Federal Register

Monday,
November 15, 2004

Book 2 of 4 Books
Pages 65681–66234

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 419

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 419

[CMS–1427–FC]

RIN 0938–AM75

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 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 and to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. In addition, the final rule with comment period describes final 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, 2005.

In this final rule with comment period, we are responding to public comments received on the January 6, 2004 interim final rule with comment period relating to MMA provisions that were effective January 1, 2004, and finalizing those policies. Further, we are responding to public comments received on the November 7, 2003 final rule with comment period pertaining to the ambulatory payment classification assignment of Healthcare Common Procedure Coding System (HCPCS) codes identified in Addendum B of that rule with the new interim (NI) comment indicators (formerly referred to as condition codes).

DATES: *Effective Date:* This final rule with comment period is effective on January 1, 2005.

Comment Date: We will consider comments on the ambulatory payment classification assignments of HCPCS codes identified in Addendum B with new interim comment codes and other areas specified throughout this preamble, if we receive them at the appropriate address, as provided below no later than 5 p.m. on January 14, 2005.

ADDRESSES: In commenting, please refer to file code CMS–1427–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. Electronically

You may submit electronic comments to *http://www.cms.hhs.gov/regulations/ecomments* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. By Mail

You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1427–FC, P.O. Box 8010, Baltimore, MD 21244–8018.

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

3. By Hand or Courier

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the Hubert H. Humphrey 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 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 received after the comment period.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public website. Written comments received timely will be available for public inspection as they are received, generally beginning approximately 4 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7195.

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786–0378, Outpatient prospective payment issues and Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health center issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 (or toll-free at 1–888–293–6498) or by faxing to (202) 512–2250. The cost for each copy is $10. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The Web site address is: *http://www.gpoaccess.gov/fr/index.html.*

Alphabetical List of Acronyms Appearing in the 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
AMP—Average manufacturer price
ASP—Average sales price
ASC—Ambulatory surgical center
AWP—Average wholesale price
BBA—Balanced Budget Act of 1997, Public Law 105–33
BIPA—Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554
BBRA—Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public Law 106–113
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)
CORF—Comprehensive outpatient rehabilitation facility
CPT—[Physicians'] Current Procedural Terminology, Fourth Edition, 2004, copyrighted by the American Medical Association
CRNA—Certified registered nurse anesthetist
CY—Calendar year
DMEPOS—Durable medical equipment, prosthetics, orthotics, and supplies
DMERC—Durable medical equipment regional carrier
DRG—Diagnosis-related group
DSH—Disproportionate share hospital
EACH—Essential Access Community Hospital
E/M—Evaluation and management
EPO—Erythropoietin
ESRD—End-stage renal disease
FACA—Federal Advisory Committee Act, Public Law 92–463
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, Public Law 104–191
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
MMA—Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MSA—Metropolitan Statistical Area
NCCI—National Correct Coding Initiative
NCD—National Coverage Determination
OCE—Outpatient code editor
OMB—Office of Management and Budget
OPD—(Hospital) outpatient department
OPPS—(Hospital) outpatient prospective payment system
PET—Positron Emission Tomography
PHP—Partial hospitalization program
PM—Program memorandum
PPI—Producer Price Index
PPS—Prospective payment system
PPV—Pneumococcal pneumonia (virus)
PRA—Paperwork Reduction Act
QIO—Quality Improvement Organization
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 of 1982, Public Law 97–248
TOPS—Transitional outpatient payments
USPDI—United States Pharmacopoeia Drug Information

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

Outline of Contents

I. Background
A. Legislative and Regulatory Authority for the Outpatient Prospective Payment System
B. Excluded OPPS Services and Hospitals
C. Prior Rulemaking
D. APC Advisory Panel
1. Authority for the APC Panel
2. Establishment of the APC Panel
3. APC Panel Meetings and Organizational Structure
E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
F. Summary of the Provisions of the August 16, 2004 Proposed Rule
G. Public Comments Received on the August 16, 2004 Proposed Rule
H. Public Comments Received on the January 6, 2004 Interim Final Rule with Comment Period
I. Public Comments Received on the November 7, 2003 Final Rule with Comment Period
II. Changes Related to Ambulatory Payment Classifications (APCs)
A. APC Changes: General
B. APC Panel Review and Recommendations
1. February 2004 Panel Meeting.
2. September 2004 Panel Meeting
3. Contents of This Section of the Preamble
4. APC 0018: Biopsy of Skin/Puncture of Lesion
5. Level I and II Arthroscopy
6. Angiography and Venography Except Extremity
a. February 2004 Panel Meeting
b. Public Comments Received
c. Final Policy for CY 2005
7. Packaged Codes in APCs
C. Limits on Variations Within APCs: Application of the 2 Times Rule
1. Cardiac and Ambulatory Blood Pressure Monitoring
2. Electrocardiograms
3. Excision/Biopsy
4. Posterior Segment Eye Procedures
5. Laparoscopy
6. Anal/Rectal Procedures
7. Nerve Injections
8. Anterior Segment Eye Procedures
9. Pathology
10. Immunizations
11. Pulmonary Tests
12. Clinic Visits
13. Other APC Assignment Issues
a. Catheters for Brachytherapy Services
b. Peripherally Inserted Central Catheters (PICC)
c. External Fixation Devices
d. Apheresis
e. Imaging for Intravenous Cholangiogram (IVC) Filter Placement and Breast Biopsy
f. Hysteroscopic Endometrial Ablation Procedures
g. Hysteroscopic Female Sterilization
h. Urinary Bladder Residual Study
i. Intracranial Studies, Electrodiagnostic Testing, Autonomic Testing, and EEG
j. Therapeutic Radiation Treatment
k. Hyperthermia Procedures
l. Physician Blood Bank Services
m. Caloric Vestibular Test
n. APC 0365—Level II Audiometry
o. Noncoronary Intravascular Ultrasound (IVUS)
p. Electronic Analysis of Neurostimulator Pulse Generators
q. Endoscopic Ultrasound Services
r. External Counterpulsation
D. Exceptions to the 2 Times Rule
E. Coding for Stereostatic Radiosurgery Services
1. Background
2. Proposal for CY 2005
3. Public Comments Received and Departmental Responses
4. Final Policy for CY 2005
F. Movement of Procedures from New Technology APCs to Clinically Appropriate APCs
1. Background
2. APC Panel Review and Recommendation
3. Proposed and Final Policy for CY 2005
a. Computerized Reconstruction CT of Aorta
b. Left Ventricular Pacing, Lead and Connector
c. Positron Emission Tomography (PET) Scans
d. Bard Endoscopic Suturing System
e. Stretta System
f. Gastrointestinal Tract Capsule Endoscopy
g. Proton Beam Therapy
4. Public Comments Received Relating to Other New Technology APC Issues
a. Computerized Reconstruction CT of Aorta
b. Kyphoplasty
c. Laser Treatment of Benign Prostatic Hyperplasia (BPH)
d. Computerized Tomographic Angiography (CTA)
e. Acoustic Heart Sound Services
f. Laparoscopic Ablation Renal Mass
g. Intrabeam Intra-Operative Therapy
h. New Technology Process Issues
G. Changes to the Inpatient List
H. Assignment of ''Unlisted'' HCPCS Codes
1. Background
2. Proposed and Final Policies for CY 2005
I. Addition of New Procedure Codes
J. OPPS Changes Relating to Coverage of Initial Preventive Physical Examinations and Mammography under Public Law 108–173
1. Payment for Initial Preventive Physical Examinations (Section 611 of Pub. L. 108–173)
a. Background
b. Amendments to Regulations
c. Assignment of New HCPCS Codes for Payment of Initial Preventive Physical Examinations
d. APC Assignment of Initial Preventive Physical Examinations
2. Payment for Certain Mammography Services (Section 614 of Pub. L. 108–173)
III. Recalibration of APC Relative Weights for CY 2005
A. Database Construction

1. Treatment of Multiple Procedure Claims
2. Use of Single Procedure Claims
B. Calculation of Median Costs for CY 2005
C. Adjustment of Median Costs for CY 2005
1. Device-Dependent APCs
a. APC 0226: Implantation of Drug Infusion Reservoir
b. APC 0048: Arthroscopy with Prosthesis
c. APC 0385: Level I Prosthetic Urological Procedures
d. APC 0119: Implantation of Infusion Device and APC 0115: Cannula/Access Device Procedures
2. Treatment of Specified APCs
a. APC 0315: Level II Implantation of Neurostimulator
b. APC 0651: Complex Interstitial Radiation Application
c. APC 0659: Hyperbaric Oxygen Therapy
3. Other APC Median Cost Issues
a. APC 0312 Radioelement Applications
b. Percutaneous Radiofrequency Ablation of Liver Tumors
c. Heparin Coated Stents
d. Aqueous Drainage Assist Device
4. Required Use of C-Codes for Devices
5. Submission of External Data
D. Calculation of Scaled OPPS Payment Weights
IV. Payment Changes For Devices
A. Pass-Through Payments For Devices
1. Expiration of Transitional Pass-Through Payments for Certain Devices
2. Proposed and Final Policies for CY 2005
B. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged Into APC Groups
1. Background
2. Proposed and Final Policies for CY 2005
C. Criteria for Establishing New Pass-Through Device Categories
V. Payment Changes for Drugs, Biologicals, and Radiopharmaceutical Agents, and Blood and Blood Products
A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals
1. Background
2. Expiration in CY 2004 of Pass-Through Status for Drugs and Biologicals
3. Drugs and Biologicals With Pass-Through Status in CY 2005
B. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status
1. Background
2. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals
3. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged
a. Payment for Specified Covered Outpatient Drugs
b. Treatment of Three Sunsetting Pass-Through Drugs as Specified Covered Outpatient Drugs
c. CY 2005 Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes But Without OPPS Hospital Claims Data
d. Payment for Separately Payable Nonpass-Through Drugs and Biologicals
e. CY 2005 Change in Payment Status for HCPCS Code J7308
4. Public Comments Received on the January 6, 2004 Interim Final rule With Comment Period and Departmental Responses
C. Coding and Billing for Specified Outpatient Drugs
D. Payment for New Drugs, Biologicals, and Radiopharmaceuticals Before HCPCS Codes Are Assigned
1. Background
2. Provisions of Public Law 108–173
E. Payment for Vaccines
F. Changes in Payment for Single Indication Orphan Drugs
G. Changes in Payment Policy for Radiopharmaceuticals
H. Coding and Payment for Drug Administration
I. Payment for Blood and Blood Products
VI. Estimated Transitional Pass-Through Spending in CY 2005 for Drugs, Biologicals, and Devices
A. Basis for Pro Rata Reduction
B. Estimate of Pass-Through Spending for CY 2005
VII. Other Policy Decisions and Policy Changes
A. Statewide Average Default Cost-to-Charge Ratios
B. Transitional Corridor Payments: Technical Change
C. Status Indicators and Comment Indicators Assigned in Outpatient Code Editor (OCE)
1. Payment Status Indicators
2. Comment Indicators
D. Observation Services
E. Procedures That Will be Paid Only as Inpatient Procedures
F. Hospital Coding for Evaluation and Management Services
1. Background
2. Proposal for Evaluation and Management Guidelines
G. Brachytherapy Payment Issues Related to Public Law 108–173
1. Payment for Brachytherapy Sources (Section 621(b) of Pub. L. 108–173)
2. HCPCS Codes and APC Assignments for Brachytherapy Sources
H. Payment for APC 0375, Ancillary Outpatient Services When Patient Expires
VIII. Conversion Factor Update for CY 2005
IX. Wage Index Changes for CY 2005
X. Determination of Payment Rates and Outlier Payments for CY 2005
A. Calculation of the National Unadjusted Medicare Payment
B. Hospital Outpatient Outlier Payments
C. Payment for Partial Hospitalization
1. Background
2. PHP APC Update for CY 2005
3. Separate Threshold for Outlier Payments to CMHCs
D. General Public Comments
XI. Beneficiary Copayments for CY 2005
A. Background
B. Copayment for CY 2005
XII. Addendum Files Available to the Public Via Internet
XIII. Collection of Information Requirements
XIV. Regulatory Impact Analysis
A. OPPS: General
B. Impact of Changes in this Final Rule with Comment Period
C. Alternatives Considered
D. Limitations of Our Analysis
E. Estimated Impacts of this Final Rule with Comment Period on Hospitals
F. Projected Distribution of Outlier Payment
G. Estimated Impacts of This Final Rule with Comment Period on Beneficiaries
XV. Regulation Text

Addenda

Addendum A—List of Ambulatory Payment Classification (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts for CY 2005
Addendum B—Payment Status by HCPCS Code and Related Information—CY 2005
Addendum C—Healthcare Common Procedure Coding System (HCPCS) Codes by Ambulatory Payment Classification (APC) (Available only on CMS Web site via Internet. See section XIII. of the preamble of this final rule with comment period.)
Addendum D1—Payment Status Indicators for Hospital Outpatient Prospective Payment System
Addendum D2—Comment Indicators
Addendum E—CPT Codes That Are Paid Only as Inpatient Procedures

I. Background

A. Legislative and Regulatory 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 Medicare, Medicaid, and SCHIP 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. Section 1833(t) of the Act was also recently amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, enacted on December 8, 2003 (these amendments are discussed later under section I.E. of this final rule with comment period). The OPPS was first

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

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this final rule with comment period. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for certain services designated by the Secretary that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. In addition, the OPPS includes payment for partial hospitalization services furnished by community mental health centers (CMHCs).

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

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

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

B. Excluded OPPS Services and Hospitals

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

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

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS not less often than annually and to revise the groups, relative payment weights, and other adjustments 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. Since implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our experience with this system. For a full discussion of the changes to the OPPS, we refer readers to these **Federal Register** final rules.[1]

On November 7, 2003, we published a final rule with comment period in the **Federal Register** (68 FR 63398) that revised the OPPS to update the payment weights and conversion factor for services payable under the calendar year (CY) 2004 OPPS on the basis of claims data from April 1, 2002 through December 31, 2002. In this final rule with comment period, we are finalizing the APC assignments and addressing public comments received pertaining to the new interim HCPCS codes listed in Addendum B of the November 7, 2003 final rule with comment period identified by new interim (NI) comment indicators (formerly referred to as condition codes). Subsequent to publishing the November 7, 2003 final rule with comment period, we published a correction of the final rule with comment period on December 31, 2003 (68 FR 75442). That December 31, 2003 document corrected technical errors in the November 7, 2003 final rule with comment period and included responses to a number of public comments that were inadvertently omitted from the November 2003 final rule with comment period.

