	$1,883.14		$376.63
23420	T		Repair of shoulder	0052	42.7126	$2,330.44		$466.09
23430	T		Repair biceps tendon	0052	42.7126	$2,330.44		$466.09
23440	T		Remove/transplant tendon	0052	42.7126	$2,330.44		$466.09
23450	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23455	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23460	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23462	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23465	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23466	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23470	T		Reconstruct shoulder joint	0048	51.4609	$2,807.76	$695.60	$561.55
23472	C		Reconstruct shoulder joint					
23480	T		Revision of collar bone	0051	34.5144	$1,883.14		$376.63
23485	T		Revision of collar bone	0051	34.5144	$1,883.14		$376.63
23490	T		Reinforce clavicle	0051	34.5144	$1,883.14		$376.63
23491	T		Reinforce shoulder bones	0051	34.5144	$1,883.14		$376.63
23500	T		Treat clavicle fracture	0043	1.9074	$104.07		$20.81
23505	T		Treat clavicle fracture	0043	1.9074	$104.07		$20.81
23515	T		Treat clavicle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23520	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23525	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23530	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23532	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23540	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23545	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23550	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23552	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23570	T		Treat shoulder blade fx	0043	1.9074	$104.07		$20.81
23575	T		Treat shoulder blade fx	0043	1.9074	$104.07		$20.81
23585	T		Treat scapula fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23600	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23605	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23615	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23616	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23620	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23625	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23630	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23650	T		Treat shoulder dislocation	0043	1.9074	$104.07		$20.81
23655	T		Treat shoulder dislocation	0045	13.5889	$741.42	$268.47	$148.28
23660	T		Treat shoulder dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23665	T		Treat dislocation/fracture	0043	1.9074	$104.07		$20.81
23670	T		Treat dislocation/fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23675	T		Treat dislocation/fracture	0043	1.9074	$104.07		$20.81
23680	T		Treat dislocation/fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23700	T		Fixation of shoulder	0045	13.5889	$741.42	$268.47	$148.28
23800	T		Fusion of shoulder joint	0051	34.5144	$1,883.14		$376.63
23802	T		Fusion of shoulder joint	0051	34.5144	$1,883.14		$376.63
23900	C		Amputation of arm & girdle					
23920	C		Amputation at shoulder joint					
23921	T		Amputation follow-up surgery	0025	5.1912	$283.24	$107.00	$56.65
23929	T		Shoulder surgery procedure	0043	1.9074	$104.07		$20.81
23930	T		Drainage of arm lesion	0008	19.4831	$1,063.02		$212.60
23931	T		Drainage of arm bursa	0007	11.8633	$647.27		$129.45
23935	T		Drain arm/elbow bone lesion	0049	19.6046	$1,069.65		$213.93
24000	T		Exploratory elbow surgery	0050	24.8651	$1,356.66		$271.33
24006	T		Release elbow joint	0050	24.8651	$1,356.66		$271.33
24065	T		Biopsy arm/elbow soft tissue	0021	14.3594	$783.46	$219.48	$156.69
24066	T		Biopsy arm/elbow soft tissue	0021	14.3594	$783.46	$219.48	$156.69
24075	T		Remove arm/elbow lesion	0021	14.3594	$783.46	$219.48	$156.69
24076	T		Remove arm/elbow lesion	0022	18.7932	$1,025.38	$354.45	$205.08
24077	T		Remove tumor of arm/elbow	0022	18.7932	$1,025.38	$354.45	$205.08
24100	T		Biopsy elbow joint lining	0049	19.6046	$1,069.65		$213.93
24101	T		Explore/treat elbow joint	0050	24.8651	$1,356.66		$271.33
24102	T		Remove elbow joint lining	0050	24.8651	$1,356.66		$271.33
24105	T		Removal of elbow bursa	0049	19.6046	$1,069.65		$213.93
24110	T		Remove humerus lesion	0049	19.6046	$1,069.65		$213.93
24115	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24116	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24120	T		Remove elbow lesion	0049	19.6046	$1,069.65		$213.93
24125	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24126	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24130	T		Removal of head of radius	0050	24.8651	$1,356.66		$271.33
24134	T		Removal of arm bone lesion	0050	24.8651	$1,356.66		$271.33
24136	T		Remove radius bone lesion	0050	24.8651	$1,356.66		$271.33
24138	T		Remove elbow bone lesion	0050	24.8651	$1,356.66		$271.33
24140	T		Partial removal of arm bone	0050	24.8651	$1,356.66		$271.33
24145	T		Partial removal of radius	0050	24.8651	$1,356.66		$271.33
24147	T		Partial removal of elbow	0050	24.8651	$1,356.66		$271.33
24149	C		Radical resection of elbow					
24150	T		Extensive humerus surgery	0052	42.7126	$2,330.44		$466.09
24151	T		Extensive humerus surgery	0052	42.7126	$2,330.44		$466.09
24152	T		Extensive radius surgery	0052	42.7126	$2,330.44		$466.09
24153	T		Extensive radius surgery	0052	42.7126	$2,330.44		$466.09
24155	T		Removal of elbow joint	0051	34.5144	$1,883.14		$376.63
24160	T		Remove elbow joint implant	0050	24.8651	$1,356.66		$271.33
24164	T		Remove radius head implant	0050	24.8651	$1,356.66		$271.33
24200	T		Removal of arm foreign body	0019	3.9493	$215.48	$71.87	$43.10
24201	T		Removal of arm foreign body	0021	14.3594	$783.46	$219.48	$156.69
24220	N		Injection for elbow x-ray					
24300	T		Manipulate elbow w/anesth	0045	13.5889	$741.42	$268.47	$148.28
24301	T		Muscle/tendon transfer	0050	24.8651	$1,356.66		$271.33
24305	T		Arm tendon lengthening	0050	24.8651	$1,356.66		$271.33
24310	T		Revision of arm tendon	0049	19.6046	$1,069.65		$213.93
24320	T		Repair of arm tendon	0051	34.5144	$1,883.14		$376.63
24330	T		Revision of arm muscles	0051	34.5144	$1,883.14		$376.63
24331	T		Revision of arm muscles	0051	34.5144	$1,883.14		$376.63
24332	T		Tenolysis, triceps	0049	19.6046	$1,069.65		$213.93
24340	T		Repair of biceps tendon	0051	34.5144	$1,883.14		$376.63
24341	T		Repair arm tendon/muscle	0051	34.5144	$1,883.14		$376.63
24342	T		Repair of ruptured tendon	0051	34.5144	$1,883.14		$376.63
24343	T		Repr elbow lat ligmnt w/tiss	0050	24.8651	$1,356.66		$271.33
24344	T		Reconstruct elbow lat ligmnt	0051	34.5144	$1,883.14		$376.63

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24345	T		Repr elbw med ligmnt w/tissu	0050	24.8651	$1,356.66		$271.33
24346	T		Reconstruct elbow med ligmnt	0051	34.5144	$1,883.14		$376.63
24350	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24351	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24352	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24354	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24356	T		Revision of tennis elbow	0050	24.8651	$1,356.66		$271.33
24360	T		Reconstruct elbow joint	0047	29.9582	$1,634.55	$537.03	$326.91
24361	T		Reconstruct elbow joint	0048	51.4609	$2,807.76	$695.60	$561.55
24362	T		Reconstruct elbow joint	0048	51.4609	$2,807.76	$695.60	$561.55
24363	T		Replace elbow joint	0048	51.4609	$2,807.76	$695.60	$561.55
24365	T		Reconstruct head of radius	0047	29.9582	$1,634.55	$537.03	$326.91
24366	T		Reconstruct head of radius	0048	51.4609	$2,807.76	$695.60	$561.55
24400	T		Revision of humerus	0050	24.8651	$1,356.66		$271.33
24410	T		Revision of humerus	0050	24.8651	$1,356.66		$271.33
24420	T		Revision of humerus	0051	34.5144	$1,883.14		$376.63
24430	T		Repair of humerus	0051	34.5144	$1,883.14		$376.63
24435	T		Repair humerus with graft	0051	34.5144	$1,883.14		$376.63
24470	T		Revision of elbow joint	0051	34.5144	$1,883.14		$376.63
24495	T		Decompression of forearm	0050	24.8651	$1,356.66		$271.33
24498	T		Reinforce humerus	0051	34.5144	$1,883.14		$376.63
24500	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24505	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24515	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24516	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24530	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24535	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24538	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24545	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24546	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24560	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24565	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24566	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24575	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24576	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24577	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24579	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24582	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24586	T		Treat elbow fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24587	T		Treat elbow fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24600	T		Treat elbow dislocation	0043	1.9074	$104.07		$20.81
24605	T		Treat elbow dislocation	0045	13.5889	$741.42	$268.47	$148.28
24615	T		Treat elbow dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
24620	T		Treat elbow fracture	0043	1.9074	$104.07		$20.81
24635	T		Treat elbow fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24640	T		Treat elbow dislocation	0043	1.9074	$104.07		$20.81
24650	T		Treat radius fracture	0043	1.9074	$104.07		$20.81
24655	T		Treat radius fracture	0043	1.9074	$104.07		$20.81
24665	T		Treat radius fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24666	T		Treat radius fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24670	T		Treat ulnar fracture	0043	1.9074	$104.07		$20.81
24675	T		Treat ulnar fracture	0043	1.9074	$104.07		$20.81
24685	T		Treat ulnar fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24800	T		Fusion of elbow joint	0051	34.5144	$1,883.14		$376.63
24802	T		Fusion/graft of elbow joint	0051	34.5144	$1,883.14		$376.63
24900	C		Amputation of upper arm					
24920	C		Amputation of upper arm					
24925	T		Amputation follow-up surgery	0049	19.6046	$1,069.65		$213.93
24930	C		Amputation follow-up surgery					
24931	C		Amputate upper arm & implant					
24935	T		Revision of amputation	0052	42.7126	$2,330.44		$466.09
24940	C		Revision of upper arm					
24999	T		Upper arm/elbow surgery	0043	1.9074	$104.07		$20.81
25000	T		Incision of tendon sheath	0049	19.6046	$1,069.65		$213.93
25001	T		Incise flexor carpi radialis	0049	19.6046	$1,069.65		$213.93
25020	T		Decompress forearm 1 space	0049	19.6046	$1,069.65		$213.93
25023	T		Decompress forearm 1 space	0050	24.8651	$1,356.66		$271.33
25024	T		Decompress forearm 2 spaces	0050	24.8651	$1,356.66		$271.33
25025	T		Decompress forearm 2 spaces	0050	24.8651	$1,356.66		$271.33
25028	T		Drainage of forearm lesion	0049	19.6046	$1,069.65		$213.93
25031	T		Drainage of forearm bursa	0049	19.6046	$1,069.65		$213.93
25035	T		Treat forearm bone lesion	0049	19.6046	$1,069.65		$213.93
25040	T		Explore/treat wrist joint	0050	24.8651	$1,356.66		$271.33
25065	T		Biopsy forearm soft tissues	0021	14.3594	$783.46	$219.48	$156.69
25066	T		Biopsy forearm soft tissues	0022	18.7932	$1,025.38	$354.45	$205.08

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25075	T		Removel forearm lesion subcu	0021	14.3594	$783.46	$219.48	$156.69
25076	T		Removel forearm lesion deep	0022	18.7932	$1,025.38	$354.45	$205.08
25077	T		Remove tumor, forearm/wrist	0022	18.7932	$1,025.38	$354.45	$205.08
25085	T		Incision of wrist capsule	0049	19.6046	$1,069.65		$213.93
25100	T		Biopsy of wrist joint	0049	19.6046	$1,069.65		$213.93
25101	T		Explore/treat wrist joint	0050	24.8651	$1,356.66		$271.33
25105	T		Remove wrist joint lining	0050	24.8651	$1,356.66		$271.33
25107	T		Remove wrist joint cartilage	0050	24.8651	$1,356.66		$271.33
25110	T		Remove wrist tendon lesion	0049	19.6046	$1,069.65		$213.93
25111	T		Remove wrist tendon lesion	0053	14.8831	$812.04	$253.49	$162.41
25112	T		Reremove wrist tendon lesion	0053	14.8831	$812.04	$253.49	$162.41
25115	T		Remove wrist/forearm lesion	0049	19.6046	$1,069.65		$213.93
25116	T		Remove wrist/forearm lesion	0049	19.6046	$1,069.65		$213.93
25118	T		Excise wrist tendon sheath	0050	24.8651	$1,356.66		$271.33
25119	T		Partial removal of ulna	0050	24.8651	$1,356.66		$271.33
25120	T		Removal of forearm lesion	0050	24.8651	$1,356.66		$271.33
25125	T		Remove/graft forearm lesion	0050	24.8651	$1,356.66		$271.33
25126	T		Remove/graft forearm lesion	0050	24.8651	$1,356.66		$271.33
25130	T		Removal of wrist lesion	0050	24.8651	$1,356.66		$271.33
25135	T		Remove & graft wrist lesion	0050	24.8651	$1,356.66		$271.33
25136	T		Remove & graft wrist lesion	0050	24.8651	$1,356.66		$271.33
25145	T		Remove forearm bone lesion	0050	24.8651	$1,356.66		$271.33
25150	T		Partial removal of ulna	0050	24.8651	$1,356.66		$271.33
25151	T		Partial removal of radius	0050	24.8651	$1,356.66		$271.33
25170	T		Extensive forearm surgery	0052	42.7126	$2,330.44		$466.09
25210	T		Removal of wrist bone	0054	24.2456	$1,322.86		$264.57
25215	T		Removal of wrist bones	0054	24.2456	$1,322.86		$264.57
25230	T		Partial removal of radius	0050	24.8651	$1,356.66		$271.33
25240	T		Partial removal of ulna	0050	24.8651	$1,356.66		$271.33
25246	N		Injection for wrist x-ray					
25248	T		Remove forearm foreign body	0049	19.6046	$1,069.65		$213.93
25250	T		Removal of wrist prosthesis	0050	24.8651	$1,356.66		$271.33
25251	T		Removal of wrist prosthesis	0050	24.8651	$1,356.66		$271.33
25259	T		Manipulate wrist w/anesthes	0043	1.9074	$104.07		$20.81
25260	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25263	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25265	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25270	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25272	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25274	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25275	T		Repair forearm tendon sheath	0050	24.8651	$1,356.66		$271.33
25280	T		Revise wrist/forearm tendon	0050	24.8651	$1,356.66		$271.33
25290	T		Incise wrist/forearm tendon	0050	24.8651	$1,356.66		$271.33
25295	T		Release wrist/forearm tendon	0049	19.6046	$1,069.65		$213.93
25300	T		Fusion of tendons at wrist	0050	24.8651	$1,356.66		$271.33
25301	T		Fusion of tendons at wrist	0050	24.8651	$1,356.66		$271.33
25310	T		Transplant forearm tendon	0051	34.5144	$1,883.14		$376.63
25312	T		Transplant forearm tendon	0051	34.5144	$1,883.14		$376.63
25315	T		Revise palsy hand tendon(s)	0051	34.5144	$1,883.14		$376.63
25316	T		Revise palsy hand tendon(s)	0051	34.5144	$1,883.14		$376.63
25320	T		Repair/revise wrist joint	0051	34.5144	$1,883.14		$376.63
25332	T		Revise wrist joint	0047	29.9582	$1,634.55	$537.03	$326.91
25335	T		Realignment of hand	0051	34.5144	$1,883.14		$376.63
25337	T		Reconstruct ulna/radioulnar	0051	34.5144	$1,883.14		$376.63
25350	T		Revision of radius	0051	34.5144	$1,883.14		$376.63
25355	T		Revision of radius	0051	34.5144	$1,883.14		$376.63
25360	T		Revision of ulna	0050	24.8651	$1,356.66		$271.33
25365	T		Revise radius & ulna	0050	24.8651	$1,356.66		$271.33
25370	T		Revise radius or ulna	0051	34.5144	$1,883.14		$376.63
25375	T		Revise radius & ulna	0051	34.5144	$1,883.14		$376.63
25390	T		Shorten radius or ulna	0050	24.8651	$1,356.66		$271.33
25391	T		Lengthen radius or ulna	0051	34.5144	$1,883.14		$376.63
25392	T		Shorten radius & ulna	0050	24.8651	$1,356.66		$271.33
25393	T		Lengthen radius & ulna	0051	34.5144	$1,883.14		$376.63
25394	T		Repair carpal bone, shorten	0053	14.8831	$812.04	$253.49	$162.41
25400	T		Repair radius or ulna	0050	24.8651	$1,356.66		$271.33
25405	T		Repair/graft radius or ulna	0050	24.8651	$1,356.66		$271.33
25415	T		Repair radius & ulna	0050	24.8651	$1,356.66		$271.33
25420	T		Repair/graft radius & ulna	0051	34.5144	$1,883.14		$376.63
25425	T		Repair/graft radius or ulna	0051	34.5144	$1,883.14		$376.63
25426	T		Repair/graft radius & ulna	0051	34.5144	$1,883.14		$376.63
25430	T		Vasc graft into carpal bone	0054	24.2456	$1,322.86		$264.57
25431	T		Repair nonunion carpal bone	0054	24.2456	$1,322.86		$264.57
25440	T		Repair/graft wrist bone	0051	34.5144	$1,883.14		$376.63
25441	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25442	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25443	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25444	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25445	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25446	T		Wrist replacement	0048	51.4609	$2,807.76	$695.60	$561.55
25447	T		Repair wrist joint(s)	0047	29.9582	$1,634.55	$537.03	$326.91
25449	T		Remove wrist joint implant	0047	29.9582	$1,634.55	$537.03	$326.91
25450	T		Revision of wrist joint	0051	34.5144	$1,883.14		$376.63
25455	T		Revision of wrist joint	0051	34.5144	$1,883.14		$376.63
25490	T		Reinforce radius	0051	34.5144	$1,883.14		$376.63
25491	T		Reinforce ulna	0051	34.5144	$1,883.14		$376.63
25492	T		Reinforce radius and ulna	0051	34.5144	$1,883.14		$376.63
25500	T		Treat fracture of radius	0043	1.9074	$104.07		$20.81
25505	T		Treat fracture of radius	0043	1.9074	$104.07		$20.81
25515	T		Treat fracture of radius	0046	32.5581	$1,776.40	$535.76	$355.28
25520	T		Treat fracture of radius	0043	1.9074	$104.07		$20.81
25525	T		Treat fracture of radius	0046	32.5581	$1,776.40	$535.76	$355.28
25526	T		Treat fracture of radius	0046	32.5581	$1,776.40	$535.76	$355.28
25530	T		Treat fracture of ulna	0043	1.9074	$104.07		$20.81
25535	T		Treat fracture of ulna	0043	1.9074	$104.07		$20.81
25545	T		Treat fracture of ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25560	T		Treat fracture radius & ulna	0043	1.9074	$104.07		$20.81
25565	T		Treat fracture radius & ulna	0043	1.9074	$104.07		$20.81
25574	T		Treat fracture radius & ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25575	T		Treat fracture radius/ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25600	T		Treat fracture radius/ulna	0043	1.9074	$104.07		$20.81
25605	T		Treat fracture radius/ulna	0043	1.9074	$104.07		$20.81
25611	T		Treat fracture radius/ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25620	T		Treat fracture radius/ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25622	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25624	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25628	T		Treat wrist bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25630	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25635	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25645	T		Treat wrist bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25650	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25651	T		Pin ulnar styloid fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25652	T		Treat fracture ulnar styloid	0046	32.5581	$1,776.40	$535.76	$355.28
25660	T		Treat wrist dislocation	0043	1.9074	$104.07		$20.81
25670	T		Treat wrist dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25671	T		Pin radioulnar dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25675	T		Treat wrist dislocation	0043	1.9074	$104.07		$20.81
25676	T		Treat wrist dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25680	T		Treat wrist fracture	0043	1.9074	$104.07		$20.81
25685	T		Treat wrist fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25690	T		Treat wrist dislocation	0043	1.9074	$104.07		$20.81
25695	T		Treat wrist dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25800	T		Fusion of wrist joint	0051	34.5144	$1,883.14		$376.63
25805	T		Fusion/graft of wrist joint	0051	34.5144	$1,883.14		$376.63
25810	T		Fusion/graft of wrist joint	0051	34.5144	$1,883.14		$376.63
25820	T		Fusion of hand bones	0053	14.8831	$812.04	$253.49	$162.41
25825	T		Fuse hand bones with graft	0054	24.2456	$1,322.86		$264.57
25830	T		Fusion, radioulnar jnt/ulna	0051	34.5144	$1,883.14		$376.63
25900	C		Amputation of forearm					
25905	C		Amputation of forearm					
25907	T		Amputation follow-up surgery	0049	19.6046	$1,069.65		$213.93
25909	C		Amputation follow-up surgery					
25915	C		Amputation of forearm					
25920	C		Amputate hand at wrist					
25922	T		Amputate hand at wrist	0049	19.6046	$1,069.65		$213.93
25924	C		Amputation follow-up surgery					
25927	C		Amputation of hand					
25929	T		Amputation follow-up surgery	0027	15.8990	$867.47	$329.72	$173.49
25931	C		Amputation follow-up surgery					
25999	T		Forearm or wrist surgery	0043	1.9074	$104.07		$20.81
26010	T		Drainage of finger abscess	0006	1.6527	$90.17	$23.26	$18.03
26011	T		Drainage of finger abscess	0007	11.8633	$647.27		$129.45
26020	T		Drain hand tendon sheath	0053	14.8831	$812.04	$253.49	$162.41
26025	T		Drainage of palm bursa	0053	14.8831	$812.04	$253.49	$162.41
26030	T		Drainage of palm bursa(s)	0053	14.8831	$812.04	$253.49	$162.41
26034	T		Treat hand bone lesion	0053	14.8831	$812.04	$253.49	$162.41
26035	T		Decompress fingers/hand	0053	14.8831	$812.04	$253.49	$162.41
26037	T		Decompress fingers/hand	0053	14.8831	$812.04	$253.49	$162.41
26040	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26045	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26055	T		Incise finger tendon sheath	0053	14.8831	$812.04	$253.49	$162.41
26060	T		Incision of finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26070	T		Explore/treat hand joint	0053	14.8831	$812.04	$253.49	$162.41
26075	T		Explore/treat finger joint	0053	14.8831	$812.04	$253.49	$162.41
26080	T		Explore/treat finger joint	0053	14.8831	$812.04	$253.49	$162.41
26100	T		Biopsy hand joint lining	0053	14.8831	$812.04	$253.49	$162.41
26105	T		Biopsy finger joint lining	0053	14.8831	$812.04	$253.49	$162.41
26110	T		Biopsy finger joint lining	0053	14.8831	$812.04	$253.49	$162.41
26115	T		Removel hand lesion subcut	0022	18.7932	$1,025.38	$354.45	$205.08
26116	T		Removel hand lesion, deep	0022	18.7932	$1,025.38	$354.45	$205.08
26117	T		Remove tumor, hand/finger	0022	18.7932	$1,025.38	$354.45	$205.08
26121	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26123	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26125	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26130	T		Remove wrist joint lining	0053	14.8831	$812.04	$253.49	$162.41
26135	T		Revise finger joint, each	0054	24.2456	$1,322.86		$264.57
26140	T		Revise finger joint, each	0053	14.8831	$812.04	$253.49	$162.41
26145	T		Tendon excision, palm/finger	0053	14.8831	$812.04	$253.49	$162.41
26160	T		Remove tendon sheath lesion	0053	14.8831	$812.04	$253.49	$162.41
26170	T		Removal of palm tendon, each	0053	14.8831	$812.04	$253.49	$162.41
26180	T		Removal of finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26185	T		Remove finger bone	0053	14.8831	$812.04	$253.49	$162.41
26200	T		Remove hand bone lesion	0053	14.8831	$812.04	$253.49	$162.41
26205	T		Remove/graft bone lesion	0054	24.2456	$1,322.86		$264.57
26210	T		Removal of finger lesion	0053	14.8831	$812.04	$253.49	$162.41
26215	T		Remove/graft finger lesion	0053	14.8831	$812.04	$253.49	$162.41
26230	T		Partial removal of hand bone	0053	14.8831	$812.04	$253.49	$162.41
26235	T		Partial removal, finger bone	0053	14.8831	$812.04	$253.49	$162.41
26236	T		Partial removal, finger bone	0053	14.8831	$812.04	$253.49	$162.41
26250	T		Extensive hand surgery	0053	14.8831	$812.04	$253.49	$162.41
26255	T		Extensive hand surgery	0054	24.2456	$1,322.86		$264.57
26260	T		Extensive finger surgery	0053	14.8831	$812.04	$253.49	$162.41
26261	T		Extensive finger surgery	0053	14.8831	$812.04	$253.49	$162.41
26262	T		Partial removal of finger	0053	14.8831	$812.04	$253.49	$162.41
26320	T		Removal of implant from hand	0021	14.3594	$783.46	$219.48	$156.69
26340	T		Manipulate finger w/anesth	0043	1.9074	$104.07		$20.81
26350	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26352	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26356	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26357	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26358	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26370	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26372	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26373	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26390	T		Revise hand/finger tendon	0054	24.2456	$1,322.86		$264.57
26392	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26410	T		Repair hand tendon	0053	14.8831	$812.04	$253.49	$162.41
26412	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26415	T		Excision, hand/finger tendon	0054	24.2456	$1,322.86		$264.57
26416	T		Graft hand or finger tendon	0054	24.2456	$1,322.86		$264.57
26418	T		Repair finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26420	T		Repair/graft finger tendon	0054	24.2456	$1,322.86		$264.57
26426	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26428	T		Repair/graft finger tendon	0054	24.2456	$1,322.86		$264.57
26432	T		Repair finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26433	T		Repair finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26434	T		Repair/graft finger tendon	0054	24.2456	$1,322.86		$264.57
26437	T		Realignment of tendons	0053	14.8831	$812.04	$253.49	$162.41
26440	T		Release palm/finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26442	T		Release palm & finger tendon	0054	24.2456	$1,322.86		$264.57
26445	T		Release hand/finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26449	T		Release forearm/hand tendon	0054	24.2456	$1,322.86		$264.57
26450	T		Incision of palm tendon	0053	14.8831	$812.04	$253.49	$162.41
26455	T		Incision of finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26460	T		Incise hand/finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26471	T		Fusion of finger tendons	0053	14.8831	$812.04	$253.49	$162.41
26474	T		Fusion of finger tendons	0053	14.8831	$812.04	$253.49	$162.41
26476	T		Tendon lengthening	0053	14.8831	$812.04	$253.49	$162.41
26477	T		Tendon shortening	0053	14.8831	$812.04	$253.49	$162.41
26478	T		Lengthening of hand tendon	0053	14.8831	$812.04	$253.49	$162.41
26479	T		Shortening of hand tendon	0053	14.8831	$812.04	$253.49	$162.41
26480	T		Transplant hand tendon	0054	24.2456	$1,322.86		$264.57
26483	T		Transplant/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26485	T		Transplant palm tendon	0054	24.2456	$1,322.86		$264.57
26489	T		Transplant/graft palm tendon	0054	24.2456	$1,322.86		$264.57

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26490	T		Revise thumb tendon	0054	24.2456	$1,322.86		$264.57
26492	T		Tendon transfer with graft	0054	24.2456	$1,322.86		$264.57
26494	T		Hand tendon/muscle transfer	0054	24.2456	$1,322.86		$264.57
26496	T		Revise thumb tendon	0054	24.2456	$1,322.86		$264.57
26497	T		Finger tendon transfer	0054	24.2456	$1,322.86		$264.57
26498	T		Finger tendon transfer	0054	24.2456	$1,322.86		$264.57
26499	T		Revision of finger	0054	24.2456	$1,322.86		$264.57
26500	T		Hand tendon reconstruction	0053	14.8831	$812.04	$253.49	$162.41
26502	T		Hand tendon reconstruction	0054	24.2456	$1,322.86		$264.57
26504	T		Hand tendon reconstruction	0054	24.2456	$1,322.86		$264.57
26508	T		Release thumb contracture	0053	14.8831	$812.04	$253.49	$162.41
26510	T		Thumb tendon transfer	0054	24.2456	$1,322.86		$264.57
26516	T		Fusion of knuckle joint	0054	24.2456	$1,322.86		$264.57
26517	T		Fusion of knuckle joints	0054	24.2456	$1,322.86		$264.57
26518	T		Fusion of knuckle joints	0054	24.2456	$1,322.86		$264.57
26520	T		Release knuckle contracture	0053	14.8831	$812.04	$253.49	$162.41
26525	T		Release finger contracture	0053	14.8831	$812.04	$253.49	$162.41
26530	T		Revise knuckle joint	0047	29.9582	$1,634.55	$537.03	$326.91
26531	T		Revise knuckle with implant	0048	51.4609	$2,807.76	$695.60	$561.55
26535	T		Revise finger joint	0047	29.9582	$1,634.55	$537.03	$326.91
26536	T		Revise/implant finger joint	0048	51.4609	$2,807.76	$695.60	$561.55
26540	T		Repair hand joint	0053	14.8831	$812.04	$253.49	$162.41
26541	T		Repair hand joint with graft	0054	24.2456	$1,322.86		$264.57
26542	T		Repair hand joint with graft	0053	14.8831	$812.04	$253.49	$162.41
26545	T		Reconstruct finger joint	0054	24.2456	$1,322.86		$264.57
26546	T		Repair nonunion hand	0054	24.2456	$1,322.86		$264.57
26548	T		Reconstruct finger joint	0054	24.2456	$1,322.86		$264.57
26550	T		Construct thumb replacement	0054	24.2456	$1,322.86		$264.57
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	24.2456	$1,322.86		$264.57
26556	C		Toe joint transfer					
26560	T		Repair of web finger	0053	14.8831	$812.04	$253.49	$162.41
26561	T		Repair of web finger	0054	24.2456	$1,322.86		$264.57
26562	T		Repair of web finger	0054	24.2456	$1,322.86		$264.57
26565	T		Correct metacarpal flaw	0054	24.2456	$1,322.86		$264.57
26567	T		Correct finger deformity	0054	24.2456	$1,322.86		$264.57
26568	T		Lengthen metacarpal/finger	0054	24.2456	$1,322.86		$264.57
26580	T		Repair hand deformity	0054	24.2456	$1,322.86		$264.57
26587	T		Reconstruct extra finger	0053	14.8831	$812.04	$253.49	$162.41
26590	T		Repair finger deformity	0054	24.2456	$1,322.86		$264.57
26591	T		Repair muscles of hand	0054	24.2456	$1,322.86		$264.57
26593	T		Release muscles of hand	0053	14.8831	$812.04	$253.49	$162.41
26596	T		Excision constricting tissue	0054	24.2456	$1,322.86		$264.57
26600	T		Treat metacarpal fracture	0043	1.9074	$104.07		$20.81
26605	T		Treat metacarpal fracture	0043	1.9074	$104.07		$20.81
26607	T		Treat metacarpal fracture	0043	1.9074	$104.07		$20.81
26608	T		Treat metacarpal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26615	T		Treat metacarpal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26641	T		Treat thumb dislocation	0043	1.9074	$104.07		$20.81
26645	T		Treat thumb fracture	0043	1.9074	$104.07		$20.81
26650	T		Treat thumb fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26665	T		Treat thumb fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26670	T		Treat hand dislocation	0043	1.9074	$104.07		$20.81
26675	T		Treat hand dislocation	0043	1.9074	$104.07		$20.81
26676	T		Pin hand dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26685	T		Treat hand dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26686	T		Treat hand dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26700	T		Treat knuckle dislocation	0043	1.9074	$104.07		$20.81
26705	T		Treat knuckle dislocation	0043	1.9074	$104.07		$20.81
26706	T		Pin knuckle dislocation	0043	1.9074	$104.07		$20.81
26715	T		Treat knuckle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26720	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26725	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26727	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26735	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26740	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26742	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26746	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26750	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26755	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26756	T		Pin finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26765	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26770	T		Treat finger dislocation	0043	1.9074	$104.07		$20.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26775	T		Treat finger dislocation	0045	13.5889	$741.42	$268.47	$148.28
26776	T		Pin finger dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26785	T		Treat finger dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26820	T		Thumb fusion with graft	0054	24.2456	$1,322.86		$264.57
26841	T		Fusion of thumb	0054	24.2456	$1,322.86		$264.57
26842	T		Thumb fusion with graft	0054	24.2456	$1,322.86		$264.57
26843	T		Fusion of hand joint	0054	24.2456	$1,322.86		$264.57
26844	T		Fusion/graft of hand joint	0054	24.2456	$1,322.86		$264.57
26850	T		Fusion of knuckle	0054	24.2456	$1,322.86		$264.57
26852	T		Fusion of knuckle with graft	0054	24.2456	$1,322.86		$264.57
26860	T		Fusion of finger joint	0054	24.2456	$1,322.86		$264.57
26861	T		Fusion of finger jnt, add-on	0054	24.2456	$1,322.86		$264.57
26862	T		Fusion/graft of finger joint	0054	24.2456	$1,322.86		$264.57
26863	T		Fuse/graft added joint	0054	24.2456	$1,322.86		$264.57
26910	T		Amputate metacarpal bone	0054	24.2456	$1,322.86		$264.57
26951	T		Amputation of finger/thumb	0053	14.8831	$812.04	$253.49	$162.41
26952	T		Amputation of finger/thumb	0053	14.8831	$812.04	$253.49	$162.41
26989	T		Hand/finger surgery	0043	1.9074	$104.07		$20.81
26990	T		Drainage of pelvis lesion	0049	19.6046	$1,069.65		$213.93
26991	T		Drainage of pelvis bursa	0049	19.6046	$1,069.65		$213.93
26992	C		Drainage of bone lesion					
27000	T		Incision of hip tendon	0049	19.6046	$1,069.65		$213.93
27001	T		Incision of hip tendon	0050	24.8651	$1,356.66		$271.33
27003	T		Incision of hip tendon	0050	24.8651	$1,356.66		$271.33
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	34.5144	$1,883.14		$376.63
27035	T		Denervation of hip joint	0052	42.7126	$2,330.44		$466.09
27036	C		Excision of hip joint/muscle					
27040	T		Biopsy of soft tissues	0020	7.0842	$386.52	$113.25	$77.30
27041	T		Biopsy of soft tissues	0019	3.9493	$215.48	$71.87	$43.10
27047	T		Remove hip/pelvis lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27048	T		Remove hip/pelvis lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27049	T		Remove tumor, hip/pelvis	0022	18.7932	$1,025.38	$354.45	$205.08
27050	T		Biopsy of sacroiliac joint	0049	19.6046	$1,069.65		$213.93
27052	T		Biopsy of hip joint	0049	19.6046	$1,069.65		$213.93
27054	C		Removal of hip joint lining					
27060	T		Removal of ischial bursa	0049	19.6046	$1,069.65		$213.93
27062	T		Remove femur lesion/bursa	0049	19.6046	$1,069.65		$213.93
27065	T		Removal of hip bone lesion	0049	19.6046	$1,069.65		$213.93
27066	T		Removal of hip bone lesion	0050	24.8651	$1,356.66		$271.33
27067	T		Remove/graft hip bone lesion	0050	24.8651	$1,356.66		$271.33
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	24.8651	$1,356.66		$271.33
27086	T		Remove hip foreign body	0020	7.0842	$386.52	$113.25	$77.30
27087	T		Remove hip foreign body	0049	19.6046	$1,069.65		$213.93
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	B		Inject sacroiliac joint					
27097	T		Revision of hip tendon	0050	24.8651	$1,356.66		$271.33
27098	T		Transfer tendon to pelvis	0050	24.8651	$1,356.66		$271.33
27100	T		Transfer of abdominal muscle	0051	34.5144	$1,883.14		$376.63
27105	T		Transfer of spinal muscle	0051	34.5144	$1,883.14		$376.63
27110	T		Transfer of iliopsoas muscle	0051	34.5144	$1,883.14		$376.63
27111	T		Transfer of iliopsoas muscle	0051	34.5144	$1,883.14		$376.63
27120	C		Reconstruction of hip socket					
27122	C		Reconstruction of hip socket					
27125	C		Partial hip replacement					
27130	C		Total hip arthroplasty					
27132	C		Total hip arthroplasty					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0043	1.9074	$104.07		$20.81
27194	T		Treat pelvic ring fracture	0045	13.5889	$741.42	$268.47	$148.28
27200	T		Treat tail bone fracture	0043	1.9074	$104.07		$20.81
27202	T		Treat tail bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27215	C		Treat pelvic fracture(s)					
27216	T		Treat pelvic ring fracture	0050	24.8651	$1,356.66		$271.33
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	1.9074	$104.07		$20.81
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	0043	1.9074	$104.07		$20.81
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	24.8651	$1,356.66		$271.33
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	1.9074	$104.07		$20.81
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	1.9074	$104.07		$20.81
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	1.9074	$104.07		$20.81
27252	T		Treat hip dislocation	0045	13.5889	$741.42	$268.47	$148.28
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	1.9074	$104.07		$20.81
27257	T		Treat hip dislocation	0045	13.5889	$741.42	$268.47	$148.28
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	1.9074	$104.07		$20.81
27266	T		Treat hip dislocation	0045	13.5889	$741.42	$268.47	$148.28
27275	T		Manipulation of hip joint	0045	13.5889	$741.42	$268.47	$148.28
27280	C		Fusion of sacroiliac joint					
27282	C		Fusion of pubic bones					
27284	C		Fusion of hip joint					
27286	C		Fusion of hip joint					
27290	C		Amputation of leg at hip					
27295	C		Amputation of leg at hip					
27299	T		Pelvis/hip joint surgery	0043	1.9074	$104.07		$20.81
27301	T		Drain thigh/knee lesion	0008	19.4831	$1,063.02		$212.60
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	19.6046	$1,069.65		$213.93
27306	T		Incision of thigh tendon	0049	19.6046	$1,069.65		$213.93
27307	T		Incision of thigh tendons	0049	19.6046	$1,069.65		$213.93
27310	T		Exploration of knee joint	0050	24.8651	$1,356.66		$271.33
27315	T		Partial removal, thigh nerve	0220	16.5554	$903.28		$180.66
27320	T		Partial removal, thigh nerve	0220	16.5554	$903.28		$180.66
27323	T		Biopsy, thigh soft tissues	0021	14.3594	$783.46	$219.48	$156.69
27324	T		Biopsy, thigh soft tissues	0022	18.7932	$1,025.38	$354.45	$205.08
27327	T		Removal of thigh lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27328	T		Removal of thigh lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27329	T		Remove tumor, thigh/knee	0022	18.7932	$1,025.38	$354.45	$205.08
27330	T		Biopsy, knee joint lining	0050	24.8651	$1,356.66		$271.33
27331	T		Explore/treat knee joint	0050	24.8651	$1,356.66		$271.33
27332	T		Removal of knee cartilage	0050	24.8651	$1,356.66		$271.33
27333	T		Removal of knee cartilage	0050	24.8651	$1,356.66		$271.33
27334	T		Remove knee joint lining	0050	24.8651	$1,356.66		$271.33
27335	T		Remove knee joint lining	0050	24.8651	$1,356.66		$271.33

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27340	T		Removal of kneecap bursa	0049	19.6046	$1,069.65		$213.93
27345	T		Removal of knee cyst	0049	19.6046	$1,069.65		$213.93
27347	T		Remove knee cyst	0049	19.6046	$1,069.65		$213.93
27350	T		Removal of kneecap	0050	24.8651	$1,356.66		$271.33
27355	T		Remove femur lesion	0050	24.8651	$1,356.66		$271.33
27356	T		Remove femur lesion/graft	0050	24.8651	$1,356.66		$271.33
27357	T		Remove femur lesion/graft	0050	24.8651	$1,356.66		$271.33
27358	T		Remove femur lesion/fixation	0050	24.8651	$1,356.66		$271.33
27360	T		Partial removal, leg bone(s)	0050	24.8651	$1,356.66		$271.33
27365	C		Extensive leg surgery					
27370	N		Injection for knee x-ray					
27372	T		Removal of foreign body	0022	18.7932	$1,025.38	$354.45	$205.08
27380	T		Repair of kneecap tendon	0049	19.6046	$1,069.65		$213.93
27381	T		Repair/graft kneecap tendon	0049	19.6046	$1,069.65		$213.93
27385	T		Repair of thigh muscle	0049	19.6046	$1,069.65		$213.93
27386	T		Repair/graft of thigh muscle	0049	19.6046	$1,069.65		$213.93
27390	T		Incision of thigh tendon	0049	19.6046	$1,069.65		$213.93
27391	T		Incision of thigh tendons	0049	19.6046	$1,069.65		$213.93
27392	T		Incision of thigh tendons	0049	19.6046	$1,069.65		$213.93
27393	T		Lengthening of thigh tendon	0050	24.8651	$1,356.66		$271.33
27394	T		Lengthening of thigh tendons	0050	24.8651	$1,356.66		$271.33
27395	T		Lengthening of thigh tendons	0051	34.5144	$1,883.14		$376.63
27396	T		Transplant of thigh tendon	0050	24.8651	$1,356.66		$271.33
27397	T		Transplants of thigh tendons	0051	34.5144	$1,883.14		$376.63
27400	T		Revise thigh muscles/tendons	0051	34.5144	$1,883.14		$376.63
27403	T		Repair of knee cartilage	0050	24.8651	$1,356.66		$271.33
27405	T		Repair of knee ligament	0051	34.5144	$1,883.14		$376.63
27407	T		Repair of knee ligament	0051	34.5144	$1,883.14		$376.63
27409	T		Repair of knee ligaments	0051	34.5144	$1,883.14		$376.63
27418	T		Repair degenerated kneecap	0051	34.5144	$1,883.14		$376.63
27420	T		Revision of unstable kneecap	0051	34.5144	$1,883.14		$376.63
27422	T		Revision of unstable kneecap	0051	34.5144	$1,883.14		$376.63
27424	T		Revision/removal of kneecap	0051	34.5144	$1,883.14		$376.63
27425	T		Lateral retinacular release	0050	24.8651	$1,356.66		$271.33
27427	T		Reconstruction, knee	0052	42.7126	$2,330.44		$466.09
27428	T		Reconstruction, knee	0052	42.7126	$2,330.44		$466.09
27429	T		Reconstruction, knee	0052	42.7126	$2,330.44		$466.09
27430	T		Revision of thigh muscles	0051	34.5144	$1,883.14		$376.63
27435	T		Incision of knee joint	0051	34.5144	$1,883.14		$376.63
27437	T		Revise kneecap	0047	29.9582	$1,634.55	$537.03	$326.91
27438	T		Revise kneecap with implant	0048	51.4609	$2,807.76	$695.60	$561.55
27440	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27441	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27442	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27443	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27445	C		Revision of knee joint					
27446	T		Revision of knee joint	0681	98.1613	$5,355.78	$2,131.36	$1,071.16
27447	C		Total knee arthroplasty					
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					
27496	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27497	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27498	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27499	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27500	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27501	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27502	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27503	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27506	C		Treatment of thigh fracture					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27507	C		Treatment of thigh fracture					
27508	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27509	T		Treatment of thigh fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27510	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
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	0043	1.9074	$104.07		$20.81
27517	T		Treat thigh fx growth plate	0043	1.9074	$104.07		$20.81
27519	C		Treat thigh fx growth plate					
27520	T		Treat kneecap fracture	0043	1.9074	$104.07		$20.81
27524	T		Treat kneecap fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27530	T		Treat knee fracture	0043	1.9074	$104.07		$20.81
27532	T		Treat knee fracture	0043	1.9074	$104.07		$20.81
27535	C		Treat knee fracture					
27536	C		Treat knee fracture					
27538	T		Treat knee fracture(s)	0043	1.9074	$104.07		$20.81
27540	C		Treat knee fracture					
27550	T		Treat knee dislocation	0043	1.9074	$104.07		$20.81
27552	T		Treat knee dislocation	0045	13.5889	$741.42	$268.47	$148.28
27556	C		Treat knee dislocation					
27557	C		Treat knee dislocation					
27558	C		Treat knee dislocation					
27560	T		Treat kneecap dislocation	0043	1.9074	$104.07		$20.81
27562	T		Treat kneecap dislocation	0045	13.5889	$741.42	$268.47	$148.28
27566	T		Treat kneecap dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27570	T		Fixation of knee joint	0045	13.5889	$741.42	$268.47	$148.28
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	19.6046	$1,069.65		$213.93
27596	C		Amputation follow-up surgery					
27598	C		Amputate lower leg at knee					
27599	T		Leg surgery procedure	0043	1.9074	$104.07		$20.81
27600	T		Decompression of lower leg	0049	19.6046	$1,069.65		$213.93
27601	T		Decompression of lower leg	0049	19.6046	$1,069.65		$213.93
27602	T		Decompression of lower leg	0049	19.6046	$1,069.65		$213.93
27603	T		Drain lower leg lesion	0007	11.8633	$647.27		$129.45
27604	T		Drain lower leg bursa	0049	19.6046	$1,069.65		$213.93
27605	T		Incision of achilles tendon	0055	18.7205	$1,021.41	$355.34	$204.28
27606	T		Incision of achilles tendon	0049	19.6046	$1,069.65		$213.93
27607	T		Treat lower leg bone lesion	0049	19.6046	$1,069.65		$213.93
27610	T		Explore/treat ankle joint	0050	24.8651	$1,356.66		$271.33
27612	T		Exploration of ankle joint	0050	24.8651	$1,356.66		$271.33
27613	T		Biopsy lower leg soft tissue	0020	7.0842	$386.52	$113.25	$77.30
27614	T		Biopsy lower leg soft tissue	0022	18.7932	$1,025.38	$354.45	$205.08
27615	T		Remove tumor, lower leg	0046	32.5581	$1,776.40	$535.76	$355.28
27618	T		Remove lower leg lesion	0021	14.3594	$783.46	$219.48	$156.69
27619	T		Remove lower leg lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27620	T		Explore/treat ankle joint	0050	24.8651	$1,356.66		$271.33
27625	T		Remove ankle joint lining	0050	24.8651	$1,356.66		$271.33
27626	T		Remove ankle joint lining	0050	24.8651	$1,356.66		$271.33
27630	T		Removal of tendon lesion	0049	19.6046	$1,069.65		$213.93
27635	T		Remove lower leg bone lesion	0050	24.8651	$1,356.66		$271.33
27637	T		Remove/graft leg bone lesion	0050	24.8651	$1,356.66		$271.33
27638	T		Remove/graft leg bone lesion	0050	24.8651	$1,356.66		$271.33
27640	T		Partial removal of tibia	0051	34.5144	$1,883.14		$376.63
27641	T		Partial removal of fibula	0050	24.8651	$1,356.66		$271.33
27645	C		Extensive lower leg surgery					
27646	C		Extensive lower leg surgery					
27647	T		Extensive ankle/heel surgery	0051	34.5144	$1,883.14		$376.63
27648	N		Injection for ankle x-ray					
27650	T		Repair achilles tendon	0051	34.5144	$1,883.14		$376.63
27652	T		Repair/graft achilles tendon	0051	34.5144	$1,883.14		$376.63
27654	T		Repair of achilles tendon	0051	34.5144	$1,883.14		$376.63
27656	T		Repair leg fascia defect	0049	19.6046	$1,069.65		$213.93
27658	T		Repair of leg tendon, each	0049	19.6046	$1,069.65		$213.93
27659	T		Repair of leg tendon, each	0049	19.6046	$1,069.65		$213.93
27664	T		Repair of leg tendon, each	0049	19.6046	$1,069.65		$213.93
27665	T		Repair of leg tendon, each	0050	24.8651	$1,356.66		$271.33
27675	T		Repair lower leg tendons	0049	19.6046	$1,069.65		$213.93
27676	T		Repair lower leg tendons	0050	24.8651	$1,356.66		$271.33
27680	T		Release of lower leg tendon	0050	24.8651	$1,356.66		$271.33
27681	T		Release of lower leg tendons	0050	24.8651	$1,356.66		$271.33

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27685	T		Revision of lower leg tendon	0050	24.8651	$1,356.66		$271.33
27686	T		Revise lower leg tendons	0050	24.8651	$1,356.66		$271.33
27687	T		Revision of calf tendon	0050	24.8651	$1,356.66		$271.33
27690	T		Revise lower leg tendon	0051	34.5144	$1,883.14		$376.63
27691	T		Revise lower leg tendon	0051	34.5144	$1,883.14		$376.63
27692	T		Revise additional leg tendon	0051	34.5144	$1,883.14		$376.63
27695	T		Repair of ankle ligament	0050	24.8651	$1,356.66		$271.33
27696	T		Repair of ankle ligaments	0050	24.8651	$1,356.66		$271.33
27698	T		Repair of ankle ligament	0050	24.8651	$1,356.66		$271.33
27700	T		Revision of ankle joint	0047	29.9582	$1,634.55	$537.03	$326.91
27702	C		Reconstruct ankle joint					
27703	C		Reconstruction, ankle joint					
27704	T		Removal of ankle implant	0049	19.6046	$1,069.65		$213.93
27705	T		Incision of tibia	0051	34.5144	$1,883.14		$376.63
27707	T		Incision of fibula	0049	19.6046	$1,069.65		$213.93
27709	T		Incision of tibia & fibula	0050	24.8651	$1,356.66		$271.33
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	24.8651	$1,356.66		$271.33
27732	T		Repair of fibula epiphysis	0050	24.8651	$1,356.66		$271.33
27734	T		Repair lower leg epiphyses	0050	24.8651	$1,356.66		$271.33
27740	T		Repair of leg epiphyses	0050	24.8651	$1,356.66		$271.33
27742	T		Repair of leg epiphyses	0051	34.5144	$1,883.14		$376.63
27745	T		Reinforce tibia	0051	34.5144	$1,883.14		$376.63
27750	T		Treatment of tibia fracture	0043	1.9074	$104.07		$20.81
27752	T		Treatment of tibia fracture	0043	1.9074	$104.07		$20.81
27756	T		Treatment of tibia fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27758	T		Treatment of tibia fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27759	T		Treatment of tibia fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27760	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27762	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27766	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27780	T		Treatment of fibula fracture	0043	1.9074	$104.07		$20.81
27781	T		Treatment of fibula fracture	0043	1.9074	$104.07		$20.81
27784	T		Treatment of fibula fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27786	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27788	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27792	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27808	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27810	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27814	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27816	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27818	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27822	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27823	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27824	T		Treat lower leg fracture	0043	1.9074	$104.07		$20.81
27825	T		Treat lower leg fracture	0043	1.9074	$104.07		$20.81
27826	T		Treat lower leg fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27827	T		Treat lower leg fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27828	T		Treat lower leg fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27829	T		Treat lower leg joint	0046	32.5581	$1,776.40	$535.76	$355.28
27830	T		Treat lower leg dislocation	0043	1.9074	$104.07		$20.81
27831	T		Treat lower leg dislocation	0043	1.9074	$104.07		$20.81
27832	T		Treat lower leg dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27840	T		Treat ankle dislocation	0043	1.9074	$104.07		$20.81
27842	T		Treat ankle dislocation	0045	13.5889	$741.42	$268.47	$148.28
27846	T		Treat ankle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27848	T		Treat ankle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27860	T		Fixation of ankle joint	0045	13.5889	$741.42	$268.47	$148.28
27870	T		Fusion of ankle joint	0051	34.5144	$1,883.14		$376.63
27871	T		Fusion of tibiofibular joint	0051	34.5144	$1,883.14		$376.63
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	19.6046	$1,069.65		$213.93
27886	C		Amputation follow-up surgery					
27888	C		Amputation of foot at ankle					
27889	T		Amputation of foot at ankle	0050	24.8651	$1,356.66		$271.33
27892	T		Decompression of leg	0049	19.6046	$1,069.65		$213.93
27893	T		Decompression of leg	0049	19.6046	$1,069.65		$213.93

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27894	T		Decompression of leg	0049	19.6046	$1,069.65		$213.93
27899	T		Leg/ankle surgery procedure	0043	1.9074	$104.07		$20.81
28001	T		Drainage of bursa of foot	0007	11.8633	$647.27		$129.45
28002	T		Treatment of foot infection	0049	19.6046	$1,069.65		$213.93
28003	T		Treatment of foot infection	0049	19.6046	$1,069.65		$213.93
28005	T		Treat foot bone lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28008	T		Incision of foot fascia	0055	18.7205	$1,021.41	$355.34	$204.28
28010	T		Incision of toe tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28011	T		Incision of toe tendons	0055	18.7205	$1,021.41	$355.34	$204.28
28020	T		Exploration of foot joint	0055	18.7205	$1,021.41	$355.34	$204.28
28022	T		Exploration of foot joint	0055	18.7205	$1,021.41	$355.34	$204.28
28024	T		Exploration of toe joint	0055	18.7205	$1,021.41	$355.34	$204.28
28030	T		Removal of foot nerve	0220	16.5554	$903.28		$180.66
28035	T		Decompression of tibia nerve	0220	16.5554	$903.28		$180.66
28043	T		Excision of foot lesion	0021	14.3594	$783.46	$219.48	$156.69
28045	T		Excision of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28046	T		Resection of tumor, foot	0055	18.7205	$1,021.41	$355.34	$204.28
28050	T		Biopsy of foot joint lining	0055	18.7205	$1,021.41	$355.34	$204.28
28052	T		Biopsy of foot joint lining	0055	18.7205	$1,021.41	$355.34	$204.28
28054	T		Biopsy of toe joint lining	0055	18.7205	$1,021.41	$355.34	$204.28
28060	T		Partial removal, foot fascia	0056	25.3930	$1,385.47	$405.81	$277.09
28062	T		Removal of foot fascia	0056	25.3930	$1,385.47	$405.81	$277.09
28070	T		Removal of foot joint lining	0056	25.3930	$1,385.47	$405.81	$277.09
28072	T		Removal of foot joint lining	0056	25.3930	$1,385.47	$405.81	$277.09
28080	T		Removal of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28086	T		Excise foot tendon sheath	0055	18.7205	$1,021.41	$355.34	$204.28
28088	T		Excise foot tendon sheath	0055	18.7205	$1,021.41	$355.34	$204.28
28090	T		Removal of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28092	T		Removal of toe lesions	0055	18.7205	$1,021.41	$355.34	$204.28
28100	T		Removal of ankle/heel lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28102	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28103	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28104	T		Removal of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28106	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28107	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28108	T		Removal of toe lesions	0055	18.7205	$1,021.41	$355.34	$204.28
28110	T		Part removal of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28111	T		Part removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28112	T		Part removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28113	T		Part removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28114	T		Removal of metatarsal heads	0055	18.7205	$1,021.41	$355.34	$204.28
28116	T		Revision of foot	0055	18.7205	$1,021.41	$355.34	$204.28
28118	T		Removal of heel bone	0055	18.7205	$1,021.41	$355.34	$204.28
28119	T		Removal of heel spur	0055	18.7205	$1,021.41	$355.34	$204.28
28120	T		Part removal of ankle/heel	0055	18.7205	$1,021.41	$355.34	$204.28
28122	T		Partial removal of foot bone	0055	18.7205	$1,021.41	$355.34	$204.28
28124	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28126	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28130	T		Removal of ankle bone	0055	18.7205	$1,021.41	$355.34	$204.28
28140	T		Removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28150	T		Removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28153	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28160	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28171	T		Extensive foot surgery	0055	18.7205	$1,021.41	$355.34	$204.28
28173	T		Extensive foot surgery	0055	18.7205	$1,021.41	$355.34	$204.28
28175	T		Extensive foot surgery	0055	18.7205	$1,021.41	$355.34	$204.28
28190	T		Removal of foot foreign body	0019	3.9493	$215.48	$71.87	$43.10
28192	T		Removal of foot foreign body	0021	14.3594	$783.46	$219.48	$156.69
28193	T		Removal of foot foreign body	0020	7.0842	$386.52	$113.25	$77.30
28200	T		Repair of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28202	T		Repair/graft of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09
28208	T		Repair of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28210	T		Repair/graft of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09
28220	T		Release of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28222	T		Release of foot tendons	0055	18.7205	$1,021.41	$355.34	$204.28
28225	T		Release of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28226	T		Release of foot tendons	0055	18.7205	$1,021.41	$355.34	$204.28
28230	T		Incision of foot tendon(s)	0055	18.7205	$1,021.41	$355.34	$204.28
28232	T		Incision of toe tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28234	T		Incision of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28238	T		Revision of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09
28240	T		Release of big toe	0055	18.7205	$1,021.41	$355.34	$204.28
28250	T		Revision of foot fascia	0056	25.3930	$1,385.47	$405.81	$277.09
28260	T		Release of midfoot joint	0056	25.3930	$1,385.47	$405.81	$277.09
28261	T		Revision of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28262	T		Revision of foot and ankle	0056	25.3930	$1,385.47	$405.81	$277.09
28264	T		Release of midfoot joint	0056	25.3930	$1,385.47	$405.81	$277.09
28270	T		Release of foot contracture	0055	18.7205	$1,021.41	$355.34	$204.28
28272	T		Release of toe joint, each	0055	18.7205	$1,021.41	$355.34	$204.28
28280	T		Fusion of toes	0055	18.7205	$1,021.41	$355.34	$204.28
28285	T		Repair of hammertoe	0055	18.7205	$1,021.41	$355.34	$204.28
28286	T		Repair of hammertoe	0055	18.7205	$1,021.41	$355.34	$204.28
28288	T		Partial removal of foot bone	0056	25.3930	$1,385.47	$405.81	$277.09
28289	T		Repair hallux rigidus	0056	25.3930	$1,385.47	$405.81	$277.09
28290	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28292	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28293	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28294	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28296	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28297	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28298	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28299	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28300	T		Incision of heel bone	0056	25.3930	$1,385.47	$405.81	$277.09
28302	T		Incision of ankle bone	0056	25.3930	$1,385.47	$405.81	$277.09
28304	T		Incision of midfoot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28305	T		Incise/graft midfoot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28306	T		Incision of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28307	T		Incision of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28308	T		Incision of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28309	T		Incision of metatarsals	0056	25.3930	$1,385.47	$405.81	$277.09
28310	T		Revision of big toe	0055	18.7205	$1,021.41	$355.34	$204.28
28312	T		Revision of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28313	T		Repair deformity of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28315	T		Removal of sesamoid bone	0055	18.7205	$1,021.41	$355.34	$204.28
28320	T		Repair of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28322	T		Repair of metatarsals	0056	25.3930	$1,385.47	$405.81	$277.09
28340	T		Resect enlarged toe tissue	0055	18.7205	$1,021.41	$355.34	$204.28
28341	T		Resect enlarged toe	0055	18.7205	$1,021.41	$355.34	$204.28
28344	T		Repair extra toe(s)	0056	25.3930	$1,385.47	$405.81	$277.09
28345	T		Repair webbed toe(s)	0056	25.3930	$1,385.47	$405.81	$277.09
28360	T		Reconstruct cleft foot	0056	25.3930	$1,385.47	$405.81	$277.09
28400	T		Treatment of heel fracture	0043	1.9074	$104.07		$20.81
28405	T		Treatment of heel fracture	0043	1.9074	$104.07		$20.81
28406	T		Treatment of heel fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28415	T		Treat heel fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28420	T		Treat/graft heel fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28430	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
28435	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
28436	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28445	T		Treat ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28450	T		Treat midfoot fracture, each	0043	1.9074	$104.07		$20.81
28455	T		Treat midfoot fracture, each	0043	1.9074	$104.07		$20.81
28456	T		Treat midfoot fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28465	T		Treat midfoot fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
28470	T		Treat metatarsal fracture	0043	1.9074	$104.07		$20.81
28475	T		Treat metatarsal fracture	0043	1.9074	$104.07		$20.81
28476	T		Treat metatarsal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28485	T		Treat metatarsal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28490	T		Treat big toe fracture	0043	1.9074	$104.07		$20.81
28495	T		Treat big toe fracture	0043	1.9074	$104.07		$20.81
28496	T		Treat big toe fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28505	T		Treat big toe fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28510	T		Treatment of toe fracture	0043	1.9074	$104.07		$20.81
28515	T		Treatment of toe fracture	0043	1.9074	$104.07		$20.81
28525	T		Treat toe fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28530	T		Treat sesamoid bone fracture	0043	1.9074	$104.07		$20.81
28531	T		Treat sesamoid bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28540	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28545	T		Treat foot dislocation	0045	13.5889	$741.42	$268.47	$148.28
28546	T		Treat foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28555	T		Repair foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28570	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28575	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28576	T		Treat foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28585	T		Repair foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28600	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28605	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28606	T		Treat foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28615	T		Repair foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28630	T		Treat toe dislocation	0043	1.9074	$104.07		$20.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28635	T		Treat toe dislocation	0045	13.5889	$741.42	$268.47	$148.28
28636	T		Treat toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28645	T		Repair toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28660	T		Treat toe dislocation	0043	1.9074	$104.07		$20.81
28665	T		Treat toe dislocation	0045	13.5889	$741.42	$268.47	$148.28
28666	T		Treat toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28675	T		Repair of toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28705	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28715	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28725	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28730	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28735	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28737	T		Revision of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28740	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28750	T		Fusion of big toe joint	0056	25.3930	$1,385.47	$405.81	$277.09
28755	T		Fusion of big toe joint	0055	18.7205	$1,021.41	$355.34	$204.28
28760	T		Fusion of big toe joint	0056	25.3930	$1,385.47	$405.81	$277.09
28800	C		Amputation of midfoot					
28805	C		Amputation thru metatarsal					
28810	T		Amputation toe & metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28820	T		Amputation of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28825	T		Partial amputation of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28899	T		Foot/toes surgery procedure	0043	1.9074	$104.07		$20.81
29000	S		Application of body cast	0058	1.0931	$59.64		$11.93
29010	S		Application of body cast	0058	1.0931	$59.64		$11.93
29015	S		Application of body cast	0058	1.0931	$59.64		$11.93
29020	S		Application of body cast	0058	1.0931	$59.64		$11.93
29025	S		Application of body cast	0058	1.0931	$59.64		$11.93
29035	S		Application of body cast	0058	1.0931	$59.64		$11.93
29040	S		Application of body cast	0058	1.0931	$59.64		$11.93
29044	S		Application of body cast	0058	1.0931	$59.64		$11.93
29046	S		Application of body cast	0058	1.0931	$59.64		$11.93
29049	S		Application of figure eight	0058	1.0931	$59.64		$11.93
29055	S		Application of shoulder cast	0058	1.0931	$59.64		$11.93
29058	S		Application of shoulder cast	0058	1.0931	$59.64		$11.93
29065	S		Application of long arm cast	0058	1.0931	$59.64		$11.93
29075	S		Application of forearm cast	0058	1.0931	$59.64		$11.93
29085	S		Apply hand/wrist cast	0058	1.0931	$59.64		$11.93
29086	S		Apply finger cast	0058	1.0931	$59.64		$11.93
29105	S		Apply long arm splint	0058	1.0931	$59.64		$11.93
29125	S		Apply forearm splint	0058	1.0931	$59.64		$11.93
29126	S		Apply forearm splint	0058	1.0931	$59.64		$11.93
29130	S		Application of finger splint	0058	1.0931	$59.64		$11.93
29131	S		Application of finger splint	0058	1.0931	$59.64		$11.93
29200	S		Strapping of chest	0058	1.0931	$59.64		$11.93
29220	S		Strapping of low back	0058	1.0931	$59.64		$11.93
29240	S		Strapping of shoulder	0058	1.0931	$59.64		$11.93
29260	S		Strapping of elbow or wrist	0058	1.0931	$59.64		$11.93
29280	S		Strapping of hand or finger	0058	1.0931	$59.64		$11.93
29305	S		Application of hip cast	0058	1.0931	$59.64		$11.93
29325	S		Application of hip casts	0058	1.0931	$59.64		$11.93
29345	S		Application of long leg cast	0058	1.0931	$59.64		$11.93
29355	S		Application of long leg cast	0058	1.0931	$59.64		$11.93
29358	S		Apply long leg cast brace	0058	1.0931	$59.64		$11.93
29365	S		Application of long leg cast	0058	1.0931	$59.64		$11.93
29405	S		Apply short leg cast	0058	1.0931	$59.64		$11.93
29425	S		Apply short leg cast	0058	1.0931	$59.64		$11.93
29435	S		Apply short leg cast	0058	1.0931	$59.64		$11.93
29440	S		Addition of walker to cast	0058	1.0931	$59.64		$11.93
29445	S		Apply rigid leg cast	0058	1.0931	$59.64		$11.93
29450	S		Application of leg cast	0058	1.0931	$59.64		$11.93
29505	S		Application, long leg splint	0058	1.0931	$59.64		$11.93
29515	S		Application lower leg splint	0058	1.0931	$59.64		$11.93
29520	S		Strapping of hip	0058	1.0931	$59.64		$11.93
29530	S		Strapping of knee	0058	1.0931	$59.64		$11.93
29540	S		Strapping of ankle	0058	1.0931	$59.64		$11.93
29550	S		Strapping of toes	0058	1.0931	$59.64		$11.93
29580	S		Application of paste boot	0058	1.0931	$59.64		$11.93
29590	S		Application of foot splint	0058	1.0931	$59.64		$11.93
29700	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29705	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29710	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29715	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29720	S		Repair of body cast	0058	1.0931	$59.64		$11.93
29730	S		Windowing of cast	0058	1.0931	$59.64		$11.93