On January 6, 2004, we published in the **Federal Register** an interim final rule with comment period (69 FR 820) that implemented provisions of Public Law 108–173 that affected payments made under the OPPS, effective January 1, 2004. We are finalizing this interim

[1] Interim final rule with comment period, August 3, 2000 (65 FR 47670); interim final rule with comment period, November 13, 2000 (65 FR 67798); final rule and interim final rule with comment period, November 2, 2001 (66 FR 55850 and 55857); final rule, November 30, 2001 (66 FR 59856); final rule, December 31, 2001 (66 FR 67494); final rule, March 1, 2002 (67 FR 9556); final rule, November 1, 2002 (67 FR 66718); final rule with comment period, November 7, 2003 (68 FR 63398); and interim final rule with comment period, January 6, 2004 (69 FR 820).

final rule and addressing public comments associated with that rule in this final rule with comment period.

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and weights under the OPPS. The Advisory Panel on APC Groups (the APC Panel), discussed under section I.D.2. of this preamble, fulfills this requirement. The Act further specifies that the Panel will act in an advisory capacity. This expert panel, which is to be composed of 15 representatives of providers subject to the OPPS (currently employed full-time, not consultants, in their respective areas of expertise), reviews and advises us about the clinical integrity of the APC groups and their weights. The APC Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the charter establishing the Advisory Panel on APC Groups. The APC Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA), as amended (Public Law 92–463). On November 1, 2002, the Secretary renewed the charter. The renewed charter indicates that the APC Panel continues to be technical in nature, is governed by the provisions of the FACA, may convene up to three meetings per year, and is chaired by a Federal official.

Originally, in establishing the APC 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 who nominated either colleagues or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the APC Panel. Because of the loss of four APC Panel members due to the expiration of terms of office on March 31, 2004, we published a **Federal Register** notice on January 23, 2004 (69 FR 3370) that solicited nominations for APC Panel membership. From the 24 nominations that we received, we chose four new members. The entire APC Panel membership is identified on the CMS Web site at *http://www.cms.hhs.gov/faca/apc/apcmem.asp.*

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since that initial meeting, the APC Panel has held five subsequent meetings, with the last meeting taking place on September 1, 2, and 3, 2004. Prior to each of these biennial meetings, we published a notice in the **Federal Register** to announce each meeting and, when necessary, to solicit nominations for APC Panel membership. For a more detailed discussion about these announcements, refer to the following **Federal Register** notices: December 5, 2000 (65 FR 75943), December 14, 2001 (66 FR 64838), December 27, 2002 (67 FR 79107), July 25, 2003 (68 FR 44089), and December 24, 2003 (68 FR 74621), and August 5, 2004 (69 FR 47446).

During these meetings, the APC Panel established its operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. Currently, the three subcommittees are the Data Subcommittee, the Observation Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel and for recommending viable options for resolving them. This subcommittee was initially established on April 23, 2001, as the Research Subcommittee and reestablished as the Data Subcommittee on April 13, 2004. The Observation Subcommittee, which was established on June 24, 2003, and reestablished with new members on March 8, 2004, reviews and makes recommendations to the APC Panel on all issues pertaining to observation services paid under the OPPS, such as coding and operational issues. The Packaging Subcommittee, which was established on March 8, 2004, studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS but are bundled or packaged APC payments. Each of these subcommittees was established by a majority vote of the APC Panel during a scheduled APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

For a detailed discussion of the APC Panel meetings, refer to the hospital OPPS final rules cited in section I.C. of this preamble. Full discussions of the APC Panel's February 2004 and September 2004 meetings and the resulting recommendations are included in sections II., III., IV., V., and VI. of this preamble under the appropriate subject headings.

E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, was enacted. Public Law 108–173 made changes to the Act relating to the Medicare OPPS. In a January 6, 2004 interim final rule with comment period, we implemented provisions of Public Law 108–173 relating to the OPPS that were effective for CY 2004. In this final rule with comment period, we are responding to public comments received on the January 6, 2004 interim final rule and finalizing that rule. In addition, in this final rule with comment period, we are implementing the following sections of Public Law 108–173 that are effective for CY 2005:

- Section 611, which provides for Medicare coverage of an initial preventive physical examination under Part B, subject to the applicable deductible and coinsurance, as an outpatient department (OPD) service payable under the OPPS. The provisions of section 611 apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under Medicare Part B begins on or after that date.
- Section 614, which provides that screening mammography and diagnostic mammography services are excluded from payment under the OPPS. This amendment applies to screening mammography services furnished on or after the date of enactment of Public Law 108–173 (that is, December 8, 2003), and in the case of diagnostic mammography, to services furnished on or after January 1, 2005.
- Section 621(a)(1), which requires special classification of certain separately paid radiopharmaceutical agents and drugs or biologicals, and specifies the pass-through payment percentages, effective for services furnished on or after January 1, 2005, for the three categories of ''specified covered OPD drugs'' defined in the statute: sole source drug; innovator multiple source drug; and noninnovator multiple source drug. In addition, payment for these drugs for CYs 2004 and 2005 does not have to be made in a budget neutral manner.
- Section 621(a)(2), which specifies the reduced threshold for the establishment of separate APCs with respect to drugs or biologicals from $150 to $50 per administration for drugs and biologicals furnished in CYs 2005 and 2006.

• Section 621(a)(3), which excludes separate drug APCs from outlier payments. Specifically, no additional payment will be made in the case of APC groups established separately for drugs and biologicals.

• Section 621(b), which requires that all devices of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2007, be paid based on the hospital's charges for each device, adjusted to cost. This provision also requires that these brachytherapy services be excluded from outlier payments.

F. Summary of the Provisions of the August 16, 2004 Proposed Rule

On August 16, 2004, we published a proposed rule in the **Federal Register** (69 FR 50447) that set forth proposed changes to the Medicare hospital OPPS and to implement provisions of Public Law 108–173 specified in section I.E. of this preamble that would be effective for services furnished on or after January 1, 2005. The following is a summary of the major changes that we proposed to make:

1. Changes to the APC Groups

As required by section 1833(t)(9)(A) of the Act, we proposed the annual update of the APC groups and the relative payment weights. This section also requires that we consult with an outside panel of experts, the Advisory Panel on APC Groups, to review the clinical integrity of the groups and weights under the OPPS. Based on analyses of Medicare claims data and recommendations of the APC Panel, we proposed to establish a number of new APCs and to make changes to the assignment of HCPCS codes under a number of existing APCs.

We also discussed the application of the 2 times rule and proposed exceptions to it; coding for stereotactic radiosurgery services; the proposed movement of procedures from the new technology APCs; the proposed changes to the list of procedures that will be paid as inpatient services; and the proposed addition of new procedure codes to the APCs.

2. Recalibrations of APC Relative Payment Weights

In the proposed rule, we discussed the methodology used to recalibrate the proposed APC relative payment weights and set forth the proposed recalibration of the relative weights for CY 2005.

3. Payment Changes for Devices

In the proposed rule, we discussed proposed changes to the pass-through payment for devices and the methodology used to reduce, if applicable, transitional pass-through payments to offset costs packaged into APC groups.

4. Payment Changes for Drugs, Biologicals, Radiopharmaceutical Agents, and Blood and Blood Products

In the proposed rule, we discussed our proposed payment changes for drugs, biologicals, radiopharmaceutical agents, and blood and blood products.

5. Estimated Transitional Pass-Through Spending in CY 2005 for Drugs, Biologicals, and Devices

In the proposed rule, we discussed the proposed methodology for measuring whether there should be an estimated pro rata reduction for transitional pass-through drugs, biologicals, and devices for CY 2005.

6. Other Policy Decisions and Proposed Policy Changes

In the proposed rule, we presented our proposals for CY 2005 regarding the following:

• Update of statewide default cost-to-charge ratios (CCRs).

• A conforming change to the regulation relating to the use of the first available cost reporting period ending after 1996 and before 2001 for determining a provider's payment-to-cost ratio to calculate transitional corridor payments for hospitals paid under the OPPS that did not have a 1996 cost report.

• Changes in the status indicators and comment indicators assigned to APCs for CY 2005.

• Elimination of the diagnostic tests criteria as a requirement for hospitals to qualify for separate payment of observation services under APC 0339 (Observation) and changes to the guidelines to hospitals for counting patients' time spent in observation care.

• Payment under the OPPS for certain procedures currently assigned to the inpatient list.

• Strategy for giving the public notice of new implementation guidelines for new evaluation and management codes.

• Addition of three new HCPCS codes and descriptors for brachytherapy sources that would be paid separately, pursuant to Public Law 108–173.

• Modification of the HCPCS code descriptors for brachytherapy source descriptors for which units of payment are not already delineated.

• Payment for services furnished emergently to an outpatient who dies before admission to a hospital as an inpatient.

7. Conversion Factor Update for CY 2005

As required by section 1833(5)(3)(C)(ii) of the Act, in the proposed rule, we proposed to update the conversion factor used to determine payment rates under the OPPS for CY 2005.

8. Wage Index Changes for CY 2005

In the proposed rule, we discussed the proposed retention of our current policy to apply the IPPS wage indices to wage adjust the APC median costs in determining the OPPS payment rate and the copayment standardized amount. These indices reflect major changes for CY 2005 relating to hospital labor market areas as a result of OMB revised definitions of geographical statistical areas; hospital reclassifications and redesignations, including the one-time reclassifications under section 508 of Public Law 108–173; and the wage index adjustment based on commuting patterns of hospital employees under section 505 of Public Law 108–173.

9. Determination of Payment Rates and Outlier Payments for CY 2005

In the proposed rule, we discussed how APC payment rates are calculated and how the payment rates are adjusted to reflect geographic differences in labor-related costs. We also discussed proposed changes in the way we would calculate outlier payments for CY 2005.

10. Regulatory Impact Analysis

In the proposed rule, we set forth our analysis of the impact that the proposed changes would have on affected hospitals and CMHCs.

G. Public Comments Received on the August 16, 2004 Proposed Rule

We received over 550 timely pieces of correspondence containing multiple comments on the August 16, 2004 proposed rule. Summaries of the public comments and our responses to those comments are set forth in the various sections of this preamble under the appropriate heading.

We received a number of general public comments on our proposed changes to the OPPS for CY 2005.

Comment: Some commenters were concerned about the extent to which OPPS payment rates have fluctuated from year to year. Because Medicare payment is a very significant portion of income for most hospitals, they stated that the instability in the OPPS payment rates makes it difficult for hospitals to plan and budget. They indicated that there is a tremendous degree of variation across APCs in terms of payment to cost ratios and that they

would expect that after three years of operating the OPPS, the payment to cost ratios would be much more stable. One commenter offered to share analysis of payment to cost ratios with CMS. Commenters stated that such variation in payments compared to costs puts full-service hospitals and their communities at risk because limited-service, or ''niche'' providers can easily identify and redirect patients with more lucrative APCs to their facilities, leaving full-service hospitals with a disproportionate share of patients who receive services that are assigned to the underpaid APCs.

Response: We recognize hospitals' need for stability in payments for hospital outpatient services. We would appreciate receiving studies of the extent to which there is variation across APCS in terms of payment to cost ratios across the multiple years of the OPPS to aid us in assessing factors that might contribute to instability in the payment rates.

Comment: One commenter indicated that the entire OPPS is underfunded, as it pays only 87 cents of every dollar of hospital outpatient care provided to Medicare beneficiaries. The commenter stated that it will continue to work with Congress to address inadequate payment rates and updates in order to ensure access to hospital-based outpatient services for Medicare beneficiaries.

Response: Our early analyses indicated that the OPPS was, in its inception, based on payment that was less than cost due to statutory reductions in payment for hospital outpatient costs prior to the enactment of the Balanced Budget Act of 1997, which authorized the current OPPS. We agree that the commenter will need to work with Congress to change certain fundamental features of the OPPS. For example, the base amounts upon which the OPPS was established, the rules concerning budget neutrality, and subsequent out-year adjustments such as annual reductions in coinsurance and adjustments to outlier and pass-through payment allocations are established in statute and, as such, would require legislation to amend.

Comment: One commenter objected to the use of the display date to start the 60-day comment period for the proposed rule. The commenter stated that the display copy did not contain all of the information included in the proposed rule, such as the comment due date, and did not satisfy the statute's requirement that the notice of proposed rulemaking be published in the **Federal Register**, with provision for a 60-day comment period. The commenter indicated that the use of the display date to start the comment period gives reviewers too short a period of time to comment properly and also, in this case, gives CMS an inadequate period of time to review the comments and prepare the final rule. The commenter urged CMS to publish a proposed rule no later than late July to provide more time for CMS to consider public comments.

Response: While the law requires that we provide a 60-day public comment period and that the notice of proposed rulemaking be published in the **Federal Register**, it does not require that the date of **Federal Register** publication be the first day of the comment period. The two requirements are independent. We post the proposed rule on the CMS Web site on the date of display of the proposed rule at the **Federal Register**, thereby making the proposed rule far more easily available to the public than was the case when the only public dissemination was publication in the **Federal Register**, and satisfying the requirement for a 60-day comment period. By making the proposed rule available on the CMS Web site (as well as at the **Federal Register**), we provided the public with access to not only the proposed rule but also to all of the supporting files and documents cited in the proposed rule in a manner that can be used for analysis. We note that the computer files posted on the Web site can be manipulated for independent analysis. Therefore, we believe that beginning the comment period for the proposed rule with the display date at the **Federal Register**, and posting the proposed rule and data files on the CMS Web site on the display date, fully complies with the statute and provides a far better opportunity for the public to have meaningful input than the past practice under which the comment period began with the publication date in the **Federal Register** a week or longer after the display date and no other data in any other form was furnished.

With respect to the publication date of the proposed rule, we publish the proposed rule as soon as it is practicable for us to do so. Our process for development of the proposed rule begins with a winter meeting of the APC Panel based on the earliest possible data analysis for the forthcoming year. We then pull claims for the period ending December of the data year and also pull cost report data for development of CCRs to apply to the claims data. This step cannot be started until approximately March 1 of the year and the development of the proposed rule data takes considerable time as there are many analyses to be performed and decisions to be made before each stage of data development can be undertaken. We have to balance the need to improve the process and to deal with each year's special issues with the need to issue a proposed rule in sufficient time to permit the public to comment and to permit us sufficient time to review the comments and develop the final rule. Each year we review the timeline and process to determine how we can best achieve that balance, while ensuring that we issue the best possible proposed rule for public comment.