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29740	S		Wedging of cast	0058	1.0931	$59.64		$11.93
29750	S		Wedging of clubfoot cast	0058	1.0931	$59.64		$11.93
29799	S		Casting/strapping procedure	0058	1.0931	$59.64		$11.93
29800	T		Jaw arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29804	T		Jaw arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29805	T		Shoulder arthroscopy, dx	0041	27.3819	$1,493.98		$298.80
29806	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29807	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29819	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29820	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29821	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29822	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29823	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29824	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29825	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29826	T		Shoulder arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29827	T		Arthroscop rotator cuff repr	0041	27.3819	$1,493.98		$298.80
29830	T		Elbow arthroscopy	0041	27.3819	$1,493.98		$298.80
29834	T		Elbow arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29835	T		Elbow arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29836	T		Elbow arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29837	T		Elbow arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29838	T		Elbow arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29840	T		Wrist arthroscopy	0041	27.3819	$1,493.98		$298.80
29843	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29844	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29845	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29846	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29847	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29848	T		Wrist endoscopy/surgery	0041	27.3819	$1,493.98		$298.80
29850	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29851	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29855	T		Tibial arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29856	T		Tibial arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29860	T		Hip arthroscopy, dx	0041	27.3819	$1,493.98		$298.80
29861	T		Hip arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29862	T		Hip arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29863	T		Hip arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29870	T		Knee arthroscopy, dx	0041	27.3819	$1,493.98		$298.80
29871	T		Knee arthroscopy/drainage	0041	27.3819	$1,493.98		$298.80
29873	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29874	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29875	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29876	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29877	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29879	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29880	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29881	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29882	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29883	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29884	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29885	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29886	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29887	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29888	T		Knee arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29889	T		Knee arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29891	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29892	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29893	T		Scope, plantar fasciotomy	0055	18.7205	$1,021.41	$355.34	$204.28
29894	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29895	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29897	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29898	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29899	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29900	T		Mcp joint arthroscopy, dx	0053	14.8831	$812.04	$253.49	$162.41
29901	T		Mcp joint arthroscopy, surg	0053	14.8831	$812.04	$253.49	$162.41
29902	T		Mcp joint arthroscopy, surg	0053	14.8831	$812.04	$253.49	$162.41
29999	T		Arthroscopy of joint	0041	27.3819	$1,493.98		$298.80
30000	T		Drainage of nose lesion	0251	1.7880	$97.56		$19.51
30020	T		Drainage of nose lesion	0251	1.7880	$97.56		$19.51
30100	T		Intranasal biopsy	0252	6.4469	$351.75	$113.41	$70.35
30110	T		Removal of nose polyp(s)	0253	15.2249	$830.69	$282.29	$166.14
30115	T		Removal of nose polyp(s)	0253	15.2249	$830.69	$282.29	$166.14
30117	T		Removal of intranasal lesion	0253	15.2249	$830.69	$282.29	$166.14
30118	T		Removal of intranasal lesion	0254	21.8901	$1,194.35	$321.35	$238.87

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30120	T		Revision of nose	0253	15.2249	$830.69	$282.29	$166.14
30124	T		Removal of nose lesion	0252	6.4469	$351.75	$113.41	$70.35
30125	T		Removal of nose lesion	0256	35.1548	$1,918.08		$383.62
30130	T		Removal of turbinate bones	0253	15.2249	$830.69	$282.29	$166.14
30140	T		Removal of turbinate bones	0254	21.8901	$1,194.35	$321.35	$238.87
30150	T		Partial removal of nose	0256	35.1548	$1,918.08		$383.62
30160	T		Removal of nose	0256	35.1548	$1,918.08		$383.62
30200	T		Injection treatment of nose	0253	15.2249	$830.69	$282.29	$166.14
30210	T		Nasal sinus therapy	0252	6.4469	$351.75	$113.41	$70.35
30220	T		Insert nasal septal button	0252	6.4469	$351.75	$113.41	$70.35
30300	X		Remove nasal foreign body	0340	0.6314	$34.45		$6.89
30310	T		Remove nasal foreign body	0253	15.2249	$830.69	$282.29	$166.14
30320	T		Remove nasal foreign body	0253	15.2249	$830.69	$282.29	$166.14
30400	T		Reconstruction of nose	0256	35.1548	$1,918.08		$383.62
30410	T		Reconstruction of nose	0256	35.1548	$1,918.08		$383.62
30420	T		Reconstruction of nose	0256	35.1548	$1,918.08		$383.62
30430	T		Revision of nose	0254	21.8901	$1,194.35	$321.35	$238.87
30435	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30450	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30460	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30462	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30465	T		Repair nasal stenosis	0256	35.1548	$1,918.08		$383.62
30520	T		Repair of nasal septum	0254	21.8901	$1,194.35	$321.35	$238.87
30540	T		Repair nasal defect	0256	35.1548	$1,918.08		$383.62
30545	T		Repair nasal defect	0256	35.1548	$1,918.08		$383.62
30560	T		Release of nasal adhesions	0251	1.7880	$97.56		$19.51
30580	T		Repair upper jaw fistula	0256	35.1548	$1,918.08		$383.62
30600	T		Repair mouth/nose fistula	0256	35.1548	$1,918.08		$383.62
30620	T		Intranasal reconstruction	0256	35.1548	$1,918.08		$383.62
30630	T		Repair nasal septum defect	0254	21.8901	$1,194.35	$321.35	$238.87
30801	T		Cauterization, inner nose	0252	6.4469	$351.75	$113.41	$70.35
30802	T		Cauterization, inner nose	0253	15.2249	$830.69	$282.29	$166.14
30901	T		Control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30903	T		Control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30905	T		Control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30906	T		Repeat control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30915	T		Ligation, nasal sinus artery	0091	28.8326	$1,573.14	$348.23	$314.63
30920	T		Ligation, upper jaw artery	0092	25.0959	$1,369.26	$505.37	$273.85
30930	T		Therapy, fracture of nose	0253	15.2249	$830.69	$282.29	$166.14
30999	T		Nasal surgery procedure	0251	1.7880	$97.56		$19.51
31000	T		Irrigation, maxillary sinus	0251	1.7880	$97.56		$19.51
31002	T		Irrigation, sphenoid sinus	0252	6.4469	$351.75	$113.41	$70.35
31020	T		Exploration, maxillary sinus	0254	21.8901	$1,194.35	$321.35	$238.87
31030	T		Exploration, maxillary sinus	0256	35.1548	$1,918.08		$383.62
31032	T		Explore sinus, remove polyps	0256	35.1548	$1,918.08		$383.62
31040	T		Exploration behind upper jaw	0254	21.8901	$1,194.35	$321.35	$238.87
31050	T		Exploration, sphenoid sinus	0256	35.1548	$1,918.08		$383.62
31051	T		Sphenoid sinus surgery	0256	35.1548	$1,918.08		$383.62
31070	T		Exploration of frontal sinus	0254	21.8901	$1,194.35	$321.35	$238.87
31075	T		Exploration of frontal sinus	0256	35.1548	$1,918.08		$383.62
31080	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31081	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31084	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31085	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31086	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31087	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31090	T		Exploration of sinuses	0256	35.1548	$1,918.08		$383.62
31200	T		Removal of ethmoid sinus	0256	35.1548	$1,918.08		$383.62
31201	T		Removal of ethmoid sinus	0256	35.1548	$1,918.08		$383.62
31205	T		Removal of ethmoid sinus	0256	35.1548	$1,918.08		$383.62
31225	C		Removal of upper jaw					
31230	C		Removal of upper jaw					
31231	T		Nasal endoscopy, dx	0071	0.8799	$48.01	$12.89	$9.60
31233	T		Nasal/sinus endoscopy, dx	0072	1.7613	$96.10	$26.68	$19.22
31235	T		Nasal/sinus endoscopy, dx	0074	13.9480	$761.02	$295.70	$152.20
31237	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41
31238	T		Nasal/sinus endoscopy, surg	0074	13.9480	$761.02	$295.70	$152.20
31239	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41
31240	T		Nasal/sinus endoscopy, surg	0074	13.9480	$761.02	$295.70	$152.20
31254	T		Revision of ethmoid sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31255	T		Removal of ethmoid sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31256	T		Exploration maxillary sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31267	T		Endoscopy, maxillary sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31276	T		Sinus endoscopy, surgical	0075	20.3815	$1,112.04	$445.92	$222.41
31287	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31288	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41
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	6.4469	$351.75	$113.41	$70.35
31300	T		Removal of larynx lesion	0254	21.8901	$1,194.35	$321.35	$238.87
31320	T		Diagnostic incision, larynx	0256	35.1548	$1,918.08		$383.62
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	35.1548	$1,918.08		$383.62
31420	T		Removal of epiglottis	0256	35.1548	$1,918.08		$383.62
31500	S		Insert emergency airway	0094	2.6345	$143.74	$48.58	$28.75
31502	T		Change of windpipe airway	0121	2.1189	$115.61	$43.80	$23.12
31505	T		Diagnostic laryngoscopy	0071	0.8799	$48.01	$12.89	$9.60
31510	T		Laryngoscopy with biopsy	0074	13.9480	$761.02	$295.70	$152.20
31511	T		Remove foreign body, larynx	0072	1.7613	$96.10	$26.68	$19.22
31512	T		Removal of larynx lesion	0074	13.9480	$761.02	$295.70	$152.20
31513	T		Injection into vocal cord	0072	1.7613	$96.10	$26.68	$19.22
31515	T		Laryngoscopy for aspiration	0074	13.9480	$761.02	$295.70	$152.20
31520	T		Diagnostic laryngoscopy	0072	1.7613	$96.10	$26.68	$19.22
31525	T		Diagnostic laryngoscopy	0074	13.9480	$761.02	$295.70	$152.20
31526	T		Diagnostic laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31527	T		Laryngoscopy for treatment	0075	20.3815	$1,112.04	$445.92	$222.41
31528	T		Laryngoscopy and dilation	0074	13.9480	$761.02	$295.70	$152.20
31529	T		Laryngoscopy and dilation	0074	13.9480	$761.02	$295.70	$152.20
31530	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31531	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31535	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31536	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31540	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31541	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31560	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31561	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31570	T		Laryngoscopy with injection	0074	13.9480	$761.02	$295.70	$152.20
31571	T		Laryngoscopy with injection	0075	20.3815	$1,112.04	$445.92	$222.41
31575	T		Diagnostic laryngoscopy	0072	1.7613	$96.10	$26.68	$19.22
31576	T		Laryngoscopy with biopsy	0075	20.3815	$1,112.04	$445.92	$222.41
31577	T		Remove foreign body, larynx	0073	3.4541	$188.46	$73.38	$37.69
31578	T		Removal of larynx lesion	0075	20.3815	$1,112.04	$445.92	$222.41
31579	T		Diagnostic laryngoscopy	0073	3.4541	$188.46	$73.38	$37.69
31580	T		Revision of larynx	0256	35.1548	$1,918.08		$383.62
31582	T		Revision of larynx	0256	35.1548	$1,918.08		$383.62
31584	C		Treat larynx fracture					
31585	T		Treat larynx fracture	0253	15.2249	$830.69	$282.29	$166.14
31586	T		Treat larynx fracture	0256	35.1548	$1,918.08		$383.62
31587	C		Revision of larynx					
31588	T		Revision of larynx	0256	35.1548	$1,918.08		$383.62
31590	T		Reinnervate larynx	0256	35.1548	$1,918.08		$383.62
31595	T		Larynx nerve surgery	0256	35.1548	$1,918.08		$383.62
31599	T		Larynx surgery procedure	0254	21.8901	$1,194.35	$321.35	$238.87
31600	T		Incision of windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31601	T		Incision of windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31603	T		Incision of windpipe	0252	6.4469	$351.75	$113.41	$70.35
31605	T		Incision of windpipe	0253	15.2249	$830.69	$282.29	$166.14
31610	T		Incision of windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31611	T		Surgery/speech prosthesis	0254	21.8901	$1,194.35	$321.35	$238.87
31612	T		Puncture/clear windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31613	T		Repair windpipe opening	0254	21.8901	$1,194.35	$321.35	$238.87
31614	T		Repair windpipe opening	0256	35.1548	$1,918.08		$383.62
31615	T		Visualization of windpipe	0076	9.2346	$503.85	$189.82	$100.77
31622	T		Dx bronchoscope/wash	0076	9.2346	$503.85	$189.82	$100.77
31623	T		Dx bronchoscope/brush	0076	9.2346	$503.85	$189.82	$100.77
31624	T		Dx bronchoscope/lavage	0076	9.2346	$503.85	$189.82	$100.77
31625	T		Bronchoscopy w/biopsy(s)	0076	9.2346	$503.85	$189.82	$100.77
31628	T		Bronchoscopy/lung bx, each	0076	9.2346	$503.85	$189.82	$100.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31629	T		Bronchoscopy/needle bx, each	0076	9.2346	$503.85	$189.82	$100.77
31630	T		Bronchoscopy dilate/fx repr	0415	20.7348	$1,131.31	$459.92	$226.26
31631	T		Bronchoscopy, dilate w/stent	0415	20.7348	$1,131.31	$459.92	$226.26
31632	T	NI	Bronchoscopy/lung bx, add'l	0076	9.2346	$503.85	$189.82	$100.77
31633	T	NI	Bronchoscopy/needle bx add'l	0076	9.2346	$503.85	$189.82	$100.77
31635	T		Bronchoscopy w/fb removal	0076	9.2346	$503.85	$189.82	$100.77
31640	T		Bronchoscopy w/tumor excise	0415	20.7348	$1,131.31	$459.92	$226.26
31641	T		Bronchoscopy, treat blockage	0415	20.7348	$1,131.31	$459.92	$226.26
31643	T		Diag bronchoscope/catheter	0076	9.2346	$503.85	$189.82	$100.77
31645	T		Bronchoscopy, clear airways	0076	9.2346	$503.85	$189.82	$100.77
31646	T		Bronchoscopy, reclear airway	0076	9.2346	$503.85	$189.82	$100.77
31656	T		Bronchoscopy, inj for x-ray	0076	9.2346	$503.85	$189.82	$100.77
31700	T		Insertion of airway catheter	0072	1.7613	$96.10	$26.68	$19.22
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	3.4541	$188.46	$73.38	$37.69
31720	T		Clearance of airways	0071	0.8799	$48.01	$12.89	$9.60
31725	C		Clearance of airways					
31730	T		Intro, windpipe wire/tube	0073	3.4541	$188.46	$73.38	$37.69
31750	T		Repair of windpipe	0256	35.1548	$1,918.08		$383.62
31755	T		Repair of windpipe	0256	35.1548	$1,918.08		$383.62
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	T		Remove windpipe lesion	0254	21.8901	$1,194.35	$321.35	$238.87
31786	C		Remove windpipe lesion					
31800	C		Repair of windpipe injury					
31805	C		Repair of windpipe injury					
31820	T		Closure of windpipe lesion	0253	15.2249	$830.69	$282.29	$166.14
31825	T		Repair of windpipe defect	0254	21.8901	$1,194.35	$321.35	$238.87
31830	T		Revise windpipe scar	0254	21.8901	$1,194.35	$321.35	$238.87
31899	T		Airways surgical procedure	0076	9.2346	$503.85	$189.82	$100.77
32000	T		Drainage of chest	0070	3.0717	$167.60		$33.52
32002	T		Treatment of collapsed lung	0070	3.0717	$167.60		$33.52
32005	T		Treat lung lining chemically	0070	3.0717	$167.60		$33.52
32020	T		Insertion of chest tube	0070	3.0717	$167.60		$33.52
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	T		Drain, percut, lung lesion	0070	3.0717	$167.60		$33.52
32215	C		Treat chest lining					
32220	C		Release of lung					
32225	C		Partial release of lung					
32310	C		Removal of chest lining					
32320	C		Free/remove chest lining					
32400	T		Needle biopsy chest lining	0005	3.2698	$178.40	$71.59	$35.68
32402	C		Open biopsy chest lining					
32405	T		Biopsy, lung or mediastinum	0685	4.8100	$262.44	$115.47	$52.49
32420	T		Puncture/clear lung	0070	3.0717	$167.60		$33.52
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32522	C		Remove lung & revise chest					
32525	C		Remove lung & revise chest					
32540	C		Removal of lung lesion					
32601	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32602	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32603	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32604	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32605	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32606	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
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	3.0717	$167.60		$33.52
32997	C		Total lung lavage					
32999	T		Chest surgery procedure	0070	3.0717	$167.60		$33.52
33010	T		Drainage of heart sac	0070	3.0717	$167.60		$33.52
33011	T		Repeat drainage of heart sac	0070	3.0717	$167.60		$33.52
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					
33206	T		Insertion of heart pacemaker	0089	117.1896	$6,393.98	$1,722.59	$1,278.80
33207	T		Insertion of heart pacemaker	0089	117.1896	$6,393.98	$1,722.59	$1,278.80
33208	T		Insertion of heart pacemaker	0655	142.7039	$7,786.07		$1,557.21
33210	T		Insertion of heart electrode	0106	58.9719	$3,217.57		$643.51
33211	T		Insertion of heart electrode	0106	58.9719	$3,217.57		$643.51
33212	T		Insertion of pulse generator	0090	96.8284	$5,283.05	$1,651.45	$1,056.61
33213	T		Insertion of pulse generator	0654	112.6957	$6,148.79		$1,229.76
33214	T		Upgrade of pacemaker system	0655	142.7039	$7,786.07		$1,557.21
33215	T		Reposition pacing-defib lead	0105	19.1898	$1,047.01	$370.40	$209.40
33216	T		Revise eltrd pacing-defib	0106	58.9719	$3,217.57		$643.51
33217	T		Insert lead pace-defib, dual	0106	58.9719	$3,217.57		$643.51
33218	T		Repair lead pace-defib, one	0106	58.9719	$3,217.57		$643.51
33220	T		Repair lead pace-defib, dual	0106	58.9719	$3,217.57		$643.51
33222	T		Revise pocket, pacemaker	0027	15.8990	$867.47	$329.72	$173.49
33223	T		Revise pocket, pacing-defib	0027	15.8990	$867.47	$329.72	$173.49
33224	T		Insert pacing lead & connect	1547		$850.00		$170.00
33225	T		L ventric pacing lead add-on	1550		$1,150.00		$230.00
33226	T		Reposition l ventric lead	0105	19.1898	$1,047.01	$370.40	$209.40
33233	T		Removal of pacemaker system	0105	19.1898	$1,047.01	$370.40	$209.40
33234	T		Removal of pacemaker system	0105	19.1898	$1,047.01	$370.40	$209.40

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33235	T		Removal pacemaker electrode	0105	19.1898	$1,047.01	$370.40	$209.40
33236	C		Remove electrode/thoracotomy					
33237	C		Remove electrode/thoracotomy					
33238	C		Remove electrode/thoracotomy					
33240	B		Insert pulse generator					
33241	T		Remove pulse generator	0105	19.1898	$1,047.01	$370.40	$209.40
33243	C		Remove eltrd/thoracotomy					
33244	T		Remove eltrd, transven	0105	19.1898	$1,047.01	$370.40	$209.40
33245	C		Insert epic eltrd pace-defib					
33246	C		Insert epic eltrd/generator					
33249	B		Eltrd/insert pace-defib					
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	0680	62.8252	$3,427.81		$685.56
33284	T		Remove pat-active ht record	0109	7.4705	$407.60	$131.49	$81.52
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					
33508	N		Endoscopic vein harvest					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	3.0717	$167.60		$33.52
34001	C		Removal of artery clot					
34051	C		Removal of artery clot					
34101	T		Removal of artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34111	T		Removal of arm artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34151	C		Removal of artery clot					
34201	T		Removal of artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34203	T		Removal of leg artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34401	C		Removal of vein clot					
34421	T		Removal of vein clot	0088	34.6942	$1,892.95	$655.22	$378.59
34451	C		Removal of vein clot					
34471	T		Removal of vein clot	0088	34.6942	$1,892.95	$655.22	$378.59
34490	T		Removal of vein clot	0088	34.6942	$1,892.95	$655.22	$378.59
34501	T		Repair valve, femoral vein	0088	34.6942	$1,892.95	$655.22	$378.59
34502	C		Reconstruct vena cava					
34510	T		Transposition of vein valve	0088	34.6942	$1,892.95	$655.22	$378.59
34520	T		Cross-over vein graft	0088	34.6942	$1,892.95	$655.22	$378.59
34530	T		Leg vein fusion	0088	34.6942	$1,892.95	$655.22	$378.59
34800	C		Endovasc abdo repair w/tube					
34802	C		Endovasc abdo repr w/device					
34804	C		Endovasc abdo repr w/device					
34805	C	NI	Endovasc abdo repair w/pros					
34808	C		Endovasc abdo occlud device					
34812	C		Xpose for endoprosth, aortic					
34813	C		Femoral endovas graft add-on					
34820	C		Xpose for endoprosth, iliac					
34825	C		Endovasc extend prosth, init					
34826	C		Endovasc exten prosth, add'l					
34830	C		Open aortic tube prosth repr					
34831	C		Open aortoiliac prosth repr					
34832	C		Open aortofemor prosth repr					
34833	C		Xpose for endoprosth, iliac					
34834	C		Xpose, endoprosth, brachial					
34900	C		Endovasc iliac repr w/graft					
35001	C		Repair defect of artery					
35002	C		Repair artery rupture, neck					
35005	C		Repair defect of artery					
35011	T		Repair defect of artery	0653	30.0334	$1,638.65		$327.73
35013	C		Repair artery rupture, arm					
35021	C		Repair defect of artery					
35022	C		Repair artery rupture, chest					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	21.3104	$1,162.72	$277.34	$232.54
35182	C		Repair blood vessel lesion					
35184	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35188	T		Repair blood vessel lesion	0088	34.6942	$1,892.95	$655.22	$378.59
35189	C		Repair blood vessel lesion					
35190	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35201	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35206	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35207	T		Repair blood vessel lesion	0088	34.6942	$1,892.95	$655.22	$378.59
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	21.3104	$1,162.72	$277.34	$232.54
35231	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35236	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
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	21.3104	$1,162.72	$277.34	$232.54
35261	T		Repair blood vessel lesion	0653	30.0334	$1,638.65		$327.73
35266	T		Repair blood vessel lesion	0653	30.0334	$1,638.65		$327.73
35271	C		Repair blood vessel lesion					
35276	C		Repair blood vessel lesion					
35281	C		Repair blood vessel lesion					
35286	T		Repair blood vessel lesion	0653	30.0334	$1,638.65		$327.73
35301	C		Rechanneling of artery					
35311	C		Rechanneling of artery					
35321	T		Rechanneling of artery	0093	21.3104	$1,162.72	$277.34	$232.54
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	35.0285	$1,911.19		$382.24
35459	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35460	T		Repair venous blockage	0081	35.0285	$1,911.19		$382.24
35470	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35471	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35472	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35473	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35474	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35475	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35476	T		Repair venous blockage	0081	35.0285	$1,911.19		$382.24
35480	C		Atherectomy, open					
35481	C		Atherectomy, open					
35482	C		Atherectomy, open					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35483	C		Atherectomy, open					
35484	T		Atherectomy, open	0081	35.0285	$1,911.19		$382.24
35485	T		Atherectomy, open	0081	35.0285	$1,911.19		$382.24
35490	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35491	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35492	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35493	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35494	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35495	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35500	T		Harvest vein for bypass	0081	35.0285	$1,911.19		$382.24
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					
35510	C	NI	Artery bypass graft					
35511	C		Artery bypass graft					
35512	C	NI	Artery bypass graft					
35515	C		Artery bypass graft					
35516	C		Artery bypass graft					
35518	C		Artery bypass graft					
35521	C		Artery bypass graft					
35522	C	NI	Artery bypass graft					
35525	C	NI	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					
35572	N		Harvest femoropopliteal vein					
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					
35685	T		Bypass graft patency/patch	0093	21.3104	$1,162.72	$277.34	$232.54
35686	T		Bypass graft/av fist patency	0093	21.3104	$1,162.72	$277.34	$232.54
35691	C		Arterial transposition					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35693	C		Arterial transposition					
35694	C		Arterial transposition					
35695	C		Arterial transposition					
35697	C	NI	Reimplant artery each					
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	25.6437	$1,399.15	$459.35	$279.83
35800	C		Explore neck vessels					
35820	C		Explore chest vessels					
35840	C		Explore abdominal vessels					
35860	T		Explore limb vessels	0093	21.3104	$1,162.72	$277.34	$232.54
35870	C		Repair vessel graft defect					
35875	T		Removal of clot in graft	0088	34.6942	$1,892.95	$655.22	$378.59
35876	T		Removal of clot in graft	0088	34.6942	$1,892.95	$655.22	$378.59
35879	T		Revise graft w/vein	0088	34.6942	$1,892.95	$655.22	$378.59
35881	T		Revise graft w/vein	0088	34.6942	$1,892.95	$655.22	$378.59
35901	C		Excision, graft, neck					
35903	T		Excision, graft, extremity	0115	25.6437	$1,399.15	$459.35	$279.83
35905	C		Excision, graft, thorax					
35907	C		Excision, graft, abdomen					
36000	N		Place needle in vein					
36002	S		Pseudoaneurysm injection trt	0267	2.4586	$134.14	$65.52	$26.83
36005	N		Injection ext 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	134.7194	$7,350.43		$1,470.09
36261	T		Revision of infusion pump	0124	23.8050	$1,298.82		$259.76
36262	T		Removal of infusion pump	0124	23.8050	$1,298.82		$259.76
36299	N		Vessel injection procedure					
36400	N		Bl draw < 3 yrs fem/jugular					
36405	N		Bl draw < 3 yrs scalp vein					
36406	N		Bl draw < 3 yrs other vein					
36410	N		Non-routine bl draw > 3 yrs					
36415	E		Drawing blood					
36416	E		Capillary blood draw					
36420	T		Vein access cutdown < 1 yr	0035	0.1691	$9.23	$2.79	$1.85
36425	T		Vein access cutdown > 1 yr	0035	0.1691	$9.23	$2.79	$1.85
36430	S		Blood transfusion service	0110	3.6718	$200.34		$40.07
36440	S		Bl push transfuse, 2 yr or <	0110	3.6718	$200.34		$40.07
36450	S		Bl exchange/transfuse, nb	0110	3.6718	$200.34		$40.07
36455	S		Bl exchange/transfuse non-nb	0110	3.6718	$200.34		$40.07
36460	S		Transfusion service, fetal	0110	3.6718	$200.34		$40.07
36468	T		Injection(s), spider veins	0098	1.0729	$58.54	$14.06	$11.71
36469	T		Injection(s), spider veins	0098	1.0729	$58.54	$14.06	$11.71
36470	T		Injection therapy of vein	0098	1.0729	$58.54	$14.06	$11.71
36471	T		Injection therapy of veins	0098	1.0729	$58.54	$14.06	$11.71
36481	N		Insertion of catheter, vein					
36488	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36489	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36490	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36491	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36493	X	DG	Repositioning of cvc	0187	4.4288	$241.64	$90.71	$48.33
36500	N		Insertion of catheter, vein					
36510	C		Insertion of catheter, vein					
36511	S		Apheresis wbc	0111	13.1719	$718.67	$200.18	$143.73

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36512	S		Apheresis rbc	0111	13.1719	$718.67	$200.18	$143.73
36513	S		Apheresis platelets	0111	13.1719	$718.67	$200.18	$143.73
36514	S		Apheresis plasma	0111	13.1719	$718.67	$200.18	$143.73
36515	S		Apheresis, adsorp/reinfuse	0112	37.5832	$2,050.58	$612.47	$410.12
36516	S		Apheresis, selective	0112	37.5832	$2,050.58	$612.47	$410.12
36522	S		Photopheresis	0112	37.5832	$2,050.58	$612.47	$410.12
36530	T	DG	Insertion of infusion pump	0119	134.7194	$7,350.43		$1,470.09
36531	T	DG	Revision of infusion pump	0124	23.8050	$1,298.82		$259.76
36532	T	DG	Removal of infusion pump	0109	7.4705	$407.60	$131.49	$81.52
36533	T	DG	Insertion of access device	0115	25.6437	$1,399.15	$459.35	$279.83
36534	T	DG	Revision of access device	0109	7.4705	$407.60	$131.49	$81.52
36535	T	DG	Removal of access device	0109	7.4705	$407.60	$131.49	$81.52
36536	T	DG	Remove cva device obstruct	1541		$250.00		$50.00
36537	T	DG	Remove cva lumen obstruct	1541		$250.00		$50.00
36540	N		Collect blood venous device					
36550	T		Declot vascular device	0677	2.1805	$118.97		$23.79
36555	T	NI	Insert non-tunnel cv cath	0032	11.4907	$626.94		$125.39
36556	T	NI	Insert non-tunnel cv cath	0032	11.4907	$626.94		$125.39
36557	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36558	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36560	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36561	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36563	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36565	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36566	T	NI	Insert tunneled cv cath	1564		$4,750.00		$950.00
36568	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36569	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36570	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36571	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36575	X	NI	Repair tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36576	X	NI	Repair tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36578	X	NI	Replace tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36580	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36581	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36582	T	NI	Replace tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36583	T	NI	Replace tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36584	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36585	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36589	X	NI	Removal tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36590	T	NI	Removal tunneled cv cath	0109	7.4705	$407.60	$131.49	$81.52
36595	T	NI	Mech remov tunneled cv cath	1541		$250.00		$50.00
36596	T	NI	Mech remov tunneled cv cath	1541		$250.00		$50.00
36597	X	NI	Reposition venous catheter	0187	4.4288	$241.64	$90.71	$48.33
36600	N		Withdrawal of arterial blood					
36620	N		Insertion catheter, artery					
36625	N		Insertion catheter, artery					
36640	T		Insertion catheter, artery	0032	11.4907	$626.94		$125.39
36660	C		Insertion catheter, artery					
36680	T		Insert needle, bone cavity	0120	1.9114	$104.29	$28.21	$20.86
36800	T		Insertion of cannula	0115	25.6437	$1,399.15	$459.35	$279.83
36810	T		Insertion of cannula	0115	25.6437	$1,399.15	$459.35	$279.83
36815	T		Insertion of cannula	0115	25.6437	$1,399.15	$459.35	$279.83
36819	T		Av fusion/uppr arm vein	0088	34.6942	$1,892.95	$655.22	$378.59
36820	T		Av fusion/forearm vein	0088	34.6942	$1,892.95	$655.22	$378.59
36821	T		Av fusion direct any site	0088	34.6942	$1,892.95	$655.22	$378.59
36822	C		Insertion of cannula(s)					
36823	C		Insertion of cannula(s)					
36825	T		Artery-vein autograft	0088	34.6942	$1,892.95	$655.22	$378.59
36830	T		Artery-vein graft	0088	34.6942	$1,892.95	$655.22	$378.59
36831	T		Open thrombect av fistula	0088	34.6942	$1,892.95	$655.22	$378.59
36832	T		Av fistula revision, open	0088	34.6942	$1,892.95	$655.22	$378.59
36833	T		Av fistula revision	0088	34.6942	$1,892.95	$655.22	$378.59
36834	T		Repair A-V aneurysm	0088	34.6942	$1,892.95	$655.22	$378.59
36835	T		Artery to vein shunt	0115	25.6437	$1,399.15	$459.35	$279.83
36838	T	NI	Dist revas ligation, hemo	0088	34.6942	$1,892.95	$655.22	$378.59
36860	T		External cannula declotting	0103	11.6202	$634.01	$223.63	$126.80
36861	T		Cannula declotting	0115	25.6437	$1,399.15	$459.35	$279.83
36870	T		Percut thrombect av fistula	0653	30.0334	$1,638.65		$327.73
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					
37182	C		Insert hepatic shunt (tips)					
37183	C		Remove hepatic shunt (tips)					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37195	C		Thrombolytic therapy, stroke					
37200	T		Transcatheter biopsy	0685	4.8100	$262.44	$115.47	$52.49
37201	T		Transcatheter therapy infuse	0676	2.7315	$149.03	$40.30	$29.81
37202	T		Transcatheter therapy infuse	0677	2.1805	$118.97		$23.79
37203	T		Transcatheter retrieval	0103	11.6202	$634.01	$223.63	$126.80
37204	T		Transcatheter occlusion	0115	25.6437	$1,399.15	$459.35	$279.83
37205	T		Transcatheter stent	0229	61.9895	$3,382.21	$771.23	$676.44
37206	T		Transcatheter stent add-on	0229	61.9895	$3,382.21	$771.23	$676.44
37207	T		Transcatheter stent	0229	61.9895	$3,382.21	$771.23	$676.44
37208	T		Transcatheter stent add-on	0229	61.9895	$3,382.21	$771.23	$676.44
37209	T		Exchange arterial catheter	0103	11.6202	$634.01	$223.63	$126.80
37250	S		Iv us first vessel add-on	0670	27.4483	$1,497.61	$542.37	$299.52
37251	S		Iv us each add vessel add-on	0670	27.4483	$1,497.61	$542.37	$299.52
37500	T		Endoscopy ligate perf veins	0092	25.0959	$1,369.26	$505.37	$273.85
37501	T		Vascular endoscopy procedure	0092	25.0959	$1,369.26	$505.37	$273.85
37565	T		Ligation of neck vein	0093	21.3104	$1,162.72	$277.34	$232.54
37600	T		Ligation of neck artery	0093	21.3104	$1,162.72	$277.34	$232.54
37605	T		Ligation of neck artery	0091	28.8326	$1,573.14	$348.23	$314.63
37606	T		Ligation of neck artery	0091	28.8326	$1,573.14	$348.23	$314.63
37607	T		Ligation of a-v fistula	0092	25.0959	$1,369.26	$505.37	$273.85
37609	T		Temporal artery procedure	0021	14.3594	$783.46	$219.48	$156.69
37615	T		Ligation of neck artery	0091	28.8326	$1,573.14	$348.23	$314.63
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	28.8326	$1,573.14	$348.23	$314.63
37650	T		Revision of major vein	0091	28.8326	$1,573.14	$348.23	$314.63
37660	C		Revision of major vein					
37700	T		Revise leg vein	0091	28.8326	$1,573.14	$348.23	$314.63
37720	T		Removal of leg vein	0092	25.0959	$1,369.26	$505.37	$273.85
37730	T		Removal of leg veins	0092	25.0959	$1,369.26	$505.37	$273.85
37735	T		Removal of leg veins/lesion	0092	25.0959	$1,369.26	$505.37	$273.85
37760	T		Revision of leg veins	0091	28.8326	$1,573.14	$348.23	$314.63
37765	T	NI	Phleb veins - extrem - to 20	0091	28.8326	$1,573.14	$348.23	$314.63
37766	T	NI	Phleb veins - extrem 20+	0091	28.8326	$1,573.14	$348.23	$314.63
37780	T		Revision of leg vein	0091	28.8326	$1,573.14	$348.23	$314.63
37785	T		Ligate/divide/excise vein	0091	28.8326	$1,573.14	$348.23	$314.63
37788	C		Revascularization, penis					
37790	T		Penile venous occlusion	0181	29.4217	$1,605.28	$621.82	$321.06
37799	T		Vascular surgery procedure	0035	0.1691	$9.23	$2.79	$1.85
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	40.8064	$2,226.44	$1,001.89	$445.29
38129	T		Laparoscope proc, spleen	0130	32.7724	$1,788.09	$659.53	$357.62
38200	N		Injection for spleen x-ray					
38204	E		Bl donor search management					
38205	S		Harvest allogenic stem cells	0111	13.1719	$718.67	$200.18	$143.73
38206	S		Harvest auto stem cells	0111	13.1719	$718.67	$200.18	$143.73
38207	E		Cryopreserve stem cells					
38208	E		Thaw preserved stem cells					
38209	E		Wash harvest stem cells					
38210	E		T-cell depletion of harvest					
38211	E		Tumor cell deplete of harvst					
38212	E		Rbc depletion of harvest					
38213	E		Platelet deplete of harvest					
38214	E		Volume deplete of harvest					
38215	E		Harvest stem cell concentrte					
38220	T		Bone marrow aspiration	0003	2.3229	$126.74		$25.35
38221	T		Bone marrow biopsy	0003	2.3229	$126.74		$25.35
38230	S		Bone marrow collection	0123	5.2882	$288.53		$57.71
38240	S		Bone marrow/stem transplant	0123	5.2882	$288.53		$57.71
38241	S		Bone marrow/stem transplant	0123	5.2882	$288.53		$57.71
38242	S		Lymphocyte infuse transplant	0111	13.1719	$718.67	$200.18	$143.73
38300	T		Drainage, lymph node lesion	0008	19.4831	$1,063.02		$212.60
38305	T		Drainage, lymph node lesion	0008	19.4831	$1,063.02		$212.60
38308	T		Incision of lymph channels	0113	19.9322	$1,087.52		$217.50
38380	C		Thoracic duct procedure					
38381	C		Thoracic duct procedure					
38382	C		Thoracic duct procedure					
38500	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38505	T		Needle biopsy, lymph nodes	0005	3.2698	$178.40	$71.59	$35.68
38510	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38520	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38525	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38530	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38542	T		Explore deep node(s), neck	0114	37.5963	$2,051.29	$485.91	$410.26
38550	T		Removal, neck/armpit lesion	0113	19.9322	$1,087.52		$217.50
38555	T		Removal, neck/armpit lesion	0113	19.9322	$1,087.52		$217.50
38562	C		Removal, pelvic lymph nodes					
38564	C		Removal, abdomen lymph nodes					
38570	T		Laparoscopy, lymph node biop	0131	40.8064	$2,226.44	$1,001.89	$445.29
38571	T		Laparoscopy, lymphadenectomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
38572	T		Laparoscopy, lymphadenectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
38589	T		Laparoscope proc, lymphatic	0130	32.7724	$1,788.09	$659.53	$357.62
38700	T		Removal of lymph nodes, neck	0113	19.9322	$1,087.52		$217.50
38720	T		Removal of lymph nodes, neck	0113	19.9322	$1,087.52		$217.50
38724	C		Removal of lymph nodes, neck					
38740	T		Remove armpit lymph nodes	0114	37.5963	$2,051.29	$485.91	$410.26
38745	T		Remove armpit lymph nodes	0114	37.5963	$2,051.29	$485.91	$410.26
38746	C		Remove thoracic lymph nodes					
38747	C		Remove abdominal lymph nodes					
38760	T		Remove groin lymph nodes	0113	19.9322	$1,087.52		$217.50
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	S		Blood/lymph system procedure	0110	3.6718	$200.34		$40.07
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	28.9392	$1,578.95	$591.64	$315.79
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	1.7880	$97.56		$19.51
40500	T		Partial excision of lip	0253	15.2249	$830.69	$282.29	$166.14
40510	T		Partial excision of lip	0254	21.8901	$1,194.35	$321.35	$238.87
40520	T		Partial excision of lip	0253	15.2249	$830.69	$282.29	$166.14
40525	T		Reconstruct lip with flap	0254	21.8901	$1,194.35	$321.35	$238.87
40527	T		Reconstruct lip with flap	0254	21.8901	$1,194.35	$321.35	$238.87
40530	T		Partial removal of lip	0254	21.8901	$1,194.35	$321.35	$238.87
40650	T		Repair lip	0252	6.4469	$351.75	$113.41	$70.35
40652	T		Repair lip	0252	6.4469	$351.75	$113.41	$70.35
40654	T		Repair lip	0252	6.4469	$351.75	$113.41	$70.35
40700	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40701	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40702	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40720	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40761	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40799	T		Lip surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
40800	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
40801	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
40804	X		Removal, foreign body, mouth	0340	0.6314	$34.45		$6.89
40805	T		Removal, foreign body, mouth	0252	6.4469	$351.75	$113.41	$70.35
40806	T		Incision of lip fold	0251	1.7880	$97.56		$19.51
40808	T		Biopsy of mouth lesion	0251	1.7880	$97.56		$19.51
40810	T		Excision of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40812	T		Excise/repair mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40814	T		Excise/repair mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40816	T		Excision of mouth lesion	0254	21.8901	$1,194.35	$321.35	$238.87
40818	T		Excise oral mucosa for graft	0251	1.7880	$97.56		$19.51
40819	T		Excise lip or cheek fold	0252	6.4469	$351.75	$113.41	$70.35
40820	T		Treatment of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40830	T		Repair mouth laceration	0251	1.7880	$97.56		$19.51
40831	T		Repair mouth laceration	0252	6.4469	$351.75	$113.41	$70.35

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40840	T		Reconstruction of mouth	0254	21.8901	$1,194.35	$321.35	$238.87
40842	T		Reconstruction of mouth	0254	21.8901	$1,194.35	$321.35	$238.87
40843	T		Reconstruction of mouth	0254	21.8901	$1,194.35	$321.35	$238.87
40844	T		Reconstruction of mouth	0256	35.1548	$1,918.08		$383.62
40845	T		Reconstruction of mouth	0256	35.1548	$1,918.08		$383.62
40899	T		Mouth surgery procedure	0252	6.4469	$351.75	$113.41	$70.35
41000	T		Drainage of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41005	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
41006	T		Drainage of mouth lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41007	T		Drainage of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41008	T		Drainage of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41009	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
41010	T		Incision of tongue fold	0253	15.2249	$830.69	$282.29	$166.14
41015	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
41016	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
41017	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
41018	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
41100	T		Biopsy of tongue	0252	6.4469	$351.75	$113.41	$70.35
41105	T		Biopsy of tongue	0253	15.2249	$830.69	$282.29	$166.14
41108	T		Biopsy of floor of mouth	0252	6.4469	$351.75	$113.41	$70.35
41110	T		Excision of tongue lesion	0253	15.2249	$830.69	$282.29	$166.14
41112	T		Excision of tongue lesion	0253	15.2249	$830.69	$282.29	$166.14
41113	T		Excision of tongue lesion	0253	15.2249	$830.69	$282.29	$166.14
41114	T		Excision of tongue lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41115	T		Excision of tongue fold	0252	6.4469	$351.75	$113.41	$70.35
41116	T		Excision of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41120	T		Partial removal of tongue	0254	21.8901	$1,194.35	$321.35	$238.87
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	1.7880	$97.56		$19.51
41251	T		Repair tongue laceration	0251	1.7880	$97.56		$19.51
41252	T		Repair tongue laceration	0252	6.4469	$351.75	$113.41	$70.35
41500	T		Fixation of tongue	0254	21.8901	$1,194.35	$321.35	$238.87
41510	T		Tongue to lip surgery	0253	15.2249	$830.69	$282.29	$166.14
41520	T		Reconstruction, tongue fold	0252	6.4469	$351.75	$113.41	$70.35
41599	T		Tongue and mouth surgery	0251	1.7880	$97.56		$19.51
41800	T		Drainage of gum lesion	0251	1.7880	$97.56		$19.51
41805	T		Removal foreign body, gum	0254	21.8901	$1,194.35	$321.35	$238.87
41806	T		Removal foreign body,jawbone	0253	15.2249	$830.69	$282.29	$166.14
41820	T		Excision, gum, each quadrant	0252	6.4469	$351.75	$113.41	$70.35
41821	T		Excision of gum flap	0252	6.4469	$351.75	$113.41	$70.35
41822	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41823	T		Excision of gum lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41825	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41826	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41827	T		Excision of gum lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41828	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41830	T		Removal of gum tissue	0253	15.2249	$830.69	$282.29	$166.14
41850	T		Treatment of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41870	T		Gum graft	0254	21.8901	$1,194.35	$321.35	$238.87
41872	T		Repair gum	0253	15.2249	$830.69	$282.29	$166.14
41874	T		Repair tooth socket	0254	21.8901	$1,194.35	$321.35	$238.87
41899	T		Dental surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
42000	T		Drainage mouth roof lesion	0251	1.7880	$97.56		$19.51
42100	T		Biopsy roof of mouth	0252	6.4469	$351.75	$113.41	$70.35
42104	T		Excision lesion, mouth roof	0253	15.2249	$830.69	$282.29	$166.14
42106	T		Excision lesion, mouth roof	0253	15.2249	$830.69	$282.29	$166.14
42107	T		Excision lesion, mouth roof	0254	21.8901	$1,194.35	$321.35	$238.87
42120	T		Remove palate/lesion	0256	35.1548	$1,918.08		$383.62
42140	T		Excision of uvula	0252	6.4469	$351.75	$113.41	$70.35
42145	T		Repair palate, pharynx/uvula	0254	21.8901	$1,194.35	$321.35	$238.87
42160	T		Treatment mouth roof lesion	0253	15.2249	$830.69	$282.29	$166.14
42180	T		Repair palate	0251	1.7880	$97.56		$19.51
42182	T		Repair palate	0256	35.1548	$1,918.08		$383.62
42200	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42205	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42210	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42215	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42220	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42225	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42226	T		Lengthening of palate	0256	35.1548	$1,918.08		$383.62
42227	T		Lengthening of palate	0256	35.1548	$1,918.08		$383.62
42235	T		Repair palate	0253	15.2249	$830.69	$282.29	$166.14
42260	T		Repair nose to lip fistula	0254	21.8901	$1,194.35	$321.35	$238.87
42280	T		Preparation, palate mold	0251	1.7880	$97.56		$19.51
42281	T		Insertion, palate prosthesis	0253	15.2249	$830.69	$282.29	$166.14
42299	T		Palate/uvula surgery	0251	1.7880	$97.56		$19.51
42300	T		Drainage of salivary gland	0253	15.2249	$830.69	$282.29	$166.14
42305	T		Drainage of salivary gland	0253	15.2249	$830.69	$282.29	$166.14
42310	T		Drainage of salivary gland	0251	1.7880	$97.56		$19.51
42320	T		Drainage of salivary gland	0251	1.7880	$97.56		$19.51
42325	T		Create salivary cyst drain	0251	1.7880	$97.56		$19.51
42326	T		Create salivary cyst drain	0252	6.4469	$351.75	$113.41	$70.35
42330	T		Removal of salivary stone	0253	15.2249	$830.69	$282.29	$166.14
42335	T		Removal of salivary stone	0253	15.2249	$830.69	$282.29	$166.14
42340	T		Removal of salivary stone	0253	15.2249	$830.69	$282.29	$166.14
42400	T		Biopsy of salivary gland	0005	3.2698	$178.40	$71.59	$35.68
42405	T		Biopsy of salivary gland	0253	15.2249	$830.69	$282.29	$166.14
42408	T		Excision of salivary cyst	0253	15.2249	$830.69	$282.29	$166.14
42409	T		Drainage of salivary cyst	0253	15.2249	$830.69	$282.29	$166.14
42410	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42415	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42420	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42425	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	35.1548	$1,918.08		$383.62
42450	T		Excise sublingual gland	0254	21.8901	$1,194.35	$321.35	$238.87
42500	T		Repair salivary duct	0254	21.8901	$1,194.35	$321.35	$238.87
42505	T		Repair salivary duct	0256	35.1548	$1,918.08		$383.62
42507	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42508	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42509	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42510	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42550	N		Injection for salivary x-ray					
42600	T		Closure of salivary fistula	0253	15.2249	$830.69	$282.29	$166.14
42650	T		Dilation of salivary duct	0252	6.4469	$351.75	$113.41	$70.35
42660	T		Dilation of salivary duct	0251	1.7880	$97.56		$19.51
42665	T		Ligation of salivary duct	0254	21.8901	$1,194.35	$321.35	$238.87
42699	T		Salivary surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
42700	T		Drainage of tonsil abscess	0251	1.7880	$97.56		$19.51
42720	T		Drainage of throat abscess	0253	15.2249	$830.69	$282.29	$166.14
42725	T		Drainage of throat abscess	0256	35.1548	$1,918.08		$383.62
42800	T		Biopsy of throat	0253	15.2249	$830.69	$282.29	$166.14
42802	T		Biopsy of throat	0253	15.2249	$830.69	$282.29	$166.14
42804	T		Biopsy of upper nose/throat	0253	15.2249	$830.69	$282.29	$166.14
42806	T		Biopsy of upper nose/throat	0254	21.8901	$1,194.35	$321.35	$238.87
42808	T		Excise pharynx lesion	0253	15.2249	$830.69	$282.29	$166.14
42809	X		Remove pharynx foreign body	0340	0.6314	$34.45		$6.89
42810	T		Excision of neck cyst	0254	21.8901	$1,194.35	$321.35	$238.87
42815	T		Excision of neck cyst	0256	35.1548	$1,918.08		$383.62
42820	T		Remove tonsils and adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42821	T		Remove tonsils and adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42825	T		Removal of tonsils	0258	20.6265	$1,125.40	$437.25	$225.08
42826	T		Removal of tonsils	0258	20.6265	$1,125.40	$437.25	$225.08
42830	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42831	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42835	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42836	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42842	T		Extensive surgery of throat	0254	21.8901	$1,194.35	$321.35	$238.87
42844	T		Extensive surgery of throat	0256	35.1548	$1,918.08		$383.62
42845	C		Extensive surgery of throat					
42860	T		Excision of tonsil tags	0258	20.6265	$1,125.40	$437.25	$225.08
42870	T		Excision of lingual tonsil	0258	20.6265	$1,125.40	$437.25	$225.08
42890	T		Partial removal of pharynx	0256	35.1548	$1,918.08		$383.62
42892	T		Revision of pharyngeal walls	0256	35.1548	$1,918.08		$383.62
42894	C		Revision of pharyngeal walls					
42900	T		Repair throat wound	0252	6.4469	$351.75	$113.41	$70.35
42950	T		Reconstruction of throat	0254	21.8901	$1,194.35	$321.35	$238.87
42953	C		Repair throat, esophagus					
42955	T		Surgical opening of throat	0254	21.8901	$1,194.35	$321.35	$238.87
42960	T		Control throat bleeding	0250	1.4697	$80.19	$28.07	$16.04
42961	C		Control throat bleeding					
42962	T		Control throat bleeding	0256	35.1548	$1,918.08		$383.62
42970	T		Control nose/throat bleeding	0250	1.4697	$80.19	$28.07	$16.04
42971	C		Control nose/throat bleeding					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42972	T		Control nose/throat bleeding	0253	15.2249	$830.69	$282.29	$166.14
42999	T		Throat surgery procedure	0252	6.4469	$351.75	$113.41	$70.35
43020	T		Incision of esophagus	0252	6.4469	$351.75	$113.41	$70.35
43030	T		Throat muscle surgery	0253	15.2249	$830.69	$282.29	$166.14
43045	C		Incision of esophagus					
43100	C		Excision of esophagus lesion					
43101	C		Excision of esophagus lesion					
43107	C		Removal of esophagus					
43108	C		Removal of esophagus					
43112	C		Removal of esophagus					
43113	C		Removal of esophagus					
43116	C		Partial removal of esophagus					
43117	C		Partial removal of esophagus					
43118	C		Partial removal of esophagus					
43121	C		Partial removal of esophagus					
43122	C		Partial removal of esophagus					
43123	C		Partial removal of esophagus					
43124	C		Removal of esophagus					
43130	T		Removal of esophagus pouch	0254	21.8901	$1,194.35	$321.35	$238.87
43135	C		Removal of esophagus pouch					
43200	T		Esophagus endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43201	T		Esoph scope w/submucous inj	0141	7.8206	$426.70	$143.38	$85.34
43202	T		Esophagus endoscopy, biopsy	0141	7.8206	$426.70	$143.38	$85.34
43204	T		Esoph scope w/sclerosis inj	0141	7.8206	$426.70	$143.38	$85.34
43205	T		Esophagus endoscopy/ligation	0141	7.8206	$426.70	$143.38	$85.34
43215	T		Esophagus endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43216	T		Esophagus endoscopy/lesion	0141	7.8206	$426.70	$143.38	$85.34
43217	T		Esophagus endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43219	T		Esophagus endoscopy	0384	20.6602	$1,127.24	$244.83	$225.45
43220	T		Esoph endoscopy, dilation	0141	7.8206	$426.70	$143.38	$85.34
43226	T		Esoph endoscopy, dilation	0141	7.8206	$426.70	$143.38	$85.34
43227	T		Esoph endoscopy, repair	0141	7.8206	$426.70	$143.38	$85.34
43228	T		Esoph endoscopy, ablation	0141	7.8206	$426.70	$143.38	$85.34
43231	T		Esoph endoscopy w/us exam	0141	7.8206	$426.70	$143.38	$85.34
43232	T		Esoph endoscopy w/us fn bx	0141	7.8206	$426.70	$143.38	$85.34
43234	T		Upper GI endoscopy, exam	0141	7.8206	$426.70	$143.38	$85.34
43235	T		Uppr gi endoscopy, diagnosis	0141	7.8206	$426.70	$143.38	$85.34
43236	T		Uppr gi scope w/submuc inj	0141	7.8206	$426.70	$143.38	$85.34
43237	T	NI	Endoscopic us exam, esoph	0141	7.8206	$426.70	$143.38	$85.34
43238	T	NI	Uppr gi endoscopy w/us fn bx	0141	7.8206	$426.70	$143.38	$85.34
43239	T		Upper GI endoscopy, biopsy	0141	7.8206	$426.70	$143.38	$85.34
43240	T		Esoph endoscope w/drain cyst	0141	7.8206	$426.70	$143.38	$85.34
43241	T		Upper GI endoscopy with tube	0141	7.8206	$426.70	$143.38	$85.34
43242	T		Uppr gi endoscopy w/us fn bx	0141	7.8206	$426.70	$143.38	$85.34
43243	T		Upper gi endoscopy & inject	0141	7.8206	$426.70	$143.38	$85.34
43244	T		Upper GI endoscopy/ligation	0141	7.8206	$426.70	$143.38	$85.34
43245	T		Uppr gi scope dilate strictr	0141	7.8206	$426.70	$143.38	$85.34
43246	T		Place gastrostomy tube	0141	7.8206	$426.70	$143.38	$85.34
43247	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43248	T		Uppr gi endoscopy/guide wire	0141	7.8206	$426.70	$143.38	$85.34
43249	T		Esoph endoscopy, dilation	0141	7.8206	$426.70	$143.38	$85.34
43250	T		Upper GI endoscopy/tumor	0141	7.8206	$426.70	$143.38	$85.34
43251	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43255	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43256	T		Uppr gi endoscopy w stent	0384	20.6602	$1,127.24	$244.83	$225.45
43258	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43259	T		Endoscopic ultrasound exam	0141	7.8206	$426.70	$143.38	$85.34
43260	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43261	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43262	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43263	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43264	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43265	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43267	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43268	T		Endo cholangiopancreatograph	0384	20.6602	$1,127.24	$244.83	$225.45
43269	T		Endo cholangiopancreatograph	0384	20.6602	$1,127.24	$244.83	$225.45
43271	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43272	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43280	T		Laparoscopy, fundoplasty	0132	57.2045	$3,121.13	$1,239.22	$624.23
43289	T		Laparoscope proc, esoph	0130	32.7724	$1,788.09	$659.53	$357.62
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 congenital					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	6.4525	$352.05	$107.24	$70.41
43453	T		Dilate esophagus	0140	6.4525	$352.05	$107.24	$70.41
43456	T		Dilate esophagus	0140	6.4525	$352.05	$107.24	$70.41
43458	T		Dilate esophagus	0140	6.4525	$352.05	$107.24	$70.41
43460	C		Pressure treatment esophagus					
43496	C		Free jejunum flap, microvasc					
43499	T		Esophagus surgery procedure	0141	7.8206	$426.70	$143.38	$85.34
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	7.8206	$426.70	$143.38	$85.34
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	57.2045	$3,121.13	$1,239.22	$624.23
43652	T		Laparoscopy, vagus nerve	0132	57.2045	$3,121.13	$1,239.22	$624.23
43653	T		Laparoscopy, gastrostomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
43659	T		Laparoscope proc, stom	0130	32.7724	$1,788.09	$659.53	$357.62
43750	T		Place gastrostomy tube	0141	7.8206	$426.70	$143.38	$85.34
43752	T		Nasal/orogastric w/stent	0121	2.1189	$115.61	$43.80	$23.12
43760	T		Change gastrostomy tube	0121	2.1189	$115.61	$43.80	$23.12
43761	T		Reposition gastrostomy tube	0121	2.1189	$115.61	$43.80	$23.12
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	7.8206	$426.70	$143.38	$85.34
43831	T		Place gastrostomy tube	0141	7.8206	$426.70	$143.38	$85.34
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	0141	7.8206	$426.70	$143.38	$85.34

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43880	C		Repair stomach-bowel fistula					
43999	T		Stomach surgery procedure	0141	7.8206	$426.70	$143.38	$85.34
44005	C		Freeing of bowel adhesion					
44010	C		Incision of small bowel					
44015	C		Insert needle cath bowel					
44020	C		Explore small intestine					
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	7.8206	$426.70	$143.38	$85.34
44110	C		Excise intestine 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/o taper, cong					
44127	C		Enterectomy w/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	40.8064	$2,226.44	$1,001.89	$445.29
44201	T		Laparoscopy, jejunostomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
44202	C		Lap resect s/intestine singl					
44203	C		Lap resect s/intestine, addl					
44204	C		Laparo partial colectomy					
44205	C		Lap colectomy part w/ileum					
44206	T		Lap part colectomy w/stoma	0132	57.2045	$3,121.13	$1,239.22	$624.23
44207	T		L colectomy/coloproctostomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
44208	T		L colectomy/coloproctostomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
44210	C		Laparo total proctocolectomy					
44211	C		Laparo total proctocolectomy					
44212	C		Laparo total proctocolectomy					
44238	T		Laparoscope proc, intestine	0130	32.7724	$1,788.09	$659.53	$357.62
44239	T		Laparoscope proc, rectum	0130	32.7724	$1,788.09	$659.53	$357.62
44300	C		Open bowel to skin					
44310	C		Ileostomy/jejunostomy					
44312	T		Revision of ileostomy	0027	15.8990	$867.47	$329.72	$173.49
44314	C		Revision of ileostomy					
44316	C		Devise bowel pouch					
44320	C		Colostomy					
44322	C		Colostomy with biopsies					
44340	T		Revision of colostomy	0027	15.8990	$867.47	$329.72	$173.49
44345	C		Revision of colostomy					
44346	C		Revision of colostomy					
44360	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44361	T		Small bowel endoscopy/biopsy	0142	8.7959	$479.91	$152.78	$95.98
44363	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44364	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44365	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44366	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44369	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44370	T		Small bowel endoscopy/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44372	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44373	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44376	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44377	T		Small bowel endoscopy/biopsy	0142	8.7959	$479.91	$152.78	$95.98