H. Public Comments Received on the January 6, 2004 Interim Final Rule With Comment Period

We received approximately 40 timely pieces of correspondence containing multiple comments on the MMA provisions relating to payment for drugs and brachytherapy under the OPPS that were included in the January 6, 2004 interim final rule with comment period. Summaries of the public comments and our responses to those comments are set forth in sections V. and VII.G. of this preamble under the appropriate heading.

I. Public Comments Received on the November 7, 2003 Final Rule With Comment Period

We received 25 timely pieces of correspondence on the November 7, 2003 final rule with comment period, some of which contained multiple comments on the APC assignment of HCPCS codes identified with the new interim condition indicators (now referred to as condition codes) in Addendum B of that final rule with comment period. Summaries of the public comments and our responses to those comments are set forth in various sections of this preamble under the appropriate subject areas.

II. Changes Related to Ambulatory Payment Classifications (APCs)

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as the Ambulatory Payment Classification Groups (or APCs), as set forth in § 419.31 of the regulations. We use Level I and Level II Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC. The APCs are organized such that each

group is homogeneous both clinically and in terms of resource use. (However, new technology APCs that are temporary groups for certain approved services are structured based on cost rather than clinical homogeneity.) Using this classification system, we have established distinct groups of surgical, diagnostic, and partial hospitalization services, and medical visits. Because of the transitional pass-through provisions, we also have developed separate APC groups for certain medical devices, drugs, biologicals, radiopharmaceuticals, and devices of brachytherapy.

We have packaged into each procedure or service within an APC group the cost associated with those items or services that are directly related and integral to performing a procedure or furnishing a service. Therefore, we would not make separate payment for packaged items or services. For example, packaged items and services include: Use of an operating, treatment, or procedure room; use of a recovery room; use of an observation bed; anesthesia; medical/surgical supplies; pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this preamble); and incidental services such as venipuncture. Our packaging methodology is discussed in section IV.B.3. of this final rule with comment period.

A. APC Changes: General

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 than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights.

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.

Section 419.31 of the regulations sets forth the requirements for the APC system and the determination of the payment weights. In this section, we discuss the changes that we proposed to the APC groups; the APC Panel's review and recommendations from the February 2004 meeting and our proposals in response to those recommendations; the application of the 2 times rule and proposed exceptions to it; coding for stereotactic radiosurgery services; the proposed movement of procedures from the new technology APCs; the proposed changes to the inpatient list; and the proposed additions of new procedures codes to the APCs. In addition, in this section under the appropriate subject heading, we present the APC Panel's review and recommendations of items discussed at the September 1, 2, and 3, 2004 meeting held after publication of the proposed rule and our final decisions on these recommendations. We then present our final policies that are effective for CY 2005.

B. APC Panel Review and Recommendations

1. February 2004 Panel Meeting

As stated above, the APC Panel held its first 2004 meeting on February 18, 19, and 20, 2004, to discuss the revised APCs for the CY 2005 OPPS. In preparation for that meeting, we published a notice in the **Federal Register** on December 24, 2003 (68 FR 74621), to announce the location, date, and time of the meeting; the agenda items; and the fact that the meeting was open to the public. In that notice, we solicited public comment specifically on the items included on the agenda for that meeting. We also provided information about the APC Panel meeting on the CMS Web site: *http://www.cms.hhs.gov/faca/apc/panel.*

Oral presentations and written comments submitted for the February 2004 APC Panel meeting met, at a minimum, the adopted guidelines for presentations set forth in the **Federal Register** document (68 FR 74621). In conducting its APC review, the APC Panel heard testimony and received evidence in support of the testimonies from a number of interested parties. For the February 2004 deliberations, the APC Panel used hospital outpatient claims data for the period January 1, 2003, through September 30, 2003, that provided, at a minimum, median costs for the APC structure in place in CY 2004 and that was based on CCRs used for setting the CY 2004 payment rates. The data set presented to the APC Panel represented 9 months of the CY 2003 data that we proposed to use to recalibrate the APC relative weights and to calculate the proposed APC payment rates for CY 2005. In sections II.B.4. through 7. and sections II.C. through I. of this preamble, we summarize the APC issues discussed during the APC Panel's February 2004 meeting, the Panel's recommendations, the proposals that we included in the August 16, 2004 proposed rule, our proposals with respect to those recommendations, and the policies that we are finalizing for CY 2005 in this final rule with comment period.

2. September 2004 Panel Meeting

As stated earlier, the APC Panel held its second 2004 meeting on September 1–3, 2004. In preparation for that meeting, we published a notice in the **Federal Register** on August 5, 2004 (69 FR 47446) to announce the location, date, and time of the meeting, the agenda items, and the fact that the meeting was open to the public. In that notice, we solicited public comments specifically on the items included on the agenda for that meeting. During the September 2004 APC Panel meeting, the APC Panel heard testimony on a number of the proposed changes in APCs included in the August 16, 2004 proposed rule. We are summarizing the topics that were discussed at the September 2004 Panel meeting and the APC Panel's recommendations on each topic in the chart below. We have included references to the appropriate section of this preamble for the more detailed discussion of each recommendation.

For the September 2004 deliberations, the APC Panel used the hospital outpatient claims data that we used in developing the proposed rule; that is, data for the period of January 1, 2003,

through December 31, 2003, including updated CCRs.

BILLING CODE 4120–01–P

Summary of APC Panel Recommendations from September 2004 Meeting

Recommendation	For Discussion, see Preamble Section
The APC Panel recommended that CMS should--	Section II.B.6
1. Continue its exploration of ways to increase the number of multiple procedure claims that can be used for OPPS ratesetting.	Section III.A.1
2. Post the crosswalk of revenue codes to cost centers on the OPPS website.	Section V.H
3. Assign a modifier to CPT codes 36540, 36600, 51701, and 97602 to facilitate identification of claims on which any of those is the only payable code on the date of service.	Section II.B.7
4. Not change the status indicator for CPT code 76937.	Section II.B.7
5. Allow separate payment for observation services even when cardiac catheterization is performed on the same day.	Section VII.D
6. Expand the list of diagnoses eligible for observation services.	Section VII. D
7. Solicit input on the inpatient list from professional organizations.	Section II.G
8. Maintain payment for low-volume blood products for CY 2005 at the CY 2004 level.	Section V.I
9. Use external data as a basis for setting payment rates for low-volume blood products.	Section V.I
10. Evaluate whether or not current statutes allow the extension of pass-through status for embolization protective system (HCPCS code C1884).	Section IV.A.2
11. Require that C-codes be reported for all devices associated with a C-code.	Section III.C.4
12. Retain the CY 2004 configuration of APCs 0385 and 0386.	Section III.C.1
13. Except for APCs 0418 and 0425, make adjustments to the medians for the device-dependent APCs listed in Table 19 of the August 16, 2004 proposed rule that increase or decrease by 5 percent for CY 2005 compared to CY 2004.	Section III.C.4
14. Assign CPT code 58563 and HCPCS code 0009T to APC 0387.	Section II.C.13
15. Evaluate the APC assignments for CPT codes 36555 through 36597 for discussion at the first CY 2005 (winter) meeting of the APC Panel.	Section II.C.13
16. Maintain CPT codes 77523 and 77525 in the new technology APC for CY 2005.	Section II. F.3
17. Assign status indicator K to HCPCS code J2790	Section V.B.2

3. Contents of This Section of the Preamble

The discussion in this section II.B. of this final rule with comment period is limited to APC changes regarding APCs other than those that violate the 2 times rule and those that represent drugs, biologicals, and transitional pass-through devices, or those that are new technology APCs. The specific APC Panel review and recommendations applicable to those APCs are discussed in sections II.C., IV., III., and II.F., respectively, of the preamble to this final rule with comment period.

4. APC 0018: Biopsy of Skin/Puncture of Lesion

During the February 2004 APC Panel meeting, one presenter recommended moving CPT tracking codes 0046T (Catheter lavage, mammary duct(s)) and 0047T (Each additional duct) from APC 0018 and placing them in an APC that more accurately reflects each of the procedures. The APC Panel recommended that we reassign CPT codes 0046T and 0047T to APC 0021, Level III Excision/Biopsy.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommendation. We did not receive any public comments on our proposal. Therefore, we are adopting as final, without modification, our proposal to reassign CPT codes 0046T and 0047T to APC 0021.

5. Level I and II Arthroscopy

APC 0041: Level I Arthroscopy

APC 0042: Level II Arthroscopy

We testified before the APC Panel at its February 2004 meeting regarding a comment that we received in 2003 requesting that we reassign CPT code 29827 (Arthroscopy, shoulder with rotator cuff repair) from APC 0041 to APC 0042, based on its similarity to CPT 29826 (Arthroscopy, shoulder decompression of subacromial space with partial acromioplasty without coracoacromial release). Our clinical staff considered the request and determined that APCs 0041 and 0042 should be reconfigured to improve clinical homogeneity. An APC Panel presenter provided evidence to support moving CPT code 29827 to an APC that would more accurately recognize the complexity of that procedure. We requested the APC Panel's recommendation regarding a total revision of these two APCs.

The APC Panel recommended that we reevaluate the codes in APCs 0041 and 0042 and propose restructuring that would improve the clinical homogeneity in the two APCs.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommendation and to revise APCs 0041 and 0042 as presented in Tables 1 and 2 of that proposed rule. We received one public comment on our proposed restructuring.

Comment: One commenter requested that we move code 0014T from APC 0041 to APC 0042. The commenter provided information in support of its belief that the procedure more accurately matches the clinical work and resource inputs of APC 0042 than of APC 0041.

Response: We agree with the commenter and are assigning the procedure to APC 0042. The tracking code 0014T is being retired and the successor code is CPT code 29868 (Arthroscopy, knee, surgical, osteochondral autograft(s) meniscal transplantation (including arthrotomy for meniscal insertion, medial or lateral). Placement of this code in APC 0042 is subject to comment in response to this final rule with comment period because the code is a new code for CY 2005.

Accordingly, restructured APCs 0041 and 0042 for CY 2005, as modified based on the public comment received, are shown in Tables 1 and 2 below.

Table 1.--Reconstructed APC 0041: Level I Arthroscopy

CPT/HCPCS Code	Description
29850	Knee arthroscopy/surgery
29870	Knee arthroscopy/diagnostic
29871	Knee arthroscopy/drainage
29873	Knee arthroscopy/surgery
29874	Knee arthroscopy/surgery
29875	Knee arthroscopy/surgery
29876	Knee arthroscopy/surgery
29877	Knee arthroscopy/surgery
29879	Knee arthroscopy/surgery
29880	Knee arthroscopy/surgery
29881	Knee arthroscopy/surgery
29882	Knee arthroscopy/surgery
29883	Knee arthroscopy/surgery
29884	Knee arthroscopy/surgery
29886	Knee arthroscopy/surgery
29805	Shoulder arthroscopy/diagnostic
29819	Shoulder arthroscopy/surgery
29820	Shoulder arthroscopy/surgery
29821	Shoulder arthroscopy/surgery
29822	Shoulder arthroscopy/surgery
29823	Shoulder arthroscopy/surgery
29825	Shoulder arthroscopy/surgery
29834	Elbow arthroscopy/surgery
29835	Elbow arthroscopy/surgery
29836	Elbow arthroscopy/surgery
29837	Elbow arthroscopy/surgery
29838	Elbow arthroscopy/surgery
29840	Wrist arthroscopy
29843	Wrist arthroscopy/surgery
29844	Wrist arthroscopy/surgery
29845	Wrist arthroscopy/surgery
29846	Wrist arthroscopy/surgery
29848	Wrist arthroscopy/surgery
29891	Wrist endoscopy/surgery
29892	Ankle arthroscopy/surgery
29894	Ankle arthroscopy/surgery
29895	Ankle arthroscopy/surgery
29897	Ankle arthroscopy/surgery
29898	Ankle arthroscopy/surgery
29804	Jaw arthroscopy/surgery
29999	Arthroscopy of joint
0012T	Osteochondral knee autograft
29830	Elbow arthroscopy
29860	Hip arthroscopy, dx
29887	Knee arthroscopy/surgery

Table 2.--Reconstructed APC 0042: Level II Arthroscopy

CPT/HCPCS Code	Description
29851	Knee arthroscopy/surgery
29885	Knee arthroscopy/surgery
29888	Knee arthroscopy/surgery
29889	Knee arthroscopy/surgery
29806	Shoulder arthroscopy/surgery
29807	Shoulder arthroscopy/surgery
29824	Shoulder arthroscopy/surgery
29826	Shoulder arthroscopy/surgery
29827	Arthroscopic rotator cuff repair
29847	Wrist arthroscopy/surgery
29855	Tibial arthroscopy/surgery
29856	Tibial arthroscopy/surgery
29899	Ankle arthroscopy/surgery
29800	Jaw arthroscopy/surgery
0013T	Osteochondral knee allograft
29861	Hip arthroscopy/surgery
29862	Hip arthroscopy/surgery
29863	Hip arthroscopy/surgery
29868	Meniscal transplantation, knee

BILLING CODE 4120–01–C

6. 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. February 2004 Panel Meeting

As requested by the APC Panel, at the February 2004 Panel meeting, we presented our proposal for reconfiguring APCs 0279, 0280, and 0668 that reflected changes based on prior input with outside clinical experts. The APC Panel had previously reviewed these APCs during its January 2003 meeting and had recommended that we not restructure these three APCs until we received input from clinical experts in the field. When we updated the APC groups in CY 2003, we accepted the APC Panel's recommendation and made no changes to APCs 0279, 0280, and 0668.

A review of these APCs was prompted by a commenter who 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. The commenter submitted evidence in support of these requests and testified before the APC Panel regarding the common use of CPT code 75978 for treating dialysis patients and the often required multiple intraoperative attempts to succeed with this procedure for such patients.

After receiving input from the clinical experts, we determined that these three APCs should be revised to improve their clinical homogeneity. At the February 2004 meeting, we presented our proposed restructuring of APCs 0279, 0280, and 0668 to the APC Panel. The APC Panel concurred with our proposal.

In addition, subsequent to the APC Panel meeting, we discovered several procedures in these APCs that were more appropriately placed in other APCs in order to remedy any 2 times rule violations. We included those modifications in our proposed restructured APCs published in Table 3 in the August 16, 2004 proposed rule.

b. Public Comments Received

Comment: Several commenters requested that CMS postpone or cancel the proposed plans for moving angiography codes 75960 (Transcatheter introduction of intravascular stent(s), (non-coronary vessel) percutaneous and/or open, radiological supervision and interpretation, each vessel), 75962 (Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation), 75964 (Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation), 75966 (Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation), and 75968 (Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation), which are integral to a number of angioplasty and stent placement procedures, from APC 0280 to APC 0668. One commenter indicated that the proposed decreases in payments for these services that would result from their APC reassignment were inconsistent with CMS' proposal to limit payment decreases for device-dependent APCs. Another commenter was particularly concerned that code 75962, which is used for angioplasty of arterial blockages, may have a wide range of associated procedure costs. The commenters stated that aggregate payment for all services billed for many high volume procedures such as peripheral transluminal angioplasty and single stent placement will decrease by 16 to 21 percent, in large part due to the reassignment of codes 75960, 75962, 75964, 75966, and 75968 to the lower level APC 0668 in the angiography and venography except extremity series and

to their placement on the bypass list. Two commenters were concerned that supervision and interpretation services as part of peripheral atherectomy procedures were assigned to higher paying APC 0279, potentially providing hospitals with an incentive to perform atherectomy instead of angioplasty or stent procedures, or both. Further, the commenters suggested that the lower payment for the supervision and interpretation services moved to APC 0668 for CY 2005 provides an incentive for hospitals to treat patients on an inpatient basis or may limit beneficiaries' access to the outpatient procedures. One commenter indicated that the cost and complexity of performing angiographic procedures for angioplasty are similar, if not more complex, than those of performing angiographic procedures for atheretomy.

The commenters did not understand why CMS reassigned the supervision and interpretation codes from a Level III to a Level I APC and believed that CMS did not take into account the higher level of hospital resources and staffing required for certain therapeutic radiology supervision and interpretation services. Further, they questioned the assumptions CMS adopted in the creation of the bypass list to develop ''pseudo''single claims. They suggested that there might be significant differences between the multiple procedure claims that CMS converts to ''pseudo'' single claims and those that CMS is unable to use. Thus, the commenters questioned the reliability of the claims data and encouraged CMS to use external data as the basis for the decisionmaking. One commenter noted that, of a large number of claims for APC 0668, 79 percent accounted for device costs and 81 percent accounted for room charges, but CMS' single claim methodology had only 4 percent of claims accounting for device costs or room charges.

Finally, one commenter, a group of providers, stated that they expected substantial payment decreases to result from the proposed restructuring of APCs 0279, 0280, and 0668. The commenter suggested that CMS should establish a mechanism (such as dampening) to offset large payment swings similar to those anticipated as a result of the CMS proposal.

Response: Our analyses of claims data used for the CY 2004 OPPS and several past comments led us to recognize the need to restructure APCs 0279, 0280, and 0668 for the CY 2005 OPPS. There were only two services in APC 0668 for CY 2004, APC 0279 was excepted from the 2 times rule in CY 2004, and the median costs for individual services in APCs 0668, 0279, and 0280 showed significant overlap. The APC Panel also acknowledged the need to reconfigure these APCs. In our proposed rule, we presented the restructured APCs in which the procedures within each APC demonstrated both clinical and resource homogeneity, and our final data confirmed the appropriate assignment of the services. For instance, the peripheral atherectomy supervision and interpretation codes (75992 through 75996) assigned to the Level II APC (0279) consistently had higher median costs than the supervision and interpretation codes for intravascular stent placement or peripheral or visceral artery balloon angioplasty, which are assigned to the Level I APC (0668). For CY 2005, the median costs for the supervision and interpretation codes for stent placement and angioplasty were much lower than the median cost of their prior APC 0280 ($1,181) and were within the range of median costs ($239–$444) for other procedures assigned to APC 0668. As APCs 0668, 0279, and 0280 are not device-dependent APCs because we expect the devices to be reported with the interventional procedures provided (that are in device-dependent APCs), it would be inappropriate to apply the device-dependent APC policy to APCs 0668, 0279, and 0280. In addition, there were no violations of the 2 times rule in the restructured APCs 0668, 0279, or 0280 based on full year 2003 hospital claims data.

The supervision and interpretation codes 75960, 75962, 75964, 75966, and 75968, along with peripheral atherectomy supervision and interpretation CPT codes, were proposed for the bypass list for CY 2005. As the commenters noted, we recognized that angiography and venography services generally involve multiple procedure claims, and less than 10 percent of bills for APCs 0668, 0279, and 0280 were available for ratesetting for CY 2004. We proposed to place a number of radiological supervision and interpretation codes on the bypass list for CY 2005 because we believed that these codes should have little packaging associated with them and we recognized that their addition to the bypass list might enable us to use significantly more data from multiple procedure claims for APCs 0668, 0279, 0280, and others. We did not expect that devices and room charges would generally be packaged with the supervision and interpretation services, but rather would be packaged with the interventional procedures they accompanied. This accounts for the low percentage of device and room costs on the single bills in APC 0668 used for the median calculation. None of the commenters provided any information about why it would be inappropriate to include these codes on the bypass list, other than to point out the decline in proposed payment rates for the services. If packaging appropriately attributable to the supervision and interpretation services through the bypass procedure had been assigned to the interventional procedures that the supervision and interpretation services accompanied (such as angioplasty or stent placement), there should have been increases in the median costs for the interventional procedures. We did not see any such significant increases, and believe that our data do not indicate any specific packaging allocation problems with respect to the supervision and interpretation services. We have no evidence of underreporting of costs used to calculate the median costs for APC 0668.

For CY 2005, we had a significantly greater number of single claims available for use in median calculation for APCs 0668, 0279, and 0280. For example, for CY 2005, the median costs for the two supervision and interpretation codes with the highest volume that were of concern to the commenters (codes 75960 and 75962) were based on 20 percent of claims in contrast to only 1 percent used last year. While it is possible, as suggested by the commenters, that there may be differences between the packaging in multiple procedure claims that we were able to convert to ''pseudo'' single claims and those that we were unable to use, we have no reason to believe that these issues are unique to these APCs or especially problematic for these supervision and interpretation services. Our goal continues to be to use as much of our historical hospital claims data to set payment rates as possible. As we have consistently stated, we are pursuing strategies to improve our ability to utilize multiple procedure claims for median calculation, including discussions with the APC Panel Data Subcommittee.

With regard to the commenter's suggestion that we establish a mechanism to offset payment changes from one year to the next, we understand the commenter's desire for a stable system. However, while we are not convinced that an overall dampening policy is required, we continue to work toward improving the hospital claims data through education, data management, and data analyses. We believe that we have achieved significant improvements so far.

c. Final Policy for CY 2005

After consideration of the APC Panel's recommendations and the public comments we received on the August 16, 2004 proposal, we are finalizing our proposal for the restructuring of APCs 0668, 0279, and 0280.

Tables 3, 4, and 5 reflect the final restructuring of APCs 0668, 0279, and 0280.

BILLING CODE 4120–01–P

Table 3.—Restructured APC 0668: Level I Angiography and Venography Except Extremity

CPT/HCPCS Code	Description	CY 2004 APC	CY 2005 APC
75660	Artery x-rays, head and neck	0279	0668
75705	Artery x-rays, spine	0279	0668
75733	Artery x-rays, adrenals	0280	0668
75960	Transcatheter introduction, stent	0280	0668
75961	Retrieval, broken catheter	0280	0668
75962	Repair arterial blockage, peripheral artery	0280	0668
75964	Repair artery blockage, each	0280	0668
75966	Repair arterial blockage, renal or other visceral	0280	0668
75968	Repair arterial blockage, each		
	additional visceral	0280	0668
75970	Vascular biopsy	0280	0668
75978	Repair venous blockage	0668	0668

Table 4.—Restructured APC 0279: Level II Angiography and Venography Except Extremity

CPT/HCPCS Code	Description	CY 2004 APC	CY 2005 APC
75658	Artery x-rays, arm	0280	0279
75741	Artery x-rays, lung	0279	0279
75746	Artery x-rays, lung	0279	0279
75756	Artery x-rays, chest	0279	0279
75774	Artery x-rays, each vessel	0668	0279
75810	Vein x-ray, spleen/liver	0279	0279
75825	Vein x-ray, trunk	0279	0279
75827	Vein x-ray, chest	0279	0279
75833	Vein x-rays, kidneys	0279	0279
75887	Vein x-ray, liver	0280	0279
75891	Vein x-ray, liver	0279	0279
75992	Atherectomy, x-ray exam	0280	0279
75993	Atherectomy, x-ray exam	0280	0279
75994	Atherectomy, x-ray exam	0280	0279
75995	Atherectomy, x-ray exam	0280	0279
75996	Atherectomy, x-ray exam	0280	0279

Table 5. —Restructured APC 0280: Level III Angiography and Venography Except Extremity

CPT/HCPCS Code	Description	CY 2004 APC	CY 2005 APC
75600	Contrast x-ray exam of aorta	0280	0280
75605	Contrast x-ray exam of aorta	0280	0280
75625	Contrast x-ray exam of aorta	0280	0280
75630	X-ray aorta, leg arteries	0280	0280
75650	Artery x-rays, head and neck	0280	0280
75662	Artery x-rays, head and neck	0279	0280
75665	Artery x-rays, head and neck	0280	0280
75671	Artery x-rays, head and neck	0280	0280
75676	Artery x-rays, neck	0280	0280
75680	Artery x-rays, neck	0280	0280
75685	Artery x-rays, spine	0279	0280
75710	Artery x-rays, arm/leg	0280	0280
75716	Artery x-rays, arms/legs	0280	0280
75722	Artery x-rays, kidney	0280	0280
75724	Artery x-rays, kidneys	0280	0280
75726	Artery x-rays, abdomen	0280	0280
75731	Artery x-rays, adrenal gland	0280	0280
75736	Artery x-rays, pelvis	0280	0280
75743	Artery x-rays, lungs	0280	0280
75885	Vein x-ray, liver	0279	0280
75889	Vein x-ray, liver	0279	0280

BILLING CODE 4120–01–C

7. Packaged Codes in APCs

As a result of requests from the public, the Packaging Subcommittee of the APC Panel was established to review all the CPT codes with a status indicator of ''N.'' Status indicator ''N'' indicates that payment for packaged codes is bundled into the payment that providers receive for separately payable codes for items or services provided on the same day. Providers have often suggested that many codes could be billed alone, without any separately payable service on the claim, and requested that these codes not be assigned status indicator ''N.'' The Packaging Subcommittee identified areas for change of some packaged CPT codes for items or services that could be provided as the sole service on a given date. During the September 2004 meeting, the APC Panel accepted the report of the Packaging Subcommittee and made the following recommendations:

- The Panel recommended that the Packaging Subcommittee review packaged codes individually instead of making a global decision for all packaged codes.
- The Panel recommended that CMS assign a modifier to CPT codes 36540 (Collect blood venous device), 36600 (Withdrawal of arterial blood), 51701 (Insert bladder catheter), and 97602 (Wound[s] care, non-selective) to be used when these codes are the only code on that particular claim for the same date of service. The APC Panel indicated that it would revise this subset of codes once data become available.
- The Panel recommended that CMS educate providers and intermediaries on the correct billing procedures for the packaged CPT codes 36540, 36600, 51701, and 97602.
- The Panel recommended that CMS not change the status indicator for CPT 76397 (Ultrasound guidance for vascular access). The Panel indicated that it would review the data on this code as they become available.
- The Panel recommended that the Packaging Subcommittee continue to meet throughout the year to discuss other problematic packaged codes.

CMS is considering the recommendation that a modifier be used when certain codes are the only codes on a particular claim for the same date of service. We note that code 97602 is assigned a status indicator of ''A'' in this final rule with comment period, and is no longer payable under OPPS. Therefore, a modifier, if applicable, would not be assigned for this code.

Comment: One commenter asked CMS to review all the packaged codes to determine which codes should become separately payable. Several commenters also requested that codes 36540 (Collect blood venous device), 36600 (Withdrawal of arterial blood), and 97602 (Wound[s] care, nonselective) become separately payable because they are often the only procedure on a bill. In cases where there is no separately payable code on a claim, providers do not receive payment for these packaged services.

Response: We appreciate the commenters' suggestions. As stated above, the APC Panel Packaging Subcommittee recently reviewed all the packaged codes. We are currently

considering whether to create a modifier to be used for CPT codes 36540, 36600, and 51701 when these codes appear on a claim without any separately payable code on the same date of service. As stated above, code 97602 will not be payable under OPPS for CY 2005 and, therefore, is excluded from this discussion. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov* with ''Packaging Subcommittee'' in the subject line.

Comment: Two commenters requested that code 76937 (Ultrasound guidance for vascular access) be assigned to APC 0268 (Ultrasound Guidance Procedures), with status indicator ''S'' instead of the proposed status indicator ''N.''

Response: We are accepting the APC Panel's recommendations that code 76937 remain packaged for CY 2005. We are concerned that there will be unnecessary utilization of this procedure if it is separately payable. In addition, because code 76937 only became effective on January 1, 2004, there are currently no claims data for this code. When we review the CY 2004 claims data for the CY 2006 payment rates, we will reexamine the status of code 76937. We also note that the APC Panel Packaging Subcommittee remains active, and additional issues and new data concerning the packaging status of codes will be shared for their consideration as information becomes available.

Comment: Several commenters requested that the following CPT codes become unpackaged: 42550 (Injection for salivary x-ray) and other x-ray injection codes; 75998 (Fluoroscopic guidance for central venous access device placement); 74328 (Endoscopic catheterization of the biliary ductal system, S&I); 74329 (Endoscopic catheterization of the pancreatic ductal system, S&I); 74330 (Combined endoscopic catheterization of the biliary and pancreatic ductal systems, S&I); 36500 (Insert of catheter, vein); 75893 (venous sampling by catheter); 75989 (abscess drainage under x-ray); 76001 (Fluoroscope exam); 76003 (Needle localization by x-ray); 76005 (Fluoroguide for spine inject); 90471 and 90472 (Immunization administration); 94760, 94761, and 94762 (Pulse oximetry); and G0269 (Occlusive device in vein art). The commenters were concerned that the OPPS has denied hospitals reimbursement for these services.