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44378	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44379	T		S bowel endoscope w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44380	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44382	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44383	T		Ileoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44385	T		Endoscopy of bowel pouch	0143	8.2957	$452.62	$186.06	$90.52
44386	T		Endoscopy, bowel pouch/biop	0143	8.2957	$452.62	$186.06	$90.52
44388	T		Colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
44389	T		Colonoscopy with biopsy	0143	8.2957	$452.62	$186.06	$90.52
44390	T		Colonoscopy for foreign body	0143	8.2957	$452.62	$186.06	$90.52
44391	T		Colonoscopy for bleeding	0143	8.2957	$452.62	$186.06	$90.52
44392	T		Colonoscopy & polypectomy	0143	8.2957	$452.62	$186.06	$90.52
44393	T		Colonoscopy, lesion removal	0143	8.2957	$452.62	$186.06	$90.52
44394	T		Colonoscopy w/snare	0143	8.2957	$452.62	$186.06	$90.52
44397	T		Colonoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44500	T		Intro, gastrointestinal tube	0121	2.1189	$115.61	$43.80	$23.12
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					
44701	N		Intraop colon lavage add-on					
44799	T		Unlisted procedure intestine	0142	8.7959	$479.91	$152.78	$95.98
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	32.7724	$1,788.09	$659.53	$357.62
44979	T		Laparoscope proc, app	0130	32.7724	$1,788.09	$659.53	$357.62
45000	T		Drainage of pelvic abscess	0148	3.8320	$209.08	$63.38	$41.82
45005	T		Drainage of rectal abscess	0148	3.8320	$209.08	$63.38	$41.82
45020	T		Drainage of rectal abscess	0148	3.8320	$209.08	$63.38	$41.82
45100	T		Biopsy of rectum	0149	17.1425	$935.31	$293.06	$187.06
45108	T		Removal of anorectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
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 reservior					
45150	T		Excision of rectal stricture	0149	17.1425	$935.31	$293.06	$187.06
45160	T		Excision of rectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
45170	T		Excision of rectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
45190	T		Destruction, rectal tumor	0150	22.1919	$1,210.81	$437.12	$242.16
45300	T		Proctosigmoidoscopy dx	0146	3.9826	$217.29	$64.40	$43.46
45303	T		Proctosigmoidoscopy dilate	0146	3.9826	$217.29	$64.40	$43.46
45305	T		Proctosigmoidoscopy w/bx	0146	3.9826	$217.29	$64.40	$43.46
45307	T		Proctosigmoidoscopy fb	0146	3.9826	$217.29	$64.40	$43.46
45308	T		Proctosigmoidoscopy removal	0147	7.6808	$419.07		$83.81
45309	T		Proctosigmoidoscopy removal	0147	7.6808	$419.07		$83.81
45315	T		Proctosigmoidoscopy removal	0147	7.6808	$419.07		$83.81
45317	T		Proctosigmoidoscopy bleed	0147	7.6808	$419.07		$83.81
45320	T		Proctosigmoidoscopy ablate	0147	7.6808	$419.07		$83.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45321	T		Proctosigmoidoscopy volvul	0147	7.6808	$419.07		$83.81
45327	T		Proctosigmoidoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
45330	T		Diagnostic sigmoidoscopy	0146	3.9826	$217.29	$64.40	$43.46
45331	T		Sigmoidoscopy and biopsy	0146	3.9826	$217.29	$64.40	$43.46
45332	T		Sigmoidoscopy w/fb removal	0146	3.9826	$217.29	$64.40	$43.46
45333	T		Sigmoidoscopy & polypectomy	0147	7.6808	$419.07		$83.81
45334	T		Sigmoidoscopy for bleeding	0147	7.6808	$419.07		$83.81
45335	T		Sigmoidoscopy w/submuc inj	0147	7.6808	$419.07		$83.81
45337	T		Sigmoidoscopy & decompress	0147	7.6808	$419.07		$83.81
45338	T		Sigmoidoscopy w/tumr remove	0147	7.6808	$419.07		$83.81
45339	T		Sigmoidoscopy w/ablate tumr	0147	7.6808	$419.07		$83.81
45340	T		Sig w/balloon dilation	0147	7.6808	$419.07		$83.81
45341	T		Sigmoidoscopy w/ultrasound	0147	7.6808	$419.07		$83.81
45342	T		Sigmoidoscopy w/us guide bx	0147	7.6808	$419.07		$83.81
45345	T		Sigmoidoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
45355	T		Surgical colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45378	T		Diagnostic colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45379	T		Colonoscopy w/fb removal	0143	8.2957	$452.62	$186.06	$90.52
45380	T		Colonoscopy and biopsy	0143	8.2957	$452.62	$186.06	$90.52
45381	T		Colonoscopy, submucous inj	0143	8.2957	$452.62	$186.06	$90.52
45382	T		Colonoscopy/control bleeding	0143	8.2957	$452.62	$186.06	$90.52
45383	T		Lesion removal colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45384	T		Lesion remove colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45385	T		Lesion removal colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45386	T		Colonoscopy dilate stricture	0143	8.2957	$452.62	$186.06	$90.52
45387	T		Colonoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
45500	T		Repair of rectum	0149	17.1425	$935.31	$293.06	$187.06
45505	T		Repair of rectum	0150	22.1919	$1,210.81	$437.12	$242.16
45520	T		Treatment of rectal prolapse	0098	1.0729	$58.54	$14.06	$11.71
45540	C		Correct rectal prolapse					
45541	C		Correct rectal prolapse					
45550	C		Repair rectum/remove sigmoid					
45560	T		Repair of rectocele	0150	22.1919	$1,210.81	$437.12	$242.16
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	3.8320	$209.08	$63.38	$41.82
45905	T		Dilation of anal sphincter	0149	17.1425	$935.31	$293.06	$187.06
45910	T		Dilation of rectal narrowing	0149	17.1425	$935.31	$293.06	$187.06
45915	T		Remove rectal obstruction	0148	3.8320	$209.08	$63.38	$41.82
45999	T		Rectum surgery procedure	0148	3.8320	$209.08	$63.38	$41.82
46020	T		Placement of seton	0148	3.8320	$209.08	$63.38	$41.82
46030	T		Removal of rectal marker	0148	3.8320	$209.08	$63.38	$41.82
46040	T		Incision of rectal abscess	0149	17.1425	$935.31	$293.06	$187.06
46045	T		Incision of rectal abscess	0150	22.1919	$1,210.81	$437.12	$242.16
46050	T		Incision of anal abscess	0148	3.8320	$209.08	$63.38	$41.82
46060	T		Incision of rectal abscess	0150	22.1919	$1,210.81	$437.12	$242.16
46070	T		Incision of anal septum	0155	10.0809	$550.02	$188.89	$110.00
46080	T		Incision of anal sphincter	0149	17.1425	$935.31	$293.06	$187.06
46083	T		Incise external hemorrhoid	0148	3.8320	$209.08	$63.38	$41.82
46200	T		Removal of anal fissure	0150	22.1919	$1,210.81	$437.12	$242.16
46210	T		Removal of anal crypt	0149	17.1425	$935.31	$293.06	$187.06
46211	T		Removal of anal crypts	0150	22.1919	$1,210.81	$437.12	$242.16
46220	T		Removal of anal tag	0149	17.1425	$935.31	$293.06	$187.06
46221	T		Ligation of hemorrhoid(s)	0148	3.8320	$209.08	$63.38	$41.82
46230	T		Removal of anal tags	0149	17.1425	$935.31	$293.06	$187.06
46250	T		Hemorrhoidectomy	0150	22.1919	$1,210.81	$437.12	$242.16
46255	T		Hemorrhoidectomy	0150	22.1919	$1,210.81	$437.12	$242.16
46257	T		Remove hemorrhoids & fissure	0150	22.1919	$1,210.81	$437.12	$242.16
46258	T		Remove hemorrhoids & fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46260	T		Hemorrhoidectomy	0150	22.1919	$1,210.81	$437.12	$242.16
46261	T		Remove hemorrhoids & fissure	0150	22.1919	$1,210.81	$437.12	$242.16
46262	T		Remove hemorrhoids & fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46270	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46275	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46280	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46285	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46288	T		Repair anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46320	T		Removal of hemorrhoid clot	0148	3.8320	$209.08	$63.38	$41.82
46500	T		Injection into hemorrhoid(s)	0155	10.0809	$550.02	$188.89	$110.00
46600	X		Diagnostic anoscopy	0340	0.6314	$34.45		$6.89
46604	T		Anoscopy and dilation	0147	7.6808	$419.07		$83.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46606	T		Anoscopy and biopsy	0147	7.6808	$419.07		$83.81
46608	T		Anoscopy, remove for body	0147	7.6808	$419.07		$83.81
46610	T		Anoscopy, remove lesion	0147	7.6808	$419.07		$83.81
46611	T		Anoscopy	0147	7.6808	$419.07		$83.81
46612	T		Anoscopy, remove lesions	0147	7.6808	$419.07		$83.81
46614	T		Anoscopy, control bleeding	0147	7.6808	$419.07		$83.81
46615	T		Anoscopy	0147	7.6808	$419.07		$83.81
46700	T		Repair of anal stricture	0150	22.1919	$1,210.81	$437.12	$242.16
46705	C		Repair of anal stricture					
46706	T		Repr of anal fistula w/glue	0148	3.8320	$209.08	$63.38	$41.82
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	22.1919	$1,210.81	$437.12	$242.16
46751	C		Repair of anal sphincter					
46753	T		Reconstruction of anus	0150	22.1919	$1,210.81	$437.12	$242.16
46754	T		Removal of suture from anus	0149	17.1425	$935.31	$293.06	$187.06
46760	T		Repair of anal sphincter	0150	22.1919	$1,210.81	$437.12	$242.16
46761	T		Repair of anal sphincter	0150	22.1919	$1,210.81	$437.12	$242.16
46762	T		Implant artificial sphincter	0150	22.1919	$1,210.81	$437.12	$242.16
46900	T		Destruction, anal lesion(s)	0016	2.5724	$140.35	$57.31	$28.07
46910	T		Destruction, anal lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
46916	T		Cryosurgery, anal lesion(s)	0013	1.1272	$61.50	$14.20	$12.30
46917	T		Laser surgery, anal lesions	0695	19.1849	$1,046.75	$266.59	$209.35
46922	T		Excision of anal lesion(s)	0695	19.1849	$1,046.75	$266.59	$209.35
46924	T		Destruction, anal lesion(s)	0695	19.1849	$1,046.75	$266.59	$209.35
46934	T		Destruction of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46935	T		Destruction of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46936	T		Destruction of hemorrhoids	0149	17.1425	$935.31	$293.06	$187.06
46937	T		Cryotherapy of rectal lesion	0149	17.1425	$935.31	$293.06	$187.06
46938	T		Cryotherapy of rectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
46940	T		Treatment of anal fissure	0149	17.1425	$935.31	$293.06	$187.06
46942	T		Treatment of anal fissure	0148	3.8320	$209.08	$63.38	$41.82
46945	T		Ligation of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46946	T		Ligation of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46999	T		Anus surgery procedure	0148	3.8320	$209.08	$63.38	$41.82
47000	T		Needle biopsy of liver	0685	4.8100	$262.44	$115.47	$52.49
47001	N		Needle biopsy, liver add-on					
47010	C		Open drainage, liver lesion					
47011	T		Percut drain, liver lesion	0037	9.8921	$539.72	$237.45	$107.94
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	DG	Partial removal, donor liver					
47135	C	DG	Transplantation of liver					
47136	C	DG	Transplantation of liver					
47140	C	NI	Partial removal, donor liver					
47141	C	NI	Partial removal, donor liver					
47142	C	NI	Partial removal, donor liver					
47300	C	DG	Surgery for liver lesion					
47350	C	DG	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	0131	40.8064	$2,226.44	$1,001.89	$445.29
47371	T		Laparo ablate liver cryosurg	0131	40.8064	$2,226.44	$1,001.89	$445.29
47379	T		Laparoscope procedure, liver	0130	32.7724	$1,788.09	$659.53	$357.62
47380	C		Open ablate liver tumor rf					
47381	C		Open ablate liver tumor cryo					
47382	T		Percut ablate liver rf	1557		$1,850.00		$370.00
47399	T		Liver surgery procedure	0037	9.8921	$539.72	$237.45	$107.94
47400	C		Incision of liver duct					
47420	C		Incision of bile duct					
47425	C		Incision of bile duct					
47460	C		Incise bile duct sphincter					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47480	C		Incision of gallbladder					
47490	T		Incision of gallbladder	0152	9.1474	$499.09	$125.28	$99.82
47500	N		Injection for liver x-rays					
47505	N		Injection for liver x-rays					
47510	T		Insert catheter, bile duct	0152	9.1474	$499.09	$125.28	$99.82
47511	T		Insert bile duct drain	0152	9.1474	$499.09	$125.28	$99.82
47525	T		Change bile duct catheter	0122	8.8621	$483.53	$99.16	$96.71
47530	T		Revise/reinsert bile tube	0122	8.8621	$483.53	$99.16	$96.71
47550	C		Bile duct endoscopy add-on					
47552	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47553	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47554	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47555	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47556	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47560	T		Laparoscopy w/cholangio	0130	32.7724	$1,788.09	$659.53	$357.62
47561	T		Laparo w/cholangio/biopsy	0130	32.7724	$1,788.09	$659.53	$357.62
47562	T		Laparoscopic cholecystectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
47563	T		Laparo cholecystectomy/graph	0131	40.8064	$2,226.44	$1,001.89	$445.29
47564	T		Laparo cholecystectomy/explr	0131	40.8064	$2,226.44	$1,001.89	$445.29
47570	C		Laparo cholecystoenterostomy					
47579	T		Laparoscope proc, biliary	0130	32.7724	$1,788.09	$659.53	$357.62
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	9.1474	$499.09	$125.28	$99.82
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	0152	9.1474	$499.09	$125.28	$99.82
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, open					
48102	T		Needle biopsy, pancreas	0685	4.8100	$262.44	$115.47	$52.49
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 pancreatic cyst					
48510	C		Drain pancreatic pseudocyst					
48511	T		Drain pancreatic pseudocyst	0037	9.8921	$539.72	$237.45	$107.94
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
48999	T		Pancreas surgery procedure	0005	3.2698	$178.40	$71.59	$35.68
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	3.0717	$167.60		$33.52
49081	T		Removal of abdominal fluid	0070	3.0717	$167.60		$33.52
49085	T		Remove abdomen foreign body	0153	20.8723	$1,138.81	$410.87	$227.76
49180	T		Biopsy, abdominal mass	0685	4.8100	$262.44	$115.47	$52.49
49200	T		Removal of abdominal lesion	0130	32.7724	$1,788.09	$659.53	$357.62
49201	C		Remove abdom lesion, complex					
49215	C		Excise sacral spine tumor					
49220	C		Multiple surgery, abdomen					
49250	T		Excision of umbilicus	0153	20.8723	$1,138.81	$410.87	$227.76
49255	C		Removal of omentum					
49320	T		Diag laparo separate proc	0130	32.7724	$1,788.09	$659.53	$357.62
49321	T		Laparoscopy, biopsy	0130	32.7724	$1,788.09	$659.53	$357.62
49322	T		Laparoscopy, aspiration	0130	32.7724	$1,788.09	$659.53	$357.62
49323	T		Laparo drain lymphocele	0130	32.7724	$1,788.09	$659.53	$357.62
49329	T		Laparo proc, abdm/per/oment	0130	32.7724	$1,788.09	$659.53	$357.62
49400	N		Air injection into abdomen					
49419	T		Insrt abdom cath for chemotx	0119	134.7194	$7,350.43		$1,470.09
49420	T		Insert abdom drain, temp	0652	27.0364	$1,475.13		$295.03
49421	T		Insert abdom drain, perm	0652	27.0364	$1,475.13		$295.03
49422	T		Remove perm cannula/catheter	0105	19.1898	$1,047.01	$370.40	$209.40
49423	T		Exchange drainage catheter	0152	9.1474	$499.09	$125.28	$99.82
49424	N		Assess cyst, contrast inject					
49425	C		Insert abdomen-venous drain					
49426	T		Revise abdomen-venous shunt	0153	20.8723	$1,138.81	$410.87	$227.76
49427	N		Injection, abdominal shunt					
49428	C		Ligation of shunt					
49429	T		Removal of shunt	0105	19.1898	$1,047.01	$370.40	$209.40
49491	T		Rpr hern preemie reduc	0154	26.9636	$1,471.16	$464.85	$294.23
49492	T		Rpr ing hern premie, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49495	T		Rpr ing hernia baby, reduc	0154	26.9636	$1,471.16	$464.85	$294.23
49496	T		Rpr ing hernia baby, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49500	T		Rpr ing hernia, init, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49501	T		Rpr ing hernia, init blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49505	T		Prp i/hern init reduc>5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49507	T		Prp i/hern init block>5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49520	T		Rerepair ing hernia, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49521	T		Rerepair ing hernia, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49525	T		Repair ing hernia, sliding	0154	26.9636	$1,471.16	$464.85	$294.23
49540	T		Repair lumbar hernia	0154	26.9636	$1,471.16	$464.85	$294.23
49550	T		Rpr rem hernia, init, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49553	T		Rpr fem hernia, init blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49555	T		Rerepair fem hernia, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49557	T		Rerepair fem hernia, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49560	T		Rpr ventral hern init, reduc	0154	26.9636	$1,471.16	$464.85	$294.23
49561	T		Rpr ventral hern init, block	0154	26.9636	$1,471.16	$464.85	$294.23
49565	T		Rerepair ventrl hern, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49566	T		Rerepair ventrl hern, block	0154	26.9636	$1,471.16	$464.85	$294.23
49568	T		Hernia repair w/mesh	0154	26.9636	$1,471.16	$464.85	$294.23
49570	T		Rpr epigastric hern, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49572	T		Rpr epigastric hern, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49580	T		Rpr umbil hern, reduc < 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49582	T		Rpr umbil hern, block < 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49585	T		Rpr umbil hern, reduc > 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49587	T		Rpr umbil hern, block > 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49590	T		Repair spigilian hernia	0154	26.9636	$1,471.16	$464.85	$294.23
49600	T		Repair umbilical lesion	0154	26.9636	$1,471.16	$464.85	$294.23
49605	C		Repair umbilical lesion					
49606	C		Repair umbilical lesion					
49610	C		Repair umbilical lesion					
49611	C		Repair umbilical lesion					
49650	T		Laparo hernia repair initial	0131	40.8064	$2,226.44	$1,001.89	$445.29
49651	T		Laparo hernia repair recur	0131	40.8064	$2,226.44	$1,001.89	$445.29
49659	T		Laparo proc, hernia repair	0131	40.8064	$2,226.44	$1,001.89	$445.29
49900	C		Repair of abdominal wall					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49904	C		Omental flap, extra-abdom					
49905	C		Omental flap					
49906	C		Free omental flap, microvasc					
49999	T		Abdomen surgery procedure	0153	20.8723	$1,138.81	$410.87	$227.76
50010	C		Exploration of kidney					
50020	C		Renal abscess, open drain					
50021	T		Renal abscess, percut drain	0037	9.8921	$539.72	$237.45	$107.94
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	33.8805	$1,848.55		$369.71
50081	T		Removal of kidney stone	0163	33.8805	$1,848.55		$369.71
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	4.8100	$262.44	$115.47	$52.49
50205	C		Biopsy of kidney					
50220	C		Remove kidney, open					
50225	C		Removal kidney open, complex					
50230	C		Removal kidney open, radical					
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	4.8100	$262.44	$115.47	$52.49
50392	T		Insert kidney drain	0161	16.8407	$918.85	$249.36	$183.77
50393	T		Insert ureteral tube	0161	16.8407	$918.85	$249.36	$183.77
50394	N		Injection for kidney x-ray					
50395	T		Create passage to kidney	0161	16.8407	$918.85	$249.36	$183.77
50396	T		Measure kidney pressure	0164	1.2021	$65.59	$17.59	$13.12
50398	T		Change kidney tube	0122	8.8621	$483.53	$99.16	$96.71
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	32.7724	$1,788.09	$659.53	$357.62
50542	T		Laparo ablate renal mass	0131	40.8064	$2,226.44	$1,001.89	$445.29
50543	T		Laparo partial nephrectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
50544	T		Laparoscopy, pyeloplasty	0130	32.7724	$1,788.09	$659.53	$357.62
50545	C		Laparo radical nephrectomy					
50546	C		Laparoscopic nephrectomy					
50547	C		Laparo removal donor kidney					
50548	C		Laparo remove w/ ureter					
50549	T		Laparoscope proc, renal	0130	32.7724	$1,788.09	$659.53	$357.62
50551	T		Kidney endoscopy	0160	6.8801	$375.39	$105.06	$75.08
50553	T		Kidney endoscopy	0161	16.8407	$918.85	$249.36	$183.77
50555	T		Kidney endoscopy & biopsy	0160	6.8801	$375.39	$105.06	$75.08
50557	T		Kidney endoscopy & treatment	0162	21.9098	$1,195.42		$239.08
50559	T		Renal endoscopy/radiotracer	0160	6.8801	$375.39	$105.06	$75.08
50561	T		Kidney endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50562	T		Renal scope w/tumor resect	0160	6.8801	$375.39	$105.06	$75.08
50570	C		Kidney endoscopy					
50572	C		Kidney endoscopy					
50574	C		Kidney endoscopy & biopsy					
50575	C		Kidney endoscopy					
50576	C		Kidney endoscopy & treatment					
50578	C		Renal endoscopy/radiotracer					
50580	C		Kidney endoscopy & treatment					
50590	T		Fragmenting of kidney stone	0169	45.1150	$2,461.52	$1,115.69	$492.30

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	1.2021	$65.59	$17.59	$13.12
50688	T		Change of ureter tube	0122	8.8621	$483.53	$99.16	$96.71
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 intestine					
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	40.8064	$2,226.44	$1,001.89	$445.29
50947	T		Laparo new ureter/bladder	0131	40.8064	$2,226.44	$1,001.89	$445.29
50948	T		Laparo new ureter/bladder	0131	40.8064	$2,226.44	$1,001.89	$445.29
50949	T		Laparoscope proc, ureter	0130	32.7724	$1,788.09	$659.53	$357.62
50951	T		Endoscopy of ureter	0160	6.8801	$375.39	$105.06	$75.08
50953	T		Endoscopy of ureter	0160	6.8801	$375.39	$105.06	$75.08
50955	T		Ureter endoscopy & biopsy	0161	16.8407	$918.85	$249.36	$183.77
50957	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50959	T		Ureter endoscopy & tracer	0161	16.8407	$918.85	$249.36	$183.77
50961	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50970	T		Ureter endoscopy	0160	6.8801	$375.39	$105.06	$75.08
50972	T		Ureter endoscopy & catheter	0160	6.8801	$375.39	$105.06	$75.08
50974	T		Ureter endoscopy & biopsy	0161	16.8407	$918.85	$249.36	$183.77
50976	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50978	T		Ureter endoscopy & tracer	0161	16.8407	$918.85	$249.36	$183.77
50980	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
51000	T		Drainage of bladder	0164	1.2021	$65.59	$17.59	$13.12
51005	T		Drainage of bladder	0164	1.2021	$65.59	$17.59	$13.12
51010	T		Drainage of bladder	0165	14.6838	$801.16		$160.23
51020	T		Incise & treat bladder	0162	21.9098	$1,195.42		$239.08
51030	T		Incise & treat bladder	0162	21.9098	$1,195.42		$239.08
51040	T		Incise & drain bladder	0162	21.9098	$1,195.42		$239.08
51045	T		Incise bladder/drain ureter	0160	6.8801	$375.39	$105.06	$75.08
51050	T		Removal of bladder stone	0162	21.9098	$1,195.42		$239.08
51060	C		Removal of ureter stone					
51065	T		Remove ureter calculus	0162	21.9098	$1,195.42		$239.08
51080	T		Drainage of bladder abscess	0007	11.8633	$647.27		$129.45
51500	T		Removal of bladder cyst	0154	26.9636	$1,471.16	$464.85	$294.23
51520	T		Removal of bladder lesion	0162	21.9098	$1,195.42		$239.08
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0164	1.2021	$65.59	$17.59	$13.12
51701	N		Insert bladder catheter					
51702	N		Insert temp bladder cath					
51703	N		Insert bladder cath, complex					
51705	T		Change of bladder tube	0121	2.1189	$115.61	$43.80	$23.12
51710	T		Change of bladder tube	0122	8.8621	$483.53	$99.16	$96.71
51715	T		Endoscopic injection/implant	0167	30.0186	$1,637.84	$555.84	$327.57
51720	T		Treatment of bladder lesion	0156	2.4747	$135.02	$40.52	$27.00
51725	T		Simple cystometrogram	0156	2.4747	$135.02	$40.52	$27.00
51726	T		Complex cystometrogram	0156	2.4747	$135.02	$40.52	$27.00
51736	T		Urine flow measurement	0164	1.2021	$65.59	$17.59	$13.12
51741	T		Electro-uroflowmetry, first	0164	1.2021	$65.59	$17.59	$13.12
51772	T		Urethra pressure profile	0164	1.2021	$65.59	$17.59	$13.12
51784	T		Anal/urinary muscle study	0164	1.2021	$65.59	$17.59	$13.12
51785	T		Anal/urinary muscle study	0164	1.2021	$65.59	$17.59	$13.12
51792	T		Urinary reflex study	0164	1.2021	$65.59	$17.59	$13.12
51795	T		Urine voiding pressure study	0164	1.2021	$65.59	$17.59	$13.12
51797	T		Intraabdominal pressure test	0164	1.2021	$65.59	$17.59	$13.12
51798	X		Us urine capacity measure	0340	0.6314	$34.45		$6.89
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	21.9098	$1,195.42		$239.08
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	40.8064	$2,226.44	$1,001.89	$445.29
51992	T		Laparo sling operation	0132	57.2045	$3,121.13	$1,239.22	$624.23
52000	T		Cystoscopy	0160	6.8801	$375.39	$105.06	$75.08
52001	T		Cystoscopy, removal of clots	0160	6.8801	$375.39	$105.06	$75.08
52005	T		Cystoscopy & ureter catheter	0161	16.8407	$918.85	$249.36	$183.77
52007	T		Cystoscopy and biopsy	0161	16.8407	$918.85	$249.36	$183.77
52010	T		Cystoscopy & duct catheter	0160	6.8801	$375.39	$105.06	$75.08
52204	T		Cystoscopy	0161	16.8407	$918.85	$249.36	$183.77
52214	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52224	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52234	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52235	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52240	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52250	T		Cystoscopy and radiotracer	0162	21.9098	$1,195.42		$239.08
52260	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52265	T		Cystoscopy and treatment	0160	6.8801	$375.39	$105.06	$75.08
52270	T		Cystoscopy & revise urethra	0161	16.8407	$918.85	$249.36	$183.77
52275	T		Cystoscopy & revise urethra	0161	16.8407	$918.85	$249.36	$183.77
52276	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52277	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52281	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52282	S		Cystoscopy, implant stent	0385	67.1530	$3,663.93		$732.79
52283	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52285	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52290	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52300	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52301	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52305	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52310	T		Cystoscopy and treatment	0160	6.8801	$375.39	$105.06	$75.08
52315	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52317	T		Remove bladder stone	0162	21.9098	$1,195.42		$239.08
52318	T		Remove bladder stone	0162	21.9098	$1,195.42		$239.08
52320	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52325	T		Cystoscopy, stone removal	0162	21.9098	$1,195.42		$239.08
52327	T		Cystoscopy, inject material	0162	21.9098	$1,195.42		$239.08
52330	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52332	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52334	T		Create passage to kidney	0162	21.9098	$1,195.42		$239.08
52341	T		Cysto w/ureter stricture tx	0162	21.9098	$1,195.42		$239.08
52342	T		Cysto w/up stricture tx	0162	21.9098	$1,195.42		$239.08
52343	T		Cysto w/renal stricture tx	0162	21.9098	$1,195.42		$239.08
52344	T		Cysto/uretero, stone remove	0162	21.9098	$1,195.42		$239.08
52345	T		Cysto/uretero w/up stricture	0162	21.9098	$1,195.42		$239.08
52346	T		Cystouretero w/renal strict	0162	21.9098	$1,195.42		$239.08
52347	T		Cystoscopy, resect ducts	0161	16.8407	$918.85	$249.36	$183.77
52351	T		Cystouretero & or pyeloscope	0161	16.8407	$918.85	$249.36	$183.77
52352	T		Cystouretero w/stone remove	0162	21.9098	$1,195.42		$239.08
52353	T		Cystouretero w/lithotripsy	0163	33.8805	$1,848.55		$369.71
52354	T		Cystouretero w/biopsy	0162	21.9098	$1,195.42		$239.08
52355	T		Cystouretero w/excise tumor	0162	21.9098	$1,195.42		$239.08
52400	T		Cystouretero w/congen repr	0162	21.9098	$1,195.42		$239.08
52450	T		Incision of prostate	0162	21.9098	$1,195.42		$239.08
52500	T		Revision of bladder neck	0162	21.9098	$1,195.42		$239.08
52510	T		Dilation prostatic urethra	0161	16.8407	$918.85	$249.36	$183.77
52601	T		Prostatectomy (TURP)	0163	33.8805	$1,848.55		$369.71
52606	T		Control postop bleeding	0162	21.9098	$1,195.42		$239.08
52612	T		Prostatectomy, first stage	0163	33.8805	$1,848.55		$369.71
52614	T		Prostatectomy, second stage	0163	33.8805	$1,848.55		$369.71
52620	T		Remove residual prostate	0163	33.8805	$1,848.55		$369.71
52630	T		Remove prostate regrowth	0163	33.8805	$1,848.55		$369.71
52640	T		Relieve bladder contracture	0162	21.9098	$1,195.42		$239.08
52647	T		Laser surgery of prostate	0163	33.8805	$1,848.55		$369.71
52648	T		Laser surgery of prostate	0163	33.8805	$1,848.55		$369.71
52700	T		Drainage of prostate abscess	0162	21.9098	$1,195.42		$239.08
53000	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53010	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53020	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53025	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53040	T		Drainage of urethra abscess	0167	30.0186	$1,637.84	$555.84	$327.57
53060	T		Drainage of urethra abscess	0166	16.7918	$916.18	$218.73	$183.24
53080	T		Drainage of urinary leakage	0166	16.7918	$916.18	$218.73	$183.24
53085	C		Drainage of urinary leakage					
53200	T		Biopsy of urethra	0166	16.7918	$916.18	$218.73	$183.24
53210	T		Removal of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53215	T		Removal of urethra	0166	16.7918	$916.18	$218.73	$183.24
53220	T		Treatment of urethra lesion	0168	30.0147	$1,637.63	$405.60	$327.53
53230	T		Removal of urethra lesion	0168	30.0147	$1,637.63	$405.60	$327.53
53235	T		Removal of urethra lesion	0166	16.7918	$916.18	$218.73	$183.24
53240	T		Surgery for urethra pouch	0168	30.0147	$1,637.63	$405.60	$327.53
53250	T		Removal of urethra gland	0166	16.7918	$916.18	$218.73	$183.24
53260	T		Treatment of urethra lesion	0166	16.7918	$916.18	$218.73	$183.24
53265	T		Treatment of urethra lesion	0166	16.7918	$916.18	$218.73	$183.24
53270	T		Removal of urethra gland	0167	30.0186	$1,637.84	$555.84	$327.57
53275	T		Repair of urethra defect	0166	16.7918	$916.18	$218.73	$183.24
53400	T		Revise urethra, stage 1	0168	30.0147	$1,637.63	$405.60	$327.53
53405	T		Revise urethra, stage 2	0168	30.0147	$1,637.63	$405.60	$327.53
53410	T		Reconstruction of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	30.0147	$1,637.63	$405.60	$327.53
53425	T		Reconstruct urethra, stage 2	0168	30.0147	$1,637.63	$405.60	$327.53
53430	T		Reconstruction of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53431	T		Reconstruct urethra/bladder	0168	30.0147	$1,637.63	$405.60	$327.53
53440	S		Correct bladder function	0385	67.1530	$3,663.93		$732.79
53442	T		Remove perineal prosthesis	0167	30.0186	$1,637.84	$555.84	$327.57
53444	S		Insert tandem cuff	0385	67.1530	$3,663.93		$732.79
53445	S		Insert uro/ves nck sphincter	0386	116.2382	$6,342.07		$1,268.41
53446	T		Remove uro sphincter	0168	30.0147	$1,637.63	$405.60	$327.53
53447	S		Remove/replace ur sphincter	0386	116.2382	$6,342.07		$1,268.41
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	30.0147	$1,637.63	$405.60	$327.53
53450	T		Revision of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53460	T		Revision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53500	T	NI	Urethrlys, transvag w/ scope	0168	30.0147	$1,637.63	$405.60	$327.53
53502	T		Repair of urethra injury	0166	16.7918	$916.18	$218.73	$183.24
53505	T		Repair of urethra injury	0167	30.0186	$1,637.84	$555.84	$327.57
53510	T		Repair of urethra injury	0166	16.7918	$916.18	$218.73	$183.24
53515	T		Repair of urethra injury	0168	30.0147	$1,637.63	$405.60	$327.53
53520	T		Repair of urethra defect	0168	30.0147	$1,637.63	$405.60	$327.53

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53600	T		Dilate urethra stricture	0156	2.4747	$135.02	$40.52	$27.00
53601	T		Dilate urethra stricture	0164	1.2021	$65.59	$17.59	$13.12
53605	T		Dilate urethra stricture	0161	16.8407	$918.85	$249.36	$183.77
53620	T		Dilate urethra stricture	0165	14.6838	$801.16		$160.23
53621	T		Dilate urethra stricture	0164	1.2021	$65.59	$17.59	$13.12
53660	T		Dilation of urethra	0164	1.2021	$65.59	$17.59	$13.12
53661	T		Dilation of urethra	0164	1.2021	$65.59	$17.59	$13.12
53665	T		Dilation of urethra	0166	16.7918	$916.18	$218.73	$183.24
53850	T		Prostatic microwave thermotx	0675	49.3452	$2,692.32		$538.46
53852	T		Prostatic rf thermotx	0675	49.3452	$2,692.32		$538.46
53853	T		Prostatic water thermother	1550		$1,150.00		$230.00
53899	T		Urology surgery procedure	0164	1.2021	$65.59	$17.59	$13.12
54000	T		Slitting of prepuce	0166	16.7918	$916.18	$218.73	$183.24
54001	T		Slitting of prepuce	0166	16.7918	$916.18	$218.73	$183.24
54015	T		Drain penis lesion	0007	11.8633	$647.27		$129.45
54050	T		Destruction, penis lesion(s)	0013	1.1272	$61.50	$14.20	$12.30
54055	T		Destruction, penis lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
54056	T		Cryosurgery, penis lesion(s)	0012	0.7694	$41.98	$11.18	$8.40
54057	T		Laser surg, penis lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
54060	T		Excision of penis lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
54065	T		Destruction, penis lesion(s)	0695	19.1849	$1,046.75	$266.59	$209.35
54100	T		Biopsy of penis	0021	14.3594	$783.46	$219.48	$156.69
54105	T		Biopsy of penis	0022	18.7932	$1,025.38	$354.45	$205.08
54110	T		Treatment of penis lesion	0181	29.4217	$1,605.28	$621.82	$321.06
54111	T		Treat penis lesion, graft	0181	29.4217	$1,605.28	$621.82	$321.06
54112	T		Treat penis lesion, graft	0181	29.4217	$1,605.28	$621.82	$321.06
54115	T		Treatment of penis lesion	0008	19.4831	$1,063.02		$212.60
54120	T		Partial removal of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54152	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54160	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54161	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54162	T		Lysis penil circumic lesion	0180	18.6176	$1,015.79	$304.87	$203.16
54163	T		Repair of circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54164	T		Frenulotomy of penis	0180	18.6176	$1,015.79	$304.87	$203.16
54200	T		Treatment of penis lesion	0156	2.4747	$135.02	$40.52	$27.00
54205	T		Treatment of penis lesion	0181	29.4217	$1,605.28	$621.82	$321.06
54220	T		Treatment of penis lesion	0156	2.4747	$135.02	$40.52	$27.00
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	14.6838	$801.16		$160.23
54235	T		Penile injection	0164	1.2021	$65.59	$17.59	$13.12
54240	T		Penis study	0164	1.2021	$65.59	$17.59	$13.12
54250	T		Penis study	0164	1.2021	$65.59	$17.59	$13.12
54300	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54304	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54308	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54312	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54316	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54318	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54322	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54324	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54326	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54328	T		Revise penis/urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54344	T		Secondary urethral surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54348	T		Secondary urethral surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54352	T		Reconstruct urethra/penis	0181	29.4217	$1,605.28	$621.82	$321.06
54360	T		Penis plastic surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54380	T		Repair penis	0181	29.4217	$1,605.28	$621.82	$321.06
54385	T		Repair penis	0181	29.4217	$1,605.28	$621.82	$321.06
54390	C		Repair penis and bladder					
54400	S		Insert semi-rigid prosthesis	0385	67.1530	$3,663.93		$732.79
54401	S		Insert self-contd prosthesis	0386	116.2382	$6,342.07		$1,268.41
54405	S		Insert multi-comp penis pros	0386	116.2382	$6,342.07		$1,268.41
54406	T		Remove muti-comp penis pros	0181	29.4217	$1,605.28	$621.82	$321.06
54408	T		Repair multi-comp penis pros	0181	29.4217	$1,605.28	$621.82	$321.06
54410	S		Remove/replace penis prosth	0386	116.2382	$6,342.07		$1,268.41
54411	C		Remov/replc penis pros, comp					
54415	T		Remove self-contd penis pros	0181	29.4217	$1,605.28	$621.82	$321.06
54416	S		Remv/repl penis contain pros	0385	67.1530	$3,663.93		$732.79

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54417	C		Remv/replc penis pros, compl					
54420	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54430	C		Revision of penis					
54435	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54440	T		Repair of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54450	T		Preputial stretching	0156	2.4747	$135.02	$40.52	$27.00
54500	T		Biopsy of testis	0037	9.8921	$539.72	$237.45	$107.94
54505	T		Biopsy of testis	0183	21.6724	$1,182.47		$236.49
54512	T		Excise lesion testis	0183	21.6724	$1,182.47		$236.49
54520	T		Removal of testis	0183	21.6724	$1,182.47		$236.49
54522	T		Orchiectomy, partial	0183	21.6724	$1,182.47		$236.49
54530	T		Removal of testis	0154	26.9636	$1,471.16	$464.85	$294.23
54535	C		Extensive testis surgery					
54550	T		Exploration for testis	0154	26.9636	$1,471.16	$464.85	$294.23
54560	C		Exploration for testis					
54600	T		Reduce testis torsion	0183	21.6724	$1,182.47		$236.49
54620	T		Suspension of testis	0183	21.6724	$1,182.47		$236.49
54640	T		Suspension of testis	0154	26.9636	$1,471.16	$464.85	$294.23
54650	C		Orchiopexy (Fowler-Stephens)					
54660	T		Revision of testis	0183	21.6724	$1,182.47		$236.49
54670	T		Repair testis injury	0183	21.6724	$1,182.47		$236.49
54680	T		Relocation of testis(es)	0183	21.6724	$1,182.47		$236.49
54690	T		Laparoscopy, orchiectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
54692	T		Laparoscopy, orchiopexy	0132	57.2045	$3,121.13	$1,239.22	$624.23
54699	T		Laparoscope proc, testis	0130	32.7724	$1,788.09	$659.53	$357.62
54700	T		Drainage of scrotum	0183	21.6724	$1,182.47		$236.49
54800	T		Biopsy of epididymis	0004	1.5882	$86.65	$22.36	$17.33
54820	T		Exploration of epididymis	0183	21.6724	$1,182.47		$236.49
54830	T		Remove epididymis lesion	0183	21.6724	$1,182.47		$236.49
54840	T		Remove epididymis lesion	0183	21.6724	$1,182.47		$236.49
54860	T		Removal of epididymis	0183	21.6724	$1,182.47		$236.49
54861	T		Removal of epididymis	0183	21.6724	$1,182.47		$236.49
54900	T		Fusion of spermatic ducts	0183	21.6724	$1,182.47		$236.49
54901	T		Fusion of spermatic ducts	0183	21.6724	$1,182.47		$236.49
55000	T		Drainage of hydrocele	0004	1.5882	$86.65	$22.36	$17.33
55040	T		Removal of hydrocele	0154	26.9636	$1,471.16	$464.85	$294.23
55041	T		Removal of hydroceles	0154	26.9636	$1,471.16	$464.85	$294.23
55060	T		Repair of hydrocele	0183	21.6724	$1,182.47		$236.49
55100	T		Drainage of scrotum abscess	0007	11.8633	$647.27		$129.45
55110	T		Explore scrotum	0183	21.6724	$1,182.47		$236.49
55120	T		Removal of scrotum lesion	0183	21.6724	$1,182.47		$236.49
55150	T		Removal of scrotum	0183	21.6724	$1,182.47		$236.49
55175	T		Revision of scrotum	0183	21.6724	$1,182.47		$236.49
55180	T		Revision of scrotum	0183	21.6724	$1,182.47		$236.49
55200	T		Incision of sperm duct	0183	21.6724	$1,182.47		$236.49
55250	T		Removal of sperm duct(s)	0183	21.6724	$1,182.47		$236.49 W≤
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	21.6724	$1,182.47		$236.49
55450	T		Ligation of sperm duct	0183	21.6724	$1,182.47		$236.49
55500	T		Removal of hydrocele	0183	21.6724	$1,182.47		$236.49
55520	T		Removal of sperm cord lesion	0183	21.6724	$1,182.47		$236.49
55530	T		Revise spermatic cord veins	0183	21.6724	$1,182.47		$236.49
55535	T		Revise spermatic cord veins	0154	26.9636	$1,471.16	$464.85	$294.23
55540	T		Revise hernia & sperm veins	0154	26.9636	$1,471.16	$464.85	$294.23
55550	T		Laparo ligate spermatic vein	0131	40.8064	$2,226.44	$1,001.89	$445.29
55559	T		Laparo proc, spermatic cord	0130	32.7724	$1,788.09	$659.53	$357.62
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	21.6724	$1,182.47		$236.49
55700	T		Biopsy of prostate	0184	3.8995	$212.76	$96.27	$42.55
55705	T		Biopsy of prostate	0184	3.8995	$212.76	$96.27	$42.55
55720	T		Drainage of prostate abscess	0162	21.9098	$1,195.42		$239.08
55725	T		Drainage of prostate abscess	0162	21.9098	$1,195.42		$239.08
55801	C		Removal of prostate					
55810	C		Extensive prostate surgery					
55812	C		Extensive prostate surgery					
55815	C		Extensive prostate surgery					
55821	C		Removal of prostate					
55831	C		Removal of prostate					
55840	C		Extensive prostate surgery					
55842	C		Extensive prostate surgery					
55845	C		Extensive prostate surgery					
55859	T		Percut/needle insert, pros	0163	33.8805	$1,848.55		$369.71
55860	T		Surgical exposure, prostate	0165	14.6838	$801.16		$160.23

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55862	C		Extensive prostate surgery					
55865	C		Extensive prostate surgery					
55866	C		Laparo radical prostatectomy					
55870	T		Vag hyst w/enterocele repair	0197	4.8280	$263.42		$52.68
55873	T		Cryoablate prostate	0674	119.9733	$6,545.86		$1,309.17
55899	T		Genital surgery procedure	0164	1.2021	$65.59	$17.59	$13.12
55970	E		Sex transformation, M to F					
55980	E		Sex transformation, F to M					
56405	T		I & D of vulva/perineum	0192	2.7121	$147.97	$39.11	$29.59
56420	T		Drainage of gland abscess	0192	2.7121	$147.97	$39.11	$29.59
56440	T		Surgery for vulva lesion	0194	18.4286	$1,005.48	$397.84	$201.10
56441	T		Lysis of labial lesion(s)	0193	15.0453	$820.89	$171.13	$164.18
56501	T		Destroy, vulva lesions, sim	0017	16.3697	$893.15	$227.84	$178.63
56515	T		Destroy vulva lesion/s compl	0695	19.1849	$1,046.75	$266.59	$209.35
56605	T		Biopsy of vulva/perineum	0019	3.9493	$215.48	$71.87	$43.10
56606	T		Biopsy of vulva/perineum	0019	3.9493	$215.48	$71.87	$43.10
56620	T		Partial removal of vulva	0195	25.6950	$1,401.94	$483.80	$280.39
56625	T		Complete removal of vulva	0195	25.6950	$1,401.94	$483.80	$280.39
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	18.4286	$1,005.48	$397.84	$201.10
56720	T		Incision of hymen	0193	15.0453	$820.89	$171.13	$164.18
56740	T		Remove vagina gland lesion	0194	18.4286	$1,005.48	$397.84	$201.10
56800	T		Repair of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
56805	T		Repair clitoris	0194	18.4286	$1,005.48	$397.84	$201.10
56810	T		Repair of perineum	0194	18.4286	$1,005.48	$397.84	$201.10
56820	T		Exam of vulva w/scope	0188	1.1365	$62.01		$12.40
56821	T		Exam/biopsy of vulva w/scope	0189	1.4232	$77.65	$18.09	$15.53
57000	T		Exploration of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57010	T		Drainage of pelvic abscess	0194	18.4286	$1,005.48	$397.84	$201.10
57020	T		Drainage of pelvic fluid	0192	2.7121	$147.97	$39.11	$29.59
57022	T		I & d vaginal hematoma, pp	0007	11.8633	$647.27		$129.45
57023	T		I & d vag hematoma, non-ob	0007	11.8633	$647.27		$129.45
57061	T		Destroy vag lesions, simple	0194	18.4286	$1,005.48	$397.84	$201.10
57065	T		Destroy vag lesions, complex	0194	18.4286	$1,005.48	$397.84	$201.10
57100	T		Biopsy of vagina	0192	2.7121	$147.97	$39.11	$29.59
57105	T		Biopsy of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57106	T		Remove vagina wall, partial	0194	18.4286	$1,005.48	$397.84	$201.10
57107	T		Remove vagina tissue, part	0195	25.6950	$1,401.94	$483.80	$280.39
57109	T		Vaginectomy partial w/nodes	0195	25.6950	$1,401.94	$483.80	$280.39
57110	C		Remove vagina wall, complete					
57111	C		Remove vagina tissue, compl					
57112	C		Vaginectomy w/nodes, compl					
57120	T		Closure of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57130	T		Remove vagina lesion	0194	18.4286	$1,005.48	$397.84	$201.10
57135	T		Remove vagina lesion	0194	18.4286	$1,005.48	$397.84	$201.10
57150	T		Treat vagina infection	0191	0.1853	$10.11	$2.93	$2.02
57155	T		Insert uteri tandems/ovoids	0193	15.0453	$820.89	$171.13	$164.18
57160	T		Insert pessary/other device	0188	1.1365	$62.01		$12.40
57170	T		Fitting of diaphragm/cap	0191	0.1853	$10.11	$2.93	$2.02
57180	T		Treat vaginal bleeding	0192	2.7121	$147.97	$39.11	$29.59
57200	T		Repair of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57210	T		Repair vagina/perineum	0194	18.4286	$1,005.48	$397.84	$201.10
57220	T		Revision of urethra	0195	25.6950	$1,401.94	$483.80	$280.39
57230	T		Repair of urethral lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57240	T		Repair bladder & vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57250	T		Repair rectum & vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57260	T		Repair of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57265	T		Extensive repair of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57268	T		Repair of bowel bulge	0195	25.6950	$1,401.94	$483.80	$280.39
57270	C		Repair of bowel pouch					
57280	C		Suspension of vagina					
57282	C		Repair of vaginal prolapse					
57284	T		Repair paravaginal defect	0195	25.6950	$1,401.94	$483.80	$280.39
57287	T		Revise/remove sling repair	0202	38.9821	$2,126.90	$1,042.18	$425.38
57288	T		Repair bladder defect	0202	38.9821	$2,126.90	$1,042.18	$425.38
57289	T		Repair bladder & vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57291	T		Construction of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57292	C		Construct vagina with graft					
57300	T		Repair rectum-vagina fistula	0195	25.6950	$1,401.94	$483.80	$280.39

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57305	C		Repair rectum-vagina fistula					
57307	C		Fistula repair & colostomy					
57308	C		Fistula repair, transperine					
57310	T		Repair urethrovaginal lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57311	C		Repair urethrovaginal lesion					
57320	T		Repair bladder-vagina lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57330	T		Repair bladder-vagina lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57410	T		Pelvic examination	0194	18.4286	$1,005.48	$397.84	$201.10
57415	T		Remove vaginal foreign body	0194	18.4286	$1,005.48	$397.84	$201.10
57420	T		Exam of vagina w/scope	0192	2.7121	$147.97	$39.11	$29.59
57421	T		Exam/biopsy of vag w/scope	0192	2.7121	$147.97	$39.11	$29.59
57425	T	NI	Laparoscopy, surg, colpopexy	0130	32.7724	$1,788.09	$659.53	$357.62
57452	T		Examination of vagina	0189	1.4232	$77.65	$18.09	$15.53
57454	T		Vagina examination & biopsy	0192	2.7121	$147.97	$39.11	$29.59
57455	T		Biopsy of cervix w/scope	0192	2.7121	$147.97	$39.11	$29.59
57456	T		Endocerv curettage w/scope	0192	2.7121	$147.97	$39.11	$29.59
57460	T		Cervix excision	0193	15.0453	$820.89	$171.13	$164.18
57461	T		Conz of cervix w/scope, leep	0194	18.4286	$1,005.48	$397.84	$201.10
57500	T		Biopsy of cervix	0192	2.7121	$147.97	$39.11	$29.59
57505	T		Endocervical curettage	0192	2.7121	$147.97	$39.11	$29.59
57510	T		Cauterization of cervix	0193	15.0453	$820.89	$171.13	$164.18
57511	T		Cryocautery of cervix	0189	1.4232	$77.65	$18.09	$15.53
57513	T		Laser surgery of cervix	0193	15.0453	$820.89	$171.13	$164.18
57520	T		Conization of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
57522	T		Conization of cervix	0195	25.6950	$1,401.94	$483.80	$280.39
57530	T		Removal of cervix	0195	25.6950	$1,401.94	$483.80	$280.39
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	25.6950	$1,401.94	$483.80	$280.39
57555	T		Remove cervix/repair vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57556	T		Remove cervix, repair bowel	0195	25.6950	$1,401.94	$483.80	$280.39
57700	T		Revision of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
57720	T		Revision of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
57800	T		Dilation of cervical canal	0193	15.0453	$820.89	$171.13	$164.18
57820	T		D & c of residual cervix	0196	16.1219	$879.63	$338.23	$175.93
58100	T		Biopsy of uterus lining	0188	1.1365	$62.01		$12.40
58120	T		Dilation and curettage	0196	16.1219	$879.63	$338.23	$175.93
58140	C		Removal of uterus lesion					
58145	T		Myomectomy vag method	0195	25.6950	$1,401.94	$483.80	$280.39
58146	C		Myomectomy abdom complex					
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		Vag hyst including t/o					
58263	C		Vag hyst w/t/o & vag repair					
58267	C		Vag hyst w/urinary repair					
58270	C		Vag hyst w/enterocele repair					
58275	C		Hysterectomy/revise vagina					
58280	C		Hysterectomy/revise vagina					
58285	C		Extensive hysterectomy					
58290	C		Vag hyst complex					
58291	C		Vag hyst incl t/o, complex					
58292	C		Vag hyst t/o & repair, compl					
58293	C		Vag hyst w/uro repair, compl					
58294	C		Vag hyst w/enterocele, compl					
58300	E		Insert intrauterine device					
58301	T		Remove intrauterine device	0189	1.4232	$77.65	$18.09	$15.53
58321	T		Artificial insemination	0197	4.8280	$263.42		$52.68
58322	T		Artificial insemination	0197	4.8280	$263.42		$52.68
58323	T		Sperm washing	0197	4.8280	$263.42		$52.68
58340	N		Catheter for hysterography					
58345	T		Reopen fallopian tube	0194	18.4286	$1,005.48	$397.84	$201.10
58346	T		Insert heyman uteri capsule	0193	15.0453	$820.89	$171.13	$164.18
58350	T		Reopen fallopian tube	0194	18.4286	$1,005.48	$397.84	$201.10
58353	T		Endometr ablate, thermal	0195	25.6950	$1,401.94	$483.80	$280.39
58400	C		Suspension of uterus					
58410	C		Suspension of uterus					
58520	C		Repair of ruptured uterus					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58540	C		Revision of uterus					
58545	T		Laparoscopic myomectomy	0130	32.7724	$1,788.09	$659.53	$357.62
58546	T		Laparo-myomectomy, complex	0131	40.8064	$2,226.44	$1,001.89	$445.29
58550	T		Laparo-asst vag hysterectomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
58552	T		Laparo-vag hyst incl t/o	0131	40.8064	$2,226.44	$1,001.89	$445.29
58553	T		Laparo-vag hyst, complex	0131	40.8064	$2,226.44	$1,001.89	$445.29
58554	T		Laparo-vag hyst w/t/o, compl	0131	40.8064	$2,226.44	$1,001.89	$445.29
58555	T		Hysteroscopy, dx, sep proc	0190	19.6922	$1,074.43	$424.28	$214.89
58558	T		Hysteroscopy, biopsy	0190	19.6922	$1,074.43	$424.28	$214.89
58559	T		Hysteroscopy, lysis	0190	19.6922	$1,074.43	$424.28	$214.89
58560	T		Hysteroscopy, resect septum	0387	28.1480	$1,535.78	$655.55	$307.16
58561	T		Hysteroscopy, remove myoma	0387	28.1480	$1,535.78	$655.55	$307.16
58562	T		Hysteroscopy, remove fb	0190	19.6922	$1,074.43	$424.28	$214.89
58563	T		Hysteroscopy, ablation	0387	28.1480	$1,535.78	$655.55	$307.16
58578	T		Laparo proc, uterus	0130	32.7724	$1,788.09	$659.53	$357.62
58579	T		Hysteroscope procedure	0190	19.6922	$1,074.43	$424.28	$214.89
58600	T		Division of fallopian tube	0195	25.6950	$1,401.94	$483.80	$280.39
58605	C		Division of fallopian tube					
58611	C		Ligate oviduct(s) add-on					
58615	T		Occlude fallopian tube(s)	0194	18.4286	$1,005.48	$397.84	$201.10
58660	T		Laparoscopy, lysis	0131	40.8064	$2,226.44	$1,001.89	$445.29
58661	T		Laparoscopy, remove adnexa	0131	40.8064	$2,226.44	$1,001.89	$445.29
58662	T		Laparoscopy, excise lesions	0131	40.8064	$2,226.44	$1,001.89	$445.29
58670	T		Laparoscopy, tubal cautery	0131	40.8064	$2,226.44	$1,001.89	$445.29
58671	T		Laparoscopy, tubal block	0131	40.8064	$2,226.44	$1,001.89	$445.29
58672	T		Laparoscopy, fimbrioplasty	0131	40.8064	$2,226.44	$1,001.89	$445.29
58673	T		Laparoscopy, salpingostomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
58679	T		Laparo proc, oviduct-ovary	0130	32.7724	$1,788.09	$659.53	$357.62
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)	0193	15.0453	$820.89	$171.13	$164.18
58805	C		Drainage of ovarian cyst(s)					
58820	T		Drain ovary abscess, open	0195	25.6950	$1,401.94	$483.80	$280.39
58822	C		Drain ovary abscess, percut					
58823	T		Drain pelvic abscess, percut	0193	15.0453	$820.89	$171.13	$164.18
58825	C		Transposition, ovary(s)					
58900	T		Biopsy of ovary(s)	0193	15.0453	$820.89	$171.13	$164.18
58920	T		Partial removal of ovary(s)	0195	25.6950	$1,401.94	$483.80	$280.39
58925	T		Removal of ovarian cyst(s)	0195	25.6950	$1,401.94	$483.80	$280.39
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	18.4286	$1,005.48	$397.84	$201.10
58974	T		Transfer of embryo	0197	4.8280	$263.42		$52.68
58976	T		Transfer of embryo	0197	4.8280	$263.42		$52.68
58999	T		Genital surgery procedure	0191	0.1853	$10.11	$2.93	$2.02
59000	T		Amniocentesis, diagnostic	0198	1.3578	$74.08	$32.19	$14.82
59001	T		Amniocentesis, therapeutic	0198	1.3578	$74.08	$32.19	$14.82
59012	T		Fetal cord puncture,prenatal	0198	1.3578	$74.08	$32.19	$14.82
59015	T		Chorion biopsy	0198	1.3578	$74.08	$32.19	$14.82
59020	T		Fetal contract stress test	0198	1.3578	$74.08	$32.19	$14.82
59025	T		Fetal non-stress test	0198	1.3578	$74.08	$32.19	$14.82
59030	T		Fetal scalp blood sample	0198	1.3578	$74.08	$32.19	$14.82
59050	E		Fetal monitor w/report					
59051	B		Fetal monitor/interpret only					
59070	T	NI	Transabdom amnioinfus w/ us	0198	1.3578	$74.08	$32.19	$14.82
59072	T	NI	Umbilical cord occlud w/ us	0198	1.3578	$74.08	$32.19	$14.82
59074	T	NI	Fetal fluid drainage w/ us	0198	1.3578	$74.08	$32.19	$14.82
59076	T	NI	Fetal shunt placement, w/ us	0198	1.3578	$74.08	$32.19	$14.82
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59140	C		Treat ectopic pregnancy					
59150	T		Treat ectopic pregnancy	0131	40.8064	$2,226.44	$1,001.89	$445.29
59151	T		Treat ectopic pregnancy	0131	40.8064	$2,226.44	$1,001.89	$445.29
59160	T		D & c after delivery	0196	16.1219	$879.63	$338.23	$175.93
59200	T		Insert cervical dilator	0189	1.4232	$77.65	$18.09	$15.53
59300	T		Episiotomy or vaginal repair	0193	15.0453	$820.89	$171.13	$164.18
59320	T		Revision of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
59325	C		Revision of cervix					
59350	C		Repair of uterus					
59400	B		Obstetrical care					
59409	T		Obstetrical care	0199	17.2831	$942.98		$188.60
59410	B		Obstetrical care					
59412	T		Antepartum manipulation	0700	2.4306	$132.62	$37.13	$26.52
59414	T		Deliver placenta	0199	17.2831	$942.98		$188.60
59425	B		Antepartum care only					
59426	B		Antepartum care only					
59430	B		Care after delivery					
59510	E		Cesarean delivery					
59514	C		Cesarean delivery only					
59515	E		Cesarean delivery					
59525	C		Remove uterus after cesarean					
59610	E		Vbac delivery					
59612	T		Vbac delivery only	0199	17.2831	$942.98		$188.60
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	16.8660	$920.23	$329.65	$184.05
59820	T		Care of miscarriage	0201	16.8660	$920.23	$329.65	$184.05
59821	T		Treatment of miscarriage	0201	16.8660	$920.23	$329.65	$184.05
59830	C		Treat uterus infection					
59840	T		Abortion	0200	17.9920	$981.66	$307.83	$196.33
59841	T		Abortion	0200	17.9920	$981.66	$307.83	$196.33
59850	C		Abortion					
59851	C		Abortion					
59852	C		Abortion					
59855	C		Abortion					
59856	C		Abortion					
59857	C		Abortion					
59866	T		Abortion (mpr)	0198	1.3578	$74.08	$32.19	$14.82
59870	T		Evacuate mole of uterus	0201	16.8660	$920.23	$329.65	$184.05
59871	T		Remove cerclage suture	0194	18.4286	$1,005.48	$397.84	$201.10
59897	T	NI	Fetal invas px w/ us	0198	1.3578	$74.08	$32.19	$14.82
59898	T		Laparo proc, ob care/deliver	0130	32.7724	$1,788.09	$659.53	$357.62
59899	T		Maternity care procedure	0198	1.3578	$74.08	$32.19	$14.82
60000	T		Drain thyroid/tongue cyst	0252	6.4469	$351.75	$113.41	$70.35
60001	T		Aspirate/inject thyriod cyst	0004	1.5882	$86.65	$22.36	$17.33
60100	T		Biopsy of thyroid	0004	1.5882	$86.65	$22.36	$17.33
60200	T		Remove thyroid lesion	0114	37.5963	$2,051.29	$485.91	$410.26
60210	T		Partial thyroid excision	0114	37.5963	$2,051.29	$485.91	$410.26
60212	T		Partial thyroid excision	0114	37.5963	$2,051.29	$485.91	$410.26
60220	T		Partial removal of thyroid	0114	37.5963	$2,051.29	$485.91	$410.26
60225	T		Partial removal of thyroid	0114	37.5963	$2,051.29	$485.91	$410.26
60240	T		Removal of thyroid	0114	37.5963	$2,051.29	$485.91	$410.26
60252	T		Removal of thyroid	0256	35.1548	$1,918.08		$383.62
60254	C		Extensive thyroid surgery					
60260	T		Repeat thyroid surgery	0256	35.1548	$1,918.08		$383.62
60270	C		Removal of thyroid					
60271	C		Removal of thyroid					
60280	T		Remove thyroid duct lesion	0114	37.5963	$2,051.29	$485.91	$410.26
60281	T		Remove thyroid duct lesion	0114	37.5963	$2,051.29	$485.91	$410.26
60500	T		Explore parathyroid glands	0256	35.1548	$1,918.08		$383.62
60502	C		Re-explore parathyroids					
60505	C		Explore parathyroid glands					
60512	T		Autotransplant parathyroid	0022	18.7932	$1,025.38	$354.45	$205.08
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	32.7724	$1,788.09	$659.53	$357.62
60699	T		Endocrine surgery procedure	0114	37.5963	$2,051.29	$485.91	$410.26

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61000	T		Remove cranial cavity fluid	0212	2.9739	$162.26	$74.67	$32.45
61001	T		Remove cranial cavity fluid	0212	2.9739	$162.26	$74.67	$32.45
61020	T		Remove brain cavity fluid	0212	2.9739	$162.26	$74.67	$32.45
61026	T		Injection into brain canal	0212	2.9739	$162.26	$74.67	$32.45
61050	T		Remove brain canal fluid	0212	2.9739	$162.26	$74.67	$32.45
61055	T		Injection into brain canal	0212	2.9739	$162.26	$74.67	$32.45
61070	T		Brain canal shunt procedure	0212	2.9739	$162.26	$74.67	$32.45
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	34.1770	$1,864.73	$453.41	$372.95
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					
61316	C		Implt cran bone flap to abdo					
61320	C		Open skull for drainage					
61321	C		Open skull for drainage					
61322	C		Decompressive craniotomy					
61323	C		Decompressive lobectomy					
61330	T		Decompress eye socket	0256	35.1548	$1,918.08		$383.62
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					
61517	C		Implt brain chemotx add-on					
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					
61537	C	NI	Removal of brain tissue					
61538	C		Removal of brain tissue					
61539	C		Removal of brain tissue					
61540	C	NI	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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
61566	C	NI	Removal of brain tissue					
61567	C	NI	Incision of brain tissue					
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					
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					
61623	T		Endovasc tempory vessel occl	1555		$1,650.00		$330.00
61624	C		Occlusion/embolization cath					
61626	T		Transcath occlusion, non-cns	0081	35.0285	$1,911.19		$382.24
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	16.5554	$903.28		$180.66
61791	T		Treat trigeminal tract	0204	2.1711	$118.46	$40.13	$23.69
61793	E		Focus radiation beam					
61795	S		Brain surgery using computer	0302	6.3268	$345.20	$130.77	$69.04
61850	C		Implant neuroelectrodes					
61860	C		Implant neuroelectrodes					
61862	C	DG	Implant neurostimul, subcort					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61863	C	NI	Implant neuroelectrode					
61864	C	NI	Implant neuroelectrde, add'l					
61867	C	NI	Implant neuroelectrode					
61868	C	NI	Implant neuroelectrde, add'l					
61870	C		Implant neuroelectrodes					
61875	C		Implant neuroelectrodes					
61880	T		Revise/remove neuroelectrode	0687	20.4416	$1,115.31	$513.05	$223.06
61885	S		Implant neurostim one array	0039	235.1866	$12,832.02		$2,566.40
61886	T		Implant neurostim arrays	0222	232.2024	$12,669.20		$2,533.84
61888	T		Revise/remove neuroreceiver	0688	46.7347	$2,549.89	$1,249.45	$509.98
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					
62148	C		Retr bone flap to fix skull					
62160	C		Neuroendoscopy add-on					
62161	C		Dissect brain w/scope					
62162	C		Remove colloid cyst w/scope					
62163	C		Neuroendoscopy w/fb removal					
62164	C		Remove brain tumor w/scope					
62165	C		Remove pituit tumor w/scope					
62180	C		Establish brain cavity shunt					
62190	C		Establish brain cavity shunt					
62192	C		Establish brain cavity shunt					
62194	T		Replace/irrigate catheter	0121	2.1189	$115.61	$43.80	$23.12
62200	C		Establish brain cavity shunt					
62201	C		Establish brain cavity shunt					
62220	C		Establish brain cavity shunt					
62223	C		Establish brain cavity shunt					
62225	T		Replace/irrigate catheter	0122	8.8621	$483.53	$99.16	$96.71
62230	T		Replace/revise brain shunt	0224	34.1770	$1,864.73	$453.41	$372.95
62252	S		Csf shunt reprogram	0691	2.8066	$153.13	$76.56	$30.63
62256	C		Remove brain cavity shunt					
62258	C		Replace brain cavity shunt					
62263	T		Lysis epidural adhesions	0203	11.5969	$632.74	$276.76	$126.55
62264	T		Epidural lysis on single day	0203	11.5969	$632.74	$276.76	$126.55
62268	T		Drain spinal cord cyst	0212	2.9739	$162.26	$74.67	$32.45
62269	T		Needle biopsy, spinal cord	0005	3.2698	$178.40	$71.59	$35.68
62270	T		Spinal fluid tap, diagnostic	0206	5.2875	$288.49	$75.55	$57.70
62272	T		Drain cerebro spinal fluid	0206	5.2875	$288.49	$75.55	$57.70
62273	T		Treat epidural spine lesion	0206	5.2875	$288.49	$75.55	$57.70
62280	T		Treat spinal cord lesion	0207	6.4554	$352.21	$123.69	$70.44
62281	T		Treat spinal cord lesion	0207	6.4554	$352.21	$123.69	$70.44
62282	T		Treat spinal canal lesion	0207	6.4554	$352.21	$123.69	$70.44
62284	N		Injection for myelogram					
62287	T		Percutaneous diskectomy	0220	16.5554	$903.28		$180.66
62290	N		Inject for spine disk x-ray					
62291	N		Inject for spine disk x-ray					
62292	T		Injection into disk lesion	0212	2.9739	$162.26	$74.67	$32.45
62294	T		Injection into spinal artery	0212	2.9739	$162.26	$74.67	$32.45
62310	T		Inject spine c/t	0206	5.2875	$288.49	$75.55	$57.70
62311	T		Inject spine l/s (cd)	0206	5.2875	$288.49	$75.55	$57.70
62318	T		Inject spine w/cath, c/t	0206	5.2875	$288.49	$75.55	$57.70
62319	T		Inject spine w/cath l/s (cd)	0206	5.2875	$288.49	$75.55	$57.70
62350	T		Implant spinal canal cath	0223	26.7610	$1,460.11		$292.02
62351	T		Implant spinal canal cath	0208	40.2830	$2,197.88		$439.58
62355	T		Remove spinal canal catheter	0203	11.5969	$632.74	$276.76	$126.55
62360	T		Insert spine infusion device	0226	136.2989	$7,436.60		$1,487.32
62361	T		Implant spine infusion pump	0227	160.8363	$8,775.39		$1,755.08
62362	T		Implant spine infusion pump	0227	160.8363	$8,775.39		$1,755.08
62365	T		Remove spine infusion device	0203	11.5969	$632.74	$276.76	$126.55
62367	S		Analyze spine infusion pump	0691	2.8066	$153.13	$76.56	$30.63
62368	S		Analyze spine infusion pump	0691	2.8066	$153.13	$76.56	$30.63