Response: Hospitals include charges for packaged services on their claims, and the costs associated with these packaged services are then bundled into the costs for separately payable procedures on the claims. Hospitals may use CPT codes to report any packaged services that were performed, consistent with CPT coding guidelines. Because these imaging codes are packaged, their presence on a claim that includes a code for another separately payable service does not necessarily result in the claim being a multiprocedure claim. Payment for these imaging services is packaged in this way into payment for the separately payable services with which the imaging services are billed.

The Packaging Subcommittee reviewed every code that was packaged in CY 2004. The Committee narrowed the list of packaged codes to a list of potentially problematic codes and subsequently reviewed utilization and median cost data for these codes. One of the main criteria evaluated by the Packaging Subcommittee to determine whether a code should become unpackaged was how likely it was for the code to be billed without any other code for separately payable services on the claim. We encourage submission of clinical scenarios involving currently packaged codes to the Packaging Subcommittee for review at future meetings. Submissions should be sent to the *APCPanel@cms.hhs.gov* with ''Packaging Subcommittee'' in the subject line.

We will continue to package CPT codes 42550 and other x-ray injection codes, 75998, 73428, 74329, 74330, 36500, 75893, 75989, 76001, 76003, 76005, 90471, 94472, 94760, 94761, 94762, and G0269 for CY 2005 and will discuss these codes with the APC Panel Packaging Subcommittee.

Comment: One commenter requested that the status indicator for code G0102 (Prostate cancer screening; digital rectal examination) be changed from packaged to separately payable. The commenter indicated that the screening is administered as part of the initial preventive physical examination. The commenter stated, ''The payment for G0102 will be zero because it is identified with status indicator 'N' which means it is packaged and not paid for separately.''

Response: Currently, under the OPPS, we do not make separate payment for code G0102. Its costs are bundled into the costs of other separately payable services furnished by the hospital on the same day. For example, a digital rectal examination is usually furnished as part of an evaluation and management service, so its payment would generally be bundled into payment for the evaluation and management service when a covered evaluation and management service is furnished on the same day as the digital rectal examination. It is a relatively quick and simple procedure. Likewise, when the examination is performed during the same visit as the initial preventive examination, we would expect that costs associated with the examination would be bundled into the costs for the initial preventive examination. Accordingly, we are continuing to package code G0102.

Comment: One commenter requested that we map code G0168 (Wound closure by adhesive) to an APC instead of assigning status indicator ''N'' to the code. The commenter was concerned that access to wound adhesives would be reduced if this code is not separately payable.

Response: Wound adhesives are considered supplies used to repair lacerations and surgical incisions. These products are used instead of sutures to close wounds. We do not make separate payments for sutures under the OPPS. Providers are paid when they use wound adhesives in the same manner as they are paid for other ''packaged'' procedures. The charges for code G0168 should be packaged into whichever procedure(s) is billed on the same date of service. Payment to the provider reflects the cost of performing the procedure and the related supplies.

C. Limits on Variations Within APCs: Application of the 2 Times Rule

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 median (or mean) of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group. 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. We implemented this statutory provision in § 419.31 of the regulations. Under this regulation, we elected to use the highest median cost and lowest median cost to determine comparability.

During the APC Panel's February 2004 meeting, we presented data and information concerning a number of APCs that violate the 2 times rule and asked the APC Panel for its recommendation. We discuss below the APC Panel's recommendations specific to each of these APCs, our proposals in

response to the APC Panel's recommendations that were discussed in the August 2004 proposed rule, and our final policies.

1. Cardiac and Ambulatory Blood Pressure Monitoring

APC 0097: Cardiac and Ambulatory Blood Pressure Monitoring

We expressed concern to the APC Panel that APC 0097 appears to violate the 2 times rule. We sought the APC Panel's recommendation on revising the APC to address the violation. Based on clinical homogeneity considerations, the APC Panel recommended that we not restructure APC 0097 for CY 2005.

We proposed to accept the APC Panel's recommendation that we make no changes to APC 0097 for CY 2005. We did not receive any public comments on our proposal. Accordingly, in this final rule, we are not making any changes to APC 0097 for CY 2005.

2. Electrocardiograms

APC 0099: Electrocardiograms

We expressed concern to the APC Panel at its February 2004 meeting that APC 0099 appears to violate the 2 times rule. We asked the APC Panel to recommend options for resolving this violation. Based on clinical homogeneity considerations, the APC Panel recommended that we not alter the structure of APC 0099 for CY 2005.

We proposed to accept the APC Panel's recommendation that we make no changes to APC 0099 for CY 2005. We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are not making any changes to APC 0099 for CY 2005.

3. 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 APC Panel at its February 2004 meeting that APC 0019 appears to violate the 2 times rule. We advised the APC Panel that this violation was not evident in CY 2004 because the CY 2002 median cost data used in calculating the CY 2004 APC updates supported moving CPT codes 11404 (Removal of skin lesion) and 11623 (Removal of skin lesion) from APC 0020 and APC 0021. However, based on the CY 2003 data reviewed by the APC Panel, APC 0019 would violate the 2 times rule. Therefore, we asked the APC Panel to recommend an approach to resolve the violation. We asked the APC Panel if we should leave this APC as is; divide APC 0019 into two separate APCs; or move some codes in APC 0019 to higher level excision/biopsy APCs. In making its recommendation, the APC Panel noted that the 2 times violation in APC 0019 was minor, and recommended that we not modify APC 0019.

We proposed to accept the APC Panel's recommendation to not make any modifications to APC 0019 for CY 2005. We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are not making any changes to APC 0019 for CY 2005.

4. Posterior Segment Eye Procedures

APC 0235: Level I Posterior Segment Eye Procedures

We expressed concern to the APC Panel at its February 2004 meeting that APC 0235 appears to violate the 2 times rule. At the August 2003 APC Panel meeting, the APC Panel recommended that we monitor the data for APC 0235 for review at its February 2004 meeting. In order to address the apparent violation, we asked the APC Panel to consider moving a few CPT codes from APC 0235 into a higher level posterior segment eye procedure APC. The APC Panel noted that the 2 times violation in APC 0235 was minor, and recommended that we not change APC 0235.

We proposed to accept the APC Panel's recommendation that we make no changes to the structure of APC 0235 for CY 2005. We receive one public comment regarding this proposal.

Comment: One commenter urged CMS not to finalize the proposal to keep the CY 2004 structure of APC 0235 for CY 2005. The commenter asked CMS to consider moving codes 67220 (Treatment of choroids lesion), 67221 (Ocular photodynamic therapy), 67225 (Eye photodynamic therapy, add-on), 67101 (Repair detached retina), and 67141 (Treatment of retina) to a higher level Posterior Segment Eye Procedure APC.

Response: After further analysis, we continue to believe that the resources and clinical characteristics of these codes are most compatible and homogeneous with those services in Level I Posterior Segment Eye Procedures, APC 0235. We plan to discuss the possible restructuring of APCs 0235, 0236, and 0237 (Level I, Level II, and Level III Posterior Segment Eye Procedures, respectively) at the next APC Panel meeting. We invite comments on these APCs.

In this final rule with comment period, we are adopting as final the proposal not to make any changes to APC 0235 for CY 2005.

5. Laparoscopy

APC 0130: Level I Laparoscopy

APC 0131: Level II Laparoscopy

We expressed concern to the APC Panel at its February 2004 meeting that APC 0130 appears to violate the 2 times rule. We suggested moving CPT code 44970 (Laparoscopy, appendectomy) from APC 0130 to APC 0131. The APC Panel recommended that we make this change.

We proposed to accept the APC Panel's recommendation to move CPT code 44970 from APC 0130 to APC 0131. We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal to move CPT code 44970 from APC 0130 to APC 0131.

6. Anal/Rectal Procedures

APC 0148: Level I Anal/Rectal Procedure

APC 0155: Level II Anal/Rectal Procedure

APC 0149: Level III Anal/Rectal Procedure

APC 0150: Level IV Anal/Rectal Procedure

We expressed concern to the APC Panel at its February 2004 meeting that APC 0148 appears to violate the 2 times rule. We suggested moving CPT code 46020 (Placement of seton) from APC 0148 to a higher level anal/rectal procedure APC. The APC Panel reviewed the four anal/rectal APCs (APC 0148, 0149, 0150, and 0155) and recommended moving CPT codes 46020 and 46706 (Repair of anal fistula with glue) from APC 0148 to APC 0150. The APC Panel also recommended moving CPT codes 45005 (Drainage of rectal abscess) and 45020 (Drainage of rectal abscess) from APC 0148 to APC 0155.

We proposed to accept the APC Panel's recommendations specific to APC 0148. We received one favorable public comment on our proposal. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT codes from APC 0148 to APCs 0150 and 0155 as shown in the Table 6 below.

Table 6.—Movement of Anal/Rectal Procedures from APC 0148 to APC 0150 and APC 0155

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
46020	Placement of seton	0148	0150
46706	Repair anal fistula with glue	0148	0150
45005	Drainage of rectal abscess	0148	0155
45020	Drainage of rectal abscess	0148	0155

7. Nerve Injections

APC 0204: Level I Nerve Injections

APC 0206: Level II Nerve Injections

APC 0207: Level III Nerve Injections

APC 0203: Level IV Nerve Injections

We expressed concern to the APC Panel that APC 0203 and APC 0207 appear to violate the 2 times rule. After careful consideration of new data presented during the February 2004 meeting, the APC Panel recommended moving CPTs 64420 (Nerve block injection, intercostal nerve), 64630 (Injection treatment of nerve), 64640 (Injection treatment of nerve), and 62280 (Treatment of a spinal cord lesion) from APC 0207 to APC 0206. The APC Panel also recommended moving CPT code 62282 (Treatment of a spinal canal lesion) from APC 0207 to APC 0203.

After reviewing more recent, complete calendar year data that was not available in February 2004, we proposed to accept only the APC Panel's recommendation to move CPTs 64630 and 64640 from APC 0207 to APC 0206 and to make some other changes that we believed were appropriate to improve the nerve injection APCs' clinical and resource homogeneity, as shown in Tables 7, 8, and 9 of the proposed rule.

We received two comments regarding our proposed reassignment of four CPT codes from APC 0203 to APC 0207 to address an apparent violation of the 2 times rule.

Comment: Commenters urged CMS not to finalize the proposed changes to CPT codes 64620 (Injection treatment of nerve), 64680 (Injection treatment of nerve), 62263 (Lysis epidural adhesions) and 62264 (Epidural lysis on single day), which we proposed to move from APC 0203 to APC 0207. The commenters stated that the proposed payment for these services was well below the cost of the resources required to provide the services at an acceptable standard of care. The commenters requested that we not move these four codes from APC 0203.

Response: After further analysis, we agree with the commenters that CPT codes 64620, 62263, and 62264 should remain in APC 0203 based on clinical and resource homogeneity with the services in APC 0203. Therefore, in this final rule with comment period, we are not moving these three codes from APC 0203, as displayed in Table 9B below.

However, based on our final CY 2003 hospital data for CPT code 64680, utilizing over half of the several hundred total bills for this service for calculation of median hospital costs, we continue to believe that the resources and clinical characteristics of destruction of the celiac plexus by neurolytic nerve agent are most compatible and homogeneous with those services in Level III Nerve Injections, APC 0207. Therefore, in this final rule with comment period, we are adopting as final the proposed movement of CPT code 64680 from APC 0203 to APC 0207, as displayed in Table 9B below.

Accordingly, all of the final APC reassignments of nerve injections codes in this final rule with comment period are displayed below in Tables 7, 8, 9A, and 9B.

Table 7.—Movement of Level III: Nerve Injections CPT Codes from APC 0207 to APC 0204 and APC 0206

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
64420	Nerve block injection, intercostal nerve	0207	0204
64421	Nerve block injection, intercostals, multiple	0207	0206
64472	Injection paravertebral cervical/thoracic, add-on	0207	0206
64476	Injection paravertebral lumbosacral, add-on	0207	0206
64630	Injection treatment of nerve	0207	0206
64640	Injection treatment of nerve	0207	0206

Table 8.—Movement of Level I: Nerve Injections CPT Codes from APC 0204 to APC 0206

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
61791	Treatment of a trigeminal tract	0204	0206
64410	Nerve block injection, phrenic	0204	0206
64412	Nerve block injection, spinal accessory	0204	0206
64446	Nerve block injection, sciatic, continuous infusion	0204	0206
G0260	Injection for sacroiliac joint anesthesia	0204	0206

Table 9A.—Movement of Level II: Nerve Injections CPT Codes from APC 0206 to APC 0204 and APC 0207

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
62270	Spinal fluid tap, diagnostic	0206	0204
62272	Drainage of cerebrospinal fluid	0206	0204
62310	Injection of spine cervical/thoracic	0206	0207
62311	Injection of spine lumbar/sacral (cd)	0206	0207
62318	Injection of spine with catheter, cervical/thoracic	0206	0207
62319	Injection of spine with catheter Lumbar/sacral (cd)	0206	0207

Table 9B.—Movement of Level III and Level IV Nerve Injections CPT Codes Between APC 0203 and APC 0207

CPT/HCPCS	Description	CY 2004 APC	CY 2005 Proposed APC	CY 2005 Final APC
62263	Lysis epidural adhesions	0203	0207	0203
62264	Epidural lysis on single day	0203	0207	0203
64620	Injection treatment of nerve	0203	0207	0203
64680	Injection treatment of nerve	0203	0207	0207

8. Anterior Segment Eye Procedures

APC 0232: Level I Anterior Segment Eye Procedures

APC 0233: Level II Anterior Segment Eye Procedures

We expressed concern to the APC Panel at its February 2004 meeting that APC 0233 appears to violate the 2 times rule. We suggested moving CPT codes 65286 (Repair of eye wound), 66030 (Injection treatment of eye), and 66625 (Removal of iris) from APC 0233 to APC 0232. The APC Panel agreed and recommended that we move CPT codes 65286, 66030, and 66625 from APC 0233 to APC 0232.

We proposed to accept the APC Panel's recommendation and to reassign these three codes. We received one public comment on our proposal.