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63001	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63003	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63005	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63011	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63012	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63015	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63016	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63017	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63020	T		Neck spine disk surgery	0208	40.2830	$2,197.88		$439.58
63030	T		Low back disk surgery	0208	40.2830	$2,197.88		$439.58
63035	T		Spinal disk surgery add-on	0208	40.2830	$2,197.88		$439.58
63040	T		Laminotomy, single cervical	0208	40.2830	$2,197.88		$439.58
63042	T		Laminotomy, single lumbar	0208	40.2830	$2,197.88		$439.58
63043	C		Laminotomy, add'l cervical					
63044	C		Laminotomy, add'l lumbar					
63045	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63046	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63047	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63048	T		Remove spinal lamina add-on	0208	40.2830	$2,197.88		$439.58
63055	T		Decompress spinal cord	0208	40.2830	$2,197.88		$439.58
63056	T		Decompress spinal cord	0208	40.2830	$2,197.88		$439.58
63057	T		Decompress spine cord add-on	0208	40.2830	$2,197.88		$439.58
63064	T		Decompress spinal cord	0208	40.2830	$2,197.88		$439.58
63066	T		Decompress spine cord add-on	0208	40.2830	$2,197.88		$439.58
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					
63101	C	NI	Removal of vertebral body					
63102	C	NI	Removal of vertebral body					
63103	C	NI	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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	16.5554	$903.28		$180.66
63610	T		Stimulation of spinal cord	0220	16.5554	$903.28		$180.66
63615	T		Remove lesion of spinal cord	0220	16.5554	$903.28		$180.66
63650	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
63655	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
63660	T		Revise/remove neuroelectrode	0687	20.4416	$1,115.31	$513.05	$223.06
63685	T		Implant neuroreceiver	0222	232.2024	$12,669.20		$2,533.84
63688	T		Revise/remove neuroreceiver	0688	46.7347	$2,549.89	$1,249.45	$509.98
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	52.2880	$2,852.89	$639.03	$570.58
63744	T		Revision of spinal shunt	0228	52.2880	$2,852.89	$639.03	$570.58
63746	T		Removal of spinal shunt	0109	7.4705	$407.60	$131.49	$81.52
64400	T		N block inj, trigeminal	0204	2.1711	$118.46	$40.13	$23.69
64402	T		N block inj, facial	0204	2.1711	$118.46	$40.13	$23.69
64405	T		N block inj, occipital	0204	2.1711	$118.46	$40.13	$23.69
64408	T		N block inj, vagus	0204	2.1711	$118.46	$40.13	$23.69
64410	T		N block inj, phrenic	0204	2.1711	$118.46	$40.13	$23.69
64412	T		N block inj, spinal accessor	0204	2.1711	$118.46	$40.13	$23.69
64413	T		N block inj, cervical plexus	0204	2.1711	$118.46	$40.13	$23.69
64415	T		Injection for nerve block	0204	2.1711	$118.46	$40.13	$23.69
64416	T		N block cont infuse, b plex	0204	2.1711	$118.46	$40.13	$23.69
64417	T		N block inj, axillary	0204	2.1711	$118.46	$40.13	$23.69
64418	T		N block inj, suprascapular	0204	2.1711	$118.46	$40.13	$23.69
64420	T		N block inj, intercost, sng	0207	6.4554	$352.21	$123.69	$70.44
64421	T		N block inj, intercost, mlt	0207	6.4554	$352.21	$123.69	$70.44
64425	T		N block inj ilio-ing/hypogi	0204	2.1711	$118.46	$40.13	$23.69
64430	T		N block inj, pudendal	0204	2.1711	$118.46	$40.13	$23.69
64435	T		N block inj, paracervical	0204	2.1711	$118.46	$40.13	$23.69
64445	T		Injection for nerve block	0204	2.1711	$118.46	$40.13	$23.69
64446	T		N blk inj, sciatic, cont inf	0204	2.1711	$118.46	$40.13	$23.69
64447	T		N block inj fem, single	0204	2.1711	$118.46	$40.13	$23.69
64448	T		N block inj fem, cont inf	0204	2.1711	$118.46	$40.13	$23.69
64449	T	NI	N block inj, lumbar plexus	0204	2.1711	$118.46	$40.13	$23.69
64450	T		N block, other peripheral	0204	2.1711	$118.46	$40.13	$23.69
64470	T		Inj paravertebral c/t	0207	6.4554	$352.21	$123.69	$70.44
64472	T		Inj paravertebral c/t add-on	0207	6.4554	$352.21	$123.69	$70.44
64475	T		Inj paravertebral l/s	0207	6.4554	$352.21	$123.69	$70.44
64476	T		Inj paravertebral l/s add-on	0207	6.4554	$352.21	$123.69	$70.44
64479	T		Inj foramen epidural c/t	0207	6.4554	$352.21	$123.69	$70.44
64480	T		Inj foramen epidural add-on	0207	6.4554	$352.21	$123.69	$70.44
64483	T		Inj foramen epidural l/s	0207	6.4554	$352.21	$123.69	$70.44
64484	T		Inj foramen epidural add-on	0207	6.4554	$352.21	$123.69	$70.44
64505	T		N block, spenopalatine gangl	0204	2.1711	$118.46	$40.13	$23.69
64508	T		N block, carotid sinus s/p	0204	2.1711	$118.46	$40.13	$23.69
64510	T		N block, stellate ganglion	0207	6.4554	$352.21	$123.69	$70.44
64517	T	NI	N block inj, hypogas plxs	0204	2.1711	$118.46	$40.13	$23.69
64520	T		N block, lumbar/thoracic	0207	6.4554	$352.21	$123.69	$70.44
64530	T		N block inj, celiac pelus	0207	6.4554	$352.21	$123.69	$70.44
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
64555	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64560	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64561	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64565	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64573	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
64575	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64577	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64580	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
64581	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64585	T		Revise/remove neuroelectrode	0687	20.4416	$1,115.31	$513.05	$223.06
64590	T		Implant neuroreceiver	0222	232.2024	$12,669.20		$2,533.84
64595	T		Revise/remove neuroreceiver	0688	46.7347	$2,549.89	$1,249.45	$509.98
64600	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64605	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64610	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64612	T		Destroy nerve, face muscle	0204	2.1711	$118.46	$40.13	$23.69
64613	T		Destroy nerve, spine muscle	0204	2.1711	$118.46	$40.13	$23.69
64614	T		Destroy nerve, extrem musc	0204	2.1711	$118.46	$40.13	$23.69
64620	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64622	T		Destr paravertebrl nerve l/s	0203	11.5969	$632.74	$276.76	$126.55
64623	T		Destr paravertebral n add-on	0203	11.5969	$632.74	$276.76	$126.55
64626	T		Destr paravertebrl nerve c/t	0203	11.5969	$632.74	$276.76	$126.55
64627	T		Destr paravertebral n add-on	0203	11.5969	$632.74	$276.76	$126.55
64630	T		Injection treatment of nerve	0207	6.4554	$352.21	$123.69	$70.44
64640	T		Injection treatment of nerve	0207	6.4554	$352.21	$123.69	$70.44
64680	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64681	T	NI	Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64702	T		Revise finger/toe nerve	0220	16.5554	$903.28		$180.66
64704	T		Revise hand/foot nerve	0220	16.5554	$903.28		$180.66
64708	T		Revise arm/leg nerve	0220	16.5554	$903.28		$180.66
64712	T		Revision of sciatic nerve	0220	16.5554	$903.28		$180.66
64713	T		Revision of arm nerve(s)	0220	16.5554	$903.28		$180.66
64714	T		Revise low back nerve(s)	0220	16.5554	$903.28		$180.66
64716	T		Revision of cranial nerve	0220	16.5554	$903.28		$180.66
64718	T		Revise ulnar nerve at elbow	0220	16.5554	$903.28		$180.66
64719	T		Revise ulnar nerve at wrist	0220	16.5554	$903.28		$180.66
64721	T		Carpal tunnel surgery	0220	16.5554	$903.28		$180.66
64722	T		Relieve pressure on nerve(s)	0220	16.5554	$903.28		$180.66
64726	T		Release foot/toe nerve	0220	16.5554	$903.28		$180.66
64727	T		Internal nerve revision	0220	16.5554	$903.28		$180.66
64732	T		Incision of brow nerve	0220	16.5554	$903.28		$180.66
64734	T		Incision of cheek nerve	0220	16.5554	$903.28		$180.66
64736	T		Incision of chin nerve	0220	16.5554	$903.28		$180.66
64738	T		Incision of jaw nerve	0220	16.5554	$903.28		$180.66
64740	T		Incision of tongue nerve	0220	16.5554	$903.28		$180.66
64742	T		Incision of facial nerve	0220	16.5554	$903.28		$180.66
64744	T		Incise nerve, back of head	0220	16.5554	$903.28		$180.66
64746	T		Incise diaphragm nerve	0220	16.5554	$903.28		$180.66
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	16.5554	$903.28		$180.66
64763	C		Incise hip/thigh nerve					
64766	C		Incise hip/thigh nerve					
64771	T		Sever cranial nerve	0220	16.5554	$903.28		$180.66
64772	T		Incision of spinal nerve	0220	16.5554	$903.28		$180.66
64774	T		Remove skin nerve lesion	0220	16.5554	$903.28		$180.66
64776	T		Remove digit nerve lesion	0220	16.5554	$903.28		$180.66
64778	T		Digit nerve surgery add-on	0220	16.5554	$903.28		$180.66
64782	T		Remove limb nerve lesion	0220	16.5554	$903.28		$180.66
64783	T		Limb nerve surgery add-on	0220	16.5554	$903.28		$180.66
64784	T		Remove nerve lesion	0220	16.5554	$903.28		$180.66
64786	T		Remove sciatic nerve lesion	0221	24.8875	$1,357.89	$463.62	$271.58
64787	T		Implant nerve end	0220	16.5554	$903.28		$180.66
64788	T		Remove skin nerve lesion	0220	16.5554	$903.28		$180.66
64790	T		Removal of nerve lesion	0220	16.5554	$903.28		$180.66
64792	T		Removal of nerve lesion	0221	24.8875	$1,357.89	$463.62	$271.58
64795	T		Biopsy of nerve	0220	16.5554	$903.28		$180.66
64802	T		Remove sympathetic nerves	0220	16.5554	$903.28		$180.66
64804	C		Remove sympathetic nerves					
64809	C		Remove sympathetic nerves					
64818	C		Remove sympathetic nerves					
64820	T		Remove sympathetic nerves	0220	16.5554	$903.28		$180.66
64821	T		Remove sympathetic nerves	0054	24.2456	$1,322.86		$264.57
64822	T		Remove sympathetic nerves	0054	24.2456	$1,322.86		$264.57
64823	T		Remove sympathetic nerves	0054	24.2456	$1,322.86		$264.57
64831	T		Repair of digit nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64832	T		Repair nerve add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64834	T		Repair of hand or foot nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64835	T		Repair of hand or foot nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64836	T		Repair of hand or foot nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64837	T		Repair nerve add-on	0221	24.8875	$1,357.89	$463.62	$271.58

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64840	T		Repair of leg nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64856	T		Repair/transpose nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64857	T		Repair arm/leg nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64858	T		Repair sciatic nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64859	T		Nerve surgery	0221	24.8875	$1,357.89	$463.62	$271.58
64861	T		Repair of arm nerves	0221	24.8875	$1,357.89	$463.62	$271.58
64862	T		Repair of low back nerves	0221	24.8875	$1,357.89	$463.62	$271.58
64864	T		Repair of facial nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64865	T		Repair of facial nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64866	C		Fusion of facial/other nerve					
64868	C		Fusion of facial/other nerve					
64870	T		Fusion of facial/other nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64872	T		Subsequent repair of nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64874	T		Repair & revise nerve add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64876	T		Repair nerve/shorten bone	0221	24.8875	$1,357.89	$463.62	$271.58
64885	T		Nerve graft, head or neck	0221	24.8875	$1,357.89	$463.62	$271.58
64886	T		Nerve graft, head or neck	0221	24.8875	$1,357.89	$463.62	$271.58
64890	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64891	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64892	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64893	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64895	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64896	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64897	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64898	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64901	T		Nerve graft add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64902	T		Nerve graft add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64905	T		Nerve pedicle transfer	0221	24.8875	$1,357.89	$463.62	$271.58
64907	T		Nerve pedicle transfer	0221	24.8875	$1,357.89	$463.62	$271.58
64999	T		Nervous system surgery	0204	2.1711	$118.46	$40.13	$23.69
65091	T		Revise eye	0242	29.4294	$1,605.70	$597.36	$321.14
65093	T		Revise eye with implant	0241	22.1969	$1,211.09	$384.47	$242.22
65101	T		Removal of eye	0242	29.4294	$1,605.70	$597.36	$321.14
65103	T		Remove eye/insert implant	0242	29.4294	$1,605.70	$597.36	$321.14
65105	T		Remove eye/attach implant	0242	29.4294	$1,605.70	$597.36	$321.14
65110	T		Removal of eye	0242	29.4294	$1,605.70	$597.36	$321.14
65112	T		Remove eye/revise socket	0242	29.4294	$1,605.70	$597.36	$321.14
65114	T		Remove eye/revise socket	0242	29.4294	$1,605.70	$597.36	$321.14
65125	T		Revise ocular implant	0240	17.4535	$952.28	$315.31	$190.46
65130	T		Insert ocular implant	0241	22.1969	$1,211.09	$384.47	$242.22
65135	T		Insert ocular implant	0241	22.1969	$1,211.09	$384.47	$242.22
65140	T		Attach ocular implant	0242	29.4294	$1,605.70	$597.36	$321.14
65150	T		Revise ocular implant	0241	22.1969	$1,211.09	$384.47	$242.22
65155	T		Reinsert ocular implant	0242	29.4294	$1,605.70	$597.36	$321.14
65175	T		Removal of ocular implant	0240	17.4535	$952.28	$315.31	$190.46
65205	S		Remove foreign body from eye	0698	0.9599	$52.37	$18.72	$10.47
65210	S		Remove foreign body from eye	0231	2.1883	$119.40	$50.94	$23.88
65220	S		Remove foreign body from eye	0231	2.1883	$119.40	$50.94	$23.88
65222	S		Remove foreign body from eye	0231	2.1883	$119.40	$50.94	$23.88
65235	T		Remove foreign body from eye	0233	14.4205	$786.80	$266.33	$157.36
65260	T		Remove foreign body from eye	0236	18.6701	$1,018.66		$203.73
65265	T		Remove foreign body from eye	0236	18.6701	$1,018.66		$203.73
65270	T		Repair of eye wound	0240	17.4535	$952.28	$315.31	$190.46
65272	T		Repair of eye wound	0233	14.4205	$786.80	$266.33	$157.36
65273	C		Repair of eye wound					
65275	T		Repair of eye wound	0233	14.4205	$786.80	$266.33	$157.36
65280	T		Repair of eye wound	0234	21.4631	$1,171.05	$511.31	$234.21
65285	T		Repair of eye wound	0234	21.4631	$1,171.05	$511.31	$234.21
65286	T		Repair of eye wound	0233	14.4205	$786.80	$266.33	$157.36
65290	T		Repair of eye socket wound	0243	21.7323	$1,185.74	$431.39	$237.15
65400	T		Removal of eye lesion	0233	14.4205	$786.80	$266.33	$157.36
65410	T		Biopsy of cornea	0233	14.4205	$786.80	$266.33	$157.36
65420	T		Removal of eye lesion	0233	14.4205	$786.80	$266.33	$157.36
65426	T		Removal of eye lesion	0234	21.4631	$1,171.05	$511.31	$234.21
65430	S		Corneal smear	0230	0.7619	$41.57	$14.97	$8.31
65435	T		Curette/treat cornea	0239	6.1331	$334.63		$66.93
65436	T		Curette/treat cornea	0233	14.4205	$786.80	$266.33	$157.36
65450	S		Treatment of corneal lesion	0231	2.1883	$119.40	$50.94	$23.88
65600	T		Revision of cornea	0240	17.4535	$952.28	$315.31	$190.46
65710	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65730	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65750	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65755	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65760	E		Revision of cornea					
65765	E		Revision of cornea					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	37.6284	$2,053.04	$803.26	$410.61
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	14.4205	$786.80	$266.33	$157.36
65775	T		Correction of astigmatism	0233	14.4205	$786.80	$266.33	$157.36
65780	T	NI	Ocular reconst, transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65781	T	NI	Ocular reconst, transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65782	T	NI	Ocular reconst, transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65800	T		Drainage of eye	0233	14.4205	$786.80	$266.33	$157.36
65805	T		Drainage of eye	0233	14.4205	$786.80	$266.33	$157.36
65810	T		Drainage of eye	0234	21.4631	$1,171.05	$511.31	$234.21
65815	T		Drainage of eye	0234	21.4631	$1,171.05	$511.31	$234.21
65820	T		Relieve inner eye pressure	0232	4.9206	$268.47	$103.17	$53.69
65850	T		Incision of eye	0234	21.4631	$1,171.05	$511.31	$234.21
65855	T		Laser surgery of eye	0247	4.9482	$269.98	$104.31	$54.00
65860	T		Incise inner eye adhesions	0247	4.9482	$269.98	$104.31	$54.00
65865	T		Incise inner eye adhesions	0233	14.4205	$786.80	$266.33	$157.36
65870	T		Incise inner eye adhesions	0234	21.4631	$1,171.05	$511.31	$234.21
65875	T		Incise inner eye adhesions	0234	21.4631	$1,171.05	$511.31	$234.21
65880	T		Incise inner eye adhesions	0233	14.4205	$786.80	$266.33	$157.36
65900	T		Remove eye lesion	0233	14.4205	$786.80	$266.33	$157.36
65920	T		Remove implant of eye	0233	14.4205	$786.80	$266.33	$157.36
65930	T		Remove blood clot from eye	0234	21.4631	$1,171.05	$511.31	$234.21
66020	T		Injection treatment of eye	0233	14.4205	$786.80	$266.33	$157.36
66030	T		Injection treatment of eye	0233	14.4205	$786.80	$266.33	$157.36
66130	T		Remove eye lesion	0234	21.4631	$1,171.05	$511.31	$234.21
66150	T		Glaucoma surgery	0233	14.4205	$786.80	$266.33	$157.36
66155	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66160	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66165	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66170	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66172	T		Incision of eye	0673	26.8390	$1,464.36	$649.56	$292.87
66180	T		Implant eye shunt	0673	26.8390	$1,464.36	$649.56	$292.87
66185	T		Revise eye shunt	0673	26.8390	$1,464.36	$649.56	$292.87
66220	T		Repair eye lesion	0236	18.6701	$1,018.66		$203.73
66225	T		Repair/graft eye lesion	0673	26.8390	$1,464.36	$649.56	$292.87
66250	T		Follow-up surgery of eye	0233	14.4205	$786.80	$266.33	$157.36
66500	T		Incision of iris	0232	4.9206	$268.47	$103.17	$53.69
66505	T		Incision of iris	0232	4.9206	$268.47	$103.17	$53.69
66600	T		Remove iris and lesion	0233	14.4205	$786.80	$266.33	$157.36
66605	T		Removal of iris	0234	21.4631	$1,171.05	$511.31	$234.21
66625	T		Removal of iris	0233	14.4205	$786.80	$266.33	$157.36
66630	T		Removal of iris	0233	14.4205	$786.80	$266.33	$157.36
66635	T		Removal of iris	0234	21.4631	$1,171.05	$511.31	$234.21
66680	T		Repair iris & ciliary body	0234	21.4631	$1,171.05	$511.31	$234.21
66682	T		Repair iris & ciliary body	0234	21.4631	$1,171.05	$511.31	$234.21
66700	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66710	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66720	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66740	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66761	T		Revision of iris	0247	4.9482	$269.98	$104.31	$54.00
66762	T		Revision of iris	0247	4.9482	$269.98	$104.31	$54.00
66770	T		Removal of inner eye lesion	0247	4.9482	$269.98	$104.31	$54.00
66820	T		Incision, secondary cataract	0232	4.9206	$268.47	$103.17	$53.69
66821	T		After cataract laser surgery	0247	4.9482	$269.98	$104.31	$54.00
66825	T		Reposition intraocular lens	0234	21.4631	$1,171.05	$511.31	$234.21
66830	T		Removal of lens lesion	0232	4.9206	$268.47	$103.17	$53.69
66840	T		Removal of lens material	0245	12.2973	$670.95	$222.22	$134.19
66850	T		Removal of lens material	0249	27.7406	$1,513.55	$524.67	$302.71
66852	T		Removal of lens material	0249	27.7406	$1,513.55	$524.67	$302.71
66920	T		Extraction of lens	0249	27.7406	$1,513.55	$524.67	$302.71
66930	T		Extraction of lens	0249	27.7406	$1,513.55	$524.67	$302.71
66940	T		Extraction of lens	0245	12.2973	$670.95	$222.22	$134.19
66982	T		Cataract surgery, complex	0246	22.9755	$1,253.57	$495.96	$250.71
66983	T		Cataract surg w/iol, 1 stage	0246	22.9755	$1,253.57	$495.96	$250.71
66984	T		Cataract surg w/iol, 1 stage	0246	22.9755	$1,253.57	$495.96	$250.71
66985	T		Insert lens prosthesis	0246	22.9755	$1,253.57	$495.96	$250.71
66986	T		Exchange lens prosthesis	0246	22.9755	$1,253.57	$495.96	$250.71
66990	N		Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	4.9206	$268.47	$103.17	$53.69
67005	T		Partial removal of eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67010	T		Partial removal of eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67015	T		Release of eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67025	T		Replace eye fluid	0236	18.6701	$1,018.66		$203.73
67027	T		Implant eye drug system	0237	34.1784	$1,864.81	$818.54	$372.96

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67028	T		Injection eye drug	0235	5.0749	$276.89	$72.04	$55.38
67030	T		Incise inner eye strands	0236	18.6701	$1,018.66		$203.73
67031	T		Laser surgery, eye strands	0247	4.9482	$269.98	$104.31	$54.00
67036	T		Removal of inner eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67038	T		Strip retinal membrane	0237	34.1784	$1,864.81	$818.54	$372.96
67039	T		Laser treatment of retina	0237	34.1784	$1,864.81	$818.54	$372.96
67040	T		Laser treatment of retina	0672	38.9476	$2,125.02	$988.43	$425.00
67101	T		Repair detached retina	0235	5.0749	$276.89	$72.04	$55.38
67105	T		Repair detached retina	0248	4.8223	$263.11	$95.08	$52.62
67107	T		Repair detached retina	0672	38.9476	$2,125.02	$988.43	$425.00
67108	T		Repair detached retina	0672	38.9476	$2,125.02	$988.43	$425.00
67110	T		Repair detached retina	0236	18.6701	$1,018.66		$203.73
67112	T		Rerepair detached retina	0672	38.9476	$2,125.02	$988.43	$425.00
67115	T		Release encircling material	0236	18.6701	$1,018.66		$203.73
67120	T		Remove eye implant material	0236	18.6701	$1,018.66		$203.73
67121	T		Remove eye implant material	0237	34.1784	$1,864.81	$818.54	$372.96
67141	T		Treatment of retina	0235	5.0749	$276.89	$72.04	$55.38
67145	T		Treatment of retina	0248	4.8223	$263.11	$95.08	$52.62
67208	T		Treatment of retinal lesion	0235	5.0749	$276.89	$72.04	$55.38
67210	T		Treatment of retinal lesion	0248	4.8223	$263.11	$95.08	$52.62
67218	T		Treatment of retinal lesion	0236	18.6701	$1,018.66		$203.73
67220	T		Treatment of choroid lesion	0235	5.0749	$276.89	$72.04	$55.38
67221	T		Ocular photodynamic ther	0235	5.0749	$276.89	$72.04	$55.38
67225	T		Eye photodynamic ther add-on	0235	5.0749	$276.89	$72.04	$55.38
67227	T		Treatment of retinal lesion	0235	5.0749	$276.89	$72.04	$55.38
67228	T		Treatment of retinal lesion	0248	4.8223	$263.11	$95.08	$52.62
67250	T		Reinforce eye wall	0240	17.4535	$952.28	$315.31	$190.46
67255	T		Reinforce/graft eye wall	0237	34.1784	$1,864.81	$818.54	$372.96
67299	T		Eye surgery procedure	0235	5.0749	$276.89	$72.04	$55.38
67311	T		Revise eye muscle	0243	21.7323	$1,185.74	$431.39	$237.15
67312	T		Revise two eye muscles	0243	21.7323	$1,185.74	$431.39	$237.15
67314	T		Revise eye muscle	0243	21.7323	$1,185.74	$431.39	$237.15
67316	T		Revise two eye muscles	0243	21.7323	$1,185.74	$431.39	$237.15
67318	T		Revise eye muscle(s)	0243	21.7323	$1,185.74	$431.39	$237.15
67320	T		Revise eye muscle(s) add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67331	T		Eye surgery follow-up add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67332	T		Rerevise eye muscles add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67334	T		Revise eye muscle w/suture	0243	21.7323	$1,185.74	$431.39	$237.15
67335	T		Eye suture during surgery	0243	21.7323	$1,185.74	$431.39	$237.15
67340	T		Revise eye muscle add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67343	T		Release eye tissue	0243	21.7323	$1,185.74	$431.39	$237.15
67345	T		Destroy nerve of eye muscle	0238	3.1954	$174.34	$58.96	$34.87
67350	T		Biopsy eye muscle	0699	2.2303	$121.69	$47.46	$24.34
67399	T		Eye muscle surgery procedure	0243	21.7323	$1,185.74	$431.39	$237.15
67400	T		Explore/biopsy eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67405	T		Explore/drain eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67412	T		Explore/treat eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67413	T		Explore/treat eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67414	T		Explr/decompress eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67415	T		Aspiration, orbital contents	0239	6.1331	$334.63		$66.93
67420	T		Explore/treat eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67430	T		Explore/treat eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67440	T		Explore/drain eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67445	T		Explr/decompress eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67450	T		Explore/biopsy eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67500	S		Inject/treat eye socket	0231	2.1883	$119.40	$50.94	$23.88
67505	T		Inject/treat eye socket	0238	3.1954	$174.34	$58.96	$34.87
67515	T		Inject/treat eye socket	0239	6.1331	$334.63		$66.93
67550	T		Insert eye socket implant	0242	29.4294	$1,605.70	$597.36	$321.14
67560	T		Revise eye socket implant	0241	22.1969	$1,211.09	$384.47	$242.22
67570	T		Decompress optic nerve	0242	29.4294	$1,605.70	$597.36	$321.14
67599	T		Orbit surgery procedure	0239	6.1331	$334.63		$66.93
67700	T		Drainage of eyelid abscess	0238	3.1954	$174.34	$58.96	$34.87
67710	T		Incision of eyelid	0239	6.1331	$334.63		$66.93
67715	T		Incision of eyelid fold	0240	17.4535	$952.28	$315.31	$190.46
67800	T		Remove eyelid lesion	0238	3.1954	$174.34	$58.96	$34.87
67801	T		Remove eyelid lesions	0239	6.1331	$334.63		$66.93
67805	T		Remove eyelid lesions	0238	3.1954	$174.34	$58.96	$34.87
67808	T		Remove eyelid lesion(s)	0240	17.4535	$952.28	$315.31	$190.46
67810	T		Biopsy of eyelid	0238	3.1954	$174.34	$58.96	$34.87
67820	S		Revise eyelashes	0698	0.9599	$52.37	$18.72	$10.47
67825	T		Revise eyelashes	0238	3.1954	$174.34	$58.96	$34.87
67830	T		Revise eyelashes	0239	6.1331	$334.63		$66.93
67835	T		Revise eyelashes	0240	17.4535	$952.28	$315.31	$190.46
67840	T		Remove eyelid lesion	0239	6.1331	$334.63		$66.93

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67850	T		Treat eyelid lesion	0239	6.1331	$334.63		$66.93
67875	T		Closure of eyelid by suture	0239	6.1331	$334.63		$66.93
67880	T		Revision of eyelid	0233	14.4205	$786.80	$266.33	$157.36
67882	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67900	T		Repair brow defect	0240	17.4535	$952.28	$315.31	$190.46
67901	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67902	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67903	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67904	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67906	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67908	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67909	T		Revise eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67911	T		Revise eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67912	T	NI	Correction eyelid w/ implant	0239	6.1331	$334.63		$66.93
67914	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67915	T		Repair eyelid defect	0239	6.1331	$334.63		$66.93
67916	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67917	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67921	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67922	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67923	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67924	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67930	T		Repair eyelid wound	0240	17.4535	$952.28	$315.31	$190.46
67935	T		Repair eyelid wound	0240	17.4535	$952.28	$315.31	$190.46
67938	S		Remove eyelid foreign body	0698	0.9599	$52.37	$18.72	$10.47
67950	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67961	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67966	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67971	T		Reconstruction of eyelid	0241	22.1969	$1,211.09	$384.47	$242.22
67973	T		Reconstruction of eyelid	0241	22.1969	$1,211.09	$384.47	$242.22
67974	T		Reconstruction of eyelid	0241	22.1969	$1,211.09	$384.47	$242.22
67975	T		Reconstruction of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67999	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
68020	T		Incise/drain eyelid lining	0240	17.4535	$952.28	$315.31	$190.46
68040	S		Treatment of eyelid lesions	0698	0.9599	$52.37	$18.72	$10.47
68100	T		Biopsy of eyelid lining	0232	4.9206	$268.47	$103.17	$53.69
68110	T		Remove eyelid lining lesion	0699	2.2303	$121.69	$47.46	$24.34
68115	T		Remove eyelid lining lesion	0239	6.1331	$334.63		$66.93
68130	T		Remove eyelid lining lesion	0233	14.4205	$786.80	$266.33	$157.36
68135	T		Remove eyelid lining lesion	0239	6.1331	$334.63		$66.93
68200	S		Treat eyelid by injection	0698	0.9599	$52.37	$18.72	$10.47
68320	T		Revise/graft eyelid lining	0240	17.4535	$952.28	$315.31	$190.46
68325	T		Revise/graft eyelid lining	0242	29.4294	$1,605.70	$597.36	$321.14
68326	T		Revise/graft eyelid lining	0241	22.1969	$1,211.09	$384.47	$242.22
68328	T		Revise/graft eyelid lining	0241	22.1969	$1,211.09	$384.47	$242.22
68330	T		Revise eyelid lining	0233	14.4205	$786.80	$266.33	$157.36
68335	T		Revise/graft eyelid lining	0241	22.1969	$1,211.09	$384.47	$242.22
68340	T		Separate eyelid adhesions	0240	17.4535	$952.28	$315.31	$190.46
68360	T		Revise eyelid lining	0234	21.4631	$1,171.05	$511.31	$234.21
68362	T		Revise eyelid lining	0234	21.4631	$1,171.05	$511.31	$234.21
68371	T	NI	Harvest eye tissue, alograft	0233	14.4205	$786.80	$266.33	$157.36
68399	T		Eyelid lining surgery	0239	6.1331	$334.63		$66.93
68400	T		Incise/drain tear gland	0238	3.1954	$174.34	$58.96	$34.87
68420	T		Incise/drain tear sac	0240	17.4535	$952.28	$315.31	$190.46
68440	T		Incise tear duct opening	0238	3.1954	$174.34	$58.96	$34.87
68500	T		Removal of tear gland	0241	22.1969	$1,211.09	$384.47	$242.22
68505	T		Partial removal, tear gland	0241	22.1969	$1,211.09	$384.47	$242.22
68510	T		Biopsy of tear gland	0240	17.4535	$952.28	$315.31	$190.46
68520	T		Removal of tear sac	0241	22.1969	$1,211.09	$384.47	$242.22
68525	T		Biopsy of tear sac	0240	17.4535	$952.28	$315.31	$190.46
68530	T		Clearance of tear duct	0240	17.4535	$952.28	$315.31	$190.46
68540	T		Remove tear gland lesion	0241	22.1969	$1,211.09	$384.47	$242.22
68550	T		Remove tear gland lesion	0242	29.4294	$1,605.70	$597.36	$321.14
68700	T		Repair tear ducts	0241	22.1969	$1,211.09	$384.47	$242.22
68705	T		Revise tear duct opening	0238	3.1954	$174.34	$58.96	$34.87
68720	T		Create tear sac drain	0242	29.4294	$1,605.70	$597.36	$321.14
68745	T		Create tear duct drain	0241	22.1969	$1,211.09	$384.47	$242.22
68750	T		Create tear duct drain	0242	29.4294	$1,605.70	$597.36	$321.14
68760	S		Close tear duct opening	0698	0.9599	$52.37	$18.72	$10.47
68761	S		Close tear duct opening	0231	2.1883	$119.40	$50.94	$23.88
68770	T		Close tear system fistula	0240	17.4535	$952.28	$315.31	$190.46
68801	S		Dilate tear duct opening	0231	2.1883	$119.40	$50.94	$23.88
68810	T		Probe nasolacrimal duct	0699	2.2303	$121.69	$47.46	$24.34
68811	T		Probe nasolacrimal duct	0240	17.4535	$952.28	$315.31	$190.46
68815	T		Probe nasolacrimal duct	0240	17.4535	$952.28	$315.31	$190.46

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68840	T		Explore/irrigate tear ducts	0699	2.2303	$121.69	$47.46	$24.34
68850	N		Injection for tear sac x-ray					
68899	T		Tear duct system surgery	0699	2.2303	$121.69	$47.46	$24.34
69000	T		Drain external ear lesion	0006	1.6527	$90.17	$23.26	$18.03
69005	T		Drain external ear lesion	0007	11.8633	$647.27		$129.45
69020	T		Drain outer ear canal lesion	0006	1.6527	$90.17	$23.26	$18.03
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	3.9493	$215.48	$71.87	$43.10
69105	T		Biopsy of external ear canal	0253	15.2249	$830.69	$282.29	$166.14
69110	T		Remove external ear, partial	0021	14.3594	$783.46	$219.48	$156.69
69120	T		Removal of external ear	0254	21.8901	$1,194.35	$321.35	$238.87
69140	T		Remove ear canal lesion(s)	0254	21.8901	$1,194.35	$321.35	$238.87
69145	T		Remove ear canal lesion(s)	0021	14.3594	$783.46	$219.48	$156.69
69150	T		Extensive ear canal surgery	0252	6.4469	$351.75	$113.41	$70.35
69155	C		Extensive ear/neck surgery					
69200	X		Clear outer ear canal	0340	0.6314	$34.45		$6.89
69205	T		Clear outer ear canal	0022	18.7932	$1,025.38	$354.45	$205.08
69210	X		Remove impacted ear wax	0340	0.6314	$34.45		$6.89
69220	T		Clean out mastoid cavity	0012	0.7694	$41.98	$11.18	$8.40
69222	T		Clean out mastoid cavity	0253	15.2249	$830.69	$282.29	$166.14
69300	T		Revise external ear	0254	21.8901	$1,194.35	$321.35	$238.87
69310	T		Rebuild outer ear canal	0256	35.1548	$1,918.08		$383.62
69320	T		Rebuild outer ear canal	0256	35.1548	$1,918.08		$383.62
69399	T		Outer ear surgery procedure	0251	1.7880	$97.56		$19.51
69400	T		Inflate middle ear canal	0251	1.7880	$97.56		$19.51
69401	T		Inflate middle ear canal	0251	1.7880	$97.56		$19.51
69405	T		Catheterize middle ear canal	0252	6.4469	$351.75	$113.41	$70.35
69410	T		Inset middle ear (baffle)	0251	1.7880	$97.56		$19.51
69420	T		Incision of eardrum	0252	6.4469	$351.75	$113.41	$70.35
69421	T		Incision of eardrum	0253	15.2249	$830.69	$282.29	$166.14
69424	T		Remove ventilating tube	0252	6.4469	$351.75	$113.41	$70.35
69433	T		Create eardrum opening	0252	6.4469	$351.75	$113.41	$70.35
69436	T		Create eardrum opening	0253	15.2249	$830.69	$282.29	$166.14
69440	T		Exploration of middle ear	0254	21.8901	$1,194.35	$321.35	$238.87
69450	T		Eardrum revision	0256	35.1548	$1,918.08		$383.62
69501	T		Mastoidectomy	0256	35.1548	$1,918.08		$383.62
69502	T		Mastoidectomy	0254	21.8901	$1,194.35	$321.35	$238.87
69505	T		Remove mastoid structures	0256	35.1548	$1,918.08		$383.62
69511	T		Extensive mastoid surgery	0256	35.1548	$1,918.08		$383.62
69530	T		Extensive mastoid surgery	0256	35.1548	$1,918.08		$383.62
69535	C		Remove part of temporal bone					
69540	T		Remove ear lesion	0253	15.2249	$830.69	$282.29	$166.14
69550	T		Remove ear lesion	0256	35.1548	$1,918.08		$383.62
69552	T		Remove ear lesion	0256	35.1548	$1,918.08		$383.62
69554	C		Remove ear lesion					
69601	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69602	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69603	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69604	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69605	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69610	T		Repair of eardrum	0254	21.8901	$1,194.35	$321.35	$238.87
69620	T		Repair of eardrum	0254	21.8901	$1,194.35	$321.35	$238.87
69631	T		Repair eardrum structures	0256	35.1548	$1,918.08		$383.62
69632	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69633	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69635	T		Repair eardrum structures	0256	35.1548	$1,918.08		$383.62
69636	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69637	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69641	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69642	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69643	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69644	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69645	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69646	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69650	T		Release middle ear bone	0254	21.8901	$1,194.35	$321.35	$238.87
69660	T		Revise middle ear bone	0256	35.1548	$1,918.08		$383.62
69661	T		Revise middle ear bone	0256	35.1548	$1,918.08		$383.62
69662	T		Revise middle ear bone	0256	35.1548	$1,918.08		$383.62
69666	T		Repair middle ear structures	0256	35.1548	$1,918.08		$383.62
69667	T		Repair middle ear structures	0256	35.1548	$1,918.08		$383.62
69670	T		Remove mastoid air cells	0256	35.1548	$1,918.08		$383.62
69676	T		Remove middle ear nerve	0256	35.1548	$1,918.08		$383.62
69700	T		Close mastoid fistula	0256	35.1548	$1,918.08		$383.62
69710	E		Implant/replace hearing aid					
69711	T		Remove/repair hearing aid	0256	35.1548	$1,918.08		$383.62

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69714	T		Implant temple bone w/stimul	0256	35.1548	$1,918.08		$383.62
69715	T		Temple bne implnt w/stimulat	0256	35.1548	$1,918.08		$383.62
69717	T		Temple bone implant revision	0256	35.1548	$1,918.08		$383.62
69718	T		Revise temple bone implant	0256	35.1548	$1,918.08		$383.62
69720	T		Release facial nerve	0256	35.1548	$1,918.08		$383.62
69725	T		Release facial nerve	0256	35.1548	$1,918.08		$383.62
69740	T		Repair facial nerve	0256	35.1548	$1,918.08		$383.62
69745	T		Repair facial nerve	0256	35.1548	$1,918.08		$383.62
69799	T		Middle ear surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
69801	T		Incise inner ear	0256	35.1548	$1,918.08		$383.62
69802	T		Incise inner ear	0256	35.1548	$1,918.08		$383.62
69805	T		Explore inner ear	0256	35.1548	$1,918.08		$383.62
69806	T		Explore inner ear	0256	35.1548	$1,918.08		$383.62
69820	T		Establish inner ear window	0256	35.1548	$1,918.08		$383.62
69840	T		Revise inner ear window	0256	35.1548	$1,918.08		$383.62
69905	T		Remove inner ear	0256	35.1548	$1,918.08		$383.62
69910	T		Remove inner ear & mastoid	0256	35.1548	$1,918.08		$383.62
69915	T		Incise inner ear nerve	0256	35.1548	$1,918.08		$383.62
69930	T		Implant cochlear device	0259	392.8622	$21,434.95	$9,394.83	$4,286.99
69949	T		Inner ear surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
69950	C		Incise inner ear nerve					
69955	T		Release facial nerve	0256	35.1548	$1,918.08		$383.62
69960	T		Release inner ear canal	0256	35.1548	$1,918.08		$383.62
69970	C		Remove inner ear lesion					
69979	T		Temporal bone surgery	0251	1.7880	$97.56		$19.51
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.5931	$196.04	$93.63	$39.21
70015	S		Contrast x-ray of brain	0274	3.5931	$196.04	$93.63	$39.21
70030	X		X-ray eye for foreign body	0260	0.7802	$42.57	$21.28	$8.51
70100	X		X-ray exam of jaw	0260	0.7802	$42.57	$21.28	$8.51
70110	X		X-ray exam of jaw	0260	0.7802	$42.57	$21.28	$8.51
70120	X		X-ray exam of mastoids	0260	0.7802	$42.57	$21.28	$8.51
70130	X		X-ray exam of mastoids	0260	0.7802	$42.57	$21.28	$8.51
70134	X		X-ray exam of middle ear	0261	1.3176	$71.89		$14.38
70140	X		X-ray exam of facial bones	0260	0.7802	$42.57	$21.28	$8.51
70150	X		X-ray exam of facial bones	0260	0.7802	$42.57	$21.28	$8.51
70160	X		X-ray exam of nasal bones	0260	0.7802	$42.57	$21.28	$8.51
70170	X		X-ray exam of tear duct	0263	2.1883	$119.40	$43.58	$23.88
70190	X		X-ray exam of eye sockets	0260	0.7802	$42.57	$21.28	$8.51
70200	X		X-ray exam of eye sockets	0260	0.7802	$42.57	$21.28	$8.51
70210	X		X-ray exam of sinuses	0260	0.7802	$42.57	$21.28	$8.51
70220	X		X-ray exam of sinuses	0260	0.7802	$42.57	$21.28	$8.51
70240	X		X-ray exam, pituitary saddle	0260	0.7802	$42.57	$21.28	$8.51
70250	X		X-ray exam of skull	0260	0.7802	$42.57	$21.28	$8.51
70260	X		X-ray exam of skull	0261	1.3176	$71.89		$14.38
70300	X		X-ray exam of teeth	0262	0.7540	$41.14	$9.82	$8.23
70310	X		X-ray exam of teeth	0262	0.7540	$41.14	$9.82	$8.23
70320	X		Full mouth x-ray of teeth	0262	0.7540	$41.14	$9.82	$8.23
70328	X		X-ray exam of jaw joint	0260	0.7802	$42.57	$21.28	$8.51
70330	X		X-ray exam of jaw joints	0260	0.7802	$42.57	$21.28	$8.51
70332	S		X-ray exam of jaw joint	0275	3.2775	$178.82	$69.09	$35.76
70336	S		Magnetic image, jaw joint	0335	6.3499	$346.46	$151.46	$69.29
70350	X		X-ray head for orthodontia	0260	0.7802	$42.57	$21.28	$8.51
70355	X		Panoramic x-ray of jaws	0260	0.7802	$42.57	$21.28	$8.51
70360	X		X-ray exam of neck	0260	0.7802	$42.57	$21.28	$8.51
70370	X		Throat x-ray & fluoroscopy	0272	1.4166	$77.29	$38.36	$15.46
70371	X		Speech evaluation, complex	0272	1.4166	$77.29	$38.36	$15.46
70373	X		Contrast x-ray of larynx	0263	2.1883	$119.40	$43.58	$23.88
70380	X		X-ray exam of salivary gland	0260	0.7802	$42.57	$21.28	$8.51
70390	X		X-ray exam of salivary duct	0264	3.0287	$165.25	$79.41	$33.05
70450	S		Ct head/brain w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70460	S		Ct head/brain w/dye	0283	4.6543	$253.94	$126.27	$50.79
70470	S		Ct head/brain w/o & w/ dye	0333	5.4241	$295.94	$146.98	$59.19
70480	S		Ct orbit/ear/fossa w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70481	S		Ct orbit/ear/fossa w/dye	0283	4.6543	$253.94	$126.27	$50.79
70482	S		Ct orbit/ear/fossa w/o&w dye	0333	5.4241	$295.94	$146.98	$59.19
70486	S		Ct maxillofacial w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70487	S		Ct maxillofacial w/dye	0283	4.6543	$253.94	$126.27	$50.79
70488	S		Ct maxillofacial w/o & w dye	0333	5.4241	$295.94	$146.98	$59.19
70490	S		Ct soft tissue neck w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70491	S		Ct soft tissue neck w/dye	0283	4.6543	$253.94	$126.27	$50.79
70492	S		Ct sft tsue nck w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
70496	S		Ct angiography, head	0662	5.8775	$320.68	$156.47	$64.14
70498	S		Ct angiography, neck	0662	5.8775	$320.68	$156.47	$64.14
70540	S		Mri orbit/face/neck w/o dye	0336	6.3897	$348.63	$174.31	$69.73

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70542	S		Mri orbit/face/neck w/dye	0284	7.1165	$388.28	$194.13	$77.66
70543	S		Mri orbt/fac/nck w/o & w dye	0337	9.2075	$502.37	$240.77	$100.47
70544	S		Mr angiography head w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70545	S		Mr angiography head w/dye	0284	7.1165	$388.28	$194.13	$77.66
70546	S		Mr angiograph head w/o&w dye	0337	9.2075	$502.37	$240.77	$100.47
70547	S		Mr angiography neck w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70548	S		Mr angiography neck w/dye	0284	7.1165	$388.28	$194.13	$77.66
70549	S		Mr angiograph neck w/o&w dye	0337	9.2075	$502.37	$240.77	$100.47
70551	S		Mri brain w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70552	S		Mri brain w/ dye	0284	7.1165	$388.28	$194.13	$77.66
70553	S		Mri brain w/o & w/ dye	0337	9.2075	$502.37	$240.77	$100.47
70557	S	NI	Mri brain w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70558	S	NI	Mri brain w/ dye	0284	7.1165	$388.28	$194.13	$77.66
70559	S	NI	Mri brain w/o & w/ dye	0337	9.2075	$502.37	$240.77	$100.47
71010	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71015	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71020	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71021	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71022	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71023	X		Chest x-ray and fluoroscopy	0272	1.4166	$77.29	$38.36	$15.46
71030	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71034	X		Chest x-ray and fluoroscopy	0272	1.4166	$77.29	$38.36	$15.46
71035	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71040	X		Contrast x-ray of bronchi	0263	2.1883	$119.40	$43.58	$23.88
71060	X		Contrast x-ray of bronchi	0264	3.0287	$165.25	$79.41	$33.05
71090	X		X-ray & pacemaker insertion	0272	1.4166	$77.29	$38.36	$15.46
71100	X		X-ray exam of ribs	0260	0.7802	$42.57	$21.28	$8.51
71101	X		X-ray exam of ribs/chest	0260	0.7802	$42.57	$21.28	$8.51
71110	X		X-ray exam of ribs	0260	0.7802	$42.57	$21.28	$8.51
71111	X		X-ray exam of ribs/ chest	0261	1.3176	$71.89		$14.38
71120	X		X-ray exam of breastbone	0260	0.7802	$42.57	$21.28	$8.51
71130	X		X-ray exam of breastbone	0260	0.7802	$42.57	$21.28	$8.51
71250	S		Ct thorax w/o dye	0332	3.3936	$185.16	$91.27	$37.03
71260	S		Ct thorax w/dye	0283	4.6543	$253.94	$126.27	$50.79
71270	S		Ct thorax w/o & w/ dye	0333	5.4241	$295.94	$146.98	$59.19
71275	S		Ct angiography, chest	0662	5.8775	$320.68	$156.47	$64.14
71550	S		Mri chest w/o dye	0336	6.3897	$348.63	$174.31	$69.73
71551	S		Mri chest w/dye	0284	7.1165	$388.28	$194.13	$77.66
71552	S		Mri chest w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
71555	B		Mri angio chest w or w/o dye					
72010	X		X-ray exam of spine	0261	1.3176	$71.89		$14.38
72020	X		X-ray exam of spine	0260	0.7802	$42.57	$21.28	$8.51
72040	X		X-ray exam of neck spine	0260	0.7802	$42.57	$21.28	$8.51
72050	X		X-ray exam of neck spine	0261	1.3176	$71.89		$14.38
72052	X		X-ray exam of neck spine	0261	1.3176	$71.89		$14.38
72069	X		X-ray exam of trunk spine	0260	0.7802	$42.57	$21.28	$8.51
72070	X		X-ray exam of thoracic spine	0260	0.7802	$42.57	$21.28	$8.51
72072	X		X-ray exam of thoracic spine	0260	0.7802	$42.57	$21.28	$8.51
72074	X		X-ray exam of thoracic spine	0260	0.7802	$42.57	$21.28	$8.51
72080	X		X-ray exam of trunk spine	0260	0.7802	$42.57	$21.28	$8.51
72090	X		X-ray exam of trunk spine	0261	1.3176	$71.89		$14.38
72100	X		X-ray exam of lower spine	0260	0.7802	$42.57	$21.28	$8.51
72110	X		X-ray exam of lower spine	0261	1.3176	$71.89		$14.38
72114	X		X-ray exam of lower spine	0261	1.3176	$71.89		$14.38
72120	X		X-ray exam of lower spine	0260	0.7802	$42.57	$21.28	$8.51
72125	S		Ct neck spine w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72126	S		Ct neck spine w/dye	0283	4.6543	$253.94	$126.27	$50.79
72127	S		Ct neck spine w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72128	S		Ct chest spine w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72129	S		Ct chest spine w/dye	0283	4.6543	$253.94	$126.27	$50.79
72130	S		Ct chest spine w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72131	S		Ct lumbar spine w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72132	S		Ct lumbar spine w/dye	0283	4.6543	$253.94	$126.27	$50.79
72133	S		Ct lumbar spine w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72141	S		Mri neck spine w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72142	S		Mri neck spine w/dye	0284	7.1165	$388.28	$194.13	$77.66
72146	S		Mri chest spine w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72147	S		Mri chest spine w/dye	0284	7.1165	$388.28	$194.13	$77.66
72148	S		Mri lumbar spine w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72149	S		Mri lumbar spine w/dye	0284	7.1165	$388.28	$194.13	$77.66
72156	S		Mri neck spine w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72157	S		Mri chest spine w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72158	S		Mri lumbar spine w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72159	E		Mr angio spine w/o&w/dye					
72170	X		X-ray exam of pelvis	0260	0.7802	$42.57	$21.28	$8.51

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72190	X		X-ray exam of pelvis	0260	0.7802	$42.57	$21.28	$8.51
72191	S		Ct angiograph pelv w/o&w/dye	0662	5.8775	$320.68	$156.47	$64.14
72192	S		Ct pelvis w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72193	S		Ct pelvis w/dye	0283	4.6543	$253.94	$126.27	$50.79
72194	S		Ct pelvis w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72195	S		Mri pelvis w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72196	S		Mri pelvis w/dye	0284	7.1165	$388.28	$194.13	$77.66
72197	S		Mri pelvis w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72198	E		Mr angio pelvis w/o & w/dye					
72200	X		X-ray exam sacroiliac joints	0260	0.7802	$42.57	$21.28	$8.51
72202	X		X-ray exam sacroiliac joints	0260	0.7802	$42.57	$21.28	$8.51
72220	X		X-ray exam of tailbone	0260	0.7802	$42.57	$21.28	$8.51
72240	S		Contrast x-ray of neck spine	0274	3.5931	$196.04	$93.63	$39.21
72255	S		Contrast x-ray, thorax spine	0274	3.5931	$196.04	$93.63	$39.21
72265	S		Contrast x-ray, lower spine	0274	3.5931	$196.04	$93.63	$39.21
72270	S		Contrast x-ray, spine	0274	3.5931	$196.04	$93.63	$39.21
72275	S		Epidurography	0274	3.5931	$196.04	$93.63	$39.21
72285	S		X-ray c/t spine disk	0388	11.6347	$634.80	$303.19	$126.96
72295	S		X-ray of lower spine disk	0388	11.6347	$634.80	$303.19	$126.96
73000	X		X-ray exam of collar bone	0260	0.7802	$42.57	$21.28	$8.51
73010	X		X-ray exam of shoulder blade	0260	0.7802	$42.57	$21.28	$8.51
73020	X		X-ray exam of shoulder	0260	0.7802	$42.57	$21.28	$8.51
73030	X		X-ray exam of shoulder	0260	0.7802	$42.57	$21.28	$8.51
73040	S		Contrast x-ray of shoulder	0275	3.2775	$178.82	$69.09	$35.76
73050	X		X-ray exam of shoulders	0260	0.7802	$42.57	$21.28	$8.51
73060	X		X-ray exam of humerus	0260	0.7802	$42.57	$21.28	$8.51
73070	X		X-ray exam of elbow	0260	0.7802	$42.57	$21.28	$8.51
73080	X		X-ray exam of elbow	0260	0.7802	$42.57	$21.28	$8.51
73085	S		Contrast x-ray of elbow	0275	3.2775	$178.82	$69.09	$35.76
73090	X		X-ray exam of forearm	0260	0.7802	$42.57	$21.28	$8.51
73092	X		X-ray exam of arm, infant	0260	0.7802	$42.57	$21.28	$8.51
73100	X		X-ray exam of wrist	0260	0.7802	$42.57	$21.28	$8.51
73110	X		X-ray exam of wrist	0260	0.7802	$42.57	$21.28	$8.51
73115	S		Contrast x-ray of wrist	0275	3.2775	$178.82	$69.09	$35.76
73120	X		X-ray exam of hand	0260	0.7802	$42.57	$21.28	$8.51
73130	X		X-ray exam of hand	0260	0.7802	$42.57	$21.28	$8.51
73140	X		X-ray exam of finger(s)	0260	0.7802	$42.57	$21.28	$8.51
73200	S		Ct upper extremity w/o dye	0332	3.3936	$185.16	$91.27	$37.03
73201	S		Ct upper extremity w/dye	0283	4.6543	$253.94	$126.27	$50.79
73202	S		Ct uppr extremity w/o&w/dye	0333	5.4241	$295.94	$146.98	$59.19
73206	S		Ct angio upr extrm w/o&w/dye	0662	5.8775	$320.68	$156.47	$64.14
73218	S		Mri upper extremity w/o dye	0336	6.3897	$348.63	$174.31	$69.73
73219	S		Mri upper extremity w/dye	0284	7.1165	$388.28	$194.13	$77.66
73220	S		Mri uppr extremity w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73221	S		Mri joint upr extrem w/o dye	0336	6.3897	$348.63	$174.31	$69.73
73222	S		Mri joint upr extrem w/dye	0284	7.1165	$388.28	$194.13	$77.66
73223	S		Mri joint upr extr w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73225	E		Mr angio upr extr w/o&w/dye					
73500	X		X-ray exam of hip	0260	0.7802	$42.57	$21.28	$8.51
73510	X		X-ray exam of hip	0260	0.7802	$42.57	$21.28	$8.51
73520	X		X-ray exam of hips	0260	0.7802	$42.57	$21.28	$8.51
73525	S		Contrast x-ray of hip	0275	3.2775	$178.82	$69.09	$35.76
73530	X		X-ray exam of hip	0261	1.3176	$71.89		$14.38
73540	X		X-ray exam of pelvis & hips	0260	0.7802	$42.57	$21.28	$8.51
73542	S		X-ray exam, sacroiliac joint	0275	3.2775	$178.82	$69.09	$35.76
73550	X		X-ray exam of thigh	0260	0.7802	$42.57	$21.28	$8.51
73560	X		X-ray exam of knee, 1 or 2	0260	0.7802	$42.57	$21.28	$8.51
73562	X		X-ray exam of knee, 3	0260	0.7802	$42.57	$21.28	$8.51
73564	X		X-ray exam, knee, 4 or more	0260	0.7802	$42.57	$21.28	$8.51
73565	X		X-ray exam of knees	0260	0.7802	$42.57	$21.28	$8.51
73580	S		Contrast x-ray of knee joint	0275	3.2775	$178.82	$69.09	$35.76
73590	X		X-ray exam of lower leg	0260	0.7802	$42.57	$21.28	$8.51
73592	X		X-ray exam of leg, infant	0260	0.7802	$42.57	$21.28	$8.51
73600	X		X-ray exam of ankle	0260	0.7802	$42.57	$21.28	$8.51
73610	X		X-ray exam of ankle	0260	0.7802	$42.57	$21.28	$8.51
73615	S		Contrast x-ray of ankle	0275	3.2775	$178.82	$69.09	$35.76
73620	X		X-ray exam of foot	0260	0.7802	$42.57	$21.28	$8.51
73630	X		X-ray exam of foot	0260	0.7802	$42.57	$21.28	$8.51
73650	X		X-ray exam of heel	0260	0.7802	$42.57	$21.28	$8.51
73660	X		X-ray exam of toe(s)	0260	0.7802	$42.57	$21.28	$8.51
73700	S		Ct lower extremity w/o dye	0332	3.3936	$185.16	$91.27	$37.03
73701	S		Ct lower extremity w/dye	0283	4.6543	$253.94	$126.27	$50.79
73702	S		Ct lwr extremity w/o&w/dye	0333	5.4241	$295.94	$146.98	$59.19
73706	S		Ct angio lwr extr w/o&w/dye	0662	5.8775	$320.68	$156.47	$64.14
73718	S		Mri lower extremity w/o dye	0336	6.3897	$348.63	$174.31	$69.73

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73719	S		Mri lower extremity w/dye	0284	7.1165	$388.28	$194.13	$77.66
73720	S		Mri lwr extremity w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73721	S		Mri jnt of lwr extre w/o dye	0336	6.3897	$348.63	$174.31	$69.73
73722	S		Mri joint of lwr extr w/dye	0284	7.1165	$388.28	$194.13	$77.66
73723	S		Mri joint lwr extr w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73725	B		Mr ang lwr ext w or w/o dye					
74000	X		X-ray exam of abdomen	0260	0.7802	$42.57	$21.28	$8.51
74010	X		X-ray exam of abdomen	0260	0.7802	$42.57	$21.28	$8.51
74020	X		X-ray exam of abdomen	0260	0.7802	$42.57	$21.28	$8.51
74022	X		X-ray exam series, abdomen	0261	1.3176	$71.89		$14.38
74150	S		Ct abdomen w/o dye	0332	3.3936	$185.16	$91.27	$37.03
74160	S		Ct abdomen w/dye	0283	4.6543	$253.94	$126.27	$50.79
74170	S		Ct abdomen w/o &w /dye	0333	5.4241	$295.94	$146.98	$59.19
74175	S		Ct angio abdom w/o & w/dye	0662	5.8775	$320.68	$156.47	$64.14
74181	S		Mri abdomen w/o dye	0336	6.3897	$348.63	$174.31	$69.73
74182	S		Mri abdomen w/dye	0284	7.1165	$388.28	$194.13	$77.66
74183	S		Mri abdomen w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
74185	B		Mri angio, abdom w orw/o dye					
74190	X		X-ray exam of peritoneum	0263	2.1883	$119.40	$43.58	$23.88
74210	S		Contrst x-ray exam of throat	0276	1.5906	$86.78	$41.72	$17.36
74220	S		Contrast x-ray, esophagus	0276	1.5906	$86.78	$41.72	$17.36
74230	S		Cine/vid x-ray, throat/esoph	0276	1.5906	$86.78	$41.72	$17.36
74235	S		Remove esophagus obstruction	0296	2.8635	$156.24	$69.20	$31.25
74240	S		X-ray exam, upper gi tract	0276	1.5906	$86.78	$41.72	$17.36
74241	S		X-ray exam, upper gi tract	0276	1.5906	$86.78	$41.72	$17.36
74245	S		X-ray exam, upper gi tract	0277	2.4444	$133.37	$60.47	$26.67
74246	S		Contrst x-ray uppr gi tract	0276	1.5906	$86.78	$41.72	$17.36
74247	S		Contrst x-ray uppr gi tract	0276	1.5906	$86.78	$41.72	$17.36
74249	S		Contrst x-ray uppr gi tract	0277	2.4444	$133.37	$60.47	$26.67
74250	S		X-ray exam of small bowel	0276	1.5906	$86.78	$41.72	$17.36
74251	S		X-ray exam of small bowel	0277	2.4444	$133.37	$60.47	$26.67
74260	S		X-ray exam of small bowel	0277	2.4444	$133.37	$60.47	$26.67
74270	S		Contrast x-ray exam of colon	0276	1.5906	$86.78	$41.72	$17.36
74280	S		Contrast x-ray exam of colon	0277	2.4444	$133.37	$60.47	$26.67
74283	S		Contrast x-ray exam of colon	0276	1.5906	$86.78	$41.72	$17.36
74290	S		Contrast x-ray, gallbladder	0276	1.5906	$86.78	$41.72	$17.36
74291	S		Contrast x-rays, gallbladder	0276	1.5906	$86.78	$41.72	$17.36
74300	X		X-ray bile ducts/pancreas	0263	2.1883	$119.40	$43.58	$23.88
74301	X		X-rays at surgery add-on	0263	2.1883	$119.40	$43.58	$23.88
74305	X		X-ray bile ducts/pancreas	0263	2.1883	$119.40	$43.58	$23.88
74320	X		Contrast x-ray of bile ducts	0264	3.0287	$165.25	$79.41	$33.05
74327	S		X-ray bile stone removal	0296	2.8635	$156.24	$69.20	$31.25
74328	N		X-ray 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	1.4166	$77.29	$38.36	$15.46
74350	X		X-ray guide, stomach tube	0263	2.1883	$119.40	$43.58	$23.88
74355	X		X-ray guide, intestinal tube	0263	2.1883	$119.40	$43.58	$23.88
74360	S		X-ray guide, GI dilation	0296	2.8635	$156.24	$69.20	$31.25
74363	S		X-ray, bile duct dilation	0297	7.7145	$420.91	$172.51	$84.18
74400	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74410	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74415	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74420	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74425	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74430	S		Contrast x-ray, bladder	0278	2.7012	$147.38	$66.07	$29.48
74440	S		X-ray, male genital tract	0278	2.7012	$147.38	$66.07	$29.48
74445	S		X-ray exam of penis	0278	2.7012	$147.38	$66.07	$29.48
74450	S		X-ray, urethra/bladder	0278	2.7012	$147.38	$66.07	$29.48
74455	S		X-ray, urethra/bladder	0278	2.7012	$147.38	$66.07	$29.48
74470	X		X-ray exam of kidney lesion	0264	3.0287	$165.25	$79.41	$33.05
74475	S		X-ray control, cath insert	0297	7.7145	$420.91	$172.51	$84.18
74480	S		X-ray control, cath insert	0296	2.8635	$156.24	$69.20	$31.25
74485	S		X-ray guide, GU dilation	0296	2.8635	$156.24	$69.20	$31.25
74710	X		X-ray measurement of pelvis	0260	0.7802	$42.57	$21.28	$8.51
74740	X		X-ray, female genital tract	0264	3.0287	$165.25	$79.41	$33.05
74742	X		X-ray, fallopian tube	0263	2.1883	$119.40	$43.58	$23.88
74775	S		X-ray exam of perineum	0278	2.7012	$147.38	$66.07	$29.48
75552	S		Heart mri for morph w/o dye	0336	6.3897	$348.63	$174.31	$69.73
75553	S		Heart mri for morph w/dye	0284	7.1165	$388.28	$194.13	$77.66
75554	S		Cardiac MRI/function	0335	6.3499	$346.46	$151.46	$69.29
75555	S		Cardiac MRI/limited study	0335	6.3499	$346.46	$151.46	$69.29
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	19.1015	$1,042.20	$353.85	$208.44
75605	S		Contrast x-ray exam of aorta	0280	19.1015	$1,042.20	$353.85	$208.44