Comment: One commenter asserted that the costs for performing the procedures under CPT codes 65286 and 66625 are similar to the costs for performing procedures in APC 0233 and requested that these codes not be moved to APC 0232.

Response: After further analysis, we continue to believe that the resources and clinical characteristics of codes 62586 and 66625 are most compatible and homogeneous with those services in Level I Anterior Segment Eye Procedures, APC 0232.

Therefore, in this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT codes 65286, 66030, and 66625 from APC 0233 to APC 0232 as shown in the Table 10 below.

Table 10.--Reassignment of Anterior Segment Eye Procedures Codes From APC 0233 to APC 0232

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
65286	Repair of eye wound	0233	0232
66030	Injection treatment of eye	0233	0232
66625	Removal of iris	0233	0232

9. Pathology

APC 0343: Level II Pathology

APC 0344: Level III Pathology

We expressed concern to the APC Panel at its February 2004 meeting that APC 0343 appears to violate the 2 times rule. We suggested moving CPT code 88346 (Immunoflourescent study) from APC 0343 to APC 0344. The APC Panel concurred with our proposal.

We proposed to accept the APC Panel's recommendation and to move CPT code 88346 from APC 0343 to APC 0344. We received one public comment on our proposal.

Comment: One commenter requested that CMS split APC 0344 into two APCs to create another level for the pathology procedures. The commenter stated that creation of another level would lead to more economically homogenous APCs to provide payment that more closely covers the costs of the procedures. The commenter pointed out that APC 0344, as currently configured, violates the 2 times rule and recommended that CMS split APC 0344 into two APCs and that CMS should assign them to a newly created APC rather than finalize its proposal to assign the new computer-assisted image analysis procedures to APC 0344.

Response: We believe that our proposed reassignment of CPT code 88346 from APC 0343 to 0344, as recommended by the APC Panel, will improve the resource and clinical homogeneity of the APCs. We are reluctant to make further reassignments without hospital cost data to support changes. Several of the codes that the commenter is concerned about, including APC codes 88360 (Morphometric analysis, tumor immunohistochemistry, quantitative or semiquantitative, each antibody; manual), 88368 (Morphometric analysis, in situ hybridization, each probe; manual), and 88367 (Morphometric analysis, in situ hybridization, each probe; using computer assisted technology) were new in CY 2004 and CY 2005 and, as such, we do not have available claims data for analysis.

Given the new codes mentioned by the commenter and the 2 times rule violations in APC 0342 and 0344, we expect that we will want to solicit the advice of the APC Panel regarding the configuration of all the pathology APCs: 0342, 0343, 0344, and 0661, at their next meeting. We will reexamine the APCs for future updates to the OPPS, but will not make other changes to the APCs at this time.

In this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT code 88346 from APC 0343 to APC 0344.

10. Immunizations

APC 0355: Level III Immunizations (for CY 2005: Level I Immunizations)

APC 0356: Level IV Immunizations (for CY 2005: Level II Immunizations)

We expressed concern to the APC Panel at its February meeting that APCs 0355 and 0356 appear to violate the 2 times rule. In order to eliminate this violation, we suggested moving CPT 90636 (Hepatitis A/Hepatitis B vaccine, adult dose, intramuscular use) from APC 0355 to APC 0356. We also suggested moving CPT codes 90375 (Rabies immune globulin, intramuscular or subcutaneous), 90740 (Hepatitis B vaccine, dialysis or immunosuppressed patient, intramuscular), 90723 (Diphtheria-pertussis-tetanus, Hepatitis B, Polio vaccine, intramuscular), and 90693 (Typhoid vaccine, AKD, subcutaneous) from APC 0356 to APC 0355.

The APC Panel recommended moving CPT 90636 from APC 0355 to APC 0356 and CPT codes 90740, 90723, and 90693 from APC 0356 to APC 0355. The APC Panel delayed making a recommendation on CPT 90375 and requested that we collect additional cost data on this procedure for discussion at the next scheduled APC Panel meeting.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommended changes to move CPT code 90740 from APC 0356 to 0355, and to move CPT code 90636 from 0355 to 0356. Based on our review of more recent claims data than were available to the APC Panel, we also determined that the medians for CPT codes 90693 and 90375 are below the $50 drug packaging threshold. Therefore, we also proposed to package both CPT codes 90693 and 90375 and to change the status indicator for CPT code 90723 to ''E'' because it is not payable by Medicare.

We received one public comment relating to CPT code 90740.

Comment: One commenter requested that CMS not reassign CPT code 90740 Recombivax 40mcg/mL (a brand name for Hepatitis B vaccine), from APC 0356 (Level II Immunizations) to APC 0355 (Level I Immunizations), as proposed. The commenter stated that the CMS median cost of $5.55 is erroneous and that the lowest published price for Recombivax 40mcg/mL in the Federal Supply Schedule is $79.33. Therefore, the commenter believed that code 90740 does not violate the 2 times rule when assigned to APC 0356.

Response: We are using the CY 2003 hospital claims as the basis for payment and we believe we have adequate claims on which to base payment for CPT code 90740 for CY 2005. We were able to use 99 percent of the claims for CPT code 90740 for median calculation and believe that our assignment of CPT code 90740 for CY 2005 is appropriate.

In this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT code 90740 from APC 0356 to APC 0355 and CPT code 90636 from APC 0355 to APC 0356, as shown in Table 11, and packaging both CPT codes 90693 and 90375.

Table 11.—Movement of Immunization CPT Codes Between APC 0355 and APC 0356

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
90636	Hepatitis A/Hepatitis B vaccine, adult dose, intramuscular use	0355	0356
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient	0356	0355

11. Pulmonary Tests

APC 0367: Level I Pulmonary Tests

APC 0368: Level II Pulmonary Tests

APC 0369: Level III Pulmonary Tests

We expressed concern to the APC Panel at its February 2004 meeting that APC 0369 appears to violate the 2 times rule. We suggested moving CPT code 94015 (Patient recorded spirometry) from APC 0369 to APC 0367. The APC Panel concurred with our proposal.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommendation and to move CPT code 94015 from APC 0369 to APC 0367. In addition, during our analysis of more recent claims data following the APC Panel meeting, we noted that APC 0367 violated the 2 times rule. Therefore, we proposed to reassign CPT codes 94375, 94750, 94450, 94014, 94690, and 93740 to APC 0368.

We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT code 94015 from APC 0369 to APC 0367 and reassigning CPT codes 93740, 94014, 94375, 94450, 94690, and 94750 to APC 0368, as shown in Table 12A.

Table 12A.—Reassignment of Certain CPT Codes Among APCs 0367, 0368 and 0369

HCPCS	Description	CY 2004 APC	CY 2005 APC
93740	Temperature gradient studies	0367	0368
94014	Patient recorded spirometry	0367	0368
94015	Patient recorded spirometry	0369	0367
94375	Respiratory flow volume loop	0367	0368
94450	Hypoxia response curve	0367	0368
94690	Exhaled air analysis	0367	0368
94750	Pulmonary compliance study	0367	0368

12. Clinic Visits

APC 0600: Low Level Clinic Visits

We expressed concern to the APC Panel at its February 2004 meeting that APC 0600 appears to violate the 2 times rule. We suggested moving HCPS code G0264 (Assessment other than CHF, chest pain, asthma) to a higher level clinic visit. The APC Panel recommended that we not make any changes to APC 0600.

We proposed to accept this recommendation and not make any changes to APC 0600 for CY 2005. We received one public comment on our proposal from a provider group.

Comment: One comment recommended that CMS investigate further the apparent two times violation in APC 0600. The commenter believed that, although the APC Panel did not recommend reassignment of HCPCS code G0264 (Initial nursing assessment of patient directly admitted to observation with diagnosis other than CHF, chest pain or asthma or patient directly admitted to observation with diagnosis of CHF, chest pain or asthma when the observation stay does not qualify for G0244), in order to remedy the apparent violation, CMS should make the reassignment of G0264 to a much higher level clinic visit (APC 0602, High Level Clinic Visit) due to the resources involved in directly admitting a patient to observation. The commenter provided examples of services that the commenter believed are part of the initial observation nursing assessment provided by a hospital, including patient registration, comprehensive nursing clinical admission assessment, initiation of physician orders, coordination and scheduling of ancillary services, administration of medications, and assessment of discharge planning needs.

Response: We do not agree with the commenter's assertion that the services coded using G0264 are necessarily more resource intensive than a low-level clinic visit. The beneficiary whose observation stay would be coded using G0264 presents to the hospital following a physician visit. The beneficiary has already been assessed by the physician who, as a result of the assessment, has decided that observation care is warranted. We are concerned that hospitals may be attributing costs to the initial nursing assessment that are more appropriately attributable to observation services themselves, such as administration of medications, scheduling of tests to be conducted during the period of observation, and discharge planning. It is not apparent why the services provided in the hospital associated with admission to observation care (including some of those listed by the commenter) should require the resources of a High Level Clinic Visit (APC 0602) as the commenter suggested. Thus, we agree with the APC Panel's recommendation to leave G0264 in APC 0600.

Accordingly, in this final rule with comment period, we are adopting as final our proposal not to make any changes to APC 0600 for CY 2005.

13. Other APC Assignment Issues

We received a number of comments about specific APC assignments and payment amounts that were generated by our proposed rates or proposed changes to HCPCS code APC assignments resulting from our revisions to address violations of the 2 times rule. Those changes were not all specifically discussed in the proposed rule, but were open to comment. We respond to these comments in this section of the final rule.

a. Catheters for Brachytherapy Services

Comment: One commenter asked that CMS consider carefully in which APCs to place new CPT codes 19296, 19297, and 19298 (for placement of catheters into the breast for brachytherapy) because the services have, heretofore, been coded under unlisted code 19499, which is assigned to APC 0028 (Level I Breast Surgery) and with a proposed payment amount of $1,081 for CY 2005. The commenter believed that this

proposed amount is too low to appropriately reflect the costs of these services.

Response: We have assigned new CPT codes 19296 and 19298 in New Technology APC 1524 (New Technology-Level XIV ($3,000–$3,500)) with a payment amount of $3,250 and CPT code 19297 in APC 1523 (New Technology-Level XXIII ($2,500–$3,000)) with a payment amount of $2,750 for CY 2005 OPPS. These are new codes and the APC assignments were not included in the proposed rule. Therefore, the APC assignments are subject to comment.

b. Peripherally Inserted Central Catheters (PICC)

We received one comment regarding our proposed APC reassignment of CPT codes 36568 (Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age) and 36569 (Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older to APC 0187 (Miscellaneous placement/repositioning). We made the proposal based on a recommendation by the APC Panel during its February 2004 meeting.

Comment: One commenter requested that we not reassign CPT codes 36568 and 36569 from APC 0032 to APC 0187 as proposed.

Response: We proposed to reassign the PICC lines to APC 0187 based on our agreement with the APC Panel that there are significant differences in the clinical complexity and resource use associated with the procedures assigned to APC 0032 compared to PICC line insertion. We will reevaluate the APC assignment of the PICC line insertion once we have sufficient data to evaluate the assignment.

c. External Fixation Devices

Comment: One commenter indicated that APC 0046 (Open/Percutaneous Treatment Fracture) contains violations of the two times rules and should be broken into multiple APCs so that CPT codes 20690 (Apply bone fixation device) and 20692 (Apply bone fixation device), which are for application of external fixation devices, could be paid appropriate amounts. Other commenters asked that CMS require that claims for these codes must contain codes for the devices and asked that we revise the definition of C1713 (Anchor/screw for opposing bone to bone or soft tissue to bone (implantable)) to also apply to external fixation devices and to remove the requirement that the device be implantable. One commenter also asked that we instruct providers to bill code 20690 or 20692 when external fixation is provided with the reduction of a fracture and asked that we create a new APC to contain CPT codes 20690 and 20692.

Response: CPT codes 20690 and 20692 are currently in APC 0050 and no changes were proposed for 2005 OPPS. There are no 2 times violations in the APC in which they are located and each of these codes represents approximately one percent of the volume in the APC. Therefore we see no reason to create a new APC for these codes. The CPT codes for treatment of a fracture often include with or without fixation in the definition of the code. Where fixation is included in the definition of the code, it would be miscoding to also report 20690 or 20692; these codes should be reported if, and only if, fixation is not included in the definition of the CPT code for treatment of the fracture. Providers should review the CPT instructions and look to the AMA's guidance on coding if they have questions about when these codes should be reported.

d. Apheresis

Comment: Two commenters disagreed with our proposed reassignment of CPT code 36515 (Apheresis, adsorp/reinfuse) to APC 0111 (Blood Product Exchange) and recommended that the code be reassigned to APC 0112 (Apheresis, Photopheresis and Plasmapheresis). One of the commenters, a medical specialty society, indicated that the procedure involves an expensive disposable supply item that costs more than the proposed payment rate for APC 0111. In addition, this commenter stated that the proposed payment rate would be significantly less than the physician's office payment, which the commenter concluded indicated that the charge data used to establish the median cost of the procedure may be incorrect.

Response: APC assignments are based on clinical homogeneity and comparable resource utilization for all CPT and HCPCS codes within an APC. After careful review, we disagree with the commenters that CPT code 36515 should be reassigned to APC 0112. We believe that the resources required for CPT code 36515 are more similar to the other CPT codes in APC 0111. Thus, for CY 2005, we are adopting as final our proposal to assign CPT code 36515 to APC 0111, effective January 1, 2005.

e. Imaging for Intravenous Cholangiogram (IVC) Filter Placement and Breast Biopsy

Comment: One commenter requested that we move CPT code 75940 (Percutaneous placement of IVC filter, radiological supervision and interpretation) from APC 0187 (Miscellaneous Placement/Repositioning) to APC 0280 (Level III Angiography and Venography Except Extremity) and CPT code 76095 (Stereotactic localization guidance for breast biopsy or needle placement, each lesion, radiological supervision and interpretation) from APC 0187 (Miscellaneous Placement/Repositioning) to APC 0289 (Needle Localization for Breast Biopsy). The commenter believed that imaging for IVC filter placement and breast biopsy are entirely unrelated services to the central venous access surgical procedures comprising the majority of the codes in APC 0187.

Response: We understand the commenter's concern regarding the clinical inconsistency between the services described by CPT codes 75940 and 76095, which are assigned to APC 0187, and the central venous access (CVA) procedures that are also assigned to APC 0187. However, we disagree with the commenter's recommendation that CPT codes 75940 and 76095 be reassigned. First, if we were to accept the commenter's recommendation to reassign CPT code 75940 to APC 0280 and CPT code 76095 to APC 0289, the resource homogeneity of those two APCs would be compromised, and we would be significantly overpaying CPT code 75940 and underpaying CPT code 76095 based on the median costs of those two codes relative to the median costs of the procedures currently assigned to APCs 0280 and 0289, respectively. Further, we lack data for a number of the CVA codes in APC 0187 because they are new codes that were established in CY 2004. We believe that these new CVA codes are clinically similar to the codes that comprise APC 0187, and we estimate that they are also similar in terms of resource costs, which is why we assigned them to APC 0187. Once we have accumulated data for these new codes, we will review the configuration of APC 0187, and make whatever changes are appropriate in future updates. Therefore, we are maintaining CPT codes 75940 and 76095 in APC 0187 for CY 2005.

f. Hysteroscopic Endometrial Ablation Procedures

Comment: Some commenters opposed the APC Panel recommendation that both CPT codes 0009T (Endometrial cryoablation) and 58563 (Hysteroscopic endometrial ablation) be assigned to APC 0387 (Level II Hysteroscopy) in CY 2005. The commenters were concerned that adding endometrial cryoablation

(CPT 0009T) to APC 0387 would seriously weaken the clinical homogeneity of APC 0387 because CPT 0009T (Endometrial ablation with ultrasonic guidance) does not use hysteroscopy, and it requires an ultrasound machine and a separate capital unit, or compressor console, to provide cryotherapeutic energy. Instead, the commenters urged CMS not to keep CPT code 58563 in APC 0387, but rather, to assign it to APC 0202, in addition to assigning code 0009T to APC 0202, as we had proposed. One commenter argued that the clinical homogeneity of APC 0202 would be enhanced by grouping the two endometrial ablation procedures that use visualization to monitor and confirm the destruction of the endometrium in the same APC. Moreover, moving both CPT codes 58563 and 0009T to APC 0202 would highlight APC 0202's clinical homogeneity as a more device-intensive family of new technology procedures while better organizing APC 0387 as the group of non-device hysteroscopic procedures involving surgical removal or resection of intrauterine tissue for reasons other than abnormal uterine bleeding (AUB). The same commenter also believed that assigning both codes to APC 0202 would negate any inappropriate incentives to use either treatment because of payment. Other commenters asked that CMS create a new APC for endometrial cryoablation and place that APC on the device-dependent list as it did for cryoablation of the prostate because they have found that the device is 70 percent of the total cost of endometrial cryoablation. The commenters asked that the new APC be paid at least $3,448 to appropriately reflect the hospital's cost of the service.

Response: After careful consideration of the comments, we have decided to make final for CY 2005 our proposal to retain hysteroscopic endometrial ablation (CPT code 58563) in APC 0387. In addition, we are making final for CY 2005 our proposal to assign endometrial cryoablation with ultrasonic guidance to APC 0202. (We note that CPT code 0009T for endometrial cryoablation with ultrasonic guidance is replaced by new CPT code 58356 for CY 2005.). We believe that the need for a hysteroscope to perform hysteroscopic endometrial ablation makes it similar to the other services in APC 0387. On the other hand, Endometrial cryoablation uses a device but not a hysteroscope and, therefore, is more clinically compatible with APC 0202, which contains other resource intensive gynecologic services that also use a device but not a hysteroscope. Moreover, APC 0202 is a device-dependent APC and, therefore, a more appropriate placement for a procedure that uses a device.

g. Hysteroscopic Female Sterilization

Comment: One commenter indicated that the AMA intended create a new CPT level III tracking code for hysteroscopic female sterilization for CY 2005 and urged CMS to assign it to APC 0202. The commenter indicated that this new service places implants through a hysteroscope to occlude the fallopian tubes and that, therefore, it should be assigned to APC 0202, which would provide appropriate payment for this new service for which the implants cost $1,000 to $1,500.

Response: This service is represented by new CPT code 58565 (Hysteroscopic fallopian tube cannulation and micro insert placement), which was created after the issuance of the proposed rule. We are placing this new code to APC 0202 for CY 2005 for the OPPS. The placements of new codes in APCs, such as this code, are subject to comment during the comment period of this final rule with comment period.

h. Urinary Bladder Residual Study

Comment: One commenter asked us to keep CPT code 78730 (Urinary bladder residual study) in APC 0404 (Renal and Genitourinary Studies Level I) instead of moving it to APC 0340 (Minor Ancillary Procedures). The commenter noted that this code is being misused to report other than urinary bladder residual imaging.

Response: CPT code 78730 was created and originally valued for the Medicare Physician Fee Schedule as a procedure that required the services of a nuclear medicine technician. Subsequently, the use of the code has changed so that it is now used primarily by urologists. We do not believe that urologists perform services requiring nuclear medicine technicians and so, as the commenter pointed out, it appears that the code may now be utilized for coding a service that is different from that for which it was created.

However, we are not reassigning the code at this time, as requested by the commenter, pending further review. To that end, we would appreciate submission of resource data from other physician specialties that use CPT code 78730 for us to review in the context of our hospital data so that we can examine this issue further.

i. Intracranial Studies, Electrodiagnostic Testing, Autonomic Testing, and EEG

We received one comment relating to the APC assignments for several electrodiagnostic testing, autonomic testing, and EEG codes.

Comment: One commenter requested that CPT code 93888 (Intracranial study) be moved from APC 0266 (Level II Diagnostic Ultrasound Except Vascular) and assigned to APC 0267 (Level III Diagnostic Ultrasound Except Vascular) as it was in CY 2002; that CPT codes 95870 (Muscle test, nonparaspinal), 95900 (Motor nerve conduction test), and 95904 (Sensory NCV) be assigned to APC 0218 (Level II Nerve Muscle Tests); that CPT codes 95921, 95922, and 95923 (Autonomic nerve function tests) be assigned to APC 216 (Level III Nerve and Muscle Tests); and that CPT codes 95953 and 95956 (EEG monitoring) be assigned to APC 209 (Extended EEG Studies and Sleep Studies, Level II).

Response: Based on our final CY 2003 hospital data for CPT codes 93888, 95870, 95900, 95904, 95921, and 95922, we continue to believe that the resources and clinical characteristics of those codes are most compatible with other services in the APCs to which they are assigned. We made no proposal to change any of those APC assignments. Therefore, in this final rule with comment period, we are finalizing our continued placement of CPT code 93888 in APC 0266; CPT codes 95870, 95900, and 95904 in APC 0215; and CPT codes 95921 and 95922 in APC 0218. We are moving CPT code 95923 from APC 0215 to APC 0218 because the resources for this code are most compatible and homogenous with those services in Level II Nerve and Muscle Tests.

Based on our further review of CPT codes 95953 and 95956, we are moving these two CPT codes, as well as code 95950, to APC 0209 (Extended EEG Studies and Sleep Studies, Level II). Based on our review of clinical and resource use characteristics of these CPT codes, we discovered that 95953, 95956 and 95950 all are more homogenous with procedures assigned to APC 0209 than in their current APCs. Although we did not propose to make these reassignments in the proposed rule, based in part on the comment received and our further review, we are making these reassignments in this final rule with comment period in the interest of clinical and resource use homogeneity.

Accordingly, we are reassigning the CPT codes relating to intracranial studies, electrodiagnostics testing, autonomic testing, and EEG to APCs, as displayed below in Table 12B.

Table 12B.—Reassignment of CPT Codes Relating to Intracranial Studies, Electrodiagnostic Testing, Autonomic Testing, and EEG

CPT/HCPCS	Description	CY 2004 Final APC	CY 2005 Final APC
95923	Autonomic nerve function test	0215	0218
95950	Ambulatory EEG monitoring	0213	0209
95953	EEG monitoring/computer	0209	0209
95956	EEG monitoring, cable/radio	0214	0209

j. Therapeutic Radiation Treatment

Comment: Some commenters objected to the proposed movement of CPT code 77370 (Radiation physics consult) from APC 0305 (Level II Therapeutic Radiation Treatment Preparation) to APC 0304 (Level I Therapeutic Radiation Treatment Preparation), with a proposed reduction in the payment rate by 51 percent from the CY 2004 payment rate of $200.60. The commenters indicated that the current CY 2004 payment rate is already inadequate. The commenters expressed concern that the proposed payment of $98.27 would not compensate for the costs incurred to deliver this service and urged that CPT code 77370 remain in APC 0305.

Response: The median of $134.22 for CPT code 77370 was based on 95 percent of the total CY 2003 claims (33,070 single procedure claims out of 34,792 total claims). Based on these claims data, we believe that the movement of CPT code 77370 from APC 0305 (with a proposed median of $229.92) to APC 0304 (with a proposed median of $99.92) is appropriate. Therefore, we are finalizing our movement of CPT code 77370 from APC 0305 to APC 0304 for CY 2005.

k. Hyperthermia Procedures

Comment: One commenter expressed concern about the 9-percent decrease in the proposed payment rate for hyperthermia procedures (CPT codes 77600 through 77605) assigned to APC 0314 (Hyperthermic Therapies). The commenter asserted that the hospital charges do not reflect the tremendous capital costs associated with hyperthermia procedures. The commenter suspected that the questionably high utilization for these procedures may be a result of miscoding. The commenter requested that CMS consider the hyperthermia practice expense data submitted through the Practice Expense Advisory Council (PEAC) and Medicare Physician Fee Schedule (MPFS) processes. The commenter urged CMS to maintain the CY 2004 payment rates for hyperthermia through CY 2005 to allow additional time for the commenter to educate providers on the proper coding and cost reporting for hyperthermia.

Response: We believe the data do not support the commenter's concern that a high utilization for these codes is indicative of miscoding, as we do not consider 552 total claims to reflect a high utilization that gives rise to question. The payment rate for APC 0314 for CY 2005 noted in the proposed rule was set using 86 percent of the total claims (that is, 452 single procedure claims out of 522 total claims), which we consider to be sufficiently robust for ratesetting purposes. Therefore, we will not consider practice expense data submitted through the PEAC or MPFS processes.

l. Physician Blood Bank Services

Comment: One commenter asked that CMS place CPT codes 86077, 86078 and 86079 (Physician blood bank services) into an APC and make payment for them under the OPPS. The commenter indicated that the current assignment of status indicator ''A'' is assigned to HCPCS codes that are paid under another fee schedule but that these services are not paid under any other fee schedule or payment system and, therefore, the hospital is not being paid for these services. The commenter noted that the services had status indicator ''X'' for minor services and had APC assignments in the CY 2003 OPPS.

Response: We agree and have assigned these CPT codes to APC 343 with status indicator ''X.'' These services consist mainly of physician professional services, which are paid through the Medicare Physician Fee Schedule, but we expect there may also be some hospital resources utilized. We have given these codes a condition code of ''NI'' (new interim) in this interim final rule with comment because they were not paid under the OPPS in CY 2004 and because we were not able to use the data for these codes in the calculation of the median cost for APC 343.

m. Caloric Vestibular Test

Comment: One commenter requested an explanation for the proposed movement of CPT code 92543 (Caloric vestibular test) from APC 0363 (Level I Otorhinolaryngologic Function Tests) to APC 0660 (Level 2 Otohinplaryngologic Function Tests), and CPT codes 92553 (Audiometry, air and bone) and 92575 (Sensorineural acuity test) from APC 0365 (Level II Audiometry) to APC 0364 ((Level I Audiometry).

Response: We regularly review CPT codes to ensure that they are in appropriate clinical APCs, based on resource use and clinical homogeneity. Upon review, we have found that code 92543 fits more appropriately in a higher-paying APC in the same family of otorhinolaryngologic function test APCs, while codes 92553 and 92575 fit in a lower-paying APC in the same family of audiometry APCs.

n. APC 0365—Level II Audiometry

Comment: One commenter stated that the services in APC 0365 (Level II Audiometry) are not clinically homogeneous and also violate the 2 times rule, sometimes by a spread of 300 percent. The commenter asked that CMS split the APC into two APCs: one containing CPT codes 92604, 92602, 92603, 92601 and 92561 and a second new APC containing CPT codes 92577, 92579, 92582, 92557.

Response: We agree that revision of this APC would result in improved clinical homogeneity and better grouping of services with similar resources. Therefore, we are establishing a new APC 0366 (Level III Audiometry), and are placing in the new APC those

services that are specific to aural rehabilitation after cochlear implantation: CPT codes 92601, 92602, 92603, and 92604.

o. Noncoronary Intravascular Ultrasound (IVUS)

Comment: One commenter requested that CMS keep CPT code 37250 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel) in APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) and to use only those claims that capture intravascular ultrasound (IVUS) device-related costs to calculate the median cost for this procedure.

Response: We assigned CPT 37250 to APC 0416 (Level I Intravascular and Intracardiac Ultrasound and Flow Reserve) in the proposed rule. We created two levels for IVUS by creating APC 0416 in order to recognize both the clinical and resource use differences between the coronary and noncoronary vessel procedures, as well as the initial vessel and each additional vessel procedures. Prior to creation of APC 0416, all IVUS procedures, coronary and noncoronary, as well as initial vessel and each additional vessel, were assigned to APC 0670. Based on analysis of our CY 2003 hospital claims data, we concluded that the services in APC 0670 had widely varying median costs, with lower median costs for both the each additional vessel (noncoronary and coronary) and initial noncoronary vessel services in APC 0670, as compared with the initial coronary vessel IVUS. We recognized that the additional vessel services would not require a second costly device in most cases. We also noted that the initial vessel coronary IVUS code, CPT 92978, includes imaging supervision and the interpretation and report, while the initial vessel noncoronary IVUS code, CPT 37250, does not include the radiological supervision and interpretation, which is billed using another CPT code. Thus, we believe that the hospital resources utilized to perform initial vessel noncoronary and coronary IVUS are likely to be different because the service elements in the CPT codes vary. Based on this review, we believe CPT 37250, a noncoronary vessel procedure with a median cost of $361, is appropriately assigned to APC 0416 and would be significantly overpaid if assigned to APC 0670.

For CY 2005, we did not have the ''C'' coded claims to use to identify device-related costs with the level of specificity that was possible for CY 2004. However, we had significantly more claims available for CPT 37250 for ratesetting this year than for CY 2004. We believe that the data on which the assignment to APC 0416 was based were reflective of hospital claims data regarding the resources utilized for the service. As we note elsewhere in this preamble, we will be requiring the use of device codes to report all devices utilized, beginning January 1, 2005.