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75625	S		Contrast x-ray exam of aorta	0280	19.1015	$1,042.20	$353.85	$208.44
75630	S		X-ray aorta, leg arteries	0280	19.1015	$1,042.20	$353.85	$208.44
75635	S		Ct angio abdominal arteries	0662	5.8775	$320.68	$156.47	$64.14
75650	S		Artery x-rays, head & neck	0280	19.1015	$1,042.20	$353.85	$208.44
75658	S		Artery x-rays, arm	0280	19.1015	$1,042.20	$353.85	$208.44
75660	S		Artery x-rays, head & neck	0279	10.7073	$584.20	$174.57	$116.84
75662	S		Artery x-rays, head & neck	0279	10.7073	$584.20	$174.57	$116.84
75665	S		Artery x-rays, head & neck	0280	19.1015	$1,042.20	$353.85	$208.44
75671	S		Artery x-rays, head & neck	0280	19.1015	$1,042.20	$353.85	$208.44
75676	S		Artery x-rays, neck	0280	19.1015	$1,042.20	$353.85	$208.44
75680	S		Artery x-rays, neck	0280	19.1015	$1,042.20	$353.85	$208.44
75685	S		Artery x-rays, spine	0279	10.7073	$584.20	$174.57	$116.84
75705	S		Artery x-rays, spine	0279	10.7073	$584.20	$174.57	$116.84
75710	S		Artery x-rays, arm/leg	0280	19.1015	$1,042.20	$353.85	$208.44
75716	S		Artery x-rays, arms/legs	0280	19.1015	$1,042.20	$353.85	$208.44
75722	S		Artery x-rays, kidney	0280	19.1015	$1,042.20	$353.85	$208.44
75724	S		Artery x-rays, kidneys	0280	19.1015	$1,042.20	$353.85	$208.44
75726	S		Artery x-rays, abdomen	0280	19.1015	$1,042.20	$353.85	$208.44
75731	S		Artery x-rays, adrenal gland	0280	19.1015	$1,042.20	$353.85	$208.44
75733	S		Artery x-rays, adrenals	0280	19.1015	$1,042.20	$353.85	$208.44
75736	S		Artery x-rays, pelvis	0280	19.1015	$1,042.20	$353.85	$208.44
75741	S		Artery x-rays, lung	0279	10.7073	$584.20	$174.57	$116.84
75743	S		Artery x-rays, lungs	0280	19.1015	$1,042.20	$353.85	$208.44
75746	S		Artery x-rays, lung	0279	10.7073	$584.20	$174.57	$116.84
75756	S		Artery x-rays, chest	0279	10.7073	$584.20	$174.57	$116.84
75774	S		Artery x-ray, each vessel	0668	10.2660	$560.12	$237.76	$112.02
75790	S		Visualize A-V shunt	0281	6.6031	$360.27	$115.16	$72.05
75801	X		Lymph vessel x-ray, arm/leg	0264	3.0287	$165.25	$79.41	$33.05
75803	X		Lymph vessel x-ray,arms/legs	0264	3.0287	$165.25	$79.41	$33.05
75805	X		Lymph vessel x-ray, trunk	0264	3.0287	$165.25	$79.41	$33.05
75807	X		Lymph vessel x-ray, trunk	0264	3.0287	$165.25	$79.41	$33.05
75809	X		Nonvascular shunt, x-ray	0263	2.1883	$119.40	$43.58	$23.88
75810	S		Vein x-ray, spleen/liver	0279	10.7073	$584.20	$174.57	$116.84
75820	S		Vein x-ray, arm/leg	0281	6.6031	$360.27	$115.16	$72.05
75822	S		Vein x-ray, arms/legs	0281	6.6031	$360.27	$115.16	$72.05
75825	S		Vein x-ray, trunk	0279	10.7073	$584.20	$174.57	$116.84
75827	S		Vein x-ray, chest	0279	10.7073	$584.20	$174.57	$116.84
75831	S		Vein x-ray, kidney	0287	6.4923	$354.23	$111.33	$70.85
75833	S		Vein x-ray, kidneys	0279	10.7073	$584.20	$174.57	$116.84
75840	S		Vein x-ray, adrenal gland	0287	6.4923	$354.23	$111.33	$70.85
75842	S		Vein x-ray, adrenal glands	0287	6.4923	$354.23	$111.33	$70.85
75860	S		Vein x-ray, neck	0287	6.4923	$354.23	$111.33	$70.85
75870	S		Vein x-ray, skull	0287	6.4923	$354.23	$111.33	$70.85
75872	S		Vein x-ray, skull	0287	6.4923	$354.23	$111.33	$70.85
75880	S		Vein x-ray, eye socket	0287	6.4923	$354.23	$111.33	$70.85
75885	S		Vein x-ray, liver	0279	10.7073	$584.20	$174.57	$116.84
75887	S		Vein x-ray, liver	0280	19.1015	$1,042.20	$353.85	$208.44
75889	S		Vein x-ray, liver	0279	10.7073	$584.20	$174.57	$116.84
75891	S		Vein x-ray, liver	0279	10.7073	$584.20	$174.57	$116.84
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	7.7145	$420.91	$172.51	$84.18
75896	S		X-rays, transcath therapy	0297	7.7145	$420.91	$172.51	$84.18
75898	X		Follow-up angiography	0264	3.0287	$165.25	$79.41	$33.05
75900	C		Arterial catheter exchange					
75901	X		Remove cva device obstruct	0264	3.0287	$165.25	$79.41	$33.05
75902	X		Remove cva lumen obstruct	0263	2.1883	$119.40	$43.58	$23.88
75940	X		X-ray placement, vein filter	0187	4.4288	$241.64	$90.71	$48.33
75945	S		Intravascular us	0267	2.4586	$134.14	$65.52	$26.83
75946	S		Intravascular us add-on	0267	2.4586	$134.14	$65.52	$26.83
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C		Iliac aneurysm endovas rpr					
75960	S		Transcatheter intro, stent	0280	19.1015	$1,042.20	$353.85	$208.44
75961	S		Retrieval, broken catheter	0280	19.1015	$1,042.20	$353.85	$208.44
75962	S		Repair arterial blockage	0280	19.1015	$1,042.20	$353.85	$208.44
75964	S		Repair artery blockage, each	0280	19.1015	$1,042.20	$353.85	$208.44
75966	S		Repair arterial blockage	0280	19.1015	$1,042.20	$353.85	$208.44
75968	S		Repair artery blockage, each	0280	19.1015	$1,042.20	$353.85	$208.44
75970	S		Vascular biopsy	0280	19.1015	$1,042.20	$353.85	$208.44
75978	S		Repair venous blockage	0668	10.2660	$560.12	$237.76	$112.02
75980	S		Contrast xray exam bile duct	0296	2.8635	$156.24	$69.20	$31.25
75982	S		Contrast xray exam bile duct	0297	7.7145	$420.91	$172.51	$84.18
75984	X		Xray control catheter change	0264	3.0287	$165.25	$79.41	$33.05
75989	N		Abscess drainage under x-ray					
75992	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75993	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75994	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75995	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75996	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75998	N	NI	Fluoroguide for vein device					
76000	X		Fluoroscope examination	0272	1.4166	$77.29	$38.36	$15.46
76001	N		Fluoroscope exam, extensive					
76003	N		Needle localization by x-ray					
76005	N		Fluoroguide for spine inject					
76006	X		X-ray stress view	0260	0.7802	$42.57	$21.28	$8.51
76010	X		X-ray, nose to rectum	0260	0.7802	$42.57	$21.28	$8.51
76012	S		Percut vertebroplasty fluor	0274	3.5931	$196.04	$93.63	$39.21
76013	S		Percut vertebroplasty, ct	0274	3.5931	$196.04	$93.63	$39.21
76020	X		X-rays for bone age	0260	0.7802	$42.57	$21.28	$8.51
76040	X		X-rays, bone evaluation	0260	0.7802	$42.57	$21.28	$8.51
76061	X		X-rays, bone survey	0261	1.3176	$71.89		$14.38
76062	X		X-rays, bone survey	0261	1.3176	$71.89		$14.38
76065	X		X-rays, bone evaluation	0261	1.3176	$71.89		$14.38
76066	X		Joint survey, single view	0260	0.7802	$42.57	$21.28	$8.51
76070	S		CT scan, bone density study	0288	1.2726	$69.43		$13.89
76071	S		Ct bone density, peripheral	0282	1.6834	$91.85	$44.51	$18.37
76075	S		Dexa, axial skeleton study	0288	1.2726	$69.43		$13.89
76076	S		Dexa, peripheral study	0665	0.7257	$39.59		$7.92
76078	X		Radiographic absorptiometry	0261	1.3176	$71.89		$14.38
76080	X		X-ray exam of fistula	0263	2.1883	$119.40	$43.58	$23.88
76082	S	NI	Computer mammogram add-on	0410	0.1523	$8.31		$1.66
76083	A	NI	Computer mammogram add-on					
76085	D	DNG	Computer mammogram add-on					
76086	X		X-ray of mammary duct	0263	2.1883	$119.40	$43.58	$23.88
76088	X		X-ray of mammary ducts	0263	2.1883	$119.40	$43.58	$23.88
76090	S		Mammogram, one breast	0271	0.6499	$35.46	$16.80	$7.09
76091	S		Mammogram, both breasts	0271	0.6499	$35.46	$16.80	$7.09
76092	A		Mammogram, screening					
76093	E		Magnetic image, breast					
76094	E		Magnetic image, both breasts					
76095	X		Stereotactic breast biopsy	0187	4.4288	$241.64	$90.71	$48.33
76096	X		X-ray of needle wire, breast	0289	3.4900	$190.42	$44.80	$38.08
76098	X		X-ray exam, breast specimen	0260	0.7802	$42.57	$21.28	$8.51
76100	X		X-ray exam of body section	0261	1.3176	$71.89		$14.38
76101	X		Complex body section x-ray	0264	3.0287	$165.25	$79.41	$33.05
76102	X		Complex body section x-rays	0264	3.0287	$165.25	$79.41	$33.05
76120	X		Cine/video x-rays	0272	1.4166	$77.29	$38.36	$15.46
76125	X		Cine/video x-rays add-on	0260	0.7802	$42.57	$21.28	$8.51
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7802	$42.57	$21.28	$8.51
76350	N		Special x-ray contrast study					
76355	S		Ct scan for localization	0283	4.6543	$253.94	$126.27	$50.79
76360	S		Ct scan for needle biopsy	0283	4.6543	$253.94	$126.27	$50.79
76362	S		Ct guide for tissue ablation	0332	3.3936	$185.16	$91.27	$37.03
76370	S		Ct scan for therapy guide	0282	1.6834	$91.85	$44.51	$18.37
76375	S		3d/holograph reconstr add-on	0282	1.6834	$91.85	$44.51	$18.37
76380	S		CAT scan follow-up study	0282	1.6834	$91.85	$44.51	$18.37
76390	E		Mr spectroscopy					
76393	S		Mr guidance for needle place	0335	6.3499	$346.46	$151.46	$69.29
76394	S		Mri for tissue ablation	0335	6.3499	$346.46	$151.46	$69.29
76400	S		Magnetic image, bone marrow	0335	6.3499	$346.46	$151.46	$69.29
76490	S	DG	Us for tissue ablation	0268	1.3081	$71.37		$14.27
76496	X		Fluoroscopic procedure	0272	1.4166	$77.29	$38.36	$15.46
76497	S		Ct procedure	0282	1.6834	$91.85	$44.51	$18.37
76498	S		Mri procedure	0335	6.3499	$346.46	$151.46	$69.29
76499	X		Radiographic procedure	0260	0.7802	$42.57	$21.28	$8.51
76506	S		Echo exam of head	0266	1.6117	$87.94	$43.97	$17.59
76511	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76512	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76513	S		Echo exam of eye, water bath	0265	1.0289	$56.14	$28.07	$11.23
76514	S	NI	Echo exam of eye, thickness	0265	1.0289	$56.14	$28.07	$11.23
76516	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76519	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76529	S		Echo exam of eye	0265	1.0289	$56.14	$28.07	$11.23
76536	S		Us exam of head and neck	0266	1.6117	$87.94	$43.97	$17.59
76604	S		Us exam, chest, b-scan	0266	1.6117	$87.94	$43.97	$17.59
76645	S		Us exam, breast(s)	0265	1.0289	$56.14	$28.07	$11.23
76700	S		Us exam, abdom, complete	0266	1.6117	$87.94	$43.97	$17.59
76705	S		Echo exam of abdomen	0266	1.6117	$87.94	$43.97	$17.59
76770	S		Us exam abdo back wall, comp	0266	1.6117	$87.94	$43.97	$17.59

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76775	S		Us exam abdo back wall, lim	0266	1.6117	$87.94	$43.97	$17.59
76778	S		Us exam kidney transplant	0266	1.6117	$87.94	$43.97	$17.59
76800	S		Us exam, spinal canal	0266	1.6117	$87.94	$43.97	$17.59
76801	S		Ob us < 14 wks, single fetus	0265	1.0289	$56.14	$28.07	$11.23
76802	S		Ob us < 14 wks, add'l fetus	0265	1.0289	$56.14	$28.07	$11.23
76805	S		Us exam, pg uterus, compl	0266	1.6117	$87.94	$43.97	$17.59
76810	S		Us exam, pg uterus, mult	0265	1.0289	$56.14	$28.07	$11.23
76811	S		Ob us, detailed, sngl fetus	0267	2.4586	$134.14	$65.52	$26.83
76812	S		Ob us, detailed, addl fetus	0266	1.6117	$87.94	$43.97	$17.59
76815	S		Us exam, pg uterus limit	0265	1.0289	$56.14	$28.07	$11.23
76816	S		Us exam pg uterus repeat	0265	1.0289	$56.14	$28.07	$11.23
76817	S		Transvaginal us, obstetric	0265	1.0289	$56.14	$28.07	$11.23
76818	S		Fetal biophys profile w/nst	0266	1.6117	$87.94	$43.97	$17.59
76819	S		Fetal biophys profil w/o nst	0266	1.6117	$87.94	$43.97	$17.59
76825	S		Echo exam of fetal heart	0671	1.6384	$89.39	$44.69	$17.88
76826	S		Echo exam of fetal heart	0697	1.4415	$78.65	$39.32	$15.73
76827	S		Echo exam of fetal heart	0671	1.6384	$89.39	$44.69	$17.88
76828	S		Echo exam of fetal heart	0697	1.4415	$78.65	$39.32	$15.73
76830	S		Transvaginal us, non-ob	0266	1.6117	$87.94	$43.97	$17.59
76831	S		Echo exam, uterus	0266	1.6117	$87.94	$43.97	$17.59
76856	S		Us exam, pelvic, complete	0266	1.6117	$87.94	$43.97	$17.59
76857	S		Us exam, pelvic, limited	0265	1.0289	$56.14	$28.07	$11.23
76870	S		Us exam, scrotum	0266	1.6117	$87.94	$43.97	$17.59
76872	S		Us, transrectal	0266	1.6117	$87.94	$43.97	$17.59
76873	S		Echograp trans r, pros study	0266	1.6117	$87.94	$43.97	$17.59
76880	S		Us exam, extremity	0266	1.6117	$87.94	$43.97	$17.59
76885	S		Us exam infant hips, dynamic	0266	1.6117	$87.94	$43.97	$17.59
76886	S		Us exam infant hips, static	0266	1.6117	$87.94	$43.97	$17.59
76930	S		Echo guide, cardiocentesis	0268	1.3081	$71.37		$14.27
76932	S		Echo guide for heart biopsy	0268	1.3081	$71.37		$14.27
76936	S		Echo guide for artery repair	0268	1.3081	$71.37		$14.27
76937	N	NI	Us guide, vascular access					
76940	S	NI	Us guide, tissue ablation	0268	1.3081	$71.37		$14.27
76941	S		Echo guide for transfusion	0268	1.3081	$71.37		$14.27
76942	S		Echo guide for biopsy	0268	1.3081	$71.37		$14.27
76945	S		Echo guide, villus sampling	0268	1.3081	$71.37		$14.27
76946	S		Echo guide for amniocentesis	0268	1.3081	$71.37		$14.27
76948	S		Echo guide, ova aspiration	0268	1.3081	$71.37		$14.27
76950	S		Echo guidance radiotherapy	0268	1.3081	$71.37		$14.27
76965	S		Echo guidance radiotherapy	0268	1.3081	$71.37		$14.27
76970	S		Ultrasound exam follow-up	0265	1.0289	$56.14	$28.07	$11.23
76975	S		GI endoscopic ultrasound	0266	1.6117	$87.94	$43.97	$17.59
76977	S		Us bone density measure	0340	0.6314	$34.45		$6.89
76986	S		Ultrasound guide intraoper	0266	1.6117	$87.94	$43.97	$17.59
76999	S		Echo examination procedure	0265	1.0289	$56.14	$28.07	$11.23
77261	E		Radiation therapy planning					
77262	E		Radiation therapy planning					
77263	E		Radiation therapy planning					
77280	X		Set radiation therapy field	0304	1.6742	$91.35	$41.52	$18.27
77285	X		Set radiation therapy field	0305	3.6767	$200.60	$91.38	$40.12
77290	X		Set radiation therapy field	0305	3.6767	$200.60	$91.38	$40.12
77295	X		Set radiation therapy field	0310	13.7165	$748.39	$325.27	$149.68
77299	E		Radiation therapy planning					
77300	X		Radiation therapy dose plan	0304	1.6742	$91.35	$41.52	$18.27
77301	S		Radiotherapy dose plan, imrt	1510		$850.00		$170.00
77305	X		Teletx isodose plan simple	0304	1.6742	$91.35	$41.52	$18.27
77310	X		Teletx isodose plan intermed	0304	1.6742	$91.35	$41.52	$18.27
77315	X		Teletx isodose plan complex	0305	3.6767	$200.60	$91.38	$40.12
77321	X		Special teletx port plan	0305	3.6767	$200.60	$91.38	$40.12
77326	X		Radiation therapy dose plan	0305	3.6767	$200.60	$91.38	$40.12
77327	X		Brachytx isodose calc interm	0305	3.6767	$200.60	$91.38	$40.12
77328	X		Brachytx isodose plan compl	0305	3.6767	$200.60	$91.38	$40.12
77331	X		Special radiation dosimetry	0304	1.6742	$91.35	$41.52	$18.27
77332	X		Radiation treatment aid(s)	0303	2.8835	$157.33	$66.95	$31.47
77333	X		Radiation treatment aid(s)	0303	2.8835	$157.33	$66.95	$31.47
77334	X		Radiation treatment aid(s)	0303	2.8835	$157.33	$66.95	$31.47
77336	X		Radiation physics consult	0304	1.6742	$91.35	$41.52	$18.27
77370	X		Radiation physics consult	0305	3.6767	$200.60	$91.38	$40.12
77399	X		External radiation dosimetry	0304	1.6742	$91.35	$41.52	$18.27
77401	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77402	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77403	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77404	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77406	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77407	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77408	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77409	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77411	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77412	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77413	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77414	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77416	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77417	X		Radiology port film(s)	0260	0.7802	$42.57	$21.28	$8.51
77418	S		Radiation tx delivery, imrt	0412	5.3904	$294.11		$58.82
77427	E		Radiation tx management, x5					
77431	E		Radiation therapy management					
77432	E		Stereotactic radiation trmt					
77470	S		Special radiation treatment	0299	5.7618	$314.37		$62.87
77499	E		Radiation therapy management					
77520	S		Proton trmt, simple w/o comp	0664	9.7295	$530.85		$106.17
77522	S		Proton trmt, simple w/comp	0664	9.7295	$530.85		$106.17
77523	S		Proton trmt, intermediate	1511		$950.00		$190.00
77525	S		Proton treatment, complex	1511		$950.00		$190.00
77600	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77605	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77610	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77615	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77620	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77750	S		Infuse radioactive materials	0300	1.4912	$81.36		$16.27
77761	S		Apply intrcav radiat simple	0312	3.6637	$199.90		$39.98
77762	S		Apply intrcav radiat interm	0312	3.6637	$199.90		$39.98
77763	S		Apply intrcav radiat compl	0312	3.6637	$199.90		$39.98
77776	S		Apply interstit radiat simpl	0312	3.6637	$199.90		$39.98
77777	S		Apply interstit radiat inter	0312	3.6637	$199.90		$39.98
77778	S		Apply interstit radiat compl	0651	10.2314	$558.24		$111.65
77781	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77782	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77783	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77784	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77789	S		Apply surface radiation	0300	1.4912	$81.36		$16.27
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	16.2481	$886.51		$177.30
78000	S		Thyroid, single uptake	0389	1.6328	$89.09	$44.54	$17.82
78001	S		Thyroid, multiple uptakes	0389	1.6328	$89.09	$44.54	$17.82
78003	S		Thyroid suppress/stimul	0389	1.6328	$89.09	$44.54	$17.82
78006	S		Thyroid imaging with uptake	0390	2.7907	$152.26	$76.13	$30.45
78007	S		Thyroid image, mult uptakes	0391	3.1956	$174.36	$87.18	$34.87
78010	S		Thyroid imaging	0390	2.7907	$152.26	$76.13	$30.45
78011	S		Thyroid imaging with flow	0390	2.7907	$152.26	$76.13	$30.45
78015	S		Thyroid met imaging	0406	4.3955	$239.82	$119.91	$47.96
78016	S		Thyroid met imaging/studies	0406	4.3955	$239.82	$119.91	$47.96
78018	S		Thyroid met imaging, body	0406	4.3955	$239.82	$119.91	$47.96
78020	S		Thyroid met uptake	0399	1.5273	$83.33	$41.66	$16.67
78070	S		Parathyroid nuclear imaging	0391	3.1956	$174.36	$87.18	$34.87
78075	S		Adrenal nuclear imaging	0391	3.1956	$174.36	$87.18	$34.87
78099	S		Endocrine nuclear procedure	0390	2.7907	$152.26	$76.13	$30.45
78102	S		Bone marrow imaging, ltd	0400	3.8242	$208.65	$104.32	$41.73
78103	S		Bone marrow imaging, mult	0400	3.8242	$208.65	$104.32	$41.73
78104	S		Bone marrow imaging, body	0400	3.8242	$208.65	$104.32	$41.73
78110	S		Plasma volume, single	0393	4.4354	$242.00	$121.00	$48.40
78111	S		Plasma volume, multiple	0393	4.4354	$242.00	$121.00	$48.40
78120	S		Red cell mass, single	0393	4.4354	$242.00	$121.00	$48.40
78121	S		Red cell mass, multiple	0393	4.4354	$242.00	$121.00	$48.40
78122	S		Blood volume	0393	4.4354	$242.00	$121.00	$48.40
78130	S		Red cell survival study	0393	4.4354	$242.00	$121.00	$48.40
78135	S		Red cell survival kinetics	0393	4.4354	$242.00	$121.00	$48.40
78140	S		Red cell sequestration	0393	4.4354	$242.00	$121.00	$48.40
78160	S		Plasma iron turnover	0393	4.4354	$242.00	$121.00	$48.40
78162	S		Radioiron absorption exam	0393	4.4354	$242.00	$121.00	$48.40
78170	S		Red cell iron utilization	0393	4.4354	$242.00	$121.00	$48.40
78172	S		Total body iron estimation	0393	4.4354	$242.00	$121.00	$48.40
78185	S		Spleen imaging	0400	3.8242	$208.65	$104.32	$41.73
78190	S		Platelet survival, kinetics	0389	1.6328	$89.09	$44.54	$17.82
78191	S		Platelet survival	0389	1.6328	$89.09	$44.54	$17.82
78195	S		Lymph system imaging	0400	3.8242	$208.65	$104.32	$41.73
78199	S		Blood/lymph nuclear exam	0400	3.8242	$208.65	$104.32	$41.73
78201	S		Liver imaging	0394	4.3714	$238.51	$119.25	$47.70
78202	S		Liver imaging with flow	0394	4.3714	$238.51	$119.25	$47.70
78205	S		Liver imaging (3D)	0394	4.3714	$238.51	$119.25	$47.70
78206	S		Liver image (3d) with flow	0394	4.3714	$238.51	$119.25	$47.70

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78215	S		Liver and spleen imaging	0394	4.3714	$238.51	$119.25	$47.70
78216	S		Liver & spleen image/flow	0394	4.3714	$238.51	$119.25	$47.70
78220	S		Liver function study	0394	4.3714	$238.51	$119.25	$47.70
78223	S		Hepatobiliary imaging	0394	4.3714	$238.51	$119.25	$47.70
78230	S		Salivary gland imaging	0395	3.9536	$215.71	$107.85	$43.14
78231	S		Serial salivary imaging	0395	3.9536	$215.71	$107.85	$43.14
78232	S		Salivary gland function exam	0395	3.9536	$215.71	$107.85	$43.14
78258	S		Esophageal motility study	0395	3.9536	$215.71	$107.85	$43.14
78261	S		Gastric mucosa imaging	0395	3.9536	$215.71	$107.85	$43.14
78262	S		Gastroesophageal reflux exam	0395	3.9536	$215.71	$107.85	$43.14
78264	S		Gastric emptying study	0395	3.9536	$215.71	$107.85	$43.14
78267	A		Breath tst attain/anal c-14					
78268	A		Breath test analysis, c-14					
78270	S		Vit B-12 absorption exam	0389	1.6328	$89.09	$44.54	$17.82
78271	S		Vit b-12 absrp exam, int fac	0389	1.6328	$89.09	$44.54	$17.82
78272	S		Vit B-12 absorp, combined	0389	1.6328	$89.09	$44.54	$17.82
78278	S		Acute GI blood loss imaging	0395	3.9536	$215.71	$107.85	$43.14
78282	S		GI protein loss exam	0395	3.9536	$215.71	$107.85	$43.14
78290	S		Meckel's divert exam	0395	3.9536	$215.71	$107.85	$43.14
78291	S		Leveen/shunt patency exam	0395	3.9536	$215.71	$107.85	$43.14
78299	S		GI nuclear procedure	0395	3.9536	$215.71	$107.85	$43.14
78300	S		Bone imaging, limited area	0396	4.1883	$228.52	$114.26	$45.70
78305	S		Bone imaging, multiple areas	0396	4.1883	$228.52	$114.26	$45.70
78306	S		Bone imaging, whole body	0396	4.1883	$228.52	$114.26	$45.70
78315	S		Bone imaging, 3 phase	0396	4.1883	$228.52	$114.26	$45.70
78320	S		Bone imaging (3D)	0396	4.1883	$228.52	$114.26	$45.70
78350	X		Bone mineral, single photon	0261	1.3176	$71.89		$14.38
78351	E		Bone mineral, dual photon					
78399	S		Musculoskeletal nuclear exam	0396	4.1883	$228.52	$114.26	$45.70
78414	S		Non-imaging heart function	0398	4.5091	$246.02	$123.01	$49.20
78428	S		Cardiac shunt imaging	0398	4.5091	$246.02	$123.01	$49.20
78445	S		Vascular flow imaging	0397	2.2183	$121.03	$60.51	$24.21
78455	S		Venous thrombosis study	0397	2.2183	$121.03	$60.51	$24.21
78456	S		Acute venous thrombus image	0397	2.2183	$121.03	$60.51	$24.21
78457	S		Venous thrombosis imaging	0397	2.2183	$121.03	$60.51	$24.21
78458	S		Ven thrombosis images, bilat	0397	2.2183	$121.03	$60.51	$24.21
78459	S		Heart muscle imaging (PET)	0285	14.1508	$772.08	$334.45	$154.42
78460	S		Heart muscle blood, single	0398	4.5091	$246.02	$123.01	$49.20
78461	S		Heart muscle blood, multiple	0377	6.8830	$375.54	$187.76	$75.11
78464	S		Heart image (3d), single	0398	4.5091	$246.02	$123.01	$49.20
78465	S		Heart image (3d), multiple	0377	6.8830	$375.54	$187.76	$75.11
78466	S		Heart infarct image	0398	4.5091	$246.02	$123.01	$49.20
78468	S		Heart infarct image (ef)	0398	4.5091	$246.02	$123.01	$49.20
78469	S		Heart infarct image (3D)	0398	4.5091	$246.02	$123.01	$49.20
78472	S		Gated heart, planar, single	0398	4.5091	$246.02	$123.01	$49.20
78473	S		Gated heart, multiple	0376	4.4510	$242.85	$121.42	$48.57
78478	S		Heart wall motion add-on	0399	1.5273	$83.33	$41.66	$16.67
78480	S		Heart function add-on	0399	1.5273	$83.33	$41.66	$16.67
78481	S		Heart first pass, single	0398	4.5091	$246.02	$123.01	$49.20
78483	S		Heart first pass, multiple	0376	4.4510	$242.85	$121.42	$48.57
78491	E		Heart image (pet), single					
78492	E		Heart image (pet), multiple					
78494	S		Heart image, spect	0398	4.5091	$246.02	$123.01	$49.20
78496	S		Heart first pass add-on	0399	1.5273	$83.33	$41.66	$16.67
78499	S		Cardiovascular nuclear exam	0398	4.5091	$246.02	$123.01	$49.20
78580	S		Lung perfusion imaging	0401	3.3736	$184.07	$92.03	$36.81
78584	S		Lung V/Q image single breath	0378	5.4852	$299.28	$149.63	$59.86
78585	S		Lung V/Q imaging	0378	5.4852	$299.28	$149.63	$59.86
78586	S		Aerosol lung image, single	0401	3.3736	$184.07	$92.03	$36.81
78587	S		Aerosol lung image, multiple	0401	3.3736	$184.07	$92.03	$36.81
78588	S		Perfusion lung image	0378	5.4852	$299.28	$149.63	$59.86
78591	S		Vent image, 1 breath, 1 proj	0401	3.3736	$184.07	$92.03	$36.81
78593	S		Vent image, 1 proj, gas	0401	3.3736	$184.07	$92.03	$36.81
78594	S		Vent image, mult proj, gas	0401	3.3736	$184.07	$92.03	$36.81
78596	S		Lung differential function	0378	5.4852	$299.28	$149.63	$59.86
78599	S		Respiratory nuclear exam	0401	3.3736	$184.07	$92.03	$36.81
78600	S		Brain imaging, ltd static	0402	5.4063	$294.97	$147.48	$58.99
78601	S		Brain imaging, ltd w/flow	0402	5.4063	$294.97	$147.48	$58.99
78605	S		Brain imaging, complete	0402	5.4063	$294.97	$147.48	$58.99
78606	S		Brain imaging, compl w/flow	0402	5.4063	$294.97	$147.48	$58.99
78607	S		Brain imaging (3D)	0402	5.4063	$294.97	$147.48	$58.99
78608	E		Brain imaging (PET)					
78609	E		Brain imaging (PET)					
78610	S		Brain flow imaging only	0402	5.4063	$294.97	$147.48	$58.99
78615	S		Cerebral vascular flow image	0402	5.4063	$294.97	$147.48	$58.99

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78630	S		Cerebrospinal fluid scan	0403	3.8402	$209.53	$104.76	$41.91
78635	S		CSF ventriculography	0403	3.8402	$209.53	$104.76	$41.91
78645	S		CSF shunt evaluation	0403	3.8402	$209.53	$104.76	$41.91
78647	S		Cerebrospinal fluid scan	0403	3.8402	$209.53	$104.76	$41.91
78650	S		CSF leakage imaging	0403	3.8402	$209.53	$104.76	$41.91
78660	S		Nuclear exam of tear flow	0403	3.8402	$209.53	$104.76	$41.91
78699	S		Nervous system nuclear exam	0402	5.4063	$294.97	$147.48	$58.99
78700	S		Kidney imaging, static	0404	3.7303	$203.53	$101.76	$40.71
78701	S		Kidney imaging with flow	0404	3.7303	$203.53	$101.76	$40.71
78704	S		Imaging renogram	0404	3.7303	$203.53	$101.76	$40.71
78707	S		Kidney flow/function image	0404	3.7303	$203.53	$101.76	$40.71
78708	S		Kidney flow/function image	0405	4.3432	$236.97	$118.48	$47.39
78709	S		Kidney flow/function image	0405	4.3432	$236.97	$118.48	$47.39
78710	S		Kidney imaging (3D)	0404	3.7303	$203.53	$101.76	$40.71
78715	S		Renal vascular flow exam	0404	3.7303	$203.53	$101.76	$40.71
78725	S		Kidney function study	0389	1.6328	$89.09	$44.54	$17.82
78730	S		Urinary bladder retention	0404	3.7303	$203.53	$101.76	$40.71
78740	S		Ureteral reflux study	0404	3.7303	$203.53	$101.76	$40.71
78760	S		Testicular imaging	0404	3.7303	$203.53	$101.76	$40.71
78761	S		Testicular imaging/flow	0404	3.7303	$203.53	$101.76	$40.71
78799	S		Genitourinary nuclear exam	0404	3.7303	$203.53	$101.76	$40.71
78800	S		Tumor imaging, limited area	0406	4.3955	$239.82	$119.91	$47.96
78801	S		Tumor imaging, mult areas	0406	4.3955	$239.82	$119.91	$47.96
78802	S		Tumor imaging, whole body	0406	4.3955	$239.82	$119.91	$47.96
78803	S		Tumor imaging (3D)	0406	4.3955	$239.82	$119.91	$47.96
78804	S	NI	Tumor imaging, whole body	1508		$650.00		$130.00
78805	S		Abscess imaging, ltd area	0406	4.3955	$239.82	$119.91	$47.96
78806	S		Abscess imaging, whole body	0406	4.3955	$239.82	$119.91	$47.96
78807	S		Nuclear localization/abscess	0406	4.3955	$239.82	$119.91	$47.96
78810	E		Tumor imaging (PET)					
78890	N		Nuclear medicine data proc					
78891	N		Nuclear med data proc					
78990	E		Provide diag radionuclide(s)					
78999	S		Nuclear diagnostic exam	0389	1.6328	$89.09	$44.54	$17.82
79000	S		Init hyperthyroid therapy	0407	3.5841	$195.55	$97.77	$39.11
79001	S		Repeat hyperthyroid therapy	0407	3.5841	$195.55	$97.77	$39.11
79020	S		Thyroid ablation	0407	3.5841	$195.55	$97.77	$39.11
79030	S		Thyroid ablation, carcinoma	0407	3.5841	$195.55	$97.77	$39.11
79035	S		Thyroid metastatic therapy	0407	3.5841	$195.55	$97.77	$39.11
79100	S		Hematopoetic nuclear therapy	0407	3.5841	$195.55	$97.77	$39.11
79200	S		Intracavitary nuclear trmt	0407	3.5841	$195.55	$97.77	$39.11
79300	S		Interstitial nuclear therapy	0407	3.5841	$195.55	$97.77	$39.11
79400	S		Nonhemato nuclear therapy	0407	3.5841	$195.55	$97.77	$39.11
79403	S	NI	Hematopoetic nuclear therapy	1507		$550.00		$110.00
79420	S		Intravascular nuclear ther	0407	3.5841	$195.55	$97.77	$39.11
79440	S		Nuclear joint therapy	0407	3.5841	$195.55	$97.77	$39.11
79900	N		Provide ther radiopharm(s)					
79999	S		Nuclear medicine therapy	0407	3.5841	$195.55	$97.77	$39.11
80048	A		Basic metabolic panel					
80050	E		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					
80074	A		Acute hepatitis panel					
80076	A		Hepatic function 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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
80174	A		Assay of imipramine					
80176	A		Assay of lidocaine					
80178	A		Assay of lithium					
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	0.4617	$25.19	$12.55	$5.04
80502	X		Lab pathology consultation	0342	0.2162	$11.80	$5.88	$2.36
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82105	A		Alpha-fetoprotein, serum					
82106	A		Alpha-fetoprotein, amniotic					
82108	A		Assay of aluminum					
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 analysis, qual					
82360	A		Calculus assay, quant					
82365	A		Calculus spectroscopy					
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					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82495	A		Assay of chromium					
82507	A		Assay of citrate					
82520	A		Assay of cocaine					
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					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82938	A		Gastrin test					
82941	A		Assay of gastrin					
82943	A		Assay of glucagon					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83633	A		Test urine for lactose					
83634	A		Assay of urine for lactose					
83655	A		Assay of lead					
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					
83880	A		Natriuretic peptide					
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		Oncoprotein, 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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84087	A		Assay phosphohexose enzymes					
84100	A		Assay of phosphorus					
84105	A		Assay of urine phosphorus					
84106	A		Test for porphobilinogen					
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, serum					
84156	A	NI	Assay of protein, urine					
84157	A	NI	Assay of protein, other					
84160	A		Assay of protein, any source					
84165	A		Electrophoreisis of 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					
84302	A		Assay of sweat 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)					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
85004	A		Automated diff wbc count					
85007	A		Differential WBC count					
85008	A		Nondifferential WBC count					
85009	A		Differential WBC count					
85013	A		Spun microhematocrit					
85014	A		Hematocrit					
85018	A		Hemoglobin					
85025	A		Automated hemogram					
85027	A		Automated hemogram					
85032	A		Manual cell count, each					
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					
85049	A		Automated platelet count					
85055	A	NI	Reticulated platelet assay					
85060	X		Blood smear interpretation	0342	0.2162	$11.80	$5.88	$2.36
85097	X		Bone marrow interpretation	0343	0.4617	$25.19	$12.55	$5.04
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85300	A		Antithrombin III test					
85301	A		Antithrombin III test					
85302	A		Blood clot inhibitor antigen					
85303	A		Blood clot inhibitor test					
85305	A		Blood clot inhibitor assay					
85306	A		Blood clot inhibitor test					
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, quant					
85380	A		Fibrin degradation, vte					
85384	A		Fibrinogen					
85385	A		Fibrinogen					
85390	A		Fibrinolysins screen					
85396	N	NI	Clotting assay, whole blood					
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 neutralization					
85530	A		Heparin-protamine tolerance					
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					
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	A		Physician blood bank service					
86078	A		Physician blood bank service					
86079	A		Physician blood bank service					
86140	A		C-reactive protein					
86141	A		C-reactive protein, hs					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86146	A		Glycoprotein antibody					
86147	A		Cardiolipin antibody					
86148	A		Phospholipid antibody					
86155	A		Chemotaxis assay					
86156	A		Cold agglutinin, screen					
86157	A		Cold agglutinin, titer					
86160	A		Complement, antigen					
86161	A		Complement/function activity					
86162	A		Complement, total (CH50)					
86171	A		Complement fixation, each					
86185	A		Counterimmunoelectrophoresis					
86215	A		Deoxyribonuclease, antibody					
86225	A		DNA antibody					
86226	A		DNA antibody, single strand					
86235	A		Nuclear antigen antibody					
86243	A		Fc receptor					
86255	A		Fluorescent antibody, screen					
86256	A		Fluorescent antibody, titer					
86277	A		Growth hormone antibody					
86280	A		Hemagglutination inhibition					
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	0.1365	$7.45	$3.03	$1.49
86490	X		Coccidioidomycosis skin test	0341	0.1365	$7.45	$3.03	$1.49
86510	X		Histoplasmosis skin test	0341	0.1365	$7.45	$3.03	$1.49
86580	X		TB intradermal test	0341	0.1365	$7.45	$3.03	$1.49
86585	X		TB tine test	0341	0.1365	$7.45	$3.03	$1.49
86586	X		Skin test, unlisted	0341	0.1365	$7.45	$3.03	$1.49
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86625	A		Campylobacter antibody					
86628	A		Candida antibody					
86631	A		Chlamydia antibody					
86632	A		Chlamydia igm antibody					
86635	A		Coccidioides antibody					
86638	A		Q fever antibody					
86641	A		Cryptococcus antibody					
86644	A		CMV antibody					
86645	A		CMV antibody, IgM					
86648	A		Diphtheria antibody					
86651	A		Encephalitis antibody					
86652	A		Encephalitis antibody					
86653	A		Encephalitis antibody					
86654	A		Encephalitis antibody					
86658	A		Enterovirus antibody					
86663	A		Epstein-barr antibody					
86664	A		Epstein-barr antibody					
86665	A		Epstein-barr antibody					
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					
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					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86805	A		Lymphocytotoxicity assay					
86806	A		Lymphocytotoxicity assay					
86807	A		Cytotoxic antibody screening					
86808	A		Cytotoxic antibody screening					
86812	A		HLA typing, A, B, or C					
86813	A		HLA typing, A, B, or C					
86816	A		HLA typing, DR/DQ					
86817	A		HLA typing, DR/DQ					
86821	A		Lymphocyte culture, mixed					
86822	A		Lymphocyte culture, primed					
86849	A		Immunology procedure					
86850	X		RBC antibody screen	0345	0.2550	$13.91	$3.10	$2.78
86860	X		RBC antibody elution	0346	0.3866	$21.09	$5.32	$4.22
86870	X		RBC antibody identification	0346	0.3866	$21.09	$5.32	$4.22
86880	X		Coombs test, direct	0409	0.1390	$7.58	$2.32	$1.52
86885	X		Coombs test, indirect, qual	0409	0.1390	$7.58	$2.32	$1.52
86886	X		Coombs test, indirect, titer	0409	0.1390	$7.58	$2.32	$1.52
86890	X		Autologous blood process	0347	0.9610	$52.43	$13.20	$10.49
86891	X		Autologous blood, op salvage	0345	0.2550	$13.91	$3.10	$2.78
86900	X		Blood typing, ABO	0409	0.1390	$7.58	$2.32	$1.52
86901	X		Blood typing, Rh (D)	0409	0.1390	$7.58	$2.32	$1.52
86903	X		Blood typing, antigen screen	0345	0.2550	$13.91	$3.10	$2.78
86904	X		Blood typing, patient serum	0345	0.2550	$13.91	$3.10	$2.78
86905	X		Blood typing, RBC antigens	0345	0.2550	$13.91	$3.10	$2.78
86906	X		Blood typing, Rh phenotype	0345	0.2550	$13.91	$3.10	$2.78
86910	E		Blood typing, paternity test					
86911	E		Blood typing, antigen system					
86920	X		Compatibility test	0346	0.3866	$21.09	$5.32	$4.22
86921	X		Compatibility test	0345	0.2550	$13.91	$3.10	$2.78
86922	X		Compatibility test	0346	0.3866	$21.09	$5.32	$4.22
86927	X		Plasma, fresh frozen	0346	0.3866	$21.09	$5.32	$4.22
86930	X		Frozen blood prep	0347	0.9610	$52.43	$13.20	$10.49
86931	X		Frozen blood thaw	0347	0.9610	$52.43	$13.20	$10.49
86932	X		Frozen blood freeze/thaw	0347	0.9610	$52.43	$13.20	$10.49
86940	A		Hemolysins/agglutinins, auto					
86941	A		Hemolysins/agglutinins					
86945	X		Blood product/irradiation	0346	0.3866	$21.09	$5.32	$4.22
86950	X		Leukacyte transfusion	0347	0.9610	$52.43	$13.20	$10.49
86965	X		Pooling blood platelets	0346	0.3866	$21.09	$5.32	$4.22
86970	X		RBC pretreatment	0345	0.2550	$13.91	$3.10	$2.78
86971	X		RBC pretreatment	0345	0.2550	$13.91	$3.10	$2.78
86972	X		RBC pretreatment	0345	0.2550	$13.91	$3.10	$2.78
86975	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86976	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86977	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86978	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86985	X		Split blood or products	0347	0.9610	$52.43	$13.20	$10.49
86999	X		Transfusion procedure	0345	0.2550	$13.91	$3.10	$2.78
87001	A		Small animal inoculation					
87003	A		Small animal inoculation					
87015	A		Specimen concentration					
87040	A		Blood culture for bacteria					
87045	A		Feces 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		Cultr bacteria, except blood					
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		Culture type immunofluoresc					
87143	A		Culture typing, glc/hplc					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	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		Macroscopic 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					
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					
87255	A		Genet virus isolate, hsv					
87260	A		Adenovirus ag, if					
87265	A		Pertussis ag, if					
87267	A		Enterovirus antibody, dfa					
87269	A	NI	Giardia ag, if					
87270	A		Chlamydia trachomatis ag, if					
87271	A		Cryptosporidum/gardia ag, if					
87272	A		Cryptosporidium 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		Cryptosporidium ag, eia					
87329	A	NI	Giardia 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		H pylori 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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87449	A		Ag detect nos, eia, mult					
87450	A		Ag detect nos, eia, single					
87451	A		Ag detect polyval, eia, mult					
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					
87660	A	NI	Trichomonas vagin, dir probe					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	0.4617	$25.19	$12.55	$5.04
88106	X		Cytopathology, fluids	0343	0.4617	$25.19	$12.55	$5.04
88107	X		Cytopathology, fluids	0343	0.4617	$25.19	$12.55	$5.04
88108	X		Cytopath, concentrate tech	0343	0.4617	$25.19	$12.55	$5.04
88112	X	NI	Cytopath, cell enhance tech	0343	0.4617	$25.19	$12.55	$5.04
88125	X		Forensic cytopathology	0342	0.2162	$11.80	$5.88	$2.36
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					
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	0.2162	$11.80	$5.88	$2.36
88161	X		Cytopath smear, other source	0343	0.4617	$25.19	$12.55	$5.04
88162	X		Cytopath smear, other source	0343	0.4617	$25.19	$12.55	$5.04
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					
88172	X		Cytopathology eval of fna	0343	0.4617	$25.19	$12.55	$5.04
88173	X		Cytopath eval, fna, report	0343	0.4617	$25.19	$12.55	$5.04
88174	A		Cytopath, c/v auto, in fluid					
88175	A		Cytopath c/v auto fluid redo					
88180	X		Cell marker study	0343	0.4617	$25.19	$12.55	$5.04
88182	X		Cell marker study	0344	0.6291	$34.32	$17.16	$6.86
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88269	A		Chromosome analys, amniotic					
88271	A		Cytogenetics, dna probe					
88272	A		Cytogenetics, 3-5					
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	0.2162	$11.80	$5.88	$2.36
88300	X		Surgical path, gross	0342	0.2162	$11.80	$5.88	$2.36
88302	X		Tissue exam by pathologist	0342	0.2162	$11.80	$5.88	$2.36
88304	X		Tissue exam by pathologist	0343	0.4617	$25.19	$12.55	$5.04
88305	X		Tissue exam by pathologist	0343	0.4617	$25.19	$12.55	$5.04
88307	X		Tissue exam by pathologist	0344	0.6291	$34.32	$17.16	$6.86
88309	X		Tissue exam by pathologist	0344	0.6291	$34.32	$17.16	$6.86
88311	X		Decalcify tissue	0342	0.2162	$11.80	$5.88	$2.36
88312	X		Special stains	0342	0.2162	$11.80	$5.88	$2.36
88313	X		Special stains	0342	0.2162	$11.80	$5.88	$2.36
88314	X		Histochemical stain	0342	0.2162	$11.80	$5.88	$2.36
88318	X		Chemical histochemistry	0342	0.2162	$11.80	$5.88	$2.36
88319	X		Enzyme histochemistry	0342	0.2162	$11.80	$5.88	$2.36
88321	X		Microslide consultation	0342	0.2162	$11.80	$5.88	$2.36
88323	X		Microslide consultation	0343	0.4617	$25.19	$12.55	$5.04
88325	X		Comprehensive review of data	0344	0.6291	$34.32	$17.16	$6.86
88329	X		Path consult introp	0342	0.2162	$11.80	$5.88	$2.36
88331	X		Path consult intraop, 1 bloc	0343	0.4617	$25.19	$12.55	$5.04
88332	X		Path consult intraop, add'l	0342	0.2162	$11.80	$5.88	$2.36
88342	X		Immunohistochemistry	0344	0.6291	$34.32	$17.16	$6.86
88346	X		Immunofluorescent study	0343	0.4617	$25.19	$12.55	$5.04
88347	X		Immunofluorescent study	0344	0.6291	$34.32	$17.16	$6.86
88348	X		Electron microscopy	0661	3.2576	$177.74	$88.87	$35.55
88349	X		Scanning electron microscopy	0661	3.2576	$177.74	$88.87	$35.55
88355	X		Analysis, skeletal muscle	0344	0.6291	$34.32	$17.16	$6.86
88356	X		Analysis, nerve	0344	0.6291	$34.32	$17.16	$6.86
88358	X		Analysis, tumor	0344	0.6291	$34.32	$17.16	$6.86
88361	X	NI	Immunohistochemistry, tumor	0344	0.6291	$34.32	$17.16	$6.86
88362	X		Nerve teasing preparations	0344	0.6291	$34.32	$17.16	$6.86
88365	X		Tissue hybridization	0344	0.6291	$34.32	$17.16	$6.86
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					
89055	A		Leukocyte assessment, fecal					
89060	A		Exam,synovial fluid crystals					
89100	X		Sample intestinal contents	0360	1.7313	$94.46	$42.45	$18.89
89105	X		Sample intestinal contents	0360	1.7313	$94.46	$42.45	$18.89
89125	A		Specimen fat stain					
89130	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89132	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89135	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89136	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89140	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89141	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89160	A		Exam feces for meat fibers					
89190	A		Nasal smear for eosinophils					
89220	X	NI	Sputum specimen collection	0343	0.4617	$25.19	$12.55	$5.04
89225	A	NI	Starch granules, feces					
89230	X	NI	Collect sweat for test	0344	0.6291	$34.32	$17.16	$6.86
89235	A	NI	Water load test					
89240	A	NI	Pathology lab procedure					
89250	X		Cultr oocyte/embryo <4 days	0348	0.8194	$44.71		$8.94
89251	X		Cultr oocyte/embryo <4 days	0348	0.8194	$44.71		$8.94
89252	X	DG	Assist oocyte fertilization	0348	0.8194	$44.71		$8.94
89253	X		Embryo hatching	0348	0.8194	$44.71		$8.94
89254	X		Oocyte identification	0348	0.8194	$44.71		$8.94
89255	X		Prepare embryo for transfer	0348	0.8194	$44.71		$8.94
89256	X	DG	Prepare cryopreserved embryo	0348	0.8194	$44.71		$8.94
89257	X		Sperm identification	0348	0.8194	$44.71		$8.94
89258	X		Cryopreservation; embryo(s)	0348	0.8194	$44.71		$8.94

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89259	X		Cryopreservation, sperm	0348	0.8194	$44.71		$8.94
89260	X		Sperm isolation, simple	0348	0.8194	$44.71		$8.94
89261	X		Sperm isolation, complex	0348	0.8194	$44.71		$8.94
89264	X		Identify sperm tissue	0348	0.8194	$44.71		$8.94
89268	X	NI	Insemination of oocytes	0348	0.8194	$44.71		$8.94
89272	X	NI	Extended culture of oocytes	0348	0.8194	$44.71		$8.94
89280	X	NI	Assist oocyte fertilization	0348	0.8194	$44.71		$8.94
89281	X	NI	Assist oocyte fertilization	0348	0.8194	$44.71		$8.94
89290	X	NI	Biopsy, oocyte polar body	0348	0.8194	$44.71		$8.94
89291	X	NI	Biopsy, oocyte polar body	0348	0.8194	$44.71		$8.94
89300	A		Semen analysis w/huhner					
89310	A		Semen analysis					
89320	A		Semen analysis, complete					
89321	A		Semen analysis & motility					
89325	A		Sperm antibody test					
89329	A		Sperm evaluation test					
89330	A		Evaluation, cervical mucus					
89335	X	NI	Cryopreserve testicular tiss	0348	0.8194	$44.71		$8.94
89342	X	NI	Storage/year; embryo(s)	0348	0.8194	$44.71		$8.94
89343	X	NI	Storage/year; sperm/semen	0348	0.8194	$44.71		$8.94
89344	X	NI	Storage/year; reprod tissue	0348	0.8194	$44.71		$8.94
89346	X	NI	Storage/year; oocyte	0348	0.8194	$44.71		$8.94
89350	X	DG	Sputum specimen collection	0343	0.4617	$25.19	$12.55	$5.04
89352	X	NI	Thawing cryopresrved; embryo	0348	0.8194	$44.71		$8.94
89353	X	NI	Thawing cryopresrved; sperm	0348	0.8194	$44.71		$8.94
89354	X	NI	Thaw cryoprsvrd; reprod tiss	0348	0.8194	$44.71		$8.94
89355	A	DG	Exam feces for starch					
89356	X	NI	Thawing cryopresrved; oocyte	0348	0.8194	$44.71		$8.94
89360	X	DG	Collect sweat for test	0343	0.4617	$25.19	$12.55	$5.04
89365	A	DG	Water load test					
89399	A	DG	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	0355	0.2749	$15.00		$3.00
90371	E		Hep b ig, im					
90375	K		Rabies ig, im/sc	0356	0.7698	$42.00		$8.40
90376	K		Rabies ig, heat treated	0356	0.7698	$42.00		$8.40
90378	E		Rsv ig, im, 50mg					
90379	K		Rsv ig, iv	0356	0.7698	$42.00		$8.40
90384	E		Rh ig, full-dose, im					
90385	K		Rh ig, minidose, im	0356	0.7698	$42.00		$8.40
90386	E		Rh ig, iv					
90389	N		Tetanus ig, im					
90393	K		Vaccina ig, im	0356	0.7698	$42.00		$8.40
90396	K		Varicella-zoster ig, im	0356	0.7698	$42.00		$8.40
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	N		Adenovirus vaccine, type 4					
90477	N		Adenovirus vaccine, type 7					
90581	K		Anthrax vaccine, sc	0355	0.2749	$15.00		$3.00
90585	N		Bcg vaccine, percut					
90586	K		Bcg vaccine, intravesical	0356	0.7698	$42.00		$8.40
90632	N		Hep a vaccine, adult im					
90633	N		Hep a vacc, ped/adol, 2 dose					
90634	N		Hep a vacc, ped/adol, 3 dose					
90636	K		Hep a/hep b vacc, adult im	0355	0.2749	$15.00		$3.00
90645	N		Hib vaccine, hboc, im					
90646	N		Hib vaccine, prp-d, im					
90647	N		Hib vaccine, prp-omp, im					
90648	N		Hib vaccine, prp-t, im					
90655	L	NI	Flu vaccine, 6-35 mo, im					
90657	L		Flu vaccine, 6-35 mo, im					
90658	L		Flu vaccine, 3 yrs, im					
90659	L	DG	Flu vaccine, whole, im					
90660	E		Flu vaccine, nasal					
90665	N		Lyme disease vaccine, im					
90669	E		Pneumococcal vacc, ped <5					
90675	K		Rabies vaccine, im	0356	0.7698	$42.00		$8.40
90676	K		Rabies vaccine, id	0356	0.7698	$42.00		$8.40

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90680	N		Rotovirus vaccine, oral					
90690	N		Typhoid vaccine, oral					
90691	N		Typhoid vaccine, im					
90692	N		Typhoid vaccine, h-p, sc/id					
90693	K		Typhoid vaccine, akd, sc	0356	0.7698	$42.00		$8.40
90698	N	NI	Dtap-hib-ip vaccine, im					
90700	N		Dtap vaccine, im					
90701	N		Dtp vaccine, im					
90702	N		Dt vaccine < 7, im					
90703	N		Tetanus vaccine, im					
90704	N		Mumps vaccine, sc					
90705	N		Measles vaccine, sc					
90706	N		Rubella vaccine, sc					
90707	N		Mmr vaccine, sc					
90708	N		Measles-rubella vaccine, sc					
90710	N		Mmrv vaccine, sc					
90712	N		Oral poliovirus vaccine					
90713	N		Poliovirus, ipv, sc					
90715	N	NI	Tdap vaccine > 7 im					
90716	K		Chicken pox vaccine, sc	0355	0.2749	$15.00		$3.00
90717	N		Yellow fever vaccine, sc					
90718	N		Td vaccine > 7, im					
90719	N		Diphtheria vaccine, im					
90720	N		Dtp/hib vaccine, im					
90721	N		Dtap/hib vaccine, im					
90723	K		Dtap-hep b-ipv vaccine, im	0356	0.7698	$42.00		$8.40
90725	K		Cholera vaccine, injectable	0355	0.2749	$15.00		$3.00
90727	N		Plague vaccine, im					
90732	L		Pneumococcal vaccine					
90733	N		Meningococcal vaccine, sc					
90734	N	NI	Meningococcal vaccine, im					
90735	N		Encephalitis vaccine, sc					
90740	K		Hepb vacc, ill pat 3 dose im	0356	0.7698	$42.00		$8.40
90743	K		Hep b vacc, adol, 2 dose, im	0356	0.7698	$42.00		$8.40
90744	K		Hepb vacc ped/adol 3 dose im	0356	0.7698	$42.00		$8.40
90746	K		Hep b vaccine, adult, im	0356	0.7698	$42.00		$8.40
90747	K		Hepb vacc, ill pat 4 dose im	0356	0.7698	$42.00		$8.40
90748	K		Hep b/hib vaccine, im	0355	0.2749	$15.00		$3.00
90749	N		Vaccine toxoid					
90780	B		IV infusion therapy, 1 hour					
90781	B		IV infusion, additional hour					
90782	X		Injection, sc/im	0353	0.3982	$21.73		$4.35
90783	X		Injection, ia	0359	0.8000	$43.65		$8.73
90784	X		Injection, iv	0359	0.8000	$43.65		$8.73
90788	X		Injection of antibiotic	0359	0.8000	$43.65		$8.73
90799	X		Ther/prophylactic/dx inject	0352	0.1230	$6.71		$1.34
90801	S		Psy dx interview	0323	1.8689	$101.97	$21.26	$20.39
90802	S		Intac psy dx interview	0323	1.8689	$101.97	$21.26	$20.39
90804	S		Psytx, office, 20-30 min	0322	1.2802	$69.85		$13.97
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.2802	$69.85		$13.97
90806	S		Psytx, off, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90808	S		Psytx, office, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90809	S		Psytx, off, 75-80, w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90810	S		Intac psytx, off, 20-30 min	0322	1.2802	$69.85		$13.97
90811	S		Intac psytx, 20-30, w/e&m	0322	1.2802	$69.85		$13.97
90812	S		Intac psytx, off, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90814	S		Intac psytx, off, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90815	S		Intac psytx, 75-80 w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90816	S		Psytx, hosp, 20-30 min	0322	1.2802	$69.85		$13.97
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.2802	$69.85		$13.97
90818	S		Psytx, hosp, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90821	S		Psytx, hosp, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90823	S		Intac psytx, hosp, 20-30 min	0322	1.2802	$69.85		$13.97
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.2802	$69.85		$13.97
90826	S		Intac psytx, hosp, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90828	S		Intac psytx, hosp, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90845	S		Psychoanalysis	0323	1.8689	$101.97	$21.26	$20.39
90846	S		Family psytx w/o patient	0324	2.4473	$133.53		$26.71
90847	S		Family psytx w/patient	0324	2.4473	$133.53		$26.71

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90849	S		Multiple family group psytx	0325	1.4865	$81.10	$18.27	$16.22
90853	S		Group psychotherapy	0325	1.4865	$81.10	$18.27	$16.22
90857	S		Intac group psytx	0325	1.4865	$81.10	$18.27	$16.22
90862	X		Medication management	0374	1.1252	$61.39		$12.28
90865	S		Narcosynthesis	0323	1.8689	$101.97	$21.26	$20.39
90870	S		Electroconvulsive therapy	0320	5.3785	$293.46	$80.06	$58.69
90871	E		Electroconvulsive therapy					
90875	E		Psychophysiological therapy					
90876	E		Psychophysiological therapy					
90880	S		Hypnotherapy	0323	1.8689	$101.97	$21.26	$20.39
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	1.2802	$69.85		$13.97
90901	A		Biofeedback train, any meth					
90911	S		Biofeedback peri/uro/rectal	0321	1.2387	$67.58	$21.78	$13.52
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	5.9678	$325.61		$65.12
90937	E		Hemodialysis, repeated eval					
90939	N		Hemodialysis study, transcut					
90940	N		Hemodialysis access study					
90945	S		Dialysis, one evaluation	0170	5.9678	$325.61		$65.12
90947	E		Dialysis, repeated eval					
90989	B		Dialysis training, complete					
90993	B		Dialysis training, incompl					
90997	E		Hemoperfusion					
90999	B		Dialysis procedure					
91000	X		Esophageal intubation	0361	3.5510	$193.75	$83.23	$38.75
91010	X		Esophagus motility study	0361	3.5510	$193.75	$83.23	$38.75
91011	X		Esophagus motility study	0361	3.5510	$193.75	$83.23	$38.75
91012	X		Esophagus motility study	0361	3.5510	$193.75	$83.23	$38.75
91020	X		Gastric motility	0361	3.5510	$193.75	$83.23	$38.75
91030	X		Acid perfusion of esophagus	0361	3.5510	$193.75	$83.23	$38.75
91032	X		Esophagus, acid reflux test	0361	3.5510	$193.75	$83.23	$38.75
91033	X		Prolonged acid reflux test	0361	3.5510	$193.75	$83.23	$38.75
91052	X		Gastric analysis test	0361	3.5510	$193.75	$83.23	$38.75
91055	X		Gastric intubation for smear	0360	1.7313	$94.46	$42.45	$18.89
91060	X		Gastric saline load test	0360	1.7313	$94.46	$42.45	$18.89
91065	X		Breath hydrogen test	0360	1.7313	$94.46	$42.45	$18.89
91100	X		Pass intestine bleeding tube	0360	1.7313	$94.46	$42.45	$18.89
91105	X		Gastric intubation treatment	0360	1.7313	$94.46	$42.45	$18.89
91110	S	NI	Gi tract capsule endoscopy	1508		$650.00		$130.00
91122	T		Anal pressure record	0156	2.4747	$135.02	$40.52	$27.00
91123	N		Irrigate fecal impaction					
91132	X		Electrogastrography	0360	1.7313	$94.46	$42.45	$18.89
91133	X		Electrogastrography w/test	0360	1.7313	$94.46	$42.45	$18.89
91299	X		Gastroenterology procedure	0360	1.7313	$94.46	$42.45	$18.89
92002	V		Eye exam, new patient	0601	0.9816	$53.56		$10.71
92004	V		Eye exam, new patient	0602	1.5041	$82.07		$16.41
92012	V		Eye exam established pat	0600	0.9278	$50.62		$10.12
92014	V		Eye exam & treatment	0602	1.5041	$82.07		$16.41
92015	E		Refraction					
92018	T		New eye exam & treatment	0699	2.2303	$121.69	$47.46	$24.34
92019	S		Eye exam & treatment	0699	2.2303	$121.69	$47.46	$24.34
92020	S		Special eye evaluation	0230	0.7619	$41.57	$14.97	$8.31
92060	S		Special eye evaluation	0230	0.7619	$41.57	$14.97	$8.31
92065	S		Orthoptic/pleoptic training	0230	0.7619	$41.57	$14.97	$8.31
92070	N		Fitting of contact lens					
92081	S		Visual field examination(s)	0230	0.7619	$41.57	$14.97	$8.31
92082	S		Visual field examination(s)	0698	0.9599	$52.37	$18.72	$10.47
92083	S		Visual field examination(s)	0698	0.9599	$52.37	$18.72	$10.47
92100	N		Serial tonometry exam(s)					
92120	S		Tonography & eye evaluation	0230	0.7619	$41.57	$14.97	$8.31
92130	S		Water provocation tonography	0698	0.9599	$52.37	$18.72	$10.47
92135	S		Opthalmic dx imaging	0230	0.7619	$41.57	$14.97	$8.31
92136	S		Ophthalmic biometry	0230	0.7619	$41.57	$14.97	$8.31
92140	S		Glaucoma provocative tests	0698	0.9599	$52.37	$18.72	$10.47

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92225	S		Special eye exam, initial	0698	0.9599	$52.37	$18.72	$10.47
92226	S		Special eye exam, subsequent	0698	0.9599	$52.37	$18.72	$10.47
92230	T		Eye exam with photos	0699	2.2303	$121.69	$47.46	$24.34
92235	T		Eye exam with photos	0699	2.2303	$121.69	$47.46	$24.34
92240	S		Icg angiography	0231	2.1883	$119.40	$50.94	$23.88
92250	S		Eye exam with photos	0230	0.7619	$41.57	$14.97	$8.31
92260	S		Ophthalmoscopy/dynamometry	0230	0.7619	$41.57	$14.97	$8.31
92265	S		Eye muscle evaluation	0231	2.1883	$119.40	$50.94	$23.88
92270	S		Electro-oculography	0698	0.9599	$52.37	$18.72	$10.47
92275	S		Electroretinography	0231	2.1883	$119.40	$50.94	$23.88
92283	S		Color vision examination	0230	0.7619	$41.57	$14.97	$8.31
92284	S		Dark adaptation eye exam	0698	0.9599	$52.37	$18.72	$10.47
92285	S		Eye photography	0230	0.7619	$41.57	$14.97	$8.31
92286	S		Internal eye photography	0698	0.9599	$52.37	$18.72	$10.47
92287	S		Internal eye photography	0231	2.1883	$119.40	$50.94	$23.88
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	2.6984	$147.23		$29.45
92312	X		Contact lens fitting	0362	2.6984	$147.23		$29.45
92313	X		Contact lens fitting	0362	2.6984	$147.23		$29.45
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	2.6984	$147.23		$29.45
92316	X		Prescription of contact lens	0362	2.6984	$147.23		$29.45
92317	X		Prescription of contact lens	0362	2.6984	$147.23		$29.45
92325	X		Modification of contact lens	0362	2.6984	$147.23		$29.45
92326	X		Replacement of contact lens	0362	2.6984	$147.23		$29.45
92330	S		Fitting of artificial eye	0230	0.7619	$41.57	$14.97	$8.31
92335	N		Fitting of artificial eye					
92340	E		Fitting of spectacles					
92341	E		Fitting of spectacles					
92342	E		Fitting of spectacles					
92352	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92353	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92354	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92355	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92358	X		Eye prosthesis service	0362	2.6984	$147.23		$29.45
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	2.6984	$147.23		$29.45
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	0.7619	$41.57	$14.97	$8.31
92502	T		Ear and throat examination	0251	1.7880	$97.56		$19.51
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	0.8799	$48.01	$12.89	$9.60
92512	X		Nasal function studies	0363	0.8641	$47.15	$17.44	$9.43
92516	X		Facial nerve function test	0660	1.7353	$94.68	$30.66	$18.94
92520	X		Laryngeal function studies	0660	1.7353	$94.68	$30.66	$18.94
92526	A		Oral function therapy					
92531	N		Spontaneous nystagmus study					
92532	N		Positional nystagmus test					
92533	N		Caloric vestibular test					
92534	N		Optokinetic nystagmus test					
92541	X		Spontaneous nystagmus test	0363	0.8641	$47.15	$17.44	$9.43
92542	X		Positional nystagmus test	0363	0.8641	$47.15	$17.44	$9.43
92543	X		Caloric vestibular test	0363	0.8641	$47.15	$17.44	$9.43
92544	X		Optokinetic nystagmus test	0363	0.8641	$47.15	$17.44	$9.43
92545	X		Oscillating tracking test	0363	0.8641	$47.15	$17.44	$9.43
92546	X		Sinusoidal rotational test	0660	1.7353	$94.68	$30.66	$18.94
92547	X		Supplemental electrical test	0363	0.8641	$47.15	$17.44	$9.43
92548	X		Posturography	0660	1.7353	$94.68	$30.66	$18.94
92551	E		Pure tone hearing test, air					
92552	X		Pure tone audiometry, air	0364	0.4459	$24.33	$9.06	$4.87
92553	X		Audiometry, air & bone	0365	1.2132	$66.19	$18.95	$13.24
92555	X		Speech threshold audiometry	0364	0.4459	$24.33	$9.06	$4.87
92556	X		Speech audiometry, complete	0364	0.4459	$24.33	$9.06	$4.87
92557	X		Comprehensive hearing test	0365	1.2132	$66.19	$18.95	$13.24
92559	E		Group audiometric testing					
92560	E		Bekesy audiometry, screen					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92561	X		Bekesy audiometry, diagnosis	0365	1.2132	$66.19	$18.95	$13.24
92562	X		Loudness balance test	0364	0.4459	$24.33	$9.06	$4.87
92563	X		Tone decay hearing test	0364	0.4459	$24.33	$9.06	$4.87
92564	X		Sisi hearing test	0364	0.4459	$24.33	$9.06	$4.87
92565	X		Stenger test, pure tone	0364	0.4459	$24.33	$9.06	$4.87
92567	X		Tympanometry	0364	0.4459	$24.33	$9.06	$4.87
92568	X		Acoustic reflex testing	0364	0.4459	$24.33	$9.06	$4.87
92569	X		Acoustic reflex decay test	0364	0.4459	$24.33	$9.06	$4.87
92571	X		Filtered speech hearing test	0364	0.4459	$24.33	$9.06	$4.87
92572	X		Staggered spondaic word test	0364	0.4459	$24.33	$9.06	$4.87
92573	X		Lombard test	0364	0.4459	$24.33	$9.06	$4.87
92575	X		Sensorineural acuity test	0365	1.2132	$66.19	$18.95	$13.24
92576	X		Synthetic sentence test	0364	0.4459	$24.33	$9.06	$4.87
92577	X		Stenger test, speech	0365	1.2132	$66.19	$18.95	$13.24
92579	X		Visual audiometry (vra)	0365	1.2132	$66.19	$18.95	$13.24
92582	X		Conditioning play audiometry	0365	1.2132	$66.19	$18.95	$13.24
92583	X		Select picture audiometry	0364	0.4459	$24.33	$9.06	$4.87
92584	X		Electrocochleography	0660	1.7353	$94.68	$30.66	$18.94
92585	S		Auditor evoke potent, compre	0216	2.8535	$155.69	$67.98	$31.14
92586	S		Auditor evoke potent, limit	0218	1.1404	$62.22		$12.44
92587	X		Evoked auditory test	0363	0.8641	$47.15	$17.44	$9.43
92588	X		Evoked auditory test	0363	0.8641	$47.15	$17.44	$9.43
92589	X		Auditory function test(s)	0364	0.4459	$24.33	$9.06	$4.87
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					
92595	E		Electro hearng aid tst, both					
92596	X		Ear protector evaluation	0365	1.2132	$66.19	$18.95	$13.24
92597	A		Voice Prosthetic Evaluation					
92601	X	NI	Cochlear implt f/up exam < 7	0365	1.2132	$66.19	$18.95	$13.24
92602	X	NI	Reprogram cochlear implt < 7	0365	1.2132	$66.19	$18.95	$13.24
92603	X	NI	Cochlear implt f/up exam 7 >	0365	1.2132	$66.19	$18.95	$13.24
92604	X	NI	Reprogram cochlear implt 7 >	0365	1.2132	$66.19	$18.95	$13.24
92605	A		Eval for nonspeech device rx					
92606	A		Non-speech device service					
92607	A		Ex for speech device rx, 1hr					
92608	A		Ex for speech device rx addl					
92609	A		Use of speech device service					
92610	A		Evaluate swallowing function					
92611	A		Motion fluoroscopy/swallow					
92612	A		Endoscopy swallow tst (fees)					
92613	E		Endoscopy swallow tst (fees)					
92614	A		Laryngoscopic sensory test					
92615	E		Eval laryngoscopy sense tst					
92616	A		Fees w/laryngeal sense test					
92617	E		Interprt fees/laryngeal test					
92700	X		Ent procedure/service	0364	0.4459	$24.33	$9.06	$4.87
92950	S		Heart/lung resuscitation cpr	0094	2.6345	$143.74	$48.58	$28.75
92953	S		Temporary external pacing	0094	2.6345	$143.74	$48.58	$28.75
92960	S		Cardioversion electric, ext	0679	5.4887	$299.47	$95.30	$59.89
92961	S		Cardioversion, electric, int	0679	5.4887	$299.47	$95.30	$59.89
92970	C		Cardioassist, internal					
92971	C		Cardioassist, external					
92973	T		Percut coronary thrombectomy	1541		$250.00		$50.00
92974	T		Cath place, cardio brachytx	1559		$2,250.00		$450.00
92975	C		Dissolve clot, heart vessel					
92977	T		Dissolve clot, heart vessel	0676	2.7315	$149.03	$40.30	$29.81
92978	S		Intravasc us, heart add-on	0670	27.4483	$1,497.61	$542.37	$299.52
92979	S		Intravasc us, heart add-on	0670	27.4483	$1,497.61	$542.37	$299.52
92980	T		Insert intracoronary stent	0104	82.6713	$4,510.63		$902.13
92981	T		Insert intracoronary stent	0104	82.6713	$4,510.63		$902.13
92982	T		Coronary artery dilation	0083	59.2047	$3,230.27		$646.05
92984	T		Coronary artery dilation	0083	59.2047	$3,230.27		$646.05
92986	T		Revision of aortic valve	0083	59.2047	$3,230.27		$646.05
92987	T		Revision of mitral valve	0083	59.2047	$3,230.27		$646.05
92990	T		Revision of pulmonary valve	0083	59.2047	$3,230.27		$646.05
92992	C		Revision of heart chamber					
92993	C		Revision of heart chamber					
92995	T		Coronary atherectomy	0082	110.2196	$6,013.69	$1,293.59	$1,202.74
92996	T		Coronary atherectomy add-on	0082	110.2196	$6,013.69	$1,293.59	$1,202.74
92997	T		Pul art balloon repr, percut	0081	35.0285	$1,911.19		$382.24
92998	T		Pul art balloon repr, percut	0081	35.0285	$1,911.19		$382.24
93000	B		Electrocardiogram, complete					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93005	S		Electrocardiogram, tracing	0099	0.3703	$20.20		$4.04
93010	A		Electrocardiogram report					
93012	N		Transmission of ecg					
93014	B		Report on transmitted ecg					
93015	B		Cardiovascular stress test					
93016	B		Cardiovascular stress test					
93017	X		Cardiovascular stress test	0100	1.5862	$86.54	$41.44	$17.31
93018	B		Cardiovascular stress test					
93024	X		Cardiac drug stress test	0100	1.5862	$86.54	$41.44	$17.31
93025	X		Microvolt t-wave assess	0100	1.5862	$86.54	$41.44	$17.31
93040	B		Rhythm ECG with report					
93041	S		Rhythm ECG, tracing	0099	0.3703	$20.20		$4.04
93042	B		Rhythm ECG, report					
93224	B		ECG monitor/report, 24 hrs					
93225	X		ECG monitor/record, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93226	X		ECG monitor/report, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93227	B		ECG monitor/review, 24 hrs					
93230	B		ECG monitor/report, 24 hrs					
93231	X		Ecg monitor/record, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93232	X		ECG monitor/report, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93233	B		ECG monitor/review, 24 hrs					
93235	B		ECG monitor/report, 24 hrs					
93236	X		ECG monitor/report, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93237	B		ECG monitor/review, 24 hrs					
93268	B		ECG record/review					
93270	X		ECG recording	0097	1.0635	$58.03	$23.80	$11.61
93271	X		Ecg/monitoring and analysis	0097	1.0635	$58.03	$23.80	$11.61
93272	B		Ecg/review, interpret only					
93278	S		ECG/signal-averaged	0099	0.3703	$20.20		$4.04
93303	S		Echo transthoracic	0269	3.2309	$176.28	$87.24	$35.26
93304	S		Echo transthoracic	0697	1.4415	$78.65	$39.32	$15.73
93307	S		Echo exam of heart	0269	3.2309	$176.28	$87.24	$35.26
93308	S		Echo exam of heart	0697	1.4415	$78.65	$39.32	$15.73
93312	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93313	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93314	N		Echo transesophageal					
93315	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93316	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93317	N		Echo transesophageal					
93318	S		Echo transesophageal intraop	0270	5.8546	$319.43	$146.79	$63.89
93320	S		Doppler echo exam, heart	0671	1.6384	$89.39	$44.69	$17.88
93321	S		Doppler echo exam, heart	0697	1.4415	$78.65	$39.32	$15.73
93325	S		Doppler color flow add-on	0697	1.4415	$78.65	$39.32	$15.73
93350	S		Echo transthoracic	0269	3.2309	$176.28	$87.24	$35.26
93501	T		Right heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93503	T		Insert/place heart catheter	0103	11.6202	$634.01	$223.63	$126.80
93505	T		Biopsy of heart lining	0103	11.6202	$634.01	$223.63	$126.80
93508	T		Cath placement, angiography	0080	36.0160	$1,965.07	$838.92	$393.01
93510	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93511	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93514	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93524	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93526	T		Rt & Lt heart catheters	0080	36.0160	$1,965.07	$838.92	$393.01
93527	T		Rt & Lt heart catheters	0080	36.0160	$1,965.07	$838.92	$393.01
93528	T		Rt & Lt heart catheters	0080	36.0160	$1,965.07	$838.92	$393.01
93529	T		Rt, lt heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93530	T		Rt heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
93531	T		R & l heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
93532	T		R & l heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
93533	T		R & l heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
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					
93580	T		Transcath closure of asd	1559		$2,250.00		$450.00
93581	T		Transcath closure of vsd	1559		$2,250.00		$450.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93600	T		Bundle of His recording	0087	39.8161	$2,172.41		$434.48
93602	T		Intra-atrial recording	0087	39.8161	$2,172.41		$434.48
93603	T		Right ventricular recording	0087	39.8161	$2,172.41		$434.48
93609	T		Map tachycardia, add-on	0087	39.8161	$2,172.41		$434.48
93610	T		Intra-atrial pacing	0087	39.8161	$2,172.41		$434.48
93612	T		Intraventricular pacing	0087	39.8161	$2,172.41		$434.48
93613	T		Electrophys map 3d, add-on	0087	39.8161	$2,172.41		$434.48
93615	T		Esophageal recording	0087	39.8161	$2,172.41		$434.48
93616	T		Esophageal recording	0087	39.8161	$2,172.41		$434.48
93618	T		Heart rhythm pacing	0087	39.8161	$2,172.41		$434.48
93619	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93620	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93621	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93622	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93623	T		Stimulation, pacing heart	0087	39.8161	$2,172.41		$434.48
93624	S		Electrophysiologic study	0084	10.5226	$574.12		$114.82
93631	T		Heart pacing, mapping	0087	39.8161	$2,172.41		$434.48
93640	S		Evaluation heart device	0084	10.5226	$574.12		$114.82
93641	S		Electrophysiology evaluation	0084	10.5226	$574.12		$114.82
93642	S		Electrophysiology evaluation	0084	10.5226	$574.12		$114.82
93650	T		Ablate heart dysrhythm focus	0086	44.9389	$2,451.91	$833.33	$490.38
93651	T		Ablate heart dysrhythm focus	0086	44.9389	$2,451.91	$833.33	$490.38
93652	T		Ablate heart dysrhythm focus	0086	44.9389	$2,451.91	$833.33	$490.38
93660	S		Tilt table evaluation	0101	4.4040	$240.29	$105.27	$48.06
93662	S		Intracardiac ecg (ice)	0670	27.4483	$1,497.61	$542.37	$299.52
93668	E		Peripheral vascular rehab					
93701	S		Bioimpedance, thoracic	0099	0.3703	$20.20		$4.04
93720	B		Total body plethysmography					
93721	X		Plethysmography tracing	0368	0.9319	$50.85	$25.42	$10.17
93722	B		Plethysmography report					
93724	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93727	S		Analyze ilr system	0690	0.4074	$22.23	$10.63	$4.45
93731	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93732	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93733	S		Telephone analy, pacemaker	0690	0.4074	$22.23	$10.63	$4.45
93734	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93735	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93736	S		Telephonic analy, pacemaker	0690	0.4074	$22.23	$10.63	$4.45
93740	X		Temperature gradient studies	0367	0.5887	$32.12	$15.16	$6.42
93741	S		Analyze ht pace device sngl	0689	0.5533	$30.19		$6.04
93742	S		Analyze ht pace device sngl	0689	0.5533	$30.19		$6.04
93743	S		Analyze ht pace device dual	0689	0.5533	$30.19		$6.04
93744	S		Analyze ht pace device dual	0689	0.5533	$30.19		$6.04
93760	E		Cephalic thermogram					
93762	E		Peripheral thermogram					
93770	N		Measure venous pressure					
93784	E		Ambulatory BP monitoring					
93786	X		Ambulatory BP recording	0097	1.0635	$58.03	$23.80	$11.61
93788	E		Ambulatory BP analysis					
93790	B		Review/report BP recording					
93797	S		Cardiac rehab	0095	0.5994	$32.70	$16.35	$6.54
93798	S		Cardiac rehab/monitor	0095	0.5994	$32.70	$16.35	$6.54
93799	S		Cardiovascular procedure	0096	1.7176	$93.71	$46.85	$18.74
93875	S		Extracranial study	0096	1.7176	$93.71	$46.85	$18.74
93880	S		Extracranial study	0267	2.4586	$134.14	$65.52	$26.83
93882	S		Extracranial study	0267	2.4586	$134.14	$65.52	$26.83
93886	S		Intracranial study	0267	2.4586	$134.14	$65.52	$26.83
93888	S		Intracranial study	0266	1.6117	$87.94	$43.97	$17.59
93922	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93923	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93924	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93925	S		Lower extremity study	0267	2.4586	$134.14	$65.52	$26.83
93926	S		Lower extremity study	0267	2.4586	$134.14	$65.52	$26.83
93930	S		Upper extremity study	0267	2.4586	$134.14	$65.52	$26.83
93931	S		Upper extremity study	0266	1.6117	$87.94	$43.97	$17.59
93965	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93970	S		Extremity study	0267	2.4586	$134.14	$65.52	$26.83
93971	S		Extremity study	0267	2.4586	$134.14	$65.52	$26.83
93975	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93976	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93978	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93979	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93980	S		Penile vascular study	0267	2.4586	$134.14	$65.52	$26.83
93981	S		Penile vascular study	0267	2.4586	$134.14	$65.52	$26.83
93990	S		Doppler flow testing	0267	2.4586	$134.14	$65.52	$26.83

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94010	X		Breathing capacity test	0368	0.9319	$50.85	$25.42	$10.17
94014	X		Patient recorded spirometry	0367	0.5887	$32.12	$15.16	$6.42
94015	X		Patient recorded spirometry	0369	2.4984	$136.32	$44.18	$27.26
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	0.9319	$50.85	$25.42	$10.17
94070	X		Evaluation of wheezing	0369	2.4984	$136.32	$44.18	$27.26
94150	X		Vital capacity test	0367	0.5887	$32.12	$15.16	$6.42
94200	X		Lung function test (MBC/MVV)	0367	0.5887	$32.12	$15.16	$6.42
94240	X		Residual lung capacity	0368	0.9319	$50.85	$25.42	$10.17
94250	X		Expired gas collection	0367	0.5887	$32.12	$15.16	$6.42
94260	X		Thoracic gas volume	0368	0.9319	$50.85	$25.42	$10.17
94350	X		Lung nitrogen washout curve	0368	0.9319	$50.85	$25.42	$10.17
94360	X		Measure airflow resistance	0367	0.5887	$32.12	$15.16	$6.42
94370	X		Breath airway closing volume	0367	0.5887	$32.12	$15.16	$6.42
94375	X		Respiratory flow volume loop	0367	0.5887	$32.12	$15.16	$6.42
94400	X		CO2 breathing response curve	0367	0.5887	$32.12	$15.16	$6.42
94450	X		Hypoxia response curve	0367	0.5887	$32.12	$15.16	$6.42
94620	X		Pulmonary stress test/simple	0368	0.9319	$50.85	$25.42	$10.17
94621	X		Pulm stress test/complex	0369	2.4984	$136.32	$44.18	$27.26
94640	S		Airway inhalation treatment	0077	0.2837	$15.48	$7.74	$3.10
94642	S		Aerosol inhalation treatment	0078	0.7917	$43.20	$14.55	$8.64
94656	S		Initial ventilator mgmt	0079	2.1494	$117.27		$23.45
94657	S		Continued ventilator mgmt	0079	2.1494	$117.27		$23.45
94660	S		Pos airway pressure, CPAP	0068	1.0807	$58.96	$29.48	$11.79
94662	S		Neg press ventilation, cnp	0079	2.1494	$117.27		$23.45
94664	S		Aerosol or vapor inhalations	0077	0.2837	$15.48	$7.74	$3.10
94667	S		Chest wall manipulation	0077	0.2837	$15.48	$7.74	$3.10
94668	S		Chest wall manipulation	0077	0.2837	$15.48	$7.74	$3.10
94680	X		Exhaled air analysis, o2	0367	0.5887	$32.12	$15.16	$6.42
94681	X		Exhaled air analysis, o2/co2	0368	0.9319	$50.85	$25.42	$10.17
94690	X		Exhaled air analysis	0367	0.5887	$32.12	$15.16	$6.42
94720	X		Monoxide diffusing capacity	0368	0.9319	$50.85	$25.42	$10.17
94725	X		Membrane diffusion capacity	0368	0.9319	$50.85	$25.42	$10.17
94750	X		Pulmonary compliance study	0367	0.5887	$32.12	$15.16	$6.42
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	0.5887	$32.12	$15.16	$6.42
94772	X		Breath recording, infant	0369	2.4984	$136.32	$44.18	$27.26
94799	X		Pulmonary service/procedure	0367	0.5887	$32.12	$15.16	$6.42
95004	X		Percut allergy skin tests	0370	0.9185	$50.11	$11.58	$10.02
95010	X		Percut allergy titrate test	0370	0.9185	$50.11	$11.58	$10.02
95015	X		Id allergy titrate-drug/bug	0370	0.9185	$50.11	$11.58	$10.02
95024	X		Id allergy test, drug/bug	0370	0.9185	$50.11	$11.58	$10.02
95027	X		Skin end point titration	0370	0.9185	$50.11	$11.58	$10.02
95028	X		Id allergy test-delayed type	0370	0.9185	$50.11	$11.58	$10.02
95044	X		Allergy patch tests	0370	0.9185	$50.11	$11.58	$10.02
95052	X		Photo patch test	0370	0.9185	$50.11	$11.58	$10.02
95056	X		Photosensitivity tests	0370	0.9185	$50.11	$11.58	$10.02
95060	X		Eye allergy tests	0370	0.9185	$50.11	$11.58	$10.02
95065	X		Nose allergy test	0370	0.9185	$50.11	$11.58	$10.02
95070	X		Bronchial allergy tests	0369	2.4984	$136.32	$44.18	$27.26
95071	X		Bronchial allergy tests	0369	2.4984	$136.32	$44.18	$27.26
95075	X		Ingestion challenge test	0361	3.5510	$193.75	$83.23	$38.75
95078	X		Provocative testing	0370	0.9185	$50.11	$11.58	$10.02
95115	X		Immunotherapy, one injection	0352	0.1230	$6.71		$1.34
95117	X		Immunotherapy injections	0353	0.3982	$21.73		$4.35
95120	B		Immunotherapy, one injection					
95125	B		Immunotherapy, many antigens					
95130	B		Immunotherapy, insect venom					
95131	B		Immunotherapy, insect venoms					
95132	B		Immunotherapy, insect venoms					
95133	B		Immunotherapy, insect venoms					
95134	B		Immunotherapy, insect venoms					
95144	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95145	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95146	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95147	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95148	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95149	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95165	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95170	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95180	X		Rapid desensitization	0370	0.9185	$50.11	$11.58	$10.02
95199	X		Allergy immunology services	0370	0.9185	$50.11	$11.58	$10.02
95250	T		Glucose monitoring, cont	1540		$150.00		$30.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95805	S		Multiple sleep latency test	0209	11.5435	$629.82	$280.58	$125.96
95806	S		Sleep study, unattended	0213	2.9055	$158.53	$65.74	$31.71
95807	S		Sleep study, attended	0209	11.5435	$629.82	$280.58	$125.96
95808	S		Polysomnography, 1-3	0209	11.5435	$629.82	$280.58	$125.96
95810	S		Polysomnography, 4 or more	0209	11.5435	$629.82	$280.58	$125.96
95811	S		Polysomnography w/cpap	0209	11.5435	$629.82	$280.58	$125.96
95812	S		Electroencephalogram (EEG)	0213	2.9055	$158.53	$65.74	$31.71
95813	S		Eeg, over 1 hour	0213	2.9055	$158.53	$65.74	$31.71
95816	S		Electroencephalogram (EEG)	0214	2.2176	$120.99	$58.12	$24.20
95819	S		Electroencephalogram (EEG)	0214	2.2176	$120.99	$58.12	$24.20
95822	S		Sleep electroencephalogram	0214	2.2176	$120.99	$58.12	$24.20
95824	S		Eeg, cerebral death only	0214	2.2176	$120.99	$58.12	$24.20
95827	S		night electroencephalogram	0209	11.5435	$629.82	$280.58	$125.96
95829	S		Surgery electrocorticogram	0214	2.2176	$120.99	$58.12	$24.20
95830	B		Insert electrodes for EEG					
95831	A		Limb muscle testing, manual					
95832	A		Hand muscle testing, manual					
95833	A		Body muscle testing, manual					
95834	A		Body muscle testing, manual					
95851	A		Range of motion measurements					
95852	A		Range of motion measurements					
95857	S		Tensilon test	0218	1.1404	$62.22		$12.44
95858	S		Tensilon test & myogram	0215	0.6457	$35.23	$15.76	$7.05
95860	S		Muscle test, one limb	0218	1.1404	$62.22		$12.44
95861	S		Muscle test, 2 limbs	0218	1.1404	$62.22		$12.44
95863	S		Muscle test, 3 limbs	0218	1.1404	$62.22		$12.44
95864	S		Muscle test, 4 limbs	0218	1.1404	$62.22		$12.44
95867	S		Muscle test, head or neck	0218	1.1404	$62.22		$12.44
95868	S		Muscle test cran nerve bilat	0218	1.1404	$62.22		$12.44
95869	S		Muscle test, thor paraspinal	0215	0.6457	$35.23	$15.76	$7.05
95870	S		Muscle test, nonparaspinal	0215	0.6457	$35.23	$15.76	$7.05
95872	S		Muscle test, one fiber	0218	1.1404	$62.22		$12.44
95875	S		Limb exercise test	0215	0.6457	$35.23	$15.76	$7.05
95900	S		Motor nerve conduction test	0215	0.6457	$35.23	$15.76	$7.05
95903	S		Motor nerve conduction test	0215	0.6457	$35.23	$15.76	$7.05
95904	S		Sense nerve conduction test	0215	0.6457	$35.23	$15.76	$7.05
95920	S		Intraop nerve test add-on	0216	2.8535	$155.69	$67.98	$31.14
95921	S		Autonomic nerv function test	0218	1.1404	$62.22		$12.44
95922	S		Autonomic nerv function test	0218	1.1404	$62.22		$12.44
95923	S		Autonomic nerv function test	0215	0.6457	$35.23	$15.76	$7.05
95925	S		Somatosensory testing	0216	2.8535	$155.69	$67.98	$31.14
95926	S		Somatosensory testing	0216	2.8535	$155.69	$67.98	$31.14
95927	S		Somatosensory testing	0216	2.8535	$155.69	$67.98	$31.14
95930	S		Visual evoked potential test	0218	1.1404	$62.22		$12.44
95933	S		Blink reflex test	0215	0.6457	$35.23	$15.76	$7.05
95934	S		H-reflex test	0215	0.6457	$35.23	$15.76	$7.05
95936	S		H-reflex test	0215	0.6457	$35.23	$15.76	$7.05
95937	S		Neuromuscular junction test	0218	1.1404	$62.22		$12.44
95950	S		Ambulatory eeg monitoring	0213	2.9055	$158.53	$65.74	$31.71
95951	S		EEG monitoring/videorecord	0209	11.5435	$629.82	$280.58	$125.96
95953	S		EEG monitoring/computer	0209	11.5435	$629.82	$280.58	$125.96
95954	S		EEG monitoring/giving drugs	0214	2.2176	$120.99	$58.12	$24.20
95955	S		EEG during surgery	0213	2.9055	$158.53	$65.74	$31.71
95956	S		Eeg monitoring, cable/radio	0214	2.2176	$120.99	$58.12	$24.20
95957	S		EEG digital analysis	0214	2.2176	$120.99	$58.12	$24.20
95958	S		EEG monitoring/function test	0213	2.9055	$158.53	$65.74	$31.71
95961	S		Electrode stimulation, brain	0216	2.8535	$155.69	$67.98	$31.14
95962	S		Electrode stim, brain add-on	0216	2.8535	$155.69	$67.98	$31.14
95965	S		Meg, spontaneous	1528		$5,250.00		$1,050.00
95966	S		Meg, evoked, single	1516		$1,450.00		$290.00
95967	S		Meg, evoked, each add'l	1511		$950.00		$190.00
95970	S		Analyze neurostim, no prog	0692	1.1057	$60.33	$30.16	$12.07
95971	S		Analyze neurostim, simple	0692	1.1057	$60.33	$30.16	$12.07
95972	S		Analyze neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95973	S		Analyze neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95974	S		Cranial neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95975	S		Cranial neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95990	T		Spin/brain pump refil & main	0125	2.1606	$117.88		$23.58
95991	T	NI	Spin/brain pump refil & main	0125	2.1606	$117.88		$23.58
95999	S		Neurological procedure	0215	0.6457	$35.23	$15.76	$7.05
96000	S		Motion analysis, video/3d	1503		$150.00		$30.00
96001	S		Motion test w/ft press meas	1503		$150.00		$30.00
96002	S		Dynamic surface emg	1503		$150.00		$30.00
96003	S		Dynamic fine wire emg	1503		$150.00		$30.00
96004	E		Phys review of motion tests					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96100	X		Psychological testing	0373	2.0899	$114.03		$22.81
96105	A		Assessment of aphasia					
96110	X		Developmental test, lim	0373	2.0899	$114.03		$22.81
96111	X		Developmental test, extend	0373	2.0899	$114.03		$22.81
96115	X		Neurobehavior status exam	0373	2.0899	$114.03		$22.81
96117	X		Neuropsych test battery	0373	2.0899	$114.03		$22.81
96150	S		Assess lth/behave, init	0322	1.2802	$69.85		$13.97
96151	S		Assess hlth/behave, subseq	0322	1.2802	$69.85		$13.97
96152	S		Intervene hlth/behave, indiv	0322	1.2802	$69.85		$13.97
96153	S		Intervene hlth/behave, group	0322	1.2802	$69.85		$13.97
96154	S		Interv hlth/behav, fam w/pt	0322	1.2802	$69.85		$13.97
96155	S		Interv hlth/behav fam no pt	0322	1.2802	$69.85		$13.97
96400	B		Chemotherapy, sc/im					
96405	B		Intralesional chemo admin					
96406	B		Intralesional chemo admin					
96408	B		Chemotherapy, push technique					
96410	B		Chemotherapy,infusion method					
96412	B		Chemo, infuse method add-on					
96414	B		Chemo, infuse method add-on					
96420	B		Chemotherapy, push technique					
96422	B		Chemotherapy,infusion method					
96423	B		Chemo, infuse method add-on					
96425	B		Chemotherapy,infusion method					
96440	B		Chemotherapy, intracavitary					
96445	B		Chemotherapy, intracavitary					
96450	B		Chemotherapy, into CNS					
96520	T		Port pump refill & main	0125	2.1606	$117.88		$23.58
96530	T		Pump refilling, maintenance	0125	2.1606	$117.88		$23.58
96542	B		Chemotherapy injection					
96545	B		Provide chemotherapy agent					
96549	B		Chemotherapy, unspecified					
96567	T		Photodynamic tx, skin	1540		$150.00		$30.00
96570	T		Photodynamic tx, 30 min	1541		$250.00		$50.00
96571	T		Photodynamic tx, addl 15 min	1541		$250.00		$50.00
96900	S		Ultraviolet light therapy	0001	0.4237	$23.12	$7.09	$4.62
96902	N		Trichogram					
96910	S		Photochemotherapy with UV-B	0001	0.4237	$23.12	$7.09	$4.62
96912	S		Photochemotherapy with UV-A	0001	0.4237	$23.12	$7.09	$4.62
96913	S		Photochemotherapy, UV-A or B	0683	1.5489	$84.51	$30.42	$16.90
96920	T		Laser tx, skin < 250 sq cm	0012	0.7694	$41.98	$11.18	$8.40
96921	T		Laser tx, skin 250-500 sq cm	0012	0.7694	$41.98	$11.18	$8.40
96922	T		Laser tx, skin > 500 sq cm	0013	1.1272	$61.50	$14.20	$12.30
96999	T		Dermatological procedure	0010	0.6480	$35.36	$10.08	$7.07
97001	A		Pt evaluation					
97002	A		Pt re-evaluation					
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	E		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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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(s) care, selective					
97602	N		Wound(s) care non-selective					
97703	A		Prosthetic checkout					
97750	A		Physical performance test					
97755	A	NI	Assistive technology assess					
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	0.2788	$15.21		$3.04
98926	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98927	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98928	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98929	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98940	S		Chiropractic manipulation	0060	0.2788	$15.21		$3.04
98941	S		Chiropractic manipulation	0060	0.2788	$15.21		$3.04
98942	S		Chiropractic manipulation	0060	0.2788	$15.21		$3.04
98943	E		Chiropractic manipulation					
99000	B		Specimen handling					
99001	B		Specimen handling					
99002	E		Device handling					
99024	B		Postop follow-up visit					
99025	B	DG	Initial surgical evaluation					
99026	E		In-hospital on call service					
99027	E		Out-of-hosp on call service					
99050	B		Medical services after hrs					
99052	B		Medical services at night					
99054	B		Medical servcs, unusual hrs					
99056	B		Non-office medical services					
99058	B		Office emergency care					
99070	B		Special supplies					
99071	B		Patient education materials					
99075	E		Medical testimony					
99078	N		Group health education					
99080	B		Special reports or forms					
99082	B		Unusual physician travel					
99090	B		Computer data analysis					
99091	E		Collect/review data from pt					
99100	B		Special anesthesia service					
99116	B		Anesthesia with hypothermia					
99135	B		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	0.1853	$10.11	$2.93	$2.02
99172	E		Ocular function screen					
99173	E		Visual acuity screen					
99175	N		Induction of vomiting					
99183	B		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	0.5607	$30.59	$10.09	$6.12
99199	B		Special service/proc/report					
99201	V		Office/outpatient visit, new	0600	0.9278	$50.62		$10.12
99202	V		Office/outpatient visit, new	0600	0.9278	$50.62		$10.12
99203	V		Office/outpatient visit, new	0601	0.9816	$53.56		$10.71
99204	V		Office/outpatient visit, new	0602	1.5041	$82.07		$16.41
99205	V		Office/outpatient visit, new	0602	1.5041	$82.07		$16.41
99211	V		Office/outpatient visit, est	0600	0.9278	$50.62		$10.12
99212	V		Office/outpatient visit, est	0600	0.9278	$50.62		$10.12
99213	V		Office/outpatient visit, est	0601	0.9816	$53.56		$10.71
99214	V		Office/outpatient visit, est	0602	1.5041	$82.07		$16.41

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99215	V		Office/outpatient visit, est	0602	1.5041	$82.07		$16.41
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	0.9278	$50.62		$10.12
99242	V		Office consultation	0600	0.9278	$50.62		$10.12
99243	V		Office consultation	0601	0.9816	$53.56		$10.71
99244	V		Office consultation	0602	1.5041	$82.07		$16.41
99245	V		Office consultation	0602	1.5041	$82.07		$16.41
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	0.9278	$50.62		$10.12
99272	V		Confirmatory consultation	0600	0.9278	$50.62		$10.12
99273	V		Confirmatory consultation	0601	0.9816	$53.56		$10.71
99274	V		Confirmatory consultation	0602	1.5041	$82.07		$16.41
99275	V		Confirmatory consultation	0602	1.5041	$82.07		$16.41
99281	V		Emergency dept visit	0610	1.3691	$74.70	$19.57	$14.94
99282	V		Emergency dept visit	0610	1.3691	$74.70	$19.57	$14.94
99283	V		Emergency dept visit	0611	2.3967	$130.77	$36.16	$26.15
99284	V		Emergency dept visit	0612	4.1476	$226.30	$54.12	$45.26
99285	V		Emergency dept visit	0612	4.1476	$226.30	$54.12	$45.26
99288	B		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	8.9992	$491.01	$142.30	$98.20
99292	N		Critical care, add'l 30 min					
99293	C		Ped critical care, initial					
99294	C		Ped critical care, subseq					
99295	C		Neonatal critical care					
99296	C		Neonatal critical care					
99298	C		Neonatal critical care					
99299	C		Ic, lbw infant 1500-2500 gm					
99301	B		Nursing facility care					
99302	B		Nursing facility care					
99303	B		Nursing facility care					
99311	B		Nursing fac care, subseq					
99312	B		Nursing fac care, subseq					
99313	B		Nursing fac care, subseq					
99315	B		Nursing fac discharge day					
99316	B		Nursing fac discharge day					
99321	B		Rest home visit, new patient					
99322	B		Rest home visit, new patient					
99323	B		Rest home visit, new patient					
99331	B		Rest home visit, est pat					
99332	B		Rest home visit, est pat					
99333	B		Rest home visit, est pat					
99341	B		Home visit, new patient					
99342	B		Home visit, new patient					
99343	B		Home visit, new patient					
99344	B		Home visit, new patient					
99345	B		Home visit, new patient					
99347	B		Home visit, est patient					
99348	B		Home visit, est patient					
99349	B		Home visit, est patient					
99350	B		Home visit, est patient					
99354	N		Prolonged service, office					
99355	N		Prolonged service, office					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	B		Physician standby services					
99361	E		Physician/team conference					
99362	E		Physician/team conference					
99371	B		Physician phone consultation					
99372	B		Physician phone consultation					
99373	B		Physician phone consultation					
99374	B		Home health care supervision					
99377	B		Hospice care supervision					
99379	B		Nursing fac care supervision					
99380	B		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	V		Initial care, normal newborn	0600	0.9278	$50.62		$10.12
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	2.6345	$143.74	$48.58	$28.75
99450	E		Life/disability evaluation					
99455	B		Disability examination					
99456	B		Disability examination					
99499	B		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					
99504	E		Home visit mech ventilator					
99505	E		Home visit, stoma care					
99506	E		Home visit, im injection					
99507	E		Home visit, cath maintain					
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 for hemodialysis					
99551	E	DG	Home infus, pain mgmt, iv/sc					
99552	E	DG	Hm infus pain mgmt, epid/ith					
99553	E	DG	Home infuse, tocolytic tx					
99554	E	DG	Home infus, hormone/platelet					
99555	E	DG	Home infuse, chemotheraphy					
99556	E	DG	Home infus, antibio/fung/vir					
99557	E	DG	Home infuse, anticoagulant					
99558	E	DG	Home infuse, immunotherapy					
99559	E	DG	Home infus, periton dialysis					
99560	E	DG	Home infus, entero nutrition					
99561	E	DG	Home infuse, hydration tx					
99562	E	DG	Home infus, parent nutrition					
99563	E	DG	Home admin, pentamidine					
99564	E	DG	Hme infus, antihemophil agnt					
99565	E	DG	Home infus, proteinase inhib					
99566	E	DG	Home infuse, iv therapy					
99567	E	DG	Home infuse, sympath agent					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99568	E	DG	Home infus, misc drug, daily					
99569	E	DG	Home infuse, each addl tx					
99600	E		Home visit nos					
99601	E	NI	Home infusion/visit, 2 hrs					
99602	E	NI	Home infusion, each addtl hr					
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 mileag					
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					
A0800	A		Amb trans 7pm-7am					
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	B		Supp for self-adm injections					
A4212	B		Non coring needle or stylet					
A4213	E		20+ CC syringe only					
A4214	A	DG	30 CC sterile water/saline					
A4215	E		Sterile needle					
A4216	A	NI	Sterile water/saline, 10 ml					
A4217	A	NI	Sterile water/saline, 500 ml					
A4220	N	NI	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	E		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					
A4248	N		Chlorhexidine antisept					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A4266	E		Diaphragm					
A4267	E		Male condom					
A4268	E		Female condom					
A4269	E		Spermicide					
A4270	A		Disposable endoscope sheath					
A4280	A		Brst prsths adhsv attchmnt					
A4281	E		Replacement breastpump tube					
A4282	E		Replacement breastpump adpt					
A4283	E		Replacement breastpump cap					
A4284	E		Replcmnt breast pump shield					
A4285	E		Replcmnt breast pump bottle					
A4286	E		Replcmnt breastpump lok ring					
A4290	E		Sacral nerve stim test lead					
A4300	N		Cath impl vasc access portal					
A4301	N		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	DG	Sterile H2O irrigation solut					
A4320	A		Irrigation tray					
A4321	A		Cath therapeutic irrig agent					
A4322	A		Irrigation syringe					
A4323	A	DG	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					
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 or abdomen bag					
A4359	A		Urinary suspensory w/o leg b					
A4361	A		Ostomy face plate					
A4362	A		Solid skin barrier					
A4364	A		Adhesive, liquid or equal					
A4365	A		Adhesive remover wipes					
A4366	A		Ostomy vent					
A4367	A		Ostomy belt					
A4368	A		Ostomy filter					
A4369	A		Skin barrier liquid per oz					
A4371	A		Skin barrier powder per oz					
A4372	A		Skin barrier solid 4x4 equiv					
A4373	A		Skin barrier with flange					
A4375	A		Drainable plastic pch w fcpl					
A4376	A		Drainable rubber pch w fcplt					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
A4405	A		Nonpectin based ostomy paste					
A4406	A		Pectin based ostomy paste					
A4407	A		Ext wear ost skn barr <=4sq≧					
A4408	A		Ext wear ost skn barr >4sq≧					
A4409	A		Ost skn barr w flng <=4 sq≧					
A4410	A		Ost skn barr w flng >4sq≧					
A4413	A		2 pc drainable ost pouch					
A4414	A		Ostomy sknbarr w flng <=4sq≧					
A4415	A		Ostomy skn barr w flng >4sq≧					
A4416	A	NI	Ost pch clsd w barrier/filtr					
A4417	A	NI	Ost pch w bar/bltinconv/fltr					
A4418	A	NI	Ost pch clsd w/o bar w filtr					
A4419	A	NI	Ost pch for bar w flange/flt					
A4420	A	NI	Ost pch clsd for bar w lk fl					
A4421	A		Ostomy supply misc					
A4422	A		Ost pouch absorbent material					
A4424	A	NI	Ost pch drain w bar & filter					
A4425	A	NI	Ost pch drain for barrier fl					
A4426	A	NI	Ost pch drain 2 piece system					
A4427	A	NI	Ost pch drain/barr lk flng/f					
A4428	A	NI	Urine ost pouch w faucet/tap					
A4429	A	NI	Urine ost pch bar w lock fln					
A4430	A	NI	Ost pch urine w lock flng/ft					
A4431	A	NI	Urine ost pch bar w lock fln					
A4432	A	NI	Ost pch urine w lock flng/ft					
A4433	A	NI	Urine ost pch bar w lock fln					
A4434	A	NI	Ost pch urine w lock flng/ft					
A4450	A		Non-waterproof tape					
A4452	A		Waterproof tape					
A4455	A		Adhesive remover per ounce					
A4458	E		Reusable enema bag					
A4462	A		Abdmnl drssng holder/binder					
A4465	A		Non-elastic extremity binder					
A4470	A		Gravlee jet washer					
A4480	A		Vabra aspirator					
A4481	A		Tracheostoma filter					
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					
A4521	E		Adult size diaper sm each					
A4522	E		Adult size diaper med each					
A4523	E		Adult size diaper lg each					
A4524	E		Adult size diaper xl each					
A4525	E		Adult size brief sm each					
A4526	E		Adult size brief med each					
A4527	E		Adult size brief lg each					
A4528	E		Adult size brief xl each					
A4529	E		Child size diaper sm/med ea					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4530	E		Child size diaper lg each					
A4531	E		Child size brief sm/med each					
A4532	E		Child size brief lg each					
A4533	E		Youth size diaper each					
A4534	E		Youth size brief each					
A4535	E		Disp incont liner/shield ea					
A4536	E		Prot underwr wshbl any sz ea					
A4537	E		Under pad reusable any sz ea					
A4538	E		Reusable diaper from dpr svc					
A4550	B		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	E		Splint					
A4575	E		Hyperbaric o2 chamber disps					
A4580	E		Cast supplies (plaster)					
A4590	E		Special casting material					
A4595	A		TENS suppl 2 lead per month					
A4606	A		Oxygen probe used w oximeter					
A4608	A		Transtracheal oxygen cath					
A4609	A		Trach suction cath clsed sys					
A4610	A		Trach sctn cath 72h clsedsys					
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					
A4617	A		Mouth piece					
A4618	A		Breathing circuits					
A4619	A		Face tent					
A4620	A		Variable concentration mask					
A4621	A	DG	Tracheotomy mask or collar					
A4622	A	DG	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	DG	Wheelchair battery					
A4632	E		Infus pump rplcemnt battery					
A4633	A		Uvl replacement bulb					
A4634	A		Replacement bulb th lightbox					
A4635	A		Underarm crutch pad					
A4636	A		Handgrip for cane etc					
A4637	A		Repl tip cane/crutch/walker					
A4638	Y	NI	Repl batt pulse gen sys					
A4639	A		Infrared ht sys replcmnt pad					
A4640	A		Alternating pressure pad					
A4641	N		Diagnostic imaging agent					
A4642	K		Satumomab pendetide per dose	0704	2.2811	$124.46		$24.89
A4643	N		High dose contrast MRI					
A4644	N	DG	Contrast 100-199 MGs iodine					
A4645	N	DG	Contrast 200-299 MGs iodine					
A4646	N	DG	Contrast 300-399 MGs iodine					
A4647	N		Supp- paramagnetic contr mat					
A4649	A		Surgical supplies					
A4651	A		Calibrated microcap tube					
A4652	A		Microcapillary tube sealant					
A4653	A		PD catheter anchor belt					
A4656	A		Dialysis needle					
A4657	A		Dialysis syringe w/wo needle					
A4660	A		Sphyg/bp app w cuff and stet					
A4663	A		Dialysis blood pressure cuff					
A4670	E		Automatic bp monitor, dial					
A4671	E	NI	Disposable cycler set					
A4672	E	NI	Drainage ext line, dialysis					
A4673	E	NI	Ext line w easy lock connect					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4674	E	NI	Chem/antisept solution, 8oz					
A4680	A		Activated carbon filter, ea					
A4690	A		Dialyzer, each					
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	DG	Sterile water inj per 10 ml					
A4714	A		Treated water per gallon					
A4719	A		≧Y set≧ 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					
A4728	E	NI	Dialysate solution, non-dex					
A4730	A		Fistula cannulation set, ea					
A4736	A		Topical anesthetic, per gram					
A4737	A		Inj anesthetic per 10 ml					
A4740	A		Shunt accessory					
A4750	A		Art or venous blood tubing					
A4755	A		Comb art/venous blood tubing					
A4760	A		Dialysate sol test kit, each					
A4765	A		Dialysate conc pow per pack					
A4766	A		Dialysate conc sol add 10 ml					
A4770	A		Blood collection tube/vacuum					
A4771	A		Serum clotting time tube					
A4772	A		Blood glucose test strips					
A4773	A		Occult blood test strips					
A4774	A		Ammonia test strips					
A4802	A		Protamine sulfate per 50 mg					
A4860	A		Disposable catheter tips					
A4870	A		Plumb/elec wk hm hemo equip					
A4890	A		Repair/maint cont hemo equip					
A4911	A		Drain bag/bottle					
A4913	A		Misc dialysis supplies noc					
A4918	A		Venous pressure clamp					
A4927	A		Non-sterile gloves					
A4928	A		Surgical mask					
A4929	A		Tourniquet for dialysis, ea					
A4930	A		Sterile, gloves per pair					
A4931	A		Reusable oral thermometer					
A4932	E		Reusable rectal thermometer					
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					
A5071	A		Urinary pouch w/barrier					
A5072	A		Urinary pouch w/o barrier					
A5073	A		Urinary pouch on barr w/flng					
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					
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					
A5503	A		Diabetic shoe w/roller/rockr					
A5504	A		Diabetic shoe with wedge					
A5505	A		Diab shoe w/metatarsal bar					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	E		Wound warming wound cover					
A6010	A		Collagen based wound filler					
A6011	A		Collagen gel/paste wound fil					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6260	A		Wound cleanser any type/size					
A6261	A		Wound filler gel/paste /oz					
A6262	A		Wound filler dry form / gram					
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					
A6407	A	NI	Packing strips, non-impreg					
A6410	A		Sterile eye pad					
A6411	A		Non-sterile eye pad					
A6412	E		Occlusive eye patch					
A6421	A	DG	Pad bandage >=3 <5in w /roll					
A6422	A	DG	Conf bandage ns >=3<5≧w/roll					
A6424	A	DG	Conf bandage ns >=5≧w /roll					
A6426	A	DG	Conf bandage s >=3<5≧ w/roll					
A6428	A	DG	Conf bandage s >=5≧ w /roll					
A6430	A	DG	Lt compres bdg >=3<5≧w /roll					
A6432	A	DG	Lt compres bdg >=5≧w /roll					
A6434	A	DG	Mo compres bdg >=3<5≧w /roll					
A6436	A	DG	Hi compres bdg >=3<5≧w /roll					
A6438	A	DG	Self-adher bdg >=3<5≧w /roll					
A6440	A	DG	Zinc paste bdg >=3<5≧w /roll					
A6441	A	NI	Pad band w>=3≧ <5≧/yd					
A6442	A	NI	Conform band n/s w<3≧/yd					
A6443	A	NI	Conform band n/s w>=3≧<5≧/yd					
A6444	A	NI	Conform band n/s w>=5≧/yd					
A6445	A	NI	Conform band s w <3≧/yd					
A6446	A	NI	Conform band s w>=3≧ <5≧/yd					
A6447	A	NI	Conform band s w >=5≧/yd					
A6448	A	NI	Lt compres band <3≧/yd					
A6449	A	NI	Lt compres band >=3≧ <5≧/yd					
A6450	A	NI	Lt compres band >=5≧/yd					
A6451	A	NI	Mod compres band w>=3≧<5≧/yd					
A6452	A	NI	High compres band w>=3≧<5≧yd					
A6453	A	NI	Self-adher band w <3≧/yd					
A6454	A	NI	Self-adher band w>=3≧ <5≧/yd					
A6455	A	NI	Self-adher band >=5≧/yd					
A6456	A	NI	Zinc paste band w >=3≧<5≧/yd					
A6501	A		Compres burngarment bodysuit					
A6502	A		Compres burngarment chinstrp					
A6503	A		Compres burngarment facehood					
A6504	A		Cmprsburngarment glove-wrist					
A6505	A		Cmprsburngarment glove-elbow					
A6506	A		Cmprsburngrmnt glove-axilla					
A6507	A		Cmprs burngarment foot-knee					
A6508	A		Cmprs burngarment foot-thigh					
A6509	A		Compres burn garment jacket					
A6510	A		Compres burn garment leotard					
A6511	A		Compres burn garment panty					
A6512	A		Compres burn garment, noc					
A6550	Y	NI	Neg pres wound ther drsg set					
A6551	Y	NI	Neg press wound ther canistr					
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					
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	DG	Saline solution dispenser					
A7020	A	DG	Sterile H2O or NSS w lgv neb					
A7025	A		Replace chest compress vest					
A7026	A		Replace chst cmprss sys hose					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A7030	A		CPAP full face mask					
A7031	A		Replacement facemask interfa					
A7032	A		Replacement nasal cushion					
A7033	A		Replacement nasal pillows					
A7034	A		Nasal application device					
A7035	A		Pos airway press headgear					
A7036	A		Pos airway press chinstrap					
A7037	A		Pos airway pressure tubing					
A7038	A		Pos airway pressure filter					
A7039	A		Filter, non disposable w pap					
A7042	A		Implanted pleural catheter					
A7043	A		Vacuum drainagebottle/tubing					
A7044	A		PAP oral interface					
A7046	Y	NI	Repl water chamber, PAP dev					
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					
A7520	A	NI	Trach/laryn tube non-cuffed					
A7521	A	NI	Trach/laryn tube cuffed					
A7522	A	NI	Trach/laryn tube stainless					
A7523	A	NI	Tracheostomy shower protect					
A7524	A	NI	Tracheostoma stent/stud/bttn					
A7525	A	NI	Tracheostomy mask					
A7526	A	NI	Tracheostomy tube collar					
A9150	B		Misc/exper non-prescript dru					
A9270	E		Non-covered item or service					
A9280	E	NI	Alert device, noc					
A9300	E		Exercise equipment					
A9500	K		Technetium TC 99m sestamibi	1600	1.1782	$64.28		$12.86
A9502	K		Technetium TC99M tetrofosmin	0705	1.0642	$58.06		$11.61
A9503	N		Technetium TC 99m medronate					
A9504	N		Technetium tc 99m apcitide					
A9505	K		Thallous chloride TL 201/mci	1603	0.3645	$19.89		$3.98
A9507	K		Indium/111 capromab pendetid	1604	12.6045	$687.71		$137.54
A9508	K		Iobenguane sulfate I-131, per 0.5 mCi	1045	3.0392	$165.82		$33.16
A9510	N		Technetium TC99m Disofenin					
A9511	K		Technetium TC 99m depreotide	1095	0.6940	$37.87		$7.57
A9512	N		Technetiumtc99mpertechnetate					
A9513	N		Technetium tc-99m mebrofenin					
A9514	N		Technetiumtc99mpyrophosphate					
A9515	N		Technetium tc-99m pentetate					
A9516	N		I-123 sodium iodide capsule					
A9517	K		Th I131 so iodide cap millic	1064	0.1004	$5.48		$1.10
A9518	D	DNG	I-131 sodium iodide solution					
A9519	N		Technetiumtc-99mmacroag albu					
A9520	N		Technetiumtc-99m sulfur clld					
A9521	K		Technetiumtc-99m exametazine	1096	3.8609	$210.65		$42.13
A9522	B		Indium111ibritumomabtiuxetan					
A9523	B		Yttrium90ibritumomabtiuxetan					
A9524	K		Iodinated I-131 serumalbumin, per 5uci	9100	0.0066	$0.36		$0.07
A9525	N	NI	Low/iso-osmolar contrast mat					
A9526	K	NI	Ammonia N-13, per dose	9025	2.6372	$143.89		$28.78
A9527	B	NI	I-131 tositumomab therapeut					
A9528	K	NI	Dx I131 so iodide cap millic	1064	0.1004	$5.48		$1.10
A9529	K	NI	Dx I131 so iodide sol millic	1065	0.1189	$6.49		$1.30
A9530	K	NI	Th I131 so iodide sol millic	1065	0.1189	$6.49		$1.30
A9531	N	NI	Dx I131 so iodide microcurie					
A9532	N	NI	I-125 serum albumin micro					
A9533	B	NI	I-131 tositumomab diagnostic					
A9534	B	NI	I-131 tositumomab therapeut					
A9600	K		Strontium-89 chloride	0701	7.3835	$402.85		$80.57
A9605	K		Samarium sm153 lexidronamm	0702	16.0268	$874.44		$174.89
A9699	N		Noc therapeutic radiopharm					
A9700	E		Echocardiography Contrast	9202	2.1737	$118.60		$23.72
A9900	A		Supply/accessory/service					
A9901	A		Delivery/set up/dispensing					
A9999	Y	NI	DME supply or accessory, nos					
B4034	A		Enter feed supkit syr by day					
B4035	A		Enteral feed supp pump per d					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
B4086	A		Gastrostomy/jejunostomy tube					
B4100	E		Food thickener oral					
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					
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	DG	Blood, L/R, CMV-NEG	1010		$121.78		$24.36
C1011	K	DG	Platelets, HLA-m, L/R, unit	1011		$499.77		$99.95
C1015	K	DG	Plt, pher,L/R,CMV, irrad	1020		$495.22		$99.04
C1016	K	DG	BLOOD,L/R,FROZ/DEGLY/Washed	1016		$301.68		$60.34
C1017	K	DG	Plt, APH/PHER,L/R,CMV-NEG	1017		$393.15		$78.63
C1018	K	DG	Blood, L/R, IRRADIATED	1018		$132.40		$26.48
C1020	K	DG	RBC, frz/deg/wsh, L/R, irrad	1021		$336.04		$67.21
C1021	K	DG	RBC, L/R, CMV neg, irrad	1022		$201.12		$40.22
C1022	K	DG	Plasma, frz within 24 hour	0955		$95.00		$19.00
C1079	K		CO 57/58 per 0.5 uCi	1079	1.2556	$68.51		$13.70
C1080	K	NI	I-131 tositumomab, dx	1080		$2,260.00		$452.00
C1081	K	NI	I-131 tositumomab, tx	1081		$19,565.00		$3,913.00
C1082	K	NF	In-111 ibritumomab tiuxetan	9118		$2,260.00		$452.00
C1083	K	NF	Yttrium 90 ibritumomab tiuxetan	9117		$19,565.00		$3,913.00
C1088	T		LASER OPTIC TR Sys	1557		$1,850.00		$370.00
C1091	K		IN111 oxyquinoline,per0.5mCi	1091	4.1151	$224.52		$44.90
C1092	K		IN 111 pentetate per 0.5 mCi	1092	3.9855	$217.45		$43.49
C1122	K		Tc 99M ARCITUMOMAB PER VIAL	1122	9.8014	$534.77		$106.95
C1166	K	DG	CYTARABINE LIPOSOMAL, 10 mg	1166	5.1134	$278.99		$55.80
C1167	K	DG	EPIRUBICIN HCL, 2 mg	1167	0.3744	$20.43		$4.09
C1178	K		BUSULFAN IV, 6 Mg	1178	5.4930	$299.70		$59.94
C1200	K		TC 99M Sodium Glucoheptonat	1200	0.5550	$30.28		$6.06
C1201	K		TC 99M SUCCIMER, PER Vial	1201	1.4706	$80.24		$16.05
C1300	S		HYPERBARIC Oxygen	0659	3.0228	$164.93		$32.99
C1305	K		Apligraf	1305	15.0691	$822.19		$164.44
C1713	N	NF	Anchor/screw bn/bn,tis/bn					
C1714	N	NF	Cath, trans atherectomy, dir					
C1715	N	NF	Brachytherapy needle					
C1716	K		Brachytx source, Gold 198	1716	1.3811	$75.35		$15.07
C1717	N	NF	Brachytx source, HDR Ir-192					
C1718	K		Brachytx source, Iodine 125	1718	0.6843	$37.34		$7.47
C1719	K		Brachytx sour,Non-HDR Ir-192	1719	0.3187	$17.39		$3.48
C1720	K		Brachytx sour, Palladium 103	1720	0.8187	$44.67		$8.93
C1721	N	NF	AICD, dual chamber					
C1722	N	NF	AICD, single chamber					
C1724	N	NF	Cath, trans atherec,rotation					
C1725	N	NF	Cath, translumin non-laser					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1726	N	NF	Cath, bal dil, non-vascular					
C1727	N	NF	Cath, bal tis dis, non-vas					
C1728	N	NF	Cath, brachytx seed adm					
C1729	N	NF	Cath, drainage					
C1730	N	NF	Cath, EP, 19 or few elect					
C1731	N	NF	Cath, EP, 20 or more elec					
C1732	N	NF	Cath, EP, diag/abl, 3D/vect					
C1733	N	NF	Cath, EP, othr than cool-tip					
C1750	N	NF	Cath, hemodialysis,long-term					
C1751	N	NF	Cath, inf, per/cent/midline					
C1752	N	NF	Cath,hemodialysis,short-term					
C1753	N	NF	Cath, intravas ultrasound					
C1754	N	NF	Catheter, intradiscal					
C1755	N	NF	Catheter, intraspinal					
C1756	N	NF	Cath, pacing, transesoph					
C1757	N	NF	Cath, thrombectomy/embolect					
C1758	N	NF	Catheter, ureteral					
C1759	N	NF	Cath, intra echocardiography					
C1760	N	NF	Closure dev, vasc					
C1762	N	NF	Conn tiss, human(inc fascia)					
C1763	N	NF	Conn tiss, non-human					
C1764	N	NF	Event recorder, cardiac					
C1765	N		Adhesion barrier					
C1766	N	NF	Intro/sheath,strble,non-peel					
C1767	N	NF	Generator, neurostim, imp					
C1768	N	NF	Graft, vascular					
C1769	N	NF	Guide wire					
C1770	N	NF	Imaging coil, MR, insertable					
C1771	N	NF	Rep dev, urinary, w/sling					
C1772	N	NF	Infusion pump, programmable					
C1773	N	NF	Ret dev, insertable					
C1774	K	DG	Darbepoetin alfa, 1 mcg	0734		$3.24		$0.65
C1775	K		FDG, per dose (4-40 mCi/ml)	1775	5.9471	$324.48		$64.90
C1776	N	NF	Joint device (implantable)					
C1777	N	NF	Lead, AICD, endo single coil					
C1778	N	NF	Lead, neurostimulator					
C1779	N	NF	Lead, pmkr, transvenous VDD					
C1780	N	NF	Lens, intraocular (new tech)					
C1781	N	NF	Mesh (implantable)					
C1782	N	NF	Morcellator					
C1783	H		Ocular imp, aqueous drain ev	1783				
C1784	N	NF	Ocular dev, intraop, det ret					
C1785	N	NF	Pmkr, dual, rate-resp					
C1786	N	NF	Pmkr, single, rate-resp					
C1787	N	NF	Patient progr, neurostim					
C1788	N	NF	Port, indwelling, imp					
C1789	N	NF	Prosthesis, breast, imp					
C1813	N	NF	Prosthesis, penile, inflatab					
C1814	H	NF	Retinal tamp, silicone oil	1814				
C1815	N	NF	Pros, urinary sph, imp					
C1816	N	NF	Receiver/transmitter, neuro					
C1817	N	NF	Septal defect imp sys					
C1818	H		Integrated keratoprosthesis	1818				
C1819	H	NI	Tissue localization-excision dev	1819				
C1874	N	NF	Stent, coated/cov w/del sys					
C1875	N	NF	Stent, coated/cov w/o del sy					
C1876	N	NF	Stent, non-coa/non-cov w/del					
C1877	N	NF	Stent, non-coat/cov w/o del					
C1878	N	NF	Matrl for vocal cord					
C1879	N	NF	Tissue marker, implantable					
C1880	N	NF	Vena cava filter					
C1881	N	NF	Dialysis access system					
C1882	N	NF	AICD, other than sing/dual					
C1883	N	NF	Adapt/ext, pacing/neuro lead					
C1884	H	NI	Embolization Protect syst	1884				
C1885	N	NF	Cath, translumin angio laser					
C1887	N	NF	Catheter, guiding					
C1888	H		Catheter, ablation, non-cardiac, endovascular (implantable).	1888				
C1891	N	NF	Infusion pump,non-prog, perm					
C1892	N	NF	Intro/sheath,fixed,peel-away					
C1893	N	NF	Intro/sheath, fixed,non-peel					
C1894	N	NF	Intro/sheath, non-laser					
C1895	N	NF	Lead, AICD, endo dual coil					
C1896	N	NF	Lead, AICD, non sing/dual					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1897	N	NF	Lead, neurostim test kit					
C1898	N	NF	Lead, pmkr, other than trans					
C1899	N	NF	Lead, pmkr/AICD combination					
C1900	H		Lead coronary venous	1900				
C2614	H		Probe, perc lumb disc	2614				
C2615	N	NF	Sealant, pulmonary, liquid					
C2616	K		Brachytx source, Yttrium-90	2616	176.2339	$9,615.50		$1,923.10
C2617	N	NF	Stent, non-cor, tem w/o del					
C2618	N		Probe, cryoablation					
C2619	N	NF	Pmkr, dual, non rate-resp					
C2620	N	NF	Pmkr, single, non rate-resp					
C2621	N	NF	Pmkr, other than sing/dual					
C2622	N	NF	Prosthesis, penile, non-inf					
C2625	N	NF	Stent, non-cor, tem w/del sy					
C2626	N	NF	Infusion pump, non-prog,temp					
C2627	N	NF	Cath, suprapubic/cystoscopic					
C2628	N	NF	Catheter, occlusion					
C2629	N	NF	Intro/sheath, laser					
C2630	N	NF	Cath, EP, cool-tip					
C2631	N	NF	Rep dev, urinary, w/o sling					
C2632	H		Brachytx sol, I-125, per mCi	2632				
C2633	K	NI	Brachytx source, Cesium-131	2633	0.8187	$44.67		$8.93
C8900	S		MRA w/cont, abd	0284	7.1165	$388.28	$194.13	$77.66
C8901	S		MRA w/o cont, abd	0336	6.3897	$348.63	$174.31	$69.73
C8902	S		MRA w/o fol w/cont, abd	0337	9.2075	$502.37	$240.77	$100.47
C8903	S		MRI w/cont, breast, uni	0284	7.1165	$388.28	$194.13	$77.66
C8904	S		MRI w/o cont, breast, uni	0336	6.3897	$348.63	$174.31	$69.73
C8905	S		MRI w/o fol w/cont, brst, un	0337	9.2075	$502.37	$240.77	$100.47
C8906	S		MRI w/cont, breast, bi	0284	7.1165	$388.28	$194.13	$77.66
C8907	S		MRI w/o cont, breast, bi	0336	6.3897	$348.63	$174.31	$69.73
C8908	S		MRI w/o fol w/cont, breast,	0337	9.2075	$502.37	$240.77	$100.47
C8909	S		MRA w/cont, chest	0284	7.1165	$388.28	$194.13	$77.66
C8910	S		MRA w/o cont, chest	0336	6.3897	$348.63	$174.31	$69.73
C8911	S		MRA w/o fol w/cont, chest	0337	9.2075	$502.37	$240.77	$100.47
C8912	S		MRA w/cont, lwr ext	0284	7.1165	$388.28	$194.13	$77.66
C8913	S		MRA w/o cont, lwr ext	0336	6.3897	$348.63	$174.31	$69.73
C8914	S		MRA w/o fol w/cont, lwr ext	0337	9.2075	$502.37	$240.77	$100.47
C8918	S	NF	MRA w/cont, pelvis	0284	7.1165	$388.28	$194.13	$77.66
C8919	S	NF	MRA w/o cont, pelvis	0336	6.3897	$348.63	$174.31	$69.73
C8920	S	NF	MRA w/o fol w/cont, pelvis	0337	9.2075	$502.37	$240.77	$100.47
C9000	N		Na chromateCr51, per 0.25mCi					
C9003	K		Palivizumab, per 50 mg	9003	6.3077	$344.15		$68.83
C9007	N		Baclofen Intrathecal kit-1am					
C9008	K		Baclofen Refill Kit-500mcg	9008	0.1264	$6.90		$1.38
C9009	K		Baclofen Refill Kit-2000mcg	9009	0.7499	$40.92		$8.18
C9010	K	DG	Baclofen Refill Kit-4000mcg	9010	0.7739	$42.22		$8.44
C9013	K		Co 57 cobaltous chloride	9013	1.0386	$56.67		$11.33
C9102	N		51 Na Chromate, 50mCi					
C9103	N		Na Iothalamate I-125, 10 uCi					
C9105	K		Hep B imm glob, per 1 ml	9105	1.3074	$71.33		$14.27
C9109	K		Tirofiban hcl, 6.25 mg	9109	2.1737	$118.60		$23.72
C9111	D	DNG	Inj, bivalirudin, 250mg vial					
C9112	G		Perflutren lipid micro, 2ml	9112		$148.20		$22.15
C9113	G		Inj pantoprazole sodium, via	9113		$25.08		$3.75
C9116	D	DNG	Ertapenem sodium, per 1 gm			$23.74		
C9119	D	DNG	Injection, pegfilgrastim					
C9120	D	DNG	Injection, fulvestrant					
C9121	G		Injection, argatroban	9121		$16.35		$2.44
C9123	G	NF	Transcyte, per 247 sq cm	9123		$770.93		$115.23
C9200	G		Orcel, per 36 cm2	9200		$1,135.25	$	$169.69
C9201	G		Dermagraft, per 37.5 sq cm	9201		$577.60		$86.34
C9202	K	NF	Octafluoropropane	9202	2.1737	$118.60		$23.72
C9203	G	NF	Perflexane lipid micro	9203		$142.50		$21.30
C9204	D	DNG	Ziprasidone mesylate					
C9205	G		Oxaliplatin	9205		$94.46		$14.12
C9207	G	NI	Injection, bortezomib	9207		$1,039.68		$155.40
C9208	G	NF	Injection, agalsidase beta	9208		$123.78		$18.50
C9209	G	NF	Injection, laronidase	9209		$644.10		$96.28
C9210	G	NI	Injection, palonosetron HCL	9210		$307.80		$46.01
C9211	G	NI	Inj, alefacept, IV	9211		$665.00		$99.40
C9212	G	NI	Inj, alefacept, IM	9212		$472.63		$70.65
C9503	K	DG	Fresh frozen plasma, ea unit	9503		$69.74		$13.95
C9701	T		Stretta System	1557		$1,850.00		$370.00
C9703	T		Bard Endoscopic Suturing Sys	1555		$1,650.00		$330.00
C9704	T	NI	Inj inert subs upper GI	1556		$1,750.00		$350.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9711	T	DG	H.E.L.P. Apheresis System	1552		$1,350.00		$270.00
D0120	E		Periodic oral evaluation					
D0140	E		Limit oral eval problm focus					
D0150	S		Comprehensve oral evaluation	0330	0.5745	$31.35		$6.27
D0160	E		Extensv oral eval prob focus					
D0170	E		Re-eval,est pt,problem focus					
D0180	E		Comp periodontal evaluation					
D0210	E		Intraor complete film series					
D0220	E		Intraoral periapical first f					
D0230	E		Intraoral periapical ea add					
D0240	S		Intraoral occlusal film	0330	0.5745	$31.35		$6.27
D0250	S		Extraoral first film	0330	0.5745	$31.35		$6.27
D0260	S		Extraoral ea additional film	0330	0.5745	$31.35		$6.27
D0270	S		Dental bitewing single film	0330	0.5745	$31.35		$6.27
D0272	S		Dental bitewings two films	0330	0.5745	$31.35		$6.27
D0274	S		Dental bitewings four films	0330	0.5745	$31.35		$6.27
D0277	S		Vert bitewings-sev to eight	0330	0.5745	$31.35		$6.27
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	0.5745	$31.35		$6.27
D0470	E		Diagnostic casts					
D0472	S		Gross exam, prep & report	0330	0.5745	$31.35		$6.27
D0473	S		Micro exam, prep & report	0330	0.5745	$31.35		$6.27
D0474	S		Micro w exam of surg margins	0330	0.5745	$31.35		$6.27
D0480	S		Cytopath smear prep & report	0330	0.5745	$31.35		$6.27
D0502	S		Other oral pathology procedu	0330	0.5745	$31.35		$6.27
D0999	S		Unspecified diagnostic proce	0330	0.5745	$31.35		$6.27
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	0.5745	$31.35		$6.27
D1515	S		Fixed bilat space maintainer	0330	0.5745	$31.35		$6.27
D1520	S		Remove unilat space maintain	0330	0.5745	$31.35		$6.27
D1525	S		Remove bilat space maintain	0330	0.5745	$31.35		$6.27
D1550	S		Recement space maintainer	0330	0.5745	$31.35		$6.27
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					
D2390	E		Ant resin-based cmpst crown					
D2391	E		Post 1 srfc resinbased cmpst					
D2392	E		Post 2 srfc resinbased cmpst					
D2393	E		Post 3 srfc resinbased cmpst					
D2394	E		Post >=4srfc resinbase cmpst					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	0.5745	$31.35		$6.27
D2980	E		Crown repair					
D2999	S		Dental unspec restorative pr	0330	0.5745	$31.35		$6.27
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	0.5745	$31.35		$6.27
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	0.5745	$31.35		$6.27