Accordingly, in this final rule we are finalizing the assignment of CPT 37250 to APC 0416 for CY 2005.

p. Electronic Analysis of Neurostimulator Pulse Generators

Comment: One commenter stated that the services in APC 0692 (Electronic Analysis of Neurostimulator Pulse Generators) are not clinically homogeneous and also violate the 2 times rule. The commenter asked that CMS split the APC into two APCs: one containing CPT codes 95972 and 95975, and a second new APC containing CPT codes 95970, 95971, and 95974.

Response: We recognize that there is a violation of the two times rule in APC 0692. Therefore, we are moving CPT code 95970 to APC 0218 (Level II Nerve and Muscle Tests), which places it in a clinical APC that is suitable in terms of resource use for the service and results in APC 0692 conforming to the 2 times rule.

q. Endoscopic Ultrasound Services

Comment: One commenter asked that CMS create a separate APC for endoscopic ultrasound services because the commenter believed that there are unique costs associated with them. The commenter also believed that ultrasound costs were not packaged into the median for endoscopic ultrasound services because of correct coding edits that define endoscopic ultrasound services as including ultrasound.

Response: We have no reason to believe that the costs for endoscopic ultrasound services do not contain the costs for the ultrasound component of the service. Ultrasound services are included in the definition of the endoscopy CPT codes, and the hospital would include charges for the ultrasound in the charge for endoscopy that uses ultrasound services. We believe that the current APC placement of the codes for endoscopic ultrasound services in APC 0141 (Level I Upper GI Procedures) is valid, both with regard to clinical homogeneity and resource use.

r. External Counterpulsation (ECP)

Comment: Several commenters requested that G0166 (External Counterpulsation) in APC 0678 (External Counterpulsation) be assigned status indicator ''S'' rather than ''T'' and that CMS maintain the payment rate for external counterpulsation at the CY 2004 level. The commenters asserted that external counterpulsation is a stand-alone procedure and that assigning it a status indicator ''T'' has contributed to declining and inadequate payment rates for the services. The commenters argued that the proposed payment rate for CY 2005 is not reflective of the costs of the service and that the rate should be consistent with other cardiovascular equipment trends such as echocardiography. They contended that the claims data CMS used are erroneous and pointed out that the payment rate has decreased every year since CY 2000, from $112.72 in CY 2004 to a proposed rate of $105.38 for CY 2005. The commenter also speculated that ''batching'' or ''misreporting'' of claims also may be contributing to the rate decline trend for external counterpulsation.

Response: We do not believe that the rate decrease for these procedures has anything to do with the ''T'' status indicator. The rate for external counterpulsation proposed in the August 16, 2004 proposed rule was based on virtually all (35,764) of the 37,565 hospital claims submitted and the APC is comprised of only this one procedure. We are confident that the claims data are representative of actual costs and as such, that the proposed decreased rate is appropriate.

The status indicator only affects the payment rate when external counterpulsation is billed with another procedure that has a status indicator ''T.'' There are few multiple procedure claims for this procedure in the CY 2003 claims data and, thus, only a very small effect of multiple procedure discounting was possible.

In the absence of supporting information from the commenters, it is not clear what the commenters mean by considering the batching of claims as contributing to the payment decrease. It is also not clear whether or not the commenters' belief that misreporting may be contributing to the rate decline trend for external counterpulsation is justified. However, we encourage hospitals to code accurately.

D. Exceptions to the 2 Times Rule

As discussed earlier, the Secretary is authorized to make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low volume items and services.

Taking into account the APC changes that we proposed for CY 2005 based on the APC Panel recommendations discussed in section II.C. of this

preamble and the use of CY 2003 claims data to calculate the median cost of procedures classified in the APCs in the August 16, 2004 proposed rule, we discussed our review of all the APCs to determine which APCs would not meet the 2 times limit. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

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

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

In the August 16, 2004 proposed rule, we proposed to exempt 54 APCs 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 APC Panel's recommendation because these recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we proposed for CY 2005. The median cost for hospital outpatient services for these and all other APCs can be found at Web site: *http//www.cms.hhs.gov.*

We received one public comment on our proposal.

Comment: One commenter recommended that we use statistical methods to determine variations in the medians of services mapped to an APC. Specifically, the commenter suggested the cost data for an APC should include the standard deviation and the coefficient of variation using the geometric mean as the basis for the measure of dispersion. The commenter recommended that very few APCs be allowed to violate the 2 times rule.

Response: We appreciate the commenter's recommendations. We will consider these recommendations for future recalibrations. We do currently review the range of standard descriptive statistics for all APCs, including, but not limited to, the standard deviation and coefficient of variation. As we stated in the proposed rule, we used multiple criteria to assess whether to propose exceptions to the 2 times rule for affected APCs, including resource and clinical homogeneity, hospital concentration, frequency of services, and opportunities for upcoding and code fragments. Despite an increase in the number of clinical APCs in the OPPS over the last several years, the number of APCs excepted from the 2 times rule has remained relatively stable.

The proposed rule listed exceptions from the 2 times rule based on data from January 1, 2004 through September 30, 2004. For this final rule with comment period, we used data from January 1, 2003 through December 31, 2003. As a result of the additional data, the list of APCs that we are excepting from the 2 times rule has been updated. In this final rule with comment period, we are adopting 57 APCs as excepted from the 2 times rule, as shown in Table 13 below.

BILLING CODE 4120–01–P

Table 13.--APCs Exceptions to the 2 Times Rule

APC	APC Description
0019	Level I Excision/ Biopsy
0024	Level I Skin Repair
0025	Level II Skin Repair
0032	Insertion of Central Venous/Arterial Catheter
0043	Closed Treatment Fracture Finger/Toe/Trunk
0046	Open/Percutaneous Treatment Fracture or Dislocation
0060	Manipulation Therapy
0080	Diagnostic Cardiac Catheterization
0081	Non-Coronary Angioplasty or Atherectomy
0087	Cardiac Electrophysiologic Recording/Mapping
0093	Vascular Reconstruction/Fistula Repair without Device
0099	Electrocardiograms
0105	Revision/Removal of Pacemakers, AICD, or Vascular
0121	Level I Tube changes and Repositioning
0122	Level II Tube changes and Repositioning
0140	Esophageal Dilation without Endoscopy
0146	Level I Sigmoidoscopy
0147	Level II Sigmoidoscopy
0148	Level I Anal/Rectal Procedure
0164	Level I Urinary and Anal Procedures
0183	Testes/Epididymis Procedures
0187	Miscellaneous Placement/Repositioning
0193	Level V Female Reproductive Proc
0203	Level IV Nerve Injections
0204	Level I Nerve Injections
0209	Extended EEG Studies and Sleep Studies, Level II
0213	Extended EEG Studies and Sleep Studies, Level I
0214	Electroencephalogram
0235	Level I Posterior Segment Eye Procedures
0236	Level II Posterior Segment Eye Procedures
0252	Level II ENT Procedures
0262	Plain Film of Teeth
0268	Ultrasound Guidance Procedures
0274	Myelography
0281	Venography of Extremity
0285	Myocardial Positron Emission Tomography (PET)
0297	Level II Therapeutic Radiologic Procedures
0303	Treatment Device Construction
0314	Hyperthermic Therapies
0322	Brief Individual Psychotherapy
0335	Magnetic Resonance Imaging, Miscellaneous
0340	Minor Ancillary Procedures
0341	Skin Tests
0342	Level I Pathology
0344	Level III Pathology
0355	Level I Immunizations
0356	Level II Immunizations
0364	Level I Audiometry
0370	Allergy Tests
0373	Neuropsychological Testing
0389	Non-imaging Nuclear Medicine
0397	Vascular Imaging
0409	Red Blood Cell Tests
0422	Level II Upper GI Procedures
0600	Low Level Clinic Visits
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver
0699	Level IV Eye Tests & Treatments

BILLING CODE 4120–01–C

E. Coding for Stereotactic Radiosurgery Services

1. Background

In the November 7, 2003 final rule with comment period (68 FR 63403), we discussed the APC Panel's consideration of HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery plan) and G0243 (Cobalt 60-based stereotactic radiosurgery delivery). At its August 22, 2003 meeting, the APC Panel discussed combining the coding for these procedures under one code, with the payment for the new code derived by adding together the payments for HCPCS codes G0242 and G0243. The APC Panel recommended that we solicit additional input from professional societies representing neurosurgeons, radiation oncologists, and other experts in the field before recommending changes to the coding configuration for Cobalt 60-based stereotactic radiosurgery planning and delivery.

In a correction to the November 7, 2003 final rule with comment period, issued on December 31, 2003 (68 FR 75442), we considered a commenter's request to combine HCPCS codes G0242 and G0243 into a single procedure code in order to capture the costs of this treatment in a single procedure claim because the majority of patients receive the planning and delivery of this treatment on the same day. We responded to the commenter's request by explaining that several other commenters stated that HCPCS code G0242 was being misused to code for the planning phase of linear accelerator-based stereotactic radiosurgery planning. Because the claims data for HCPCS code G0242 represent costs for linear accelerator-based stereotactic radiosurgery planning (due to misuse of the code), in addition to Cobalt 60-based stereotactic radiosurgery planning, we were uncertain of how to combine these data with HCPCS code G0243 to determine an accurate payment rate for a combined code for planning and delivery of Cobalt 60-based stereotactic radiosurgery.

In consideration of the misuse of HCPCS code G0242 and the potential for causing greater confusion by combining HCPCS codes G0242 and G0243, we created a planning code for linear accelerator-based stereotactic radiosurgery (HCPCS code G0338) to distinguish this procedure from Cobalt 60-based stereotactic radiosurgery planning. We maintained both HCPCS codes G0242 and G0243 for the planning and delivery of Cobalt 60-based stereotactic radiosurgery treatment, consistent with the use of two G-codes for planning (HCPCS code G0338) and delivery (HCPCS codes G0173, G0251, G0339, G0340, as applicable) of each type of linear accelerator-based treatment. We indicated that we intend to maintain these new codes in their current new technology APCs until the payment rates could be set using medians from this expanded set of codes. We also stated that we would solicit input from the APC Panel at its February 2004 meeting.

During the February 2004 APC Panel meeting, several presenters discussed with the APC Panel their rationale for requesting that HCPCS codes G0242 and G0243 be combined into a single procedure code. One presenter explained that the request to combine the codes was made because certain fiscal intermediaries were rejecting claims in which HCPCS codes G0242 and G0243 were reported with a surgery revenue code. Although we have not issued any national instructions to fiscal intermediaries to deny claims for these services if they are billed with a surgery revenue code, the presenter stated that we may have indirectly led some fiscal intermediaries to believe that Cobalt 60-based stereotactic radiosurgery should be reported with a radiation therapy revenue code because the procedure is separated into a planning code and a delivery code, which reflect the coding pattern of a radiation therapy procedure rather than a single code for a surgical procedure. The presenter stated that because of the way that CMS has coded this procedure, some fiscal intermediaries have established local edits to deny claims in which HCPCS codes G0242 and G0243 are reported on a claim with a surgery revenue code.

The APC Panel recommended that CMS work with the presenters to determine if any fiscal intermediaries have established local edits to reject claims in which HCPCS codes G0242 and G0243 are reported on a claim, and to determine specific reasons for any such local edits. The APC Panel also recommended that CMS take necessary action to ensure that any such claims are not being denied payment due to local edits. The APC Panel did not agree that the solution to ensuring payment was to combine HCPCS codes G0242 and G0243 into a single code, but rather recommended that CMS educate fiscal intermediaries as to the appropriate procedures for submission of these claims for Medicare payment.

2. Proposal for CY 2005

In the August 16, 2004 proposed rule, for CY 2005, we proposed to accept the APC Panel's recommendation to work with the presenters to ensure that claims in which HCPCS codes G0242 and G0243 are reported are not being inappropriately denied payment due to local edits established by fiscal intermediaries. In the meantime, for CY 2005, we proposed to maintain HCPCS code G0242 in New Technology APC 1516 (New Technology, Level XVI) at a payment rate of $1,450, and HCPCS code G0243 in New Technology APC 1528 (New Technology, Level XXVIII) at a payment rate of $5,250. These payment rates are the same as those established for CY 2004.

3. Public Comments Received and Departmental Responses

Comment: Numerous comments urged CMS to replace HCPCS codes G0242 (Cobalt 60-based multisource photon SRS, planning) and G0243 (Cobalt 60-based multisource photon SRS, delivery) with one surgical code (that is, CPT code 61793, Stereotactic radiosurgery, one or more lesions) for billing Cobalt 60-based multisource photon stereotactic radiosurgery. These commenters explained that Cobalt 60-based multisource photon SRS is considered to be a one session, neurosurgical procedure and is not separated into planning and delivery sessions. One commenter contended that this procedure is managed and performed exclusively by neurosurgeons.

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter suggested that a combined surgical code representing Cobalt 60-based stereotactic radiosurgery could be appropriately assigned to APC 0222 (Implantation of Neurological Device), APC 0226 (Implantation of Drug Infusion Reservoir), or APC 0227 (Implantation of Drug Infusion Device) to reflect the device costs, the neurosurgical nature of the procedure, and the clinical homogeneity of the other CPT codes that currently reside in these APCs.

In response to the OPPS final rule with comment period published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, several commenters indicated that the current coding structure has resulted in a low volume of single procedure claims for these codes, reflecting the fact that single procedure claims are billed in error for this procedure due to the necessity of billing both HCPCS codes G0242 and G0243 to capture the planning and delivery costs of this procedure. These commenters explained that the concept of planning and delivery is representative of radiation

therapy and, therefore, does not accurately describe Cobalt 60-based multisource photon SRS. The commenters believed that the creation of HCPCS codes G0242 and G0243 has created an unnecessary burden on hospitals because commercial payors do not recognize these codes. One commenter described the burden of reporting the same service using two different coding systems as the costs associated with hiring and training additional staff, preparing individual negotiations with insurers, and addressing the rejection of claims and the delay of treatments.

In contrast, three commenters objected to the use of the term ''radiosurgery'' to describe Cobalt 60-based multisource photon SRS planning and delivery. One of these commenters indicated that Cobalt 60-based multisource photon