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4210	E		Gingivectomy/plasty per quad					
D4211	E		Gingivectomy/plasty per toot					
D4240	E		Gingival flap proc w/ planin					
D4241	E		Gngvl flap w rootplan 1-3 th					
D4245	E		Apically positioned flap					
D4249	E		Crown lengthen hard tissue					
D4260	S		Osseous surgery per quadrant	0330	0.5745	$31.35		$6.27
D4261	E		Osseous surgl-3teethperquad					
D4263	S		Bone replce graft first site	0330	0.5745	$31.35		$6.27
D4264	S		Bone replce graft each add	0330	0.5745	$31.35		$6.27
D4265	E		Bio mtrls to aid soft/os reg					
D4266	E		Guided tiss regen resorble					
D4267	E		Guided tiss regen nonresorb					
D4268	S		Surgical revision procedure	0330	0.5745	$31.35		$6.27
D4270	S		Pedicle soft tissue graft pr	0330	0.5745	$31.35		$6.27
D4271	S		Free soft tissue graft proc	0330	0.5745	$31.35		$6.27
D4273	S		Subepithelial tissue graft	0330	0.5745	$31.35		$6.27
D4274	E		Distal/proximal wedge proc					
D4275	E		Soft tissue allograft					
D4276	E		Con tissue w dble ped graft					
D4320	E		Provision splnt intracoronal					
D4321	E		Provisional splint extracoro					
D4341	E		Periodontal scaling & root					
D4342	E		Periodontal scaling 1-3teeth					
D4355	S		Full mouth debridement	0330	0.5745	$31.35		$6.27
D4381	S		Localized chemo delivery	0330	0.5745	$31.35		$6.27
D4910	E		Periodontal maint procedures					
D4920	E		Unscheduled dressing change					
D4999	E		Unspecified periodontal proc					
D5110	E		Dentures complete maxillary					
D5120	E		Dentures complete mandible					
D5130	E		Dentures immediat maxillary					
D5140	E		Dentures immediat mandible					
D5211	E		Dentures maxill part resin					
D5212	E		Dentures mand part resin					
D5213	E		Dentures maxill part metal					
D5214	E		Dentures mandibl part metal					
D5281	E		Removable partial denture					
D5410	E		Dentures adjust cmplt maxil					
D5411	E		Dentures adjust cmplt mand					
D5421	E		Dentures adjust part maxill					
D5422	E		Dentures adjust part mandbl					
D5510	E		Dentur repr broken compl bas					
D5520	E		Replace denture teeth complt					
D5610	E		Dentures repair resin base					
D5620	E		Rep part denture cast frame					
D5630	E		Rep partial denture clasp					
D5640	E		Replace part denture teeth					
D5650	E		Add tooth to partial denture					
D5660	E		Add clasp to partial denture					
D5670	E		Replc tth&acrlc on mtl frmwk					
D5671	E		Replc tth&acrlc mandibular					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5899	E		Removable prosthodontic proc					
D5911	S		Facial moulage sectional	0330	0.5745	$31.35		$6.27
D5912	S		Facial moulage complete	0330	0.5745	$31.35		$6.27
D5913	E		Nasal prosthesis					
D5914	E		Auricular prosthesis					
D5915	E		Orbital prosthesis					
D5916	E		Ocular prosthesis					
D5919	E		Facial prosthesis					
D5922	E		Nasal septal prosthesis					
D5923	E		Ocular prosthesis interim					
D5924	E		Cranial prosthesis					
D5925	E		Facial augmentation implant					
D5926	E		Replacement nasal prosthesis					
D5927	E		Auricular replacement					
D5928	E		Orbital replacement					
D5929	E		Facial replacement					
D5931	E		Surgical obturator					
D5932	E		Postsurgical obturator					
D5933	E		Refitting of obturator					
D5934	E		Mandibular flange prosthesis					
D5935	E		Mandibular denture prosth					
D5936	E		Temp obturator prosthesis					
D5937	E		Trismus appliance					
D5951	E		Feeding aid					
D5952	E		Pediatric speech aid					
D5953	E		Adult speech aid					
D5954	E		Superimposed prosthesis					
D5955	E		Palatal lift prosthesis					
D5958	E		Intraoral con def inter plt					
D5959	E		Intraoral con def mod palat					
D5960	E		Modify speech aid prosthesis					
D5982	E		Surgical stent					
D5983	S		Radiation applicator	0330	0.5745	$31.35		$6.27
D5984	S		Radiation shield	0330	0.5745	$31.35		$6.27
D5985	S		Radiation cone locator	0330	0.5745	$31.35		$6.27
D5986	E		Fluoride applicator					
D5987	S		Commissure splint	0330	0.5745	$31.35		$6.27
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					
D6053	E		Implnt/abtmnt spprt remv dnt					
D6054	E		Implnt/abtmnt spprt remvprtl					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
D6253	E		Provisional pontic					
D6545	E		Dental retainr cast metl					
D6548	E		Porcelain/ceramic retainer					
D6600	E		Porcelain/ceramic inlay 2srf					
D6601	E		Porc/ceram inlay >= 3 surfac					
D6602	E		Cst hgh nble mtl inlay 2 srf					
D6603	E		Cst hgh nble mtl inlay >=3sr					
D6604	E		Cst bse mtl inlay 2 surfaces					
D6605	E		Cst bse mtl inlay >= 3 surfa					
D6606	E		Cast noble metal inlay 2 sur					
D6607	E		Cst noble mtl inlay >=3 surf					
D6608	E		Onlay porc/crmc 2 surfaces					
D6609	E		Onlay porc/crmc >=3 surfaces					
D6610	E		Onlay cst hgh nbl mtl 2 srfc					
D6611	E		Onlay cst hgh nbl mtl >=3srf					
D6612	E		Onlay cst base mtl 2 surface					
D6613	E		Onlay cst base mtl >=3 surfa					
D6614	E		Onlay cst nbl mtl 2 surfaces					
D6615	E		Onlay cst nbl mtl >=3 surfac					
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					
D6793	E		Provisional retainer crown					
D6920	S		Dental connector bar	0330	0.5745	$31.35		$6.27
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					
D6985	E		Pediatric partial denture fx					
D6999	E		Fixed prosthodontic proc					
D7111	S		Coronal remnants deciduous t	0330	0.5745	$31.35		$6.27
D7140	S		Extraction erupted tooth/exr	0330	0.5745	$31.35		$6.27
D7210	S		Rem imp tooth w mucoper flp	0330	0.5745	$31.35		$6.27
D7220	S		Impact tooth remov soft tiss	0330	0.5745	$31.35		$6.27
D7230	S		Impact tooth remov part bony	0330	0.5745	$31.35		$6.27
D7240	S		Impact tooth remov comp bony	0330	0.5745	$31.35		$6.27
D7241	S		Impact tooth rem bony w/comp	0330	0.5745	$31.35		$6.27
D7250	S		Tooth root removal	0330	0.5745	$31.35		$6.27
D7260	S		Oral antral fistula closure	0330	0.5745	$31.35		$6.27
D7261	S		Primary closure sinus perf	0330	0.5745	$31.35		$6.27
D7270	E		Tooth reimplantation					
D7272	E		Tooth transplantation					
D7280	E		Exposure impact tooth orthod					
D7281	E		Exposure tooth aid eruption					
D7282	E		Mobilize erupted/malpos toot					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7287	E		Cytology sample collection					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	0.5745	$31.35		$6.27
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					
D7411	E		Excision benign lesion>1.25c					
D7412	E		Excision benign lesion compl					
D7413	E		Excision malig lesion<=1.25c					
D7414	E		Excision malig lesion>1.25cm					
D7415	E		Excision malig les complicat					
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					
D7472	E		Removal of torus palatinus					
D7473	E		Remove torus mandibularis					
D7485	E		Surg reduct osseoustuberosit					
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					
D7671	E		Alveolus open reduction					
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					
D7771	E		Alveolus clsd reduc stblz te					
D7780	E		Reduct compnd facial bone fx					
D7810	E		Tmj open reduct-dislocation					
D7820	E		Closed tmp manipulation					
D7830	E		Tmj manipulation under anest					
D7840	E		Removal of tmj condyle					
D7850	E		Tmj meniscectomy					
D7852	E		Tmj repair of joint disc					
D7854	E		Tmj excisn of joint membrane					
D7856	E		Tmj cutting of a muscle					
D7858	E		Tmj reconstruction					
D7860	E		Tmj cutting into joint					
D7865	E		Tmj reshaping components					
D7870	E		Tmj aspiration joint fluid					
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	0.5745	$31.35		$6.27

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
D7972	E		Surg redct fibrous tuberosit					
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					
D9410	E		Dental house call					
D9420	E		Hospital call					
D9430	E		Office visit during hours					
D9440	E		Office visit after hours					
D9450	E		Case presentation tx plan					
D9610	E		Dent therapeutic drug inject					
D9630	S		Other drugs/medicaments	0330	0.5745	$31.35		$6.27
D9910	E		Dent appl desensitizing med					
D9911	E		Appl desensitizing resin					
D9920	E		Behavior management					
D9930	S		Treatment of complications	0330	0.5745	$31.35		$6.27
D9940	S		Dental occlusal guard	0330	0.5745	$31.35		$6.27
D9941	E		Fabrication athletic guard					
D9950	S		Occlusion analysis	0330	0.5745	$31.35		$6.27
D9951	S		Limited occlusal adjustment	0330	0.5745	$31.35		$6.27
D9952	S		Complete occlusal adjustment	0330	0.5745	$31.35		$6.27
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E0117	A		Underarm springassist crutch					
E0118	E	NI	Crutch substitute					
E0130	A		Walker rigid adjust/fixed ht					
E0135	A		Walker folding adjust/fixed					
E0140	Y	NI	Walker w trunk support					
E0141	A		Rigid walker wheeled wo seat					
E0142	A	DG	Walker rigid wheeled with se					
E0143	A		Walker folding wheeled w/o s					
E0144	A		Enclosed walker w rear seat					
E0145	A	DG	Walker whled seat/crutch att					
E0146	A	DG	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	DG	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					
E0190	E	NI	Positioning cushion					
E0191	A		Protector heel or elbow					
E0192	A		Pad wheelchr low press/posit					
E0193	A		Powered air flotation bed					
E0194	A		Air fluidized bed					
E0196	A		Gel pressure mattress					
E0197	A		Air pressure pad for 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					
E0203	A		Therapeutic lightbox tabletp					
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					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0231	E		Wound warming device					
E0232	E		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					
E0240	E	NI	Bath/shower chair					
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					
E0247	E	NI	Trans bench w/wo comm open					
E0248	E	NI	HDtrans bench w/wo comm open					
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					
E0300	Y	NI	Enclosed ped crib hosp grade					
E0301	Y	NI	HD hosp bed, 350-600 lbs					
E0302	Y	NI	Ex hd hosp bed > 600 lbs					
E0303	Y	NI	Hosp bed hvy dty xtra wide					
E0304	Y	NI	Hosp bed xtra hvy dty x wide					
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					
E0442	A		Oxygen contents, liquid					
E0443	A		Portable 02 contents, gas					
E0444	A		Portable 02 contents, liquid					
E0445	A		Oximeter non-invasive					
E0450	A		Volume vent stationary/porta					
E0454	A		Pressure ventilator					
E0455	A		Oxygen tent excl croup/ped t					
E0457	A		Chest shell					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0459	A		Chest wrap					
E0460	A		Neg press vent portabl/statn					
E0461	A		Vol vent noninvasive interfa					
E0462	A		Rocking bed w/ or w/o side r					
E0470	Y	NI	RAD w/o backup non-inv intfc					
E0471	Y	NI	RAD w/backup non inv intrfc					
E0472	Y	NI	RAD w backup invasive intrfc					
E0480	A		Percussor elect/pneum home m					
E0481	E		Intrpulmnry percuss vent sys					
E0482	A		Cough stimulating device					
E0483	A		Chest compression gen system					
E0484	A		Non-elec oscillatory pep dvc					
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					
E0561	Y	NI	Humidifier nonheated w PAP					
E0562	Y	NI	Humidifier heated used w PAP					
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		Manual 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					
E0610	A		Pacemaker monitr audible/vis					
E0615	A		Pacemaker monitr digital/vis					
E0616	N		Cardiac event recorder					
E0617	A		Automatic ext defibrillator					
E0618	A		Apnea monitor					
E0619	A		Apnea monitor w recorder					
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					
E0636	A		PT support & positioning sys					
E0637	Y	NI	Sit-stand w seatlift wheeled					
E0638	Y	NI	Standing frame sys wheeled					
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					
E0675	Y	NI	Pneumatic compression device					
E0691	A		Uvl pnl 2 sq ft or less					
E0692	A		Uvl sys panel 4 ft					
E0693	A		Uvl sys panel 6 ft					
E0694	A		Uvl md cabinet sys 6 ft					
E0700	E		Safety equipment					
E0701	A		Helmet w face guard prefab					
E0710	E		Restraints any type					
E0720	A		Tens two lead					
E0730	A		Tens four lead					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	N		Neurostimulator electrode					
E0754	A		Pulsegenerator pt programmer					
E0755	E		Electronic salivary reflex s					
E0756	N		Implantable pulse generator					
E0757	N		Implantable RF receiver					
E0758	A		External RF transmitter					
E0759	A		Replace rdfrquncy transmittr					
E0760	E		Osteogen ultrasound stimltor					
E0761	E		Nontherm electromgntc device					
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	N		Non-programble infusion pump					
E0783	N		Programmable infusion pump					
E0784	A		Ext amb infusn pump insulin					
E0785	N		Replacement impl pump cathet					
E0786	N		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	DG	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		Toe loop/holder, each					
E0953	E		Pneumatic tire					
E0954	E		Wheelchair semi-pneumatic ca					
E0955	Y	NI	Cushioned headrest					
E0956	Y	NI	W/c lateral trunk/hip suppor					
E0957	Y	NI	W/c medial thigh support					
E0958	A		Whlchr att- conv 1 arm drive					
E0959	B		Amputee adapter					
E0960	Y	NI	W/c shoulder harness/straps					
E0961	B		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	B		Wheelchair head rest extensi					
E0967	B		Wheelchair hand rims					
E0968	A		Wheelchair commode seat					
E0969	B		Wheelchair narrowing device					
E0970	B		Wheelchair no. 2 footplates					
E0971	B		Wheelchair anti-tipping devi					
E0972	A		Transfer board or device					
E0973	B		Wheelchair adjustabl height					
E0974	B		Wheelchair grade-aid					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0975	B	DG	Wheelchair reinforced seat u					
E0976	B	DG	Wheelchair reinforced back u					
E0977	B		Wheelchair wedge cushion					
E0978	B		Wheelchair belt w/airplane b					
E0979	B	DG	Wheelchair belt with velcro					
E0980	B		Wheelchair safety vest					
E0981	Y	NI	Seat upholstery, replacement					
E0982	Y	NI	Back upholstery, replacement					
E0983	Y	NI	Add pwr joystick					
E0984	Y	NI	Add pwr tiller					
E0985	Y	NI	W/c seat lift mechanism					
E0986	Y	NI	Man w/c push-rim pow assist					
E0990	B		Whellchair elevating leg res					
E0991	B	DG	Wheelchair upholstry seat					
E0992	B		Wheelchair solid seat insert					
E0993	B	DG	Wheelchair back upholstery					
E0994	B		Wheelchair arm rest					
E0995	B		Wheelchair calf rest					
E0996	B		Wheelchair tire solid					
E0997	B		Wheelchair caster w/ a fork					
E0998	B		Wheelchair caster w/o a fork					
E0999	B		Wheelchr pneumatic tire w/wh					
E1000	B		Wheelchair tire pneumatic ca					
E1001	B		Wheelchair wheel					
E1002	Y	NI	Pwr seat tilt					
E1003	Y	NI	Pwr seat recline					
E1004	Y	NI	Pwr seat recline mech					
E1005	Y	NI	Pwr seat recline pwr					
E1006	Y	NI	Pwr seat combo w/o shear					
E1007	Y	NI	Pwr seat combo w/shear					
E1008	Y	NI	Pwr seat combo pwr shear					
E1009	Y	NI	Add mech leg elevation					
E1010	Y	NI	Add pwr leg elevation					
E1011	A		Ped wc modify width adjustm					
E1012	A		Int seat sys planar ped w/c					
E1013	A		Int seat sys contour ped w/c					
E1014	A		Reclining back add ped w/c					
E1015	A		Shock absorber for man w/c					
E1016	A		Shock absorber for power w/c					
E1017	A		HD shck absrbr for hd man wc					
E1018	A		HD shck absrber for hd powwc					
E1019	Y	NI	HD feature power seat					
E1020	A		Residual limb support system					
E1021	Y	NI	Ex hd feature power seat					
E1025	A		Pedwc lat/thor sup nocontour					
E1026	A		Pedwc contoured lat/thor sup					
E1027	A		Ped wc lat/ant support					
E1028	Y	NI	W/c manual swingaway					
E1029	Y	NI	W/c vent tray fixed					
E1030	Y	NI	W/c vent tray gimbaled					
E1031	A		Rollabout chair with casters					
E1035	B		Patient transfer system					
E1037	A		Transport chair, ped size					
E1038	A		Transport chair, adult size					
E1050	A		Whelchr fxd full length arms					
E1060	A		Wheelchair detachable arms					
E1065	B		Wheelchair power attachment					
E1066	B	DG	Wheelchair battery charger					
E1069	B	DG	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	D	DNG	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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1150	A		Wheelchair standard w/ leg r					
E1160	A		Wheelchair fixed arms					
E1161	A		Manual adult wc w tiltinspac					
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	B		W/ch access anti-rollback					
E1227	B		Wheelchair spec sz spec ht a					
E1228	A		Wheelchair spec sz spec ht b					
E1230	A		Power operated vehicle					
E1231	A		Rigid ped w/c tilt-in-space					
E1232	A		Folding ped wc tilt-in-space					
E1233	A		Rig ped wc tltnspc w/o seat					
E1234	A		Fld ped wc tltnspc w/o seat					
E1235	A		Rigid ped wc adjustable					
E1236	A		Folding ped wc adjustable					
E1237	A		Rgd ped wc adjstabl w/o seat					
E1238	A		Fld ped wc adjstabl w/o seat					
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					
E1391	Y	NI	Oxygen concentrator, dual					
E1399	N	NI	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					
E1530	A		Replacement air bubble detec					
E1540	A		Replacement pressure alarm					
E1550	A		Bath conductivity meter					
E1560	A		Replace blood leak detector					
E1570	A		Adjustable chair for esrd pt					
E1575	A		Transducer protect/fld bar					
E1580	A		Unipuncture control system					
E1590	A		Hemodialysis machine					
E1592	A		Auto interm peritoneal dialy					
E1594	A		Cycler dialysis machine					
E1600	A		Deli/install chrg hemo equip					
E1610	A		Reverse osmosis h2o puri sys					
E1615	A		Deionizer H2O puri system					
E1620	A		Replacement blood pump					
E1625	A		Water softening system					
E1630	A		Reciprocating peritoneal dia					
E1632	A		Wearable artificial kidney					
E1634	E	NI	Peritoneal dialysis clamp					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1635	A		Compact travel hemodialyzer					
E1636	A		Sorbent cartridges per 10					
E1637	A		Hemostats for dialysis, each					
E1639	A		Dialysis scale					
E1699	A		Dialysis equipment noc					
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					
E1802	A		Adjst forearm pro/sup 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					
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					
E2120	Y	NI	Pulse gen sys tx endolymp fl					
E2201	Y	NI	Man w/ch acc seat w>=20≧<24≧					
E2202	Y	NI	Seat width 24-27 in					
E2203	Y	NI	Frame depth less than 22 in					
E2204	Y	NI	Frame depth 22 to 25 in					
E2300	Y	NI	Pwr seat elevation sys					
E2301	Y	NI	Pwr standing					
E2310	Y	NI	Electro connect btw control					
E2311	Y	NI	Electro connect btw 2 sys					
E2320	Y	NI	Hand chin control					
E2321	Y	NI	Hand interface joystick					
E2322	Y	NI	Mult mech switches					
E2323	Y	NI	Special joystick handle					
E2324	Y	NI	Chin cup interface					
E2325	Y	NI	Sip and puff interface					
E2326	Y	NI	Breath tube kit					
E2327	Y	NI	Head control interface mech					
E2328	Y	NI	Head/extremity control inter					
E2329	Y	NI	Head control nonproportional					
E2330	Y	NI	Head control proximity switc					
E2331	Y	NI	Attendant control					
E2340	Y	NI	W/c wdth 20-23 in seat frame					
E2341	Y	NI	W/c wdth 24-27 in seat frame					
E2342	Y	NI	W/c dpth 20-21 in seat frame					
E2343	Y	NI	W/c dpth 22-25 in seat frame					
E2350	Y	NI	W/c hd pt wt > 250 lbs					
E2351	Y	NI	Electronic SGD interface					
E2360	Y	NI	22nf nonsealed leadacid					
E2361	Y	NI	22nf sealed leadacid battery					
E2362	Y	NI	Gr24 nonsealed leadacid					
E2363	Y	NI	Gr24 sealed leadacid battery					
E2364	Y	NI	U1nonsealed leadacid battery					
E2365	Y	NI	U1 sealed leadacid battery					
E2366	Y	NI	Battery charger, single mode					
E2367	Y	NI	Battery charger, dual mode					
E2399	Y	NI	Noc interface					
E2402	Y	NI	Neg press wound therapy pump					
E2500	Y	NI	SGD digitized pre-rec <=8min					
E2502	Y	NI	SGD prerec msg >8min <=20min					
E2504	Y	NI	SGD prerec msg>20min <=40min					
E2506	Y	NI	SGD prerec msg > 40 min					
E2508	Y	NI	SGD spelling phys contact					
E2510	Y	NI	SGD w multi methods msg/accs					
E2511	Y	NI	SGD sftwre prgrm for PC/PDA					
E2512	Y	NI	SGD accessory, mounting sys					
E2599	Y	NI	SGD accessory noc					
G0001	A		Drawing blood for specimen					
G0008	L		Admin influenza virus vac					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0009	L		Admin pneumococcal vaccine					
G0010	K		Admin hepatitis b vaccine	0355	0.2749	$15.00		$3.00
G0025	D	DNG	Collagen skin test kit					
G0027	A	NI	Semen analysis					
G0030	S		PET imaging prev PET single	0285	14.1508	$772.08	$334.45	$154.42
G0031	S		PET imaging prev PET multple	0285	14.1508	$772.08	$334.45	$154.42
G0032	S		PET follow SPECT 78464 singl	0285	14.1508	$772.08	$334.45	$154.42
G0033	S		PET follow SPECT 78464 mult	0285	14.1508	$772.08	$334.45	$154.42
G0034	S		PET follow SPECT 76865 singl	0285	14.1508	$772.08	$334.45	$154.42
G0035	S		PET follow SPECT 78465 mult	0285	14.1508	$772.08	$334.45	$154.42
G0036	S		PET follow cornry angio sing	0285	14.1508	$772.08	$334.45	$154.42
G0037	S		PET follow cornry angio mult	0285	14.1508	$772.08	$334.45	$154.42
G0038	S		PET follow myocard perf sing	0285	14.1508	$772.08	$334.45	$154.42
G0039	S		PET follow myocard perf mult	0285	14.1508	$772.08	$334.45	$154.42
G0040	S		PET follow stress echo singl	0285	14.1508	$772.08	$334.45	$154.42
G0041	S		PET follow stress echo mult	0285	14.1508	$772.08	$334.45	$154.42
G0042	S		PET follow ventriculogm sing	0285	14.1508	$772.08	$334.45	$154.42
G0043	S		PET follow ventriculogm mult	0285	14.1508	$772.08	$334.45	$154.42
G0044	S		PET following rest ECG singl	0285	14.1508	$772.08	$334.45	$154.42
G0045	S		PET following rest ECG mult	0285	14.1508	$772.08	$334.45	$154.42
G0046	S		PET follow stress ECG singl	0285	14.1508	$772.08	$334.45	$154.42
G0047	S		PET follow stress ECG mult	0285	14.1508	$772.08	$334.45	$154.42
G0101	V		CA screen;pelvic/breast exam	0600	0.9278	$50.62		$10.12
G0102	N		Prostate ca screening; dre					
G0103	A		Psa, total screening					
G0104	S		CA screen;flexi sigmoidscope	0159	2.7823	$151.81		$37.95
G0105	T		Colorectal scrn; hi risk ind	0158	7.4244	$405.08		$101.27
G0106	S		Colon CA screen;barium enema	0157	2.5693	$140.18		$28.04
G0107	A		CA screen; fecal blood test					
G0108	A		Diab manage trn per indiv					
G0109	A		Diab manage trn ind/group					
G0110	A	DG	Nett pulm-rehab educ; ind					
G0111	A	DG	Nett pulm-rehab educ; group					
G0112	A	DG	Nett;nutrition guid, initial					
G0113	A	DG	Nett;nutrition guid,subseqnt					
G0114	A	DG	Nett; psychosocial consult					
G0115	A	DG	Nett; psychological testing					
G0116	A	DG	Nett; psychosocial counsel					
G0117	S		Glaucoma scrn hgh risk direc	0230	0.7619	$41.57	$14.97	$8.31
G0118	S		Glaucoma scrn hgh risk direc	0230	0.7619	$41.57	$14.97	$8.31
G0120	S		Colon ca scrn; barium enema	0157	2.5693	$140.18		$28.04
G0121	T		Colon ca scrn not hi rsk ind	0158	7.4244	$405.08		$101.27
G0122	E		Colon ca scrn; barium enema					
G0123	A		Screen cerv/vag thin layer					
G0124	A		Screen c/v thin layer by MD					
G0125	S		PET img WhBD sgl pulm ring	1516		$1,450.00		$290.00
G0127	T		Trim nail(s)	0009	0.6652	$36.29	$8.34	$7.26
G0128	B		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	5.2569	$286.82		$57.36
G0130	X		Single energy x-ray study	0260	0.7802	$42.57	$21.28	$8.51
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	B		HHCP-serv of pt,ea 15 min					
G0152	B		HHCP-serv of ot,ea 15 min					
G0153	B		HHCP-svs of s/l path,ea 15mn					
G0154	B		HHCP-svs of rn,ea 15 min					
G0155	B		HHCP-svs of csw,ea 15 min					
G0156	B		HHCP-svs of aide,ea 15 min					
G0166	T		Extrnl counterpulse, per tx	0678	2.0659	$112.72		$22.54
G0167	B	DG	Hyperbaric oz tx;no md reqrd					
G0168	X		Wound closure by adhesive	0340	0.6314	$34.45		$6.89
G0173	S		Stereo radoisurgery,complete	1528		$5,250.00		$1,050.00
G0175	V		OPPS Service,sched team conf	0602	1.5041	$82.07		$16.41
G0176	P		OPPS/PHP;activity therapy	0033	5.2569	$286.82		$57.36
G0177	P		OPPS/PHP; train & educ serv	0033	5.2569	$286.82		$57.36
G0179	E		MD recertification HHA PT					
G0180	E		MD certification HHA patient					
G0181	E		Home health care supervision					
G0182	E		Hospice care supervision					
G0186	T		Dstry eye lesn,fdr vssl tech	0235	5.0749	$276.89	$72.04	$55.38
G0202	A		Screeningmammographydigital					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0204	S		Diagnosticmammographydigital	0669	0.9009	$49.15		$9.83
G0206	S		Diagnosticmammographydigital	0669	0.9009	$49.15		$9.83
G0210	S		PET img whbd ring dxlung ca	1516		$1,450.00		$290.00
G0211	S		PET img whbd ring init lung	1516		$1,450.00		$290.00
G0212	S		PET img whbd ring restag lun	1516		$1,450.00		$290.00
G0213	S		PET img whbd ring dx colorec	1516		$1,450.00		$290.00
G0214	S		PET img whbd ring init colre	1516		$1,450.00		$290.00
G0215	S		PET img whbd restag col	1516		$1,450.00		$290.00
G0216	S		PET img whbd ring dx melanom	1516		$1,450.00		$290.00
G0217	S		PET img whbd ring init melan	1516		$1,450.00		$290.00
G0218	S		PET img whbd ring restag mel	1516		$1,450.00		$290.00
G0219	E		PET img whbd ring noncov ind					
G0220	S		PET img whbd ring dx lymphom	1516		$1,450.00		$290.00
G0221	S		PET img whbd ring init lymph	1516		$1,450.00		$290.00
G0222	S		PET img whbd ring resta lymp	1516		$1,450.00		$290.00
G0223	S		PET img whbd reg ring dx hea	1516		$1,450.00		$290.00
G0224	S		PETimg whbd reg ring ini hea	1516		$1,450.00		$290.00
G0225	S		PET img whbd ring restag hea	1516		$1,450.00		$290.00
G0226	S		PET img whbd dx esophag	1516		$1,450.00		$290.00
G0227	S		PET img whbd ring ini esopha	1516		$1,450.00		$290.00
G0228	S		PET img whbd ring restg esop	1516		$1,450.00		$290.00
G0229	S		PET img metabolic brain ring	1516		$1,450.00		$290.00
G0230	S		PET myocard viability ring	1516		$1,450.00		$290.00
G0231	S		PET WhBD colorec; gamma cam	1516		$1,450.00		$290.00
G0232	S		PET whbd lymphoma; gamma cam	1516		$1,450.00		$290.00
G0233	S		PET whbd melanoma; gamma cam	1516		$1,450.00		$290.00
G0234	S		PET WhBD pulm nod; gamma cam	1516		$1,450.00		$290.00
G0236	D	DNG	Digital film convert diag ma					
G0237	S		Therapeutic procd strg endur	0411	0.4367	$23.83		$4.77
G0238	S		Oth resp proc, indiv	0411	0.4367	$23.83		$4.77
G0239	S		Oth resp proc, group	0411	0.4367	$23.83		$4.77
G0242	S		Multisource photon ster plan	1516		$1,450.00		$290.00
G0243	S		Multisour photon stero treat	1528		$5,250.00		$1,050.00
G0244	S		Observ care by facility topt	0339	3.8356	$209.27		$41.85
G0245	V		Initial Foot Exam PTLOPS	0600	0.9278	$50.62		$10.12
G0246	V		Follow-up Eval of Foot PTLOPS	0600	0.9278	$50.62		$10.12
G0247	T		Routine footcare w LOPS	0009	0.6652	$36.29	$8.34	$7.26
G0248	S		Demonstrate use home INR mon	1503		$150.00		$30.00
G0249	S		Provide test material,equipm	1503		$150.00		$30.00
G0250	E		MD review interpret of test					
G0251	S		Linear acc based stero radio	1513		$1,150.00		$230.00
G0252	E		PET imaging initial dx					
G0253	S		PET image brst dection recur	1516		$1,450.00		$290.00
G0254	S		PET image brst eval to tx	1516		$1,450.00		$290.00
G0255	E		Current percep threshold tst					
G0256	D	DNG	Prostate brachy w palladium					
G0257	S		Unsched dialysis ESRD pt hos	0170	5.9678	$325.61		$65.12
G0259	N		Inject for sacroiliac joint					
G0260	T		Inj for sacroiliac jt anesth	0204	2.1711	$118.46	$40.13	$23.69
G0261	D	DNG	Prostate brachy w iodine see					
G0262	S	DG	Sm intestinal image capsule	1508		$650.00		$130.00
G0263	N		Adm with CHF, CP, asthma					
G0264	V		Assmt otr CHF, CP, asthma	0600	0.9278	$50.62		$10.12
G0265	A		Cryopresevation Freeze+stora					
G0266	A		Thawing + expansion froz cel					
G0267	S		Bone marrow or psc harvest	0110	3.6718	$200.34		$40.07
G0268	X		Removal of impacted wax md	0340	0.6314	$34.45		$6.89
G0269	N		Occlusive device in vein art					
G0270	A		MNT subs tx for change dx					
G0271	A		Group MNT 2 or more 30 mins					
G0272	X	DG	Naso/oro gastric tube pl MD	0272	1.4166	$77.29	$38.36	$15.46
G0273	D	DNG	Pretx planning, non-Hodgkins					
G0274	D	DNG	Radiopharm tx, non-Hodgkins					
G0275	N		Renal angio, cardiac cath					
G0278	N		Iliac art angio,cardiac cath					
G0279	A		Excorp shock tx, elbow epi					
G0280	A		Excorp shock tx other than					
G0281	A		Elec stim unattend for press					
G0282	A		Elect stim wound care not pd					
G0283	A		Elec stim other than wound					
G0288	S		Recon, CTA for pre & post sug	1506		$450.00		$90.00
G0289	N		Arthro, loose body + chondro					
G0290	T		Drug-eluting stents, single	0656	103.4907	$5,646.56		$1,129.31
G0291	T		Drug-eluting stents,each add	0656	103.4907	$5,646.56		$1,129.31
G0292	S		Adm exp drugs,clinical trial	1503		$150.00		$30.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0293	S		Non-cov surg proc,clin trial	1505		$350.00		$70.00
G0294	S		Non-cov proc, clinical trial	1502		$75.00		$15.00
G0295	E		Electromagnetic therapy onc					
G0296	S	NF	PET imge restag thyrod cance	1516		$1,450.00		$290.00
G0297	T	NF	Insert single chamber/cd	0107	337.1304	$18,394.17	$3,699.14	$3,678.83
G0298	T	NF	Insert dual chamber/cd	0107	337.1304	$18,394.17	$3,699.14	$3,678.83
G0299	T	NF	Inser/repos single icd+leads	0108	433.2998	$23,641.27		$4,728.25
G0300	T	NF	Insert reposit lead dual+gen	0108	433.2998	$23,641.27		$4,728.25
G0302	S	NI	Pre-op service LVRS complete	1509		$750.00		$150.00
G0303	S	NI	Pre-op service LVRS 10-15dos	1507		$550.00		$110.00
G0304	S	NI	Pre-op service LVRS 1-9 dos	1504		$250.00		$50.00
G0305	S	NI	Post op service LVRS min 6	1504		$250.00		$50.00
G0306	A	NI	CBC/diffwbc w/o platelet					
G0307	A	NI	CBC without platelet					
G0323	A	NI	ESRD related svs home mo 20+					
G0324	A	NI	ESRD related svs home/dy/2y					
G0325	A	NI	ESRD relate home/dy 2-11yr					
G0326	A	NI	ESRD relate home/dy 12-19y					
G0327	A	NI	ESRD relate home/dy 20+yrs					
G0338	S	NI	Linear accelerator stero pln	1516		$1,450.00		$290.00
G0339	S	NI	Robot lin-radsurg com, first	1528		$5,250.00		$1,050.00
G0340	S	NI	Robot lin-radsurg fractx 2-5	1525		$3,750.00		$750.00
G3001	S	NI	Admin + supply, tositumomab	1522		$2,250.00		$450.00
G9001	B		MCCD, initial rate					
G9002	B		MCCD,maintenance rate					
G9003	B		MCCD, risk adj hi, initial					
G9004	B		MCCD, risk adj lo, initial					
G9005	B		MCCD, risk adj, maintenance					
G9006	B		MCCD, Home monitoring					
G9007	B		MCCD, sch team conf					
G9008	B		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	E		Demo-smoking cessation coun					
J0120	N		Tetracyclin injection					
J0130	K		Abciximab injection	1605	5.3048	$289.44		$57.89
J0150	K		Injection adenosine 6 MG	0379	0.2078	$11.34		$2.27
J0151	D	DNG	Adenosine injection					
J0152	K	NI	Adenosine injection	0917	1.0393	$56.71		$11.34
J0170	N		Adrenalin epinephrin inject					
J0190	N		Inj biperiden lactate/5 mg					
J0200	N		Alatrofloxacin mesylate					
J0205	K		Alglucerase injection	0900		$37.13		$7.43
J0207	K		Amifostine	7000	5.3041	$289.40		$57.88
J0210	N		Methyldopate hcl injection					
J0215	B		Alefacept					
J0256	K		Alpha 1 proteinase inhibitor	0901		$3.43		$0.69
J0270	B		Alprostadil for injection					
J0275	B		Alprostadil urethral suppos					
J0280	N		Aminophyllin 250 MG inj					
J0282	N		Amiodarone HCl					
J0285	N		Amphotericin B					
J0287	K		Amphotericin b lipid complex	9024	0.3823	$20.86		$4.17
J0288	K		Ampho b cholesteryl sulfate	9024	0.3823	$20.86		$4.17
J0289	K		Amphotericin b liposome inj	9024	0.3823	$20.86		$4.17
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					
J0350	K		Injection anistreplase 30 u	1606	27.7939	$1,516.46		$303.29
J0360	N		Hydralazine hcl injection					
J0380	N		Inj metaraminol bitartrate					
J0390	N		Chloroquine injection					
J0395	N		Arbutamine HCl injection					
J0456	N		Azithromycin					
J0460	N		Atropine sulfate injection					
J0470	N		Dimecaprol injection					
J0475	N		Baclofen 10 MG injection					
J0476	B		Baclofen intrathecal trial					
J0500	N		Dicyclomine injection					
J0515	N		Inj benztropine mesylate					
J0520	N		Bethanechol chloride inject					
J0530	N		Penicillin g benzathine inj					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
J0583	G	NI	Bivalirudin	9111		$1.60		$0.04
J0585	K		Botulinum toxin a per unit	0902	0.0588	$3.21		$0.64
J0587	K		Botulinum toxin type B	9018	0.1279	$6.98		$1.40
J0592	N		Buprenorphine hydrochloride					
J0595	N	NI	Butorphanol tartrate 1 mg					
J0600	N		Edetate calcium disodium inj					
J0610	N		Calcium gluconate injection					
J0620	N		Calcium glycer & lact/10 ML					
J0630	N		Calcitonin salmon injection					
J0636	N		Inj calcitriol per 0.1 mcg					
J0637	K		Caspofungin acetate	9019	0.5432	$29.64		$5.93
J0640	N		Leucovorin calcium injection					
J0670	N		Inj mepivacaine HCL/10 ml					
J0690	N		Cefazolin sodium injection					
J0692	N		Cefepime HCl for injection					
J0694	N		Cefoxitin sodium injection					
J0696	N		Ceftriaxone sodium injection					
J0697	N		Sterile cefuroxime injection					
J0698	N		Cefotaxime sodium injection					
J0702	N		Betamethasone acet&sod phosp					
J0704	N		Betamethasone sod phosp/4 MG					
J0706	N		Caffeine citrate injection					
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					
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					
J0835	N		Inj cosyntropin per 0.25 MG					
J0850	K		Cytomegalovirus imm IV /vial	0903	5.3368	$291.18		$58.24
J0880	E		Darbepoetin alfa injection					
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					
J1051	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					
J1094	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	K		Dexrazoxane HCl injection	0726	2.0616	$112.48		$22.50
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	0380	0.2525	$13.78		$2.76
J1250	N		Inj dobutamine HCL/250 mg					
J1260	N		Dolasetron mesylate					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1270	N		Injection, doxercalciferol					
J1320	N		Amitriptyline injection					
J1325	N		Epoprostenol injection					
J1327	K		Eptifibatide injection	1607	0.1465	$7.99		$1.60
J1330	N		Ergonovine maleate injection					
J1335	G	NI	Ertapenem injection	9116		$23.74		$3.55
J1364	N		Erythro lactobionate /500 MG					
J1380	N		Estradiol valerate 10 MG inj					
J1390	N		Estradiol valerate 20 MG inj					
J1410	N		Inj estrogen conjugate 25 MG					
J1435	N		Injection estrone per 1 MG					
J1436	N		Etidronate disodium inj					
J1438	K		Etanercept injection	1608	1.8762	$102.37		$20.47
J1440	K		Filgrastim 300 mcg injection	0728	2.2631	$123.48		$24.70
J1441	K		Filgrastim 480 mcg injection	7049	3.2251	$175.96		$35.19
J1450	N		Fluconazole					
J1452	N		Intraocular Fomivirsen na					
J1455	N		Foscarnet sodium injection					
J1460	N		Gamma globulin 1 CC inj					
J1470	B		Gamma globulin 2 CC inj					
J1480	B		Gamma globulin 3 CC inj					
J1490	B		Gamma globulin 4 CC inj					
J1500	B		Gamma globulin 5 CC inj					
J1510	B		Gamma globulin 6 CC inj					
J1520	B		Gamma globulin 7 CC inj					
J1530	B		Gamma globulin 8 CC inj					
J1540	B		Gamma globulin 9 CC inj					
J1550	B		Gamma globulin 10 CC inj					
J1560	B		Gamma globulin > 10 CC inj					
J1563	K		Immune globulin, 1 g	0905	0.8057	$43.96		$8.79
J1564	K		Immune globulin 10 mg	9021	0.0080	$0.44		$0.09
J1565	K		RSV-ivig	0906	0.8910	$48.61		$9.72
J1570	K		Ganciclovir sodium injection	0907	0.5918	$32.29		$6.46
J1580	N		Garamycin gentamicin inj					
J1590	N		Gatifloxacin injection					
J1595	N		Injection glatiramer acetate					
J1600	N		Gold sodium thiomaleate inj					
J1610	N		Glucagon hydrochloride/1 MG					
J1620	N		Gonadorelin hydroch/ 100 mcg					
J1626	K		Granisetron HCl injection	0764	0.1044	$5.70		$1.14
J1630	N		Haloperidol injection					
J1631	N		Haloperidol decanoate inj					
J1642	N		Inj heparin sodium per 10 u					
J1644	N		Inj heparin sodium per 1000u					
J1645	N		Dalteparin sodium					
J1650	N		Inj enoxaparin sodium					
J1652	N		Fondaparinux sodium					
J1655	N		Tinzaparin sodium injection					
J1670	N		Tetanus immune globulin inj					
J1700	N		Hydrocortisone acetate inj					
J1710	N		Hydrocortisone sodium ph inj					
J1720	N		Hydrocortisone sodium succ i					
J1730	N		Diazoxide injection					
J1742	N		Ibutilide fumarate injection					
J1745	K		Infliximab injection	7043	0.7122	$38.86		$7.77
J1750	N		Iron dextran					
J1756	N		Iron sucrose injection					
J1785	K		Injection imiglucerase /unit	0916		$3.71		$0.74
J1790	N		Droperidol injection					
J1800	N		Propranolol injection					
J1810	E		Droperidol/fentanyl inj					
J1815	N		Insulin injection					
J1817	N		Insulin for insulin pump use					
J1825	K		Interferon beta-1a	0909	3.3868	$184.79		$36.96
J1830	K		Interferon beta-1b / .25 MG	0910	1.8421	$100.51		$20.10
J1835	N		Itraconazole 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	DG	Kutapressin injection					
J1940	N		Furosemide injection					
J1950	K		Leuprolide acetate /3.75 MG	0800	3.3525	$182.92		$36.58
J1955	B		Inj levocarnitine per 1 gm					
J1956	N		Levofloxacin injection					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1960	N		Levorphanol tartrate inj					
J1980	N		Hyoscyamine sulfate inj					
J1990	N		Chlordiazepoxide injection					
J2000	N	DG	Lidocaine injection					
J2001	N	NI	Lidocaine injection					
J2010	N		Lincomycin injection					
J2020	K		Linezolid injection	9001	0.2771	$15.12		$3.02
J2060	N		Lorazepam injection					
J2150	N		Mannitol injection					
J2175	N		Meperidine hydrochl /100 MG					
J2180	N		Meperidine/promethazine inj					
J2185	N	NI	Meropenem					
J2210	N		Methylergonovin maleate inj					
J2250	N		Inj midazolam hydrochloride					
J2260	K		Inj milrinone lactate, per 5 mg	7007	0.2129	$11.62		$2.32
J2270	N		Morphine sulfate injection					
J2271	N		Morphine so4 injection 100mg					
J2275	N		Morphine sulfate injection					
J2280	N	NI	Inj, moxifloxacin 100 mg					
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					
J2324	G		Nesiritide, per 0.5 mg vial	9114		$151.62		$22.66
J2352	D	DNG	Octreotide acetate injection					
J2353	K	NI	Octreotide injection, depot	1207	1.2049	$65.74		$13.15
J2354	K	NI	Octreotide inj, non-depot	7031	0.0264	$1.44		$0.29
J2355	K		Oprelvekin injection	7011		$248.16		$49.63
J2360	N		Orphenadrine injection					
J2370	N		Phenylephrine hcl injection					
J2400	N		Chloroprocaine hcl injection					
J2405	N		Ondansetron hcl injection					
J2410	N		Oxymorphone hcl injection					
J2430	K		Pamidronate disodium /30 MG	0730	3.1949	$174.32		$34.86
J2440	N		Papaverin hcl injection					
J2460	N		Oxytetracycline injection					
J2501	N		Paricalcitol					
J2505	G	NI	Injection, pegfilgrastim 6mg	9119		$2,802.50		$418.90
J2510	N		Penicillin g procaine inj					
J2515	N		Pentobarbital sodium inj					
J2540	N		Penicillin g potassium inj					
J2543	N		Piperacillin/tazobactam					
J2545	Y		Pentamidine isethionte/300mg					
J2550	N		Promethazine hcl injection					
J2560	N		Phenobarbital sodium inj					
J2590	N		Oxytocin injection					
J2597	N		Inj desmopressin acetate					
J2650	N		Prednisolone acetate inj					
J2670	N		Totazoline hcl injection					
J2675	N		Inj progesterone per 50 MG					
J2680	N		Fluphenazine decanoate 25 MG					
J2690	N		Procainamide hcl injection					
J2700	N		Oxacillin sodium 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	N		Metoclopramide hcl injection					
J2770	N		Quinupristin/dalfopristin					
J2780	N		Ranitidine hydrochloride inj					
J2783	N	NI	Rasburicase					
J2788	K		Rho d immune globulin 50 mcg	9023	0.0310	$1.69		$0.34
J2790	K		Rho d immune globulin inj	0884	0.1863	$10.16		$2.03
J2792	K		Rho(D) immune globulin h, sd	1609	0.1789	$9.76		$1.95
J2795	N		Ropivacaine HCl injection					
J2800	N		Methocarbamol injection					
J2810	N		Inj theophylline per 40 MG					
J2820	K		Sargramostim injection	0731	0.2991	$16.32		$3.26
J2910	N		Aurothioglucose injeciton					
J2912	N		Sodium chloride injection					
J2916	N		Na ferric gluconate complex					
J2920	N		Methylprednisolone injection					
J2930	N		Methylprednisolone injection					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2940	N		Somatrem injection					
J2941	K		Somatropin injection	7034	0.7547	$41.18		$8.24
J2950	N		Promazine hcl injection					
J2993	K		Reteplase injection	9005	10.4165	$568.33		$113.67
J2995	K		Inj streptokinase /250000 IU	0911	1.5733	$85.84		$17.17
J2997	K		Alteplase recombinant	7048	0.2856	$15.58		$3.12
J3000	N		Streptomycin injection					
J3010	N		Fentanyl citrate injeciton					
J3030	N		Sumatriptan succinate / 6 MG					
J3070	N		Pentazocine hcl injection					
J3100	K		Tenecteplase injection	9002	23.7669	$1,296.75		$259.35
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					
J3240	K		Thyrotropin injection	9108		$572.00		$114.40
J3245	K		Tirofiban hydrochloride	7041	4.176	$227.85		$45.57
J3250	N		Trimethobenzamide hcl inj					
J3260	N		Tobramycin sulfate injection					
J3265	N		Injection torsemide 10 mg/ml					
J3280	N		Thiethylperazine maleate inj					
J3301	N		Triamcinolone acetonide inj					
J3302	N		Triamcinolone diacetate inj					
J3303	N		Triamcinolone hexacetonl inj					
J3305	K		Inj trimetrexate glucoronate	7045	1.1246	$61.36		$12.27
J3310	N		Perphenazine injeciton					
J3315	G		Triptorelin pamoate	9122		$398.62		$59.58
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	3.7855	$206.54		$41.31
J3370	N		Vancomycin hcl injection					
J3395	K		Verteporfin injection	1203	16.4439	$897.20		$179.44
J3400	N		Triflupromazine hcl inj					
J3410	N		Hydroxyzine hcl injection					
J3411	N	NI	Thiamine hcl 100 mg					
J3415	N	NI	Pyridoxine hcl 100 mg					
J3420	N		Vitamin b12 injection					
J3430	N		Vitamin k phytonadione inj					
J3465	N	NI	Injection, voriconazole					
J3470	N		Hyaluronidase injection					
J3475	N		Inj magnesium sulfate					
J3480	N		Inj potassium chloride					
J3485	N		Zidovudine					
J3486	G	NI	Ziprasidone mesylate	9204		$20.79		$3.11
J3487	G		Zoledronic acid	9115		$217.43		$32.50
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					
J3590	N		Unclassified biologics					
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	K		Factor viii	0925		$0.51		$0.10
J7191	K		Factor VIII (porcine)	0926		$1.52		$0.30
J7192	K		Factor viii recombinant	0927		$1.01		$0.20
J7193	K		Factor IX non-recombinant	0931		$0.51		$0.10
J7194	K		Factor ix complex	0928		$0.51		$0.10
J7195	K		Factor IX recombinant	0932		$1.01		$0.20
J7197	N		Antithrombin iii injection					
J7198	K		Anti-inhibitor	0929		$1.01		$0.20
J7199	B		Hemophilia clot factor noc					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7300	E		Intraut copper contraceptive					
J7302	E		Levonorgestrel iu contracept					
J7303	E	NI	Contraceptive vaginal ring					
J7308	N		Aminolevulinic acid hcl top					
J7310	K		Ganciclovir long act implant	0913	1.5861	$86.54		$17.31
J7317	K		Sodium hyaluronate injection	7316	2.5436	$138.78		$27.76
J7320	K		Hylan G-F 20 injection	1611	2.2628	$123.46		$24.69
J7330	E		Cultured chondrocytes implnt					
J7340	E		Metabolic active D/E tissue					
J7342	N		Metabolically active tissue					
J7350	N		Injectable human tissue					
J7500	N		Azathioprine oral 50mg					
J7501	N		Azathioprine parenteral					
J7502	K		Cyclosporine oral 100 mg	0888	0.0470	$2.56		$0.51
J7504	K		Lymphocyte immune globulin	0890	2.3439	$127.89		$25.58
J7505	K		Monoclonal antibodies	7038	5.8803	$320.84		$64.17
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891	0.0246	$1.34		$0.27
J7508	B	DG	Tacrolimus oral per 5 MG					
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104	2.9978	$163.56		$32.71
J7513	K		Daclizumab, parenteral	1612		$393.78		$78.76
J7515	N		Cyclosporine oral 25 mg					
J7516	N		Cyclosporin parenteral 250mg					
J7517	K		Mycophenolate mofetil oral	9015	0.0374	$2.04		$0.41
J7520	K		Sirolimus, oral	9020	0.0529	$2.89		$0.58
J7525	K		Tacrolimus injection	9006	0.1048	$5.72		$1.14
J7599	N		Immunosuppressive drug noc					
J7608	Y		Acetylcysteine inh sol u d					
J7618	Y		Albuterol inh sol con					
J7619	Y		Albuterol inh sol u d					
J7621	Y	NI	(Levo)albuterol/Ipra-bromide					
J7622	A		Beclomethasone inhalatn sol					
J7624	A		Betamethasone inhalation sol					
J7626	A		Budesonide inhalation sol					
J7628	Y		Bitolterol mes inhal sol con					
J7629	Y		Bitolterol mes inh sol u d					
J7631	Y		Cromolyn sodium inh sol u d					
J7633	N		Budesonide concentrated sol					
J7635	Y		Atropine inhal sol con					
J7636	Y		Atropine inhal sol unit dose					
J7637	Y		Dexamethasone inhal sol con					
J7638	Y		Dexamethasone inhal sol u d					
J7639	Y		Dornase alpha inhal sol u d					
J7641	A		Flunisolide, inhalation sol					
J7642	Y		Glycopyrrolate inhal sol con					
J7643	Y		Glycopyrrolate inhal sol u d					
J7644	Y		Ipratropium brom inh sol u d					
J7648	Y		Isoetharine hcl inh sol con					
J7649	Y		Isoetharine hcl inh sol u d					
J7658	Y		Isoproterenolhcl inh sol con					
J7659	Y		Isoproterenol hcl inh sol ud					
J7668	Y		Metaproterenol inh sol con					
J7669	Y		Metaproterenol inh sol u d					
J7680	Y		Terbutaline so4 inh sol con					
J7681	Y		Terbutaline so4 inh sol u d					
J7682	Y		Tobramycin inhalation sol					
J7683	Y		Triamcinolone inh sol con					
J7684	Y		Triamcinolone inh sol u d					
J7699	Y		Inhalation solution for DME					
J7799	Y		Non-inhalation drug for DME					
J8499	E		Oral prescrip drug non chemo					
J8510	K		Oral busulfan	7015	0.0288	$1.57		$0.31
J8520	K		Capecitabine, oral, 150 mg	7042	0.0302	$1.65		$0.33
J8521	E		Capecitabine, oral, 500 mg					
J8530	N		Cyclophosphamide oral 25 MG					
J8560	K		Etoposide oral 50 MG	0802	0.5016	$27.37		$5.47
J8600	N		Melphalan oral 2 MG					
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolmide	1086	0.0690	$3.76		$0.75
J8999	B		Oral prescription drug chemo					
J9000	K		Doxorubic hcl 10 MG vl chemo	0847	0.1212	$6.61		$1.32
J9001	K		Doxorubicin hcl liposome inj	7046	4.6982	$256.34		$51.27
J9010	K		Alemtuzumab injection	9110	7.7873	$424.88		$84.98

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9015	K		Aldesleukin/single use vial	0807		$680.35		$136.07
J9017	K		Arsenic trioxide	9012	0.4933	$26.91		$5.38
J9020	K		Asparaginase injection	0814	0.2957	$16.13		$3.23
J9031	K		Bcg live intravesical vac	0809	1.9015	$103.75		$20.75
J9040	K		Bleomycin sulfate injection	0857	2.9427	$160.56		$32.11
J9045	K		Carboplatin injection	0811	1.5849	$86.47		$17.29
J9050	N		Carmus bischl nitro inj					
J9060	K		Cisplatin 10 MG injection	0813	0.3985	$21.74		$4.35
J9062	B		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858	0.6931	$37.82		$7.56
J9070	K		Cyclophosphamide 100 MG inj	0815	0.0868	$4.74		$0.95
J9080	B		Cyclophosphamide 200 MG inj					
J9090	B		Cyclophosphamide 500 MG inj					
J9091	B		Cyclophosphamide 1.0 grm inj					
J9092	B		Cyclophosphamide 2.0 grm inj					
J9093	K		Cyclophosphamide lyophilized	0816	0.0825	$4.50		$0.90
J9094	B		Cyclophosphamide lyophilized					
J9095	B		Cyclophosphamide lyophilized					
J9096	B		Cyclophosphamide lyophilized					
J9097	B		Cyclophosphamide lyophilized					
J9098	K	NI	Cytarabine liposome	1166	5.1134	$278.99		$55.80
J9100	K		Cytarabine hcl 100 MG inj	0817	0.0930	$5.07		$1.01
J9110	B		Cytarabine hcl 500 MG inj					
J9120	N		Dactinomycin actinomycin d					
J9130	K		Dacarbazine 100 mg inj	0819	0.0974	$5.31		$1.06
J9140	B		Dacarbazine 200 MG inj					
J9150	K		Daunorubicin	0820	1.3557	$73.97		$14.79
J9151	K		Daunorubicin citrate liposom	0821	2.9976	$163.55		$32.71
J9160	K		Denileukin diftitox, 300 mcg	1084		$1,232.88		$246.58
J9165	N		Diethylstilbestrol injection					
J9170	K		Docetaxel	0823	4.0499	$220.97		$44.19
J9178	K	NI	Inj, epirubicin hcl, 2 mg	1167	0.3744	$20.43		$4.09
J9180	B	DG	Epirubicin HCl injection					
J9181	K		Etoposide 10 MG inj	0824	0.0836	$4.56		$0.91
J9182	B		Etoposide 100 MG inj					
J9185	K		Fludarabine phosphate inj	0842	3.7708	$205.74		$41.15
J9190	N		Fluorouracil injection					
J9200	K		Floxuridine injection	0827	2.0928	$114.19		$22.84
J9201	K		Gemcitabine HCl	0828	1.4742	$80.43		$16.09
J9202	K		Goserelin acetate implant	0810	5.2265	$285.16		$57.03
J9206	K		Irinotecan injection	0830	1.8428	$100.55		$20.11
J9208	K		Ifosfomide injection	0831	1.9435	$106.04		$21.21
J9209	K		Mesna injection	0732	0.5211	$28.43		$5.69
J9211	K		Idarubicin hcl injection	0832	3.2663	$178.21		$35.64
J9212	N		Interferon alfacon-1					
J9213	K		Interferon alfa-2a inj	0834	0.3777	$20.61		$4.12
J9214	K		Interferon alfa-2b inj	0836	0.2003	$10.93		$2.19
J9215	K		Interferon alfa-n3 inj	0865	1.4598	$79.65		$15.93
J9216	K		Interferon gamma 1-b inj	0838		$180.15		$36.03
J9217	K		Leuprolide acetate suspnsion	9217	5.7252	$312.37		$62.47
J9218	K		Leuprolide acetate injeciton	0861	0.7991	$43.60		$8.72
J9219	K		Leuprolide acetate implant	7051	67.2039	$3,666.71		$733.34
J9230	N		Mechlorethamine hcl inj					
J9245	K		Inj melphalan hydrochl 50 MG	0840	4.6719	$254.90		$50.98
J9250	N		Methotrexate sodium inj					
J9260	B		Methotrexate sodium inj					
J9263	B	NI	Oxaliplatin					
J9265	K		Paclitaxel injection	0863	2.0553	$112.14		$22.43
J9266	N		Pegaspargase/singl dose vial					
J9268	K		Pentostatin injection	0844	17.7045	$965.98		$193.20
J9270	K		Plicamycin (mithramycin) inj	0860	0.2826	$15.42		$3.08
J9280	K		Mitomycin 5 MG inj	0862	0.9719	$53.03		$10.61
J9290	B		Mitomycin 20 MG inj					
J9291	B		Mitomycin 40 MG inj					
J9293	K		Mitoxantrone hydrochl / 5 MG	0864	3.1832	$173.68		$34.74
J9300	K		Gemtuzumab ozogamicin	9004		$2,022.90		$404.58
J9310	K		Rituximab cancer treatment	0849	5.6158	$306.40		$61.28
J9320	K		Streptozocin injection	0850	1.1948	$65.19		$13.04
J9340	K		Thiotepa injection	0851	1.0984	$59.93		$11.99
J9350	K		Topotecan	0852	7.9435	$433.41		$86.68
J9355	K		Trastuzumab	1613	0.7434	$40.56		$8.11
J9357	K		Valrubicin, 200 mg	1614	8.4635	$461.78		$92.36
J9360	N		Vinblastine sulfate inj					
J9370	N		Vincristine sulfate 1 MG inj					
J9375	B		Vincristine sulfate 2 MG inj					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9380	B		Vincristine sulfate 5 MG inj					
J9390	K		Vinorelbine tartrate/10 mg	0855	1.1874	$64.79		$12.96
J9395	G	NI	Injection, Fulvestrant	9120		$87.58		$87.58
J9600	K		Porfimer sodium	0856	29.2205	$1,594.30		$318.86
J9999	N		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					
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					
K0014	A		Other power whlchr base					
K0015	A		Detach non-adjus hght armrst					
K0016	A	DG	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					
K0022	A	DG	Reinforced back upholstery					
K0023	A		Planr back insrt foam w/strp					
K0024	A		Plnr back insrt foam w/hrdwr					
K0025	A	DG	Hook-on headrest extension					
K0026	A	DG	Back upholst lgtwt whlchr					
K0027	A	DG	Back upholst other whlchr					
K0028	A	DG	Manual fully reclining back					
K0029	A	DG	Reinforced seat upholstery					
K0030	A	DG	Solid plnr seat sngl dnsfoam					
K0031	A	DG	Safety belt/pelvic strap					
K0032	A	DG	Seat uphols lgtwt whlchr					
K0033	A	DG	Seat upholstery other whlchr					
K0035	A	DG	Heel loop with ankle strap					
K0036	A	DG	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	DG	Elevate legrest complete					
K0049	A	DG	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	DG	Seat wdth 10-12/15/17/20 wc					
K0055	A	DG	Seat dpth 15/17/18 ltwt wc					
K0056	A		Seat ht 17 or 21 ltwt wc					
K0057	A	DG	Seat wdth 19/20 hvy dty wc					
K0058	A	DG	Seat dpth 17/18 power wc					
K0059	A		Plastic coated handrim each					
K0060	A		Steel handrim each					
K0061	A		Aluminum handrim each					
K0062	A	DG	Handrim 8-10 vert/obliq proj					
K0063	A	DG	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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	DG	Wheel lock extension pair					
K0080	A	DG	Anti-rollback device pair					
K0081	A		Wheel lock assembly complete					
K0082	A	DG	22 nf deep cycl acid battery					
K0083	A	DG	22 nf gel cell battery each					
K0084	A	DG	Grp 24 deep cycl acid battry					
K0085	A	DG	Group 24 gel cell battery					
K0086	A	DG	U-1 lead acid battery each					
K0087	A	DG	U-1 gel cell battery each					
K0088	A	DG	Battry chrgr acid/gel cell					
K0089	A	DG	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	DG	Amputee adapter pair					
K0102	A		Crutch and cane holder					
K0103	A	DG	Transfer board < 25≧					
K0104	A		Cylinder tank carrier					
K0105	A		Iv hanger					
K0106	A		Arm trough each					
K0107	A	DG	Wheelchair tray					
K0108	A		W/c component-accessory NOS					
K0112	A	DG	Trunk vest supprt innr frame					
K0113	A	DG	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					
K0195	A		Elevating whlchair leg rests					
K0268	A	DG	Humidifier nonheated w PAP					
K0415	B		RX antiemetic drg, oral NOS					
K0416	B		Rx antiemetic drg,rectal NOS					
K0452	A		Wheelchair bearings					
K0455	A		Pump uninterrupted infusion					
K0460	A	DG	WC power add-on joystick					
K0461	A	DG	WC power add-on tiller cntrl					
K0462	A		Temporary replacement eqpmnt					
K0531	A	DG	Heated humidifier used w pap					
K0532	A	DG	Noninvasive assist wo backup					
K0533	A	DG	Noninvasive assist w backup					
K0534	A	DG	Invasive assist w backup					
K0538	A	DG	Neg pressure wnd thrpy pump					
K0539	A	DG	Neg pres wnd thrpy dsg set					
K0540	A	DG	Neg pres wnd thrp canister					
K0541	A	DG	SGD prerecorded msg <= 8 min					
K0542	A	DG	SGD prerecorded msg > 8 min					
K0543	A	DG	SGD msg formed by spelling					
K0544	A	DG	SGD w multi methods msg/accs					
K0545	A	DG	SGD sftwre prgrm for PC/PDA					
K0546	A	DG	SGD accessory,mounting systm					
K0547	A	DG	SGD accessory NOC					
K0548	N	NI	Insulin lispro					
K0549	A	DG	Hosp bed hvy dty xtra wide					
K0550	A	DG	Hosp bed xtra hvy dty x wide					
K0552	Y	NF	Supply/Ext inf pump syr type					
K0556	A	DG	Socket insert w lock mech					
K0557	A	DG	Socket insert w/o lock mech					
K0558	A	DG	Intl custm cong/atyp insert					
K0559	A	DG	Initial custom socket insert					
K0560	N	DG	Mcp joint 2-piece for implant					
K0581	A	DG	Ost pch clsd w barrier/filtr					
K0582	A	DG	Ost pch w bar/bltinconv/fltr					
K0583	A	DG	Ost pch clsd w/o bar w filtr					
K0584	A	DG	Ost pch for bar w flange/flt					
K0585	A	DG	Ost pch clsd for bar w lk fl					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0586	A	DG	Ost pch for bar w lk fl/fltr					
K0587	A	DG	Ost pch drain w bar & filter					
K0588	A	DG	Ost pch drain for barrier fl					
K0589	A	DG	Ost pch drain 2 piece system					
K0590	A	DG	Ost pch drain/barr lk flng/f					
K0591	A	DG	Urine ost pouch w faucet/tap					
K0592	A	DG	Urine ost pouch w bltinconv					
K0593	A	DG	Ost urine pch w b/bltin conv					
K0594	A	DG	Ost pch urine w barrier/tapv					
K0595	A	DG	Os pch urine w bar/fange/tap					
K0596	A	DG	Urine ost pch bar w lock fln					
K0597	A	DG	Ost pch urine w lock flng/ft					
K0600	Y	NF	Functional neuromuscular stim					
K0601	Y	NF	Repl batt silver oxide 1.5 v					
K0602	Y	NF	Repl batt silver oxide 3 v					
K0603	Y	NF	Repl batt alkaline 1.5 v					
K0604	Y	NF	Repl batt lithium 3.6 v					
K0605	Y	NF	Repl batt lithium 4.5 v					
K0606	Y	NF	AED garment w/elec analysis					
K0607	Y	NF	Repl batt for AED device					
K0608	Y	NF	Repl garment for AED					
K0609	Y	NF	Repl electrode for AED					
K0610	E	DG	Peritoneal dialysis clamp					
K0611	E	DG	Disposable cycler set					
K0612	E	DG	Drainage ext line, dialysis					
K0613	E	DG	Ext line w/easy lock connect					
K0614	E	DG	Chem/antiseptic solution, 8oz					
K0615	Y	DG	SGD prerec mes >8min <20min					
K0616	Y	DG	SGD prerec mes >20min <40min					
K0617	Y	DG	SGD prerec mes >40min					
K0618	A		TLSO 2 piece rigid shell					
K0619	A		TLSO 3 piece rigid shell					
K0620	A		Tubular elastic dressing					
K0621	A	DG	Gauze, non-impreg pack strip					
K0622	A	DG	Confrm band non str <3in/rol					
K0623	A	DG	Confrm band sterl>3in/roll					
K0624	A	DG	Lite compress wdth<3in/roll					
K0625	A	DG	Self adher wdth <3 in, roll					
K0626	A	DG	Self adher wdth >=5 in, roll					
L0100	A		Cranial orthosis/helmet mold					
L0110	A		Cranial orthosis/helmet nonm					
L0112	A	NI	Cranial cervical orthosis					
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					
L0450	A		TLSO flex prefab thoracic					
L0452	A		tlso flex custom fab thoraci					
L0454	A		TLSO flex prefab sacrococ-T9					
L0456	A		TLSO flex prefab					
L0458	A		TLSO 2Mod symphis-xipho pre					
L0460	A		TLSO2Mod symphysis-stern pre					
L0462	A		TLSO 3Mod sacro-scap pre					
L0464	A		TLSO 4Mod sacro-scap pre					
L0466	A		TLSO rigid frame pre soft ap					
L0468	A		TLSO rigid frame prefab pelv					
L0470	A		TLSO rigid frame pre subclav					
L0472	A		TLSO rigid frame hyperex pre					
L0474	A		TLSO rigid frame pre pelvic					
L0476	A		TLSO flexion compres jac pre					
L0478	A		TLSO flexion compres jac cus					
L0480	A		TLSO rigid plastic custom fa					
L0482	A		TLSO rigid lined custom fab					
L0484	A		TLSO rigid plastic cust fab					
L0486	A		TLSO rigidlined cust fab two					
L0488	A		TLSO rigid lined pre one pie					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L0490	A		TLSO rigid plastic pre one					
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					
L0861	A	NI	Halo repl liner/interface					
L0960	A		Post surgical support pads					
L0970	A		Tlso corset front					
L0972	A		Lso corset front					
L0974	A		Tlso full corset					
L0976	A		Lso full corset					
L0978	A		Axillary crutch extension					
L0980	A		Peroneal straps pair					
L0982	A		Stocking supp grips set of f					
L0984	A		Protective body sock each					
L0999	A		Add to spinal orthosis NOS					
L1000	A		Ctlso milwauke initial model					
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					
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					
L1652	A		HO bi thighcuffs w sprdr bar					
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					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L1831	A	NI	Knee orth pos locking joint					
L1832	A		KO adj jnt pos rigid support					
L1834	A		Ko w/0 joint rigid molded to					
L1836	A		Rigid KO wo joints					
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	DG	Knee upright w/resistance					
L1900	A		Afo sprng wir drsflx calf bd					
L1901	A		Prefab ankle orthosis					
L1902	A		Afo ankle gauntlet					
L1904	A		Afo molded ankle gauntlet					
L1906	A		Afo multiligamentus ankle su					
L1907	A	NI	AFO supramalleolar custom					
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					
L1951	A	NI	AFO spiral prefabricated					
L1960	A		Afo pos solid ank plastic mo					
L1970	A		Afo plastic molded w/ankle j					
L1971	A	NI	AFO w/ankle joint, prefab					
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	E	DG	Afo tibial fx cast plstr mol					
L2104	E	DG	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	E	DG	Kafo fem fx cast plaster mol					
L2124	E	DG	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					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	B		Ft insert ucb berkeley shell					
L3001	B		Foot insert remov molded spe					
L3002	B		Foot insert plastazote or eq					
L3003	B		Foot insert silicone gel eac					
L3010	B		Foot longitudinal arch suppo					
L3020	B		Foot longitud/metatarsal sup					
L3030	B		Foot arch support remov prem					
L3031	E	NI	Foot lamin/prepreg composite					
L3040	B		Ft arch suprt premold longit					
L3050	B		Foot arch supp premold metat					
L3060	B		Foot arch supp longitud/meta					
L3070	B		Arch suprt att to sho longit					
L3080	B		Arch supp att to shoe metata					
L3090	B		Arch supp att to shoe long/m					
L3100	B		Hallus-valgus nght dynamic s					
L3140	B		Abduction rotation bar shoe					
L3150	B		Abduct rotation bar w/o shoe					
L3160	B		Shoe styled positioning dev					
L3170	B		Foot plastic heel stabilizer					
L3201	B		Oxford w supinat/pronat inf					
L3202	B		Oxford w/ supinat/pronator c					
L3203	B		Oxford w/ supinator/pronator					
L3204	B		Hightop w/ supp/pronator inf					
L3206	B		Hightop w/ supp/pronator chi					
L3207	B		Hightop w/ supp/pronator jun					
L3208	B		Surgical boot each infant					
L3209	B		Surgical boot each child					
L3211	B		Surgical boot each junior					
L3212	B		Benesch boot pair infant					
L3213	B		Benesch boot pair child					
L3214	B		Benesch boot pair junior					
L3215	B		Orthopedic ftwear ladies oxf					
L3216	B		Orthoped ladies shoes dpth i					
L3217	B		Ladies shoes hightop depth i					
L3219	B		Orthopedic mens shoes oxford					
L3221	B		Orthopedic mens shoes dpth i					
L3222	B		Mens shoes hightop depth inl					
L3224	A		Woman's shoe oxford brace					
L3225	A		Man's shoe oxford brace					
L3230	B		Custom shoes depth inlay					
L3250	B		Custom mold shoe remov prost					
L3251	B		Shoe molded to pt silicone s					
L3252	B		Shoe molded plastazote cust					
L3253	B		Shoe molded plastazote cust					
L3254	B		Orth foot non-stndard size/w					
L3255	B		Orth foot non-standard size/					
L3257	B		Orth foot add charge split s					
L3260	B		Ambulatory surgical boot eac					
L3265	B		Plastazote sandal each					
L3300	B		Sho lift taper to metatarsal					
L3310	B		Shoe lift elev heel/sole neo					
L3320	B		Shoe lift elev heel/sole cor					
L3330	B		Lifts elevation metal extens					
L3332	B		Shoe lifts tapered to one-ha					
L3334	B		Shoe lifts elevation heel /i					
L3340	B		Shoe wedge sach					
L3350	E		Shoe heel wedge					
L3360	B		Shoe sole wedge outside sole					
L3370	B		Shoe sole wedge between sole					
L3380	B		Shoe clubfoot wedge					
L3390	B		Shoe outflare wedge					
L3400	B		Shoe metatarsal bar wedge ro					
L3410	B		Shoe metatarsal bar between					
L3420	B		Full sole/heel wedge btween					
L3430	B		Sho heel count plast reinfor					
L3440	B		Heel leather reinforced					
L3450	B		Shoe heel sach cushion type					
L3455	B		Shoe heel new leather standa					
L3460	B		Shoe heel new rubber standar					
L3465	B		Shoe heel thomas with wedge					
L3470	B		Shoe heel thomas extend to b					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3480	B		Shoe heel pad & depress for					
L3485	B		Shoe heel pad removable for					
L3500	B		Ortho shoe add leather insol					
L3510	B		Orthopedic shoe add rub insl					
L3520	B		O shoe add felt w leath insl					
L3530	B		Ortho shoe add half sole					
L3540	B		Ortho shoe add full sole					
L3550	B		O shoe add standard toe tap					
L3560	B		O shoe add horseshoe toe tap					
L3570	B		O shoe add instep extension					
L3580	B		O shoe add instep velcro clo					
L3590	B		O shoe convert to sof counte					
L3595	B		Ortho shoe add march bar					
L3600	B		Trans shoe calip plate exist					
L3610	B		Trans shoe caliper plate new					
L3620	B		Trans shoe solid stirrup exi					
L3630	B		Trans shoe solid stirrup new					
L3640	B		Shoe dennis browne splint bo					
L3649	B		Orthopedic shoe modifica NOS					
L3650	A		Shlder fig 8 abduct restrain					
L3651	A		Prefab shoulder orthosis					
L3652	A		Prefab dbl shoulder orthosis					
L3660	A		Abduct restrainer canvas&web					
L3670	A		Acromio/clavicular canvas&we					
L3675	A		Canvas vest SO					
L3677	E		SO hard plastic stabilizer					
L3700	A		Elbow orthoses elas w stays					
L3701	A		Prefab elbow orthosis					
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	A		EO withjoint, Prefabricated					
L3762	A		Rigid EO wo joints					
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	B		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					
L3909	A		Prefab wrist orthosis					
L3910	A		Whfo swanson design					
L3911	A		Prefab hand finger orthosis					
L3912	A		Flex glove w/elastic finger					
L3914	A		WHO wrist extension cock-up					
L3916	A		Whfo wrist extens w/ outrigg					
L3917	A	NI	Prefab metacarpl fx orthosis					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3940	A		Dorsal wrist w/ outrigger at					
L3942	A		Reverse knuckle bender					
L3944	A		Reverse knuckle bend w/ outr					
L3946	A		HFO composite elastic					
L3948	A		Finger knuckle bender					
L3950	A		Oppenheimer w/ knuckle bend					
L3952	A		Oppenheimer w/ rev knuckle 2					
L3954	A		Spreading hand					
L3956	A		Add joint upper ext orthosis					
L3960	A		Sewho airplan desig abdu pos					
L3962	A		Sewho erbs palsey design abd					
L3963	A		Molded w/ articulating elbow					
L3964	A		Seo mobile arm sup att to wc					
L3965	A		Arm supp att to wc rancho ty					
L3966	A		Mobile arm supports reclinin					
L3968	A		Friction dampening arm supp					
L3969	A		Monosuspension arm/hand supp					
L3970	A		Elevat proximal arm support					
L3972	A		Offset/lat rocker arm w/ ela					
L3974	A		Mobile arm support supinator					
L3980	A		Upp ext fx orthosis humeral					
L3982	A		Upper ext fx orthosis rad/ul					
L3984	A		Upper ext fx orthosis wrist					
L3985	A		Forearm hand fx orth w/ wr h					
L3986	A		Humeral rad/ulna wrist fx or					
L3995	A		Sock fracture or equal each					
L3999	A		Upper limb orthosis NOS					
L4000	A		Repl girdle milwaukee orth					
L4010	A		Replace trilateral socket br					
L4020	A		Replace quadlat socket brim					
L4030	A		Replace socket brim cust fit					
L4040	A		Replace molded thigh lacer					
L4045	A		Replace non-molded thigh lac					
L4050	A		Replace molded calf lacer					
L4055	A		Replace non-molded calf lace					
L4060	A		Replace high roll cuff					
L4070	A		Replace prox & dist upright					
L4080	A		Repl met band kafo-afo prox					
L4090	A		Repl met band kafo-afo calf/					
L4100	A		Repl leath cuff kafo prox th					
L4110	A		Repl leath cuff kafo-afo cal					
L4130	A		Replace pretibial shell					
L4205	A		Ortho dvc repair per 15 min					
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					
L4386	A		Non-pneumatic walking 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					
L5301	A		BK mold socket SACH ft endo					
L5311	A		Knee disart, SACH ft, endo					
L5321	A		AK open end SACH					
L5331	A		Hip disart canadian SACH ft					
L5341	A		Hemipelvectomy canadian SACH					
L5400	A		Postop dress & 1 cast chg bk					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L5661	A		Multi-durometer symes					
L5665	A		Multi-durometer below knee					
L5666	A		Below knee cuff suspension					
L5668	A		Socket insert w/o lock lower					
L5670	A		Bk molded supracondylar susp					
L5671	A		BK/AK locking mechanism					
L5672	A		Bk removable medial brim sus					
L5673	A	NI	Socket insert w lock mech					
L5674	A		Bk suspension sleeve					
L5675	A		Bk heavy duty susp sleeve					
L5676	A		Bk knee joints single axis p					
L5677	A		Bk knee joints polycentric p					
L5678	A		Bk joint covers pair					
L5679	A	NI	Socket insert w/o lock mech					
L5680	A		Bk thigh lacer non-molded					
L5681	A	NI	Intl custm cong/latyp insert					
L5682	A		Bk thigh lacer glut/ischia m					
L5683	A	NI	Initial custom socket insert					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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 cover BK					
L5705	A		Custom shape cover AK					
L5706	A		Custom shape cvr knee disart					
L5707	A		Custom shape cvr 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					
L5781	A		Lower limb pros vacuum pump					
L5782	A		HD low limb pros vacuum pump					
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					
L5848	A		Knee-shin sys hydraul stance					
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					
L5984	A		Endoskeletal axial rotation					
L5985	A		Lwr ext dynamic prosth pylon					

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CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L5995	A		Lower ext pros heavyduty fea					
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					
L6025	A		Part hand disart myoelectric					
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/extension 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					
L6638	A		Elec lock on manual pw elbow					
L6640	A		Shoulder abduction joint pai					
L6641	A		Excursion amplifier pulley t					
L6642	A		Excursion amplifier lever ty					
L6645	A		Shoulder flexion-abduction j					
L6646	A		Multipo locking shoulder jnt					
L6647	A		Shoulder lock actuator					
L6648	A		Ext pwrd shlder lock/unlock					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6686	A		Suction socket					
L6687	A		Frame typ socket bel elbow/w					
L6688	A		Frame typ sock above elb/dis					
L6689	A		Frame typ socket shoulder di					
L6690	A		Frame typ sock interscap-tho					
L6691	A		Removable insert each					
L6692	A		Silicone gel insert or equal					
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					W≤
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L7040	A		Prehensile actuator hosmer s					
L7045	A		Electron hook child michigan					
L7170	A		Electronic elbow hosmer swit					
L7180	A		Electronic elbow utah myoele					
L7185	A		Electron elbow adolescent sw					
L7186	A		Electron elbow child switch					
L7190	A		Elbow adolescent myoelectron					
L7191	A		Elbow child myoelectronic ct					
L7260	A		Electron wrist rotator otto					
L7261	A		Electron wrist rotator utah					
L7266	A		Servo control steeper or equ					
L7272	A		Analogue control unb or equa					
L7274	A		Proportional ctl 12 volt uta					
L7360	A		Six volt bat otto bock/eq ea					
L7362	A		Battery chrgr six volt otto					
L7364	A		Twelve volt battery utah/equ					
L7366	A		Battery chrgr 12 volt utah/e					
L7367	A		Replacemnt lithium ionbatter					
L7368	A		Lithium ion battery charger					
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		Male vacuum erection system					
L8000	A		Mastectomy bra					
L8001	A		Breast prosthesis bra & 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	A		Compression stocking BK30-40					
L8120	A		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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L8507	A		Trach-esoph voice pros pt in					
L8509	A		Trach-esoph voice pros md in					
L8510	A		Voice amplifier					
L8511	A	NI	Indwelling trach insert					
L8512	A	NI	Gel cap for trach voice pros					
L8513	A	NI	Trach pros cleaning device					
L8514	A	NI	Repl trach puncture dilator					
L8600	N		Implant breast silicone/eq					
L8603	N		Collagen imp urinary 2.5 ml					
L8606	N		Synthetic implnt urinary 1ml					
L8610	N		Ocular implant					
L8612	N		Aqueous shunt prosthesis					
L8613	N		Ossicular implant					
L8614	N		Cochlear device/system					
L8619	A		Replace cochlear processor					
L8630	N		Metacarpophalangeal implant					
L8631	A	NI	MCP joint repl 2 pc or more					
L8641	N		Metatarsal joint implant					
L8642	N		Hallux implant					
L8658	N		Interphalangeal joint spacer					
L8659	A	NI	Interphalangeal joint repl					
L8670	N		Vascular graft, synthetic					
L8699	N		Prosthetic implant NOS					
L9900	A		O&P supply/accessory/service					
M0064	X		Visit for drug monitoring	0374	1.1252	$61.39		$12.28
M0075	E		Cellular therapy					
M0076	E		Prolotherapy					
M0100	E		Intragastric hypothermia					
M0300	E		IV chelationtherapy					
M0301	E		Fabric wrapping of aneurysm					
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	B		Screening pap smear by phys					
P7001	E		Culture bacterial urine					
P9010	K		Whole blood for transfusion	0950		$87.93		$17.59
P9011	K		Blood split unit	0957		$41.44		$8.29
P9012	K		Cryoprecipitate each unit	0952		$29.31		$5.86
P9016	K		RBC leukocytes reduced	0954		$119.26		$23.85
P9017	K		Plasma 1 donor frz w/in 8 hr	0955		$95.00		$19.00
P9019	K		Platelets, each unit	0957		$41.44		$8.29
P9020	K		Plaelet rich plasma unit	0958		$53.56		$10.71
P9021	K		Red blood cells unit	0959		$86.41		$17.28
P9022	K		Washed red blood cells unit	0960		$160.69		$32.14
P9023	K		Frozen plasma, pooled, sd	0949		$124.31		$24.86
P9031	K		Platelets leukocytes reduced	1013		$49.52		$9.90
P9032	K		Platelets, irradiated	9500		$74.79		$14.96
P9033	K		Platelets leukoreduced irrad	0954		$119.26		$23.85
P9034	K		Platelets, pheresis	9501		$408.81		$81.76
P9035	K		Platelet pheres leukoreduced	9501		$408.81		$81.76
P9036	K		Platelet pheresis irradiated	9502		$443.68		$88.74
P9037	K		Plate pheres leukoredu irrad	1019		$406.28		$81.26
P9038	K		RBC irradiated	9505		$108.65		$21.73
P9039	K		RBC deglycerolized	9504		$183.44		$36.69
P9040	K		RBC leukoreduced irradiated	9504		$183.44		$36.69
P9041	K		Albumin (human),5%, 50ml	0961	0.2802	$15.29		$3.06
P9043	K		Plasma protein fract,5%,50ml	0956		$92.98		$18.60
P9044	K		Cryoprecipitatereducedplasma	1009		$37.39		$7.48
P9045	K		Albumin (human), 5%, 250 ml	0963	1.0901	$59.48		$11.90
P9046	K		Albumin (human), 25%, 20 ml	0964	0.3741	$20.41		$4.08
P9047	K		Albumin (human), 25%, 50ml	0965	0.8869	$48.39		$9.68
P9048	K		Plasmaprotein fract,5%,250ml	0966		$464.90		$92.98
P9050	K		Granulocytes, pheresis unit	9506		$1,248.66		$249.73
P9051	K	NI	Blood, l/r, cmv-neg	1010		$121.78		$24.36
P9052	K	NI	Platelets, hla-m, l/r, unit	1011		$499.77		$99.95
P9053	K	NI	Plt, pher, l/r cmv-neg, irr	1020		$495.22		$99.04

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9054	K	NI	Blood, l/r, froz/degly/wash	1016		$301.68		$60.34
P9055	K	NI	Plt, aph/pher, l/r, cmv-neg	1017		$393.15		$78.63
P9056	K	NI	Blood, l/r, irradiated	1018		$132.40		$26.48
P9057	K	NI	RBC, frz/deg/wsh, l/r, irrad	1021		$336.04		$67.21
P9058	K	NI	RBC, l/r, cmv-neg, irrad	1022		$201.12		$40.22
P9059	K	NI	Plasma, frz between 8-24hour	0955		$95.00		$19.00
P9060	K	NI	Fr frz plasma donor retested	9503		$69.74		$13.95
P9604	A		One-way allow prorated trip					
P9612	N		Catheterize for urine spec					
P9615	N		Urine specimen collect mult					
Q0035	X		Cardiokymography	0100	1.5862	$86.54	$41.44	$17.31
Q0081	T		Infusion ther other than che	0120	1.9114	$104.29	$28.21	$20.86
Q0083	S		Chemo by other than infusion	0116	0.7996	$43.63		$8.73
Q0084	S		Chemotherapy by infusion	0117	3.0360	$165.65	$42.54	$33.13
Q0085	E		Chemo by both infusion and o					
Q0086	A	DG	Physical therapy evaluation/					
Q0091	T		Obtaining screen pap smear	0191	0.1853	$10.11	$2.93	$2.02
Q0092	N		Set up port xray equipment					
Q0111	A		Wet mounts/ w preparations					
Q0112	A		Potassium hydroxide preps					
Q0113	A		Pinworm examinations					
Q0114	A		Fern test					
Q0115	A		Post-coital mucous exam					
Q0136	K		Non esrd epoetin alpha inj	0733	0.1802	$9.83		$1.97
Q0137	K	NI	Darbepoetin alfa, non esrd	0734		$3.24		$0.65
Q0144	E		Azithromycin dihydrate, oral					
Q0163	N		Diphenhydramine HCl 50mg					
Q0164	N		Prochlorperazine maleate 5mg					
Q0165	B		Prochlorperazine maleate10mg					
Q0166	K		Granisetron HCl 1 mg oral	0765	0.6322	$34.49		$6.90
Q0167	N		Dronabinol 2.5mg oral					
Q0168	B		Dronabinol 5mg oral					
Q0169	N		Promethazine HCl 12.5mg oral					
Q0170	B		Promethazine HCl 25 mg oral					
Q0171	N		Chlorpromazine HCl 10mg oral					
Q0172	B		Chlorpromazine HCl 25mg oral					
Q0173	N		Trimethobenzamide HCl 250mg					
Q0174	N		Thiethylperazine maleate10mg					
Q0175	N		Perphenazine 4mg oral					
Q0176	B		Perphenazine 8mg oral					
Q0177	N		Hydroxyzine pamoate 25mg					
Q0178	B		Hydroxyzine pamoate 50mg					
Q0179	N		Ondansetron HCl 8mg oral					
Q0180	K		Dolasetron mesylate oral	0763	0.7514	$41.00		$8.20
Q0181	E		Unspecified oral anti-emetic					
Q0182	B	NI	Nonmetabolic act d/e tissue					
Q0183	N		Nonmetabolic active tissue					
Q0187	K		Factor viia recombinant	1409		$1,083.93		$216.79
Q1001	N		Ntiol category 1					
Q1002	N		Ntiol category 2					
Q1003	N		Ntiol category 3					
Q1004	N		Ntiol category 4					
Q1005	N		Ntiol category 5					
Q2001	E		Oral cabergoline 0.5 mg					
Q2002	N		Elliotts b solution per ml					
Q2003	K		Aprotinin, 10,000 kiu	7019	0.0215	$1.17		$0.23
Q2004	N		Bladder calculi irrig sol					
Q2005	K		Corticorelin ovine triflutat	7024	4.1221	$224.91		$44.98
Q2006	K		Digoxin immune fab (ovine)	7025	4.9694	$271.14		$54.23
Q2007	K		Ethanolamine oleate 100 mg	7026	0.5099	$27.82		$5.56
Q2008	K		Fomepizole, 15 mg	7027	0.1325	$7.23		$1.45
Q2009	K		Fosphenytoin, 50 mg	7028	0.0895	$4.88		$0.98
Q2010	N	DG	Glatiramer acetate, per dose					
Q2011	K		Hemin, per 1 mg	7030	0.0118	$0.64		$0.13
Q2012	N		Pegademase bovine, 25 iu					
Q2013	K		Pentastarch 10% solution	7040	0.4838	$26.40		$5.28
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035	2.5185	$137.41		$27.48
Q2018	K		Urofollitropin, 75 iu	7037	1.1634	$63.48		$12.70
Q2019	K		Basiliximab	1615		$1,425.06		$285.01
Q2020	E		Histrelin acetate					
Q2021	N		Lepirudin					
Q2022	K		VonWillebrandFactrCmplxperIU	1618		$1.01		$0.20
Q3000	K	NF	Rubidium-Rb-82	9025	2.6372	$143.89		$28.78
Q3001	N		Brachytherapy Radioelements					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q3002	K		Gallium ga 67	1619	0.2056	$11.22		$2.24
Q3003	K		Technetium tc99m bicisate	1620	3.3666	$183.69		$36.74
Q3004	N		Xenon xe 133					
Q3005	K		Technetium tc99m mertiatide	1622	0.3782	$20.63		$4.13
Q3006	N		Technetium tc99m glucepatate					
Q3007	K		Sodium phosphate p32	1624	1.2941	$70.61		$14.12
Q3008	K		Indium 111-in pentetreotide	1625	8.2447	$449.84		$89.97
Q3009	N		Technetium tc99m oxidronate					
Q3010	N		Technetium tc99mlabeledrbcs					
Q3011	K		Chromic phosphate p32	1628	1.8057	$98.52		$19.70
Q3012	K		Cyanocobalamin cobalt co57	1089	1.0460	$57.07		$11.41
Q3014	A		Telehealth facility fee					
Q3019	A		ALS emer trans no ALS serv					
Q3020	A		ALS nonemer trans no ALS se					
Q3021	E		Ped hepatitis b vaccine inj					
Q3022	E		Hepatitis b vaccine adult ds					
Q3023	E		Injection hepatitis Bvaccine					
Q3025	K		IM inj interferon beta 1-a	9022	1.1290	$61.60		$12.32
Q3026	N		Subc inj interferon beta-1a					
Q3031	N	NI	Collagen skin test					
Q4001	B		Cast sup body cast plaster					
Q4002	B		Cast sup body cast fiberglas					
Q4003	B		Cast sup shoulder cast plstr					
Q4004	B		Cast sup shoulder cast fbrgl					
Q4005	B		Cast sup long arm adult plst					
Q4006	B		Cast sup long arm adult fbrg					
Q4007	B		Cast sup long arm ped plster					
Q4008	B		Cast sup long arm ped fbrgls					
Q4009	B		Cast sup sht arm adult plstr					
Q4010	B		Cast sup sht arm adult fbrgl					
Q4011	B		Cast sup sht arm ped plaster					
Q4012	B		Cast sup sht arm ped fbrglas					
Q4013	B		Cast sup gauntlet plaster					
Q4014	B		Cast sup gauntlet fiberglass					
Q4015	B		Cast sup gauntlet ped plster					
Q4016	B		Cast sup gauntlet ped fbrgls					
Q4017	B		Cast sup lng arm splint plst					
Q4018	B		Cast sup lng arm splint fbrg					
Q4019	B		Cast sup lng arm splnt ped p					
Q4020	B		Cast sup lng arm splnt ped f					
Q4021	B		Cast sup sht arm splint plst					
Q4022	B		Cast sup sht arm splint fbrg					
Q4023	B		Cast sup sht arm splnt ped p					
Q4024	B		Cast sup sht arm splnt ped f					
Q4025	B		Cast sup hip spica plaster					
Q4026	B		Cast sup hip spica fiberglas					
Q4027	B		Cast sup hip spica ped plstr					
Q4028	B		Cast sup hip spica ped fbrgl					
Q4029	B		Cast sup long leg plaster					
Q4030	B		Cast sup long leg fiberglass					
Q4031	B		Cast sup lng leg ped plaster					
Q4032	B		Cast sup lng leg ped fbrgls					
Q4033	B		Cast sup lng leg cylinder pl					
Q4034	B		Cast sup lng leg cylinder fb					
Q4035	B		Cast sup lngleg cylndr ped p					
Q4036	B		Cast sup lngleg cylndr ped f					
Q4037	B		Cast sup shrt leg plaster					
Q4038	B		Cast sup shrt leg fiberglass					
Q4039	B		Cast sup shrt leg ped plster					
Q4040	B		Cast sup shrt leg ped fbrgls					
Q4041	B		Cast sup lng leg splnt plstr					
Q4042	B		Cast sup lng leg splnt fbrgl					
Q4043	B		Cast sup lng leg splnt ped p					
Q4044	B		Cast sup lng leg splnt ped f					
Q4045	B		Cast sup sht leg splnt plstr					
Q4046	B		Cast sup sht leg splnt fbrgl					
Q4047	B		Cast sup sht leg splnt ped p					
Q4048	B		Cast sup sht leg splnt ped f					
Q4049	B		Finger splint, static					
Q4050	B		Cast supplies unlisted					
Q4051	B		Splint supplies misc					
Q4052	K	DG	Octreotide injection, depot	1207	1.2049	$65.74		$13.15
Q4053	D	DNG	Pegfilgrastim, per 1 mg					
Q4054	A	NI	Darbepoetin alfa, esrd use					
Q4055	A	NI	Epoetin alfa, esrd use					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q4075	N	NI	Acyclovir, 5 mg					
Q4076	N	NI	Dopamine hcl, 40 mg					
Q4077	N	NI	Treprostinil, 1 mg					
Q4078	K	DG	Ammonia N-13, per dose	9025	2.6372	$143.89		$28.78
Q9920	A	DG	Epoetin with hct <= 20					
Q9921	A	DG	Epoetin with hct = 21					
Q9922	A	DG	Epoetin with hct = 22					
Q9923	A	DG	Epoetin with hct = 23					
Q9924	A	DG	Epoetin with hct = 24					
Q9925	A	DG	Epoetin with hct = 25					
Q9926	A	DG	Epoetin with hct = 26					
Q9927	A	DG	Epoetin with hct = 27					
Q9928	A	DG	Epoetin with hct = 28					
Q9929	A	DG	Epoetin with hct = 29					
Q9930	A	DG	Epoetin with hct = 30					
Q9931	A	DG	Epoetin with hct = 31					
Q9932	A	DG	Epoetin with hct = 32					
Q9933	A	DG	Epoetin with hct = 33					
Q9934	A	DG	Epoetin with hct = 34					
Q9935	A	DG	Epoetin with hct = 35					
Q9936	A	DG	Epoetin with hct = 36					
Q9937	A	DG	Epoetin with hct = 37					
Q9938	A	DG	Epoetin with hct = 38					
Q9939	A	DG	Epoetin with hct = 39					
Q9940	A	DG	Epoetin with hct >= 40					
R0070	N		Transport portable x-ray					
R0075	N		Transport port x-ray multipl					
R0076	N		Transport portable EKG					
V2020	A		Vision svcs frames purchases					
V2025	E		Eyeglasses delux frames					
V2100	A		Lens 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	DG	Nonaspheric lens bifocal					
V2117	A	DG	Aspheric lens bifocal					
V2118	A		Lens aniseikonic single					
V2121	A	NI	Lenticular lens, 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	DG	Lens lenticular nonaspheric					
V2217	A	DG	Lens lenticular aspheric bif					
V2218	A		Lens aniseikonic bifocal					
V2219	A		Lens bifocal seg width over					
V2220	A		Lens bifocal add over 3.25d					
V2221	A	NI	Lenticular lens, bifocal					
V2299	A		Lens bifocal speciality					
V2300	A		Lens sphere trifocal 4.00d					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	DG	Lens lenticular nonaspheric					
V2317	A	DG	Lens lenticular aspheric tri					
V2318	A		Lens aniseikonic trifocal					
V2319	A		Lens trifocal seg width > 28					
V2320	A		Lens trifocal add over 3.25d					
V2321	A	NI	Lenticular lens, trifocal					
V2399	A		Lens trifocal speciality					
V2410	A		Lens variab asphericity sing					
V2430	A		Lens variable asphericity bi					
V2499	A		Variable asphericity lens					
V2500	A		Contact lens pmma spherical					
V2501	A		Cntct lens pmma-toric/prism					
V2502	A		Contact lens pmma bifocal					
V2503	A		Cntct lens pmma color vision					
V2510	A		Cntct gas permeable sphericl					
V2511	A		Cntct toric prism ballast					
V2512	A		Cntct lens gas permbl bifocl					
V2513	A		Contact lens extended wear					
V2520	A		Contact lens hydrophilic					
V2521	A		Cntct lens hydrophilic toric					
V2522	A		Cntct lens hydrophil bifocl					
V2523	A		Cntct lens hydrophil extend					
V2530	A		Contact lens gas impermeable					
V2531	A		Contact lens gas permeable					
V2599	A		Contact lens/es other type					
V2600	A		Hand held low vision aids					
V2610	A		Single lens spectacle mount					
V2615	A		Telescop/othr compound lens					
V2623	A		Plastic eye prosth custom					
V2624	A		Polishing artifical eye					
V2625	A		Enlargemnt of eye prosthesis					
V2626	A		Reduction of eye prosthesis					
V2627	A		Scleral cover shell					
V2628	A		Fabrication & fitting					
V2629	A		Prosthetic eye other type					
V2630	N		Anter chamber intraocul lens					
V2631	N		Iris support intraoclr lens					
V2632	N		Post chmbr intraocular lens					
V2700	A		Balance lens					
V2710	A		Glass/plastic slab off prism					
V2715	A		Prism lens/es					
V2718	A		Fresnell prism press-on lens					
V2730	A		Special base curve					
V2740	A	DG	Rose tint plastic					
V2741	A	DG	Non-rose tint plastic					
V2742	A	DG	Rose tint glass					
V2743	A	DG	Non-rose tint glass					
V2744	A		Tint photochromatic lens/es					
V2745	A	NI	Tint, any color/solid/grad					
V2750	A		Anti-reflective coating					
V2755	A		UV lens/es					
V2756	E	NI	Eye glass case					
V2760	A		Scratch resistant coating					
V2761	E	NI	Mirror coating					
V2762	A	NI	Polarization, any lens					
V2770	A		Occluder lens/es					
V2780	A		Oversize lens/es					
V2781	B		Progressive lens per lens					
V2782	A	NI	Lens, 1.54-1.65 p/1.60-1.79g					
V2783	A	NI	Lens, >= 1.66 p/>=1.80 g					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2784	A	NI	Lens polycarb or equal					
V2785	F		Corneal tissue processing					
V2786	A	NI	Occupational multifocal lens					
V2790	N		Amniotic membrane					
V2797	A	NI	Vis item/svc in other code					
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					
V5095	E		Implant mid ear hearing pros					
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					
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					
V5298	E		Hearing aid noc					
V5299	B		Hearing service					
V5336	E		Repair communication device					
V5362	E		Speech screening					
V5363	E		Language screening					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5364	E		Dysphagia screening					

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ADDENDUM D1.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Item/code/service	Status
A	Services furnished to a Hospital Outpatient that are paid under a Fee Schedule/Payment System other than OPPS, e.g.: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. • Screening Mammography	Not paid under OPPS. Paid by Intermediaries under a Fee Schedule/Payment System other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x).	Not paid under OPPS. • May be paid by Intermediaries when submitted on a different bill type, e.g., 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient; Bill as Inpatient.
D	Deleted Codes	Not paid under OPPS. Not paid under Medicare.
E	Items, Codes, and Services: • That are not covered by Medicare based on Statutory Exclusion. • That are not covered by Medicare for reasons other than Statutory Exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare	Not paid under OPPS.
F	Corneal Tissue Acquisition; Certain CRNA Services	Not paid under OPPS. Paid at reasonable cost.
G	Drug/Biological Pass-Through	Paid under OPPS; Separate APC payment includes Pass-Through amount.
H	Device Category Pass-Through	Paid under OPPS; Separate cost-based Pass-Through payment.
K	Non Pass-Through Drugs and Biologicals; Radiopharmaceutical Agents; Certain Brachytherapy Sources.	Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
N	Items and Services packaged into APC Rates	Paid under OPPS. However, payment is packaged into payment for other services, including Outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than Home Health Agencies bill to DMERC.
X	Ancillary Service	Paid under OPPS; Separate APC payment.

ADDENDUM D2.—CODE CONDITIONS

Code condition	Descriptor
DG	Deleted code with a grace period; Payment will be made under the deleted code during the 90-day grace period.
DNG	Deleted code with no grace period; Payment will not be made under the deleted code after December 31, 2003.
NF	New code final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
NI	New code interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
0001T	C	Endovas repr abdo ao aneurys
0001T	C	Endovas repr abdo ao aneurys
0005T	C	Perc cath stent/brain cv art

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
0033T	C	Endovasc taa repr incl subcl
0034T	C	Endovasc taa repr w/o subcl
0035T	C	Insert endovasc prosth, taa
0036T	C	Endovasc prosth, taa, add-on
0037T	C	Artery transpose/endovas taa
0038T	C	Rad endovasc taa rpr w/cover
0039T	C	Rad s/i, endovasc taa repair
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
0040T	C	Rad s/i, endovasc taa prosth
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
0048T	C	Implant ventricular device
0049T	C	External circulation assist
0050T	C	Removal circulation assist
0051T	C	Implant total heart system
00524	C	Anesth, chest drainage
0052T	C	Replace component heart syst
0053T	C	Replace component heart syst
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00580	C	Anesth, heart/lung transplnt
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, hip arthroplasty
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, knee arthroplasty
01404	C	Anesth, amputation at knee

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
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, rem 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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	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
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
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
22325	C	Treat spine fracture

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CPT/HCPCS	NPRM SI	Description
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat each add spine fx
22532	C	Lat thorax spine fusion
22533	C	Lat lumbar spine fusion
22534	C	Lat thor/lumb, add'l seg
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
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
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
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
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
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

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CPT/HCPCS	NPRM SI	Description
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
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 arthroplasty
27132	C	Total hip arthroplasty
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)
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat 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

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CPT/HCPCS	NPRM SI	Description
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee arthroplasty
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
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

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CPT/HCPCS	NPRM SI	Description
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
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
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
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
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

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CPT/HCPCS	NPRM SI	Description
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
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

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CPT/HCPCS	NPRM SI	Description
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
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

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CPT/HCPCS	NPRM SI	Description
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
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

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CPT/HCPCS	NPRM SI	Description
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
34805	C	Endovasc abdo repair w/pros
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Femoral endovas graft add-on
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
34833	C	Xpose for endoprosth, iliac
34834	C	Xpose, endoprosth, brachial
34900	C	Endovasc iliac repr w/graft
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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
35510	C	Artery bypass graft
35511	C	Artery bypass graft
35512	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35522	C	Artery bypass graft
35525	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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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CPT/HCPCS	NPRM SI	Description
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
35697	C	Reimplant artery each
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
37182	C	Insert hepatic shunt (tips)
37183	C	Remove hepatic shunt (tips)
37195	C	Thrombolytic therapy, stroke
37616	C	Ligation of chest artery
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
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

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[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Partial removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
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 congenital
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

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[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
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	Explore small intestine
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excise intestine 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/o taper, cong
44127	C	Enterectomy w/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

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CPT/HCPCS	NPRM SI	Description
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	Lap resect s/intestine singl
44203	C	Lap resect s/intestine, addl
44204	C	Laparo partial colectomy
44205	C	Lap colectomy part w/ileum
44210	C	Laparo total proctocolectomy
44211	C	Laparo total proctocolectomy
44212	C	Laparo total proctocolectomy
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
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 reservior
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
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
47140	C	Partial removal, donor liver
47141	C	Partial removal, donor liver
47142	C	Partial removal, donor liver
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
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

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CPT/HCPCS	NPRM SI	Description
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, open
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 pancreatic 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	Remove abdom lesion, complex
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49904	C	Omental flap, extra-abdom
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	Remove kidney, open
50225	C	Removal kidney open, complex
50230	C	Removal kidney open, radical
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion

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CPT/HCPCS	NPRM SI	Description
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
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 intestine
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

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CPT/HCPCS	NPRM SI	Description
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	Remov/replc penis pros, comp
54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
55866	C	Laparo radical prostatectomy
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
58146	C	Myomectomy abdom complex
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	Vag hyst including t/o
58263	C	Vag hyst w/t/o & vag repair
58267	C	Vag hyst w/urinary repair
58270	C	Vag hyst w/enterocele repair
58275	C	Hysterectomy/revise vagina
58280	C	Hysterectomy/revise vagina
58285	C	Extensive hysterectomy
58290	C	Vag hyst complex
58291	C	Vag hyst incl t/o, complex
58292	C	Vag hyst t/o & repair, compl
58293	C	Vag hyst w/uro repair, compl
58294	C	Vag hyst w/enterocele, compl
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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
61316	C	Implt cran bone flap to abdo
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61322	C	Decompressive craniotomy
61323	C	Decompressive lobectomy
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
61517	C	Implt brain chemotx add-on
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
61537	C	Removal of brain tissue
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61540	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
61566	C	Removal of brain tissue
61567	C	Incision of brain tissue
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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
61863	C	Implant neuroelectrode
61864	C	Implant neuroelectrde, add'l
61867	C	Implant neuroelectrode
61868	C	Implant neuroelectrde, add'l
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
62148	C	Retr bone flap to fix skull
62161	C	Dissect brain w/scope
62162	C	Remove colloid cyst w/scope
62163	C	Neuroendoscopy w/fb removal
62164	C	Remove brain tumor w/scope
62165	C	Remove pituit tumor w/scope
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
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
63101	C	Removal of vertebral body
63102	C	Removal of vertebral body
63103	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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69155	C	Extensive ear/neck surgery
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
75954	C	Iliac aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
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
99293	C	Ped critical care, initial
99294	C	Ped critical care, subseq
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99298	C	Neonatal critical care
99299	C	Ic, lbw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital

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ADDENDUM H—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 [2] Abilene, TX	0.7780
Taylor, TX	
0060 Aguadilla, PR	0.4306
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9442
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0863
Dougherty, GA	
Lee, GA	
0160 [2] Albany-Schenectady-Troy, NY	0.8526
Albany, NY	
Montgomery, NY	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9300
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8037
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9721
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.8827
Blair, PA	
0320 Amarillo, TX	0.8986

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2351
Anchorage, AK	
0440 Ann Arbor, MI	1.1074
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8090
Calhoun, AL	
0460 [2] Appleton-Oshkosh-Neenah, WI	0.9304
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4155
Arecibo, PR	
Camuy, PR	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Hatillo, PR	
0480 Asheville, NC	0.9720
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9818
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 [1] Atlanta, GA	1.0130
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	1.0795
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8494
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9625
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 [1] Austin-San Marcos, TX	0.9609
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 [2] Bakersfield, CA	0.9967
Kern, CA	
0720 [1] Baltimore, MD	0.9919
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9904
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.2956
Barnstable, MA	
0760 Baton Rouge, LA	0.8406
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8424
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1757

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Whatcom, WA	
0870 Benton Harbor, MI	0.8935
Berrien, MI	
0875 [1] Bergen-Passaic, NJ	1.1731
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.8961
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.9029
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 [2] Binghamton, NY	0.8526
Broome, NY	
Tioga, NY1000 Birmingham, AL	0.9212
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL1010 Bismarck, ND	0.8033
Burleigh, ND	
Morton, ND	
1020 [2] Bloomington, IN	0.8824
Monroe, IN	
1040 Bloomington-Normal, IL	0.8832
McLean, IL	
1080 Boise City, ID	0.9232
Ada, ID	
Canyon, ID	
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1233
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0049
Boulder, CO	
1145 Brazoria, TX	0.8137
Brazoria, TX	
1150 Bremerton, WA	1.0580
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	1.0303
Cameron, TX	
1260 Bryan-College Station, TX	0.9019
Brazos, TX	
1280 [1] Buffalo-Niagara Falls, NY	0.9604
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9704
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4201
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9071
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9209

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Natrona, WY	
1360 Cedar Rapids, IA	0.8874
Linn, IA	
1400 Champaign-Urbana, IL	0.9907
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9332
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8880
Kanawha, WV	
Putnam, WV	
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9730
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0025
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9086
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 [2] Cheyenne, WY	0.9110
Laramie, WY	
1600 [1] Chicago, IL	1.0892
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0193
Butte, CA	
1640 [1] Cincinnati, OH-KY-IN	0.9413
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	0.8354
Christian, KY	
Montgomery, TN	
1680 [1] Cleveland-Lorain-Elyria, OH	0.9671
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9833
El Paso, CO	
1740 Columbia, MO	0.8695
Boone, MO	
1760 Columbia, SC	0.8902
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8694
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 [1] Columbus, OH	0.9648
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8521
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1516
Benton, OR	
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.9125
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (WV Hospitals)	0.8200
Allegany, MD	
Mineral, WV	
1920 [1] Dallas, TX	0.9974
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA.	
Danville City, VA	
Pittsylvania, VA	0.9035
1960 Davenport-Moline-Rock Island, IA-IL	0.8985
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9529
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9060
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8828
Lawrence, AL	
Morgan, AL	
2040 [2] Decatur, IL	0.8254
Macon, IL	
2080 [1] Denver, CO	1.0837
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9106
Dallas, IA	
Polk, IA	
Warren, IA	
2160 [1] Detroit, MI	1.0101
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7765
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9805
Kent, DE	
2200 Dubuque, IA	0.8886
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0171
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0934
Dutchess, NY	
2290 [2] Eau Claire, WI	0.9304
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9196
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9783
Elkhart, IN	
2335 [2] Elmira, NY	0.8526
Chemung, NY	
2340 Enid, OK	0.8559
Garfield, OK	
2360 Erie, PA	0.8601
Erie, PA	
2400 Eugene-Springfield, OR	1.1456
Lane, OR	
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8824
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8429
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9797
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8986
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8396
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.1333
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0858
Genesee, MI	
2650 Florence, AL	0.7797
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8709

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0148
Larimer, CO	
2680 [1] Ft. Lauderdale, FL	1.0479
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9816
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0124
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8424
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8966
Okaloosa, FL	
2760 Fort Wayne, IN	0.9585
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 [1] Forth Worth-Arlington, TX	0.9359
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0142
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8229
Etowah, AL	
2900 Gainesville, FL	0.9693
Alachua, FL	
2920 Galveston-Texas City, TX	0.9279
Galveston, TX	
2960 Gary, IN	0.9410
Lake, IN	
Porter, IN	
2975 [2] Glens Falls, NY	0.8526
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8622
Wayne, NC	
2985 Grand Forks, ND-MN (ND Hospitals)	0.8636
Polk, MN	
Grand Forks, ND	
2985 [2] Grand Forks, ND-MN (MN Hospitals)	0.9345
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9921
Mesa, CO	
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9469
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8918
Cascade, MT	
3060 Greeley, CO	0.9453
Weld, CO	
3080 Green Bay, WI	0.9518
Brown, WI	
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9166

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9167
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9335
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9172
Washington, MD	
3200 Hamilton-Middletown, OH	0.9214
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9164
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 [1] [2] Hartford, CT	1.2183
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7778
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9242
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1116
Honolulu, HI	
3350 Houma, LA	0.7771
Lafourche, LA	
Terrebonne, LA	
3360 [1] Houston, TX	0.9834
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9595
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.9245
Limestone, AL	
Madison, AL	
3480 [1] Indianapolis, IN	0.9916
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9548
Johnson, IA	
3520 Jackson, MI	0.8986
Jackson, MI	
3560 Jackson, MS	0.8399
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8984
Madison, TN	
Chester, TN	
3600 [1] Jacksonville, FL	0.9563
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8544
Onslow, NC	
3610 [2] Jamestown, NY	0.8526
Chautauqua, NY	
3620 [2] Janesville-Beloit, WI	0.9304
Rock, WI	
3640 Jersey City, NJ	1.1115
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8256
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8498
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 [2] Johnstown, PA	0.8378
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7809
Craighead, AR	
3710 Joplin, MO	0.8681
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0500
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	1.0419
Kankakee, IL	
3760 [1] Kansas City, KS-MO	0.9715
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	0.9761
Kenosha, WI	
3810 Killeen-Temple, TX	0.9159
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8820
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9045
Howard, IN	
Tipton, IN	
3870 [2] La Crosse, WI-MN	0.9304
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8225
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 [2] Lafayette, IN	0.8824
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7841
Calcasieu, LA	
3980 [2] Lakeland-Winter Haven, FL	0.8855
Polk, FL	
4000 Lancaster, PA	0.9282
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9714
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8091
Webb, TX	
4100 Las Cruces, NM	0.8688
Dona Ana, NM	
4120 [1] Las Vegas, NV-AZ	1.1528
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 [2] Lawrence, KS	0.8074
Douglas, KS	
4200 Lawton, OK	0.8267
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9383
Androscoggin, ME	
4280 Lexington, KY	0.8685
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9522
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0033
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8923

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.9113
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 [1] Los Angeles-Long Beach, CA	1.1832
Los Angeles, CA	
4520 [1] Louisville, KY-IN	0.9242
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8272
Lubbock, TX	
4640 Lynchburg, VA	0.9134
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8975
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0264
Dane, WI	
4800 Mansfield, OH	0.9180
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4795
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8381
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0772
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9776
Brevard, Fl	
4920 [1] Memphis, TN-AR-MS	0.9009
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 [2] Merced, CA	0.9967
Merced, CA	
5000 [1] Miami, FL	0.9894
Dade, FL	
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1366
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 [1] Milwaukee-Waukesha, WI	0.9988
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 [1] Minneapolis-St. Paul, MN-WI	1.1001
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	0.8884
Missoula, MT	
5160 Mobile, AL	0.7994
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.1275
Stanislaus, CA	
5190 [1] Monmouth-Ocean, NJ	1.1083
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.7922
Ouachita, LA	
5240 Montgomery, AL	0.7907
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 [2] Muncie, IN	0.8824
Delaware, IN	
5330 Myrtle Beach, SC	0.9112
Horry, SC	
5345 Naples, FL	0.9790
Collier, FL	
5360 [1] Nashville, TN	0.9855
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 [1] Nassau-Suffolk, NY	1.3140
Nassau, NY	
Suffolk, NY	
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2468
Fairfield, CT	
New Haven, CT	
5523 [2] New London-Norwich, CT	1.2183
New London, CT	
5560 [1] New Orleans, LA	0.9174
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	1.4018
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 [1] Newark, NJ	1.1518
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1509
Orange, NY	
Pike, PA	
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8619
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	1.5119
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9728
Marion, FL	
5800 Odessa-Midland, TX	0.9327
Ector, TX	
Midland, TX	
5880 [1] Oklahoma City, OK	0.8984
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0963
Thurston, WA	
5920 Omaha, NE-IA	0.9745
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 [1] Orange County, CA	1.1492
Orange, CA	
5960 [1] Orlando, FL	0.9654
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8374
Daviess, KY	
6015 [2] Panama City, FL	0.8855
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8039
Washington, OH	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Wood, WV	
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8820
Washington, OH	
Wood, WV	
6080 [2] Pensacola, FL	0.8855
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8734
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 [1] Philadelphia, PA-NJ	1.0883
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 [1] Phoenix-Mesa, AZ	1.0129
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7865
Jefferson, AR	
6280 [1] Pittsburgh, PA	0.8901
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 [2] Pittsfield, MA	1.0432
Berkshire, MA	
6340 Pocatello, ID	0.9249
Bannock, ID	
6360 Ponce, PR	0.4708
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9949
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 [1] Portland-Vancouver, OR-WA	1.1213
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 [1] Providence-Warwick-Pawtucket, RI	1.0977
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9976
Utah, UT	
6560 [2] Pueblo, CO	0.9328
Pueblo, CO	
6580 Punta Gorda, FL	0.9510
Charlotte, FL	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6600 [2] Racine, WI	0.9304
Racine, WI	
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9959
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8806
Pennington, SD	
6680 Reading, PA	0.9133
Berks, PA	
6690 Redding, CA	1.1352
Shasta, CA	
6720 Reno, NV	1.0682
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0609
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9349
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	1.1348
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8700
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1739
Olmsted, MN	
6840 [1] Rochester, NY	0.9430
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9666
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9076
Edgecombe, NC	
Nash, NC	
6920 [1] Sacramento, CA	1.1845
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	1.0032
Bay, MI	
Midland, MI	
Saginaw, MI	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6980 St. Cloud, MN	0.9679
Benton, MN	
Stearns, MN	
7000 [2] St. Joseph, MO	0.8056
Andrew, MO	
Buchanan, MO	
7040 [1] St. Louis, MO-IL	0.9033
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0482
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4339
Monterey, CA	
7160 [1] Salt Lake City-Ogden, UT	0.9913
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8535
Tom Green, TX	
7240 [1] San Antonio, TX	0.8870
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 [1] San Diego, CA	1.1147
San Diego, CA	
7360 [1] San Francisco, CA	1.4514
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 [1] San Jose, CA	1.4626
Santa Clara, CA	
7440 [1] San Juan-Bayamon, PR	0.4909
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	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1429
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0441
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.2942
Santa Cruz, CA	
7490 Santa Fe, NM	1.0653
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2877
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9971
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9488
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8412
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 [1] Seattle-Bellevue-Everett, WA	1.1562
Island, WA	
King, WA	
Snohomish, WA	
7610 [2] Sharon, PA	0.8378
Mercer, PA	
7620 [2] Sheboygan, WI	0.9304
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9700
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9083
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8993
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9309
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9821
St. Joseph, IN	
7840 Spokane, WA	1.0901
Spokane, WA	
7880 Springfield, IL	0.8944
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8457
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0543
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8740
Centre, PA	
8080 [2] Steubenville-Weirton, OH-WV (OH Hospitals)	0.8820
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8398
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0404
San Joaquin, CA	
8140 [2] Sumter, SC	0.8498
Sumter, SC	
8160 Syracuse, NY	0.9412
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1116
Pierce, WA	
8240 [2] Tallahassee, FL	0.8855
Gadsden, FL	
Leon, FL	
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9103
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 [2] Terre Haute, IN	0.8824
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8150
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9397
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9108
Shawnee, KS	
8480 Trenton, NJ	1.0517
Mercer, NJ	
8520 [2] Tucson, AZ	0.9270
Pima, AZ	
8560 Tulsa, OK.	
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	0.9185
8600 Tuscaloosa, AL	0.8212
Tuscaloosa, AL	
8640 Tyler, TX	0.9404
Smith, TX	
8680 [2] Utica-Rome, NY	0.8526
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3425
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1064
Ventura, CA	
8750 Victoria, TX	0.8184
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0405
Cumberland, NJ	
8780 [2] Visalia-Tulare-Porterville, CA	0.9967
Tulare, CA	
8800 Waco, TX	0.8394
McLennan, TX	
8840 [1] Washington, DC-MD-VA-WV	1.0904
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 [2] Waterloo-Cedar Falls, IA	0.8416
Black Hawk, IA	
8940 Wausau, WI	0.9783
Marathon, WI	
8960 [1] West Palm Beach-Boca Raton, FL	0.9798
Palm Beach, FL	
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.8018
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8820
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9238
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8341
Archer, TX	
Wichita, TX	
9140 [2] Williamsport, PA	0.8378
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0882
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9563
New Hanover, NC	
Brunswick, NC	
9260 [2] Yakima, WA	1.0388
Yakima, WA	
9270 [2] Yolo, CA	0.9967
Yolo, CA	
9280 York, PA	0.9119
York, PA	
9320 Youngstown-Warren, OH	0.9214
Columbiana, OH	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0196
Sutter, CA	
Yuba, CA	
9360 [2] Yuma, AZ	0.9270
Yuma, AZ	

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2004.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage Index
Alabama	0.7492
Alaska	1.1886
Arizona	0.9270
Arkansas	0.7734
California	0.9967
Colorado	0.9328
Connecticut	1.2183
Delaware	0.9595
Florida	0.8855
Georgia	0.8595
Hawaii	0.9958
Idaho	0.8974
Illinois	0.8254
Indiana	0.8824
Iowa	0.8416
Kansas	0.8074
Kentucky	0.7974
Louisiana	0.7467
Maine	0.8812
Maryland	0.9125
Massachusetts	1.0432
Michigan	0.8877
Minnesota	0.9345
Mississippi	0.7778
Missouri	0.8056
Montana	0.8800
Nebraska	0.8822
Nevada	0.9806
New Hampshire	1.0030
New Jersey [1]	.....
New Mexico	0.8270
New York	0.8526
North Carolina	0.8456
North Dakota	0.7778
Ohio	0.8820
Oklahoma	0.7537
Oregon	0.9994
Pennsylvania	0.8378
Puerto Rico	0.4018
Rhode Island [1]	.....
South Carolina	0.8498
South Dakota	0.8195
Tennessee	0.7886
Texas	0.7780
Utah	0.8974
Vermont	0.9534
Virginia	0.8498
Washington	1.0388
West Virginia	0.8018
Wisconsin	0.9304

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage Index
Wyoming	0.9110

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Akron, OH	0.9442
Albany, GA	1.0664
Albuquerque, NM (NM hospitals)	0.9300
Albuquerque, NM (CO hospitals)	0.9328
Alexandria, LA	0.8037
Allentown-Bethlehem-Easton, PA	0.9721
Altoona, PA	0.8827
Amarillo, TX	0.8858
Anchorage, AK	1.2351
Ann Arbor, MI	1.0846
Anniston, AL	0.7975
Asheville, NC	0.9477
Athens, GA	0.9564
Atlanta, GA	0.9990
Atlantic-Cape May, NJ	1.0531
Augusta-Aiken, GA-SC	0.9433
Austin-San Marcos, TX	0.9609
Bangor, ME	0.9904
Barnstable-Yarmouth, MA	1.2720
Baton Rouge, LA	0.8406
Bellingham, WA	1.1305
Benton Harbor, MI	0.8935
Bergen-Passaic, NJ	1.1731
Billings, MT	0.8961
Biloxi-Gulfport-Pascagoula, MS	0.8407
Binghamton, NY	0.8428
Birmingham, AL	0.9212
Bismarck, ND	0.8033
Bloomington-Normal, IL	0.8832
Boise City, ID	0.9232
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1233
Burlington, VT	0.9332
Caguas, PR	0.4201
Casper, WY	0.9209
Champaign-Urbana, IL	0.9460
Charleston-North Charleston, SC	0.9332
Charleston, WV (WV Hospitals)	0.8568
Charleston, WV (OH Hospitals)	0.8820
Charlotte-Gastonia-Rock Hill, NC-SC	0.9730
Charlottesville, VA	0.9877
Chattanooga, TN-GA	0.9086
Chicago, IL	1.0752
Cincinnati, OH-KY-IN	0.9413
Clarksville-Hopkinsville, TN-KY	0.8354
Cleveland-Lorain-Elyria, OH	0.9671
Columbia, MO	0.8557
Columbia, SC	0.8902
Columbus, GA-AL	0.8595
Columbus, OH	0.9648
Corpus Christi, TX	0.8521
Corvallis, OR	1.1241
Dallas, TX	0.9974
Davenport-Moline-Rock Island, IA-IL	0.8985
Dayton-Springfield, OH	0.9529
Decatur, AL	0.8580
Denver, CO	1.0664

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Des Moines, IA	0.9106
Detroit, MI	1.0101
Dothan, AL	0.7765
Duluth-Superior, MN-WI	1.0171
Elkhart-Goshen, IN	0.9554
Erie, PA	0.8526
Eugene-Springfield, OR	1.0977
Fargo-Moorhead, ND-MN	0.9501
Fayetteville, NC	0.8817
Flagstaff, AZ-UT	1.1079
Flint, MI	1.0703
Florence, AL	0.7797
Fort Collins-Loveland, CO	1.0148
Ft. Lauderdale, FL	1.0479
Fort Pierce-Port St. Lucie, FL	1.0124
Fort Smith, AR-OK	0.8077
Fort Walton Beach, FL	0.8804
Forth Worth-Arlington, TX	0.9359
Gadsden, AL	0.8229
Gainesville, FL	0.9693
Grand Forks, ND-MN	0.8636
Grand Junction, CO	0.9921
Grand Rapids-Muskegon-Holland, MI	0.9469
Great Falls, MT	0.8918
Greeley, CO	0.9453
Green Bay, WI	0.9518
Greensboro-Winston-Salem-High Point, NC	0.9058
Greenville, NC	0.9167
Hamilton-Middletown, OH	0.9214
Harrisburg-Lebanon-Carlisle, PA	0.9164
Hartford, CT	1.1359
Hickory-Morganton-Lenoir, NC	0.9113
Honolulu, HI	1.1116
Houston, TX	0.9834
Huntington-Ashland, WV-KY-OH	0.9076
Huntsville, AL	0.9120
Indianapolis, IN	0.9916
Iowa City, IA	0.9404
Jackson, MS	0.8399
Jackson, TN	0.8819
Jacksonville, FL	0.9563
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8498
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8256
Jonesboro, AR (AR Hospitals)	0.7809
Jonesboro, AR (MO Hospitals)	0.8056
Joplin, MO	0.8558
Kalamazoo-Battlecreek, MI	1.0500
Kansas City, KS-MO	0.9715
Knoxville, TN	0.8820
Kokomo, IN	0.9045
Lafayette, LA	0.8225
Lakeland-Winter Haven, FL	0.8855
Las Vegas, NV-AZ	1.1401
Lawton, OK	0.8140
Lexington, KY	0.8475
Lima, OH	0.9522
Lincoln, NE	0.9597
Little Rock-North Little Rock, AR	0.8923
Longview-Marshall, TX	0.8943
Los Angeles-Long Beach, CA	1.1832
Louisville, KY-IN	0.9118
Lubbock, TX	0.8272
Lynchburg, VA	0.8941
Macon, GA	0.8975
Madison, WI	1.0117

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Medford-Ashland, OR	1.0425
Melbourne-Titusville-Palm Bay, FL	0.9776
Memphis, TN-AR-MS	0.8786
Miami, FL	0.9894
Milwaukee-Waukesha, WI	0.9829
Minneapolis-St. Paul, MN-WI	1.1001
Missoula, MT	0.8884
Mobile, AL	0.7994
Modesto, CA	1.1148
Monmouth-Ocean, NJ	1.1083
Monroe, LA	0.7922
Montgomery, AL	0.7907
Nashville, TN	0.9591
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2468
New Orleans, LA	0.9174
New York, NY	1.4018
Newark, NJ	1.1518
Newburgh, NY-PA	1.1048
Oakland, CA	1.5119
Odessa-Midland, TX	0.9076
Oklahoma City, OK	0.8984
Olympia, WA	1.0963
Omaha, NE-IA	0.9745
Orange County, CA	1.1492
Orlando, FL	0.9654
Peoria-Pekin, IL	0.8734
Philadelphia, PA-NJ	1.0883
Phoenix-Mesa, AZ	1.0129
Pittsburgh, PA	0.8901
Pittsfield, MA	0.9795
Pocatello, ID	0.9249
Portland, ME	0.9658
Portland-Vancouver, OR-WA	1.1213
Provo-Orem, UT	0.9976
Raleigh-Durham-Chapel Hill, NC	0.9725
Rapid City, SD	0.8806

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Reading, PA	0.8998
Redding, CA	1.1352
Reno, NV	1.0682
Richland-Kennewick-Pasco, WA (WA Hospitals)	1.0388
Richland-Kennewick-Pasco, WA (ID Hospitals)	1.0215
Richmond-Petersburg, VA	0.9349
Roanoke, VA	0.8700
Rochester, MN	1.1739
Rockford, IL	0.9441
Sacramento, CA	1.1845
Saginaw-Bay City-Midland, MI	0.9751
St. Cloud, MN	0.9679
St. Joseph, MO	0.8578
St. Louis, MO-IL	0.9033
Salinas, CA	1.4339
Salt Lake City-Ogden, UT	0.9913
San Antonio, TX	0.8870
Santa Fe, NM	0.9524
Santa Rosa, CA	1.2877
Sarasota-Bradenton, FL	0.9971
Savannah, GA	0.9488
Seattle-Bellevue-Everett, WA	1.1562
Sherman-Denison, TX	0.9203
Shreveport-Bossier City, LA	0.8937
Sioux City, IA-NE (NE Hospitals)	0.8822
Sioux City, IA-NE (SD Hospitals)	0.8785
Sioux Falls, SD	0.9184
South Bend, IN	0.9715
Spokane, WA	1.0717
Springfield, IL	0.8944
Springfield, MO	0.8259
Syracuse, NY	0.9412
Tampa-St. Petersburg-Clearwater, FL	0.9103
Texarkana, AR-Texarkana, TX	0.7969

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Toledo, OH	0.9397
Topeka, KS	0.9108
Tucson, AZ	0.9270
Tulsa, OK	0.8938
Tuscaloosa, AL	0.8101
Tyler, TX	0.9155
Vallejo-Fairfield-Napa, CA	1.3425
Victoria, TX	0.8184
Waco, TX	0.8394
Washington, DC-MD-VA-WV	1.0904
Waterloo-Cedar Falls, IA	0.8416
Wausau, WI	0.9783
West Palm Beach-Boca Raton, FL	0.9798
Wichita, KS	0.9004
Wichita Falls, TX	0.8341
Wilmington-Newark, DE-MD	1.0710
Wilmington, NC	0.9424
Youngstown-Warren, OH	0.9214
Rural Florida	0.8699
Rural Illinois (IA Hospitals)	0.8416
Rural Illinois (MO Hospitals)	0.8254
Rural Kentucky	0.7974
Rural Louisiana	0.7467
Rural Minnesota	0.9345
Rural Missouri	0.8056
Rural Nebraska	0.8822
Rural Nevada	0.9276
Rural New Hampshire	1.0030
Rural Texas	0.7780
Rural Washington	1.0388
Rural Wyoming	0.8984

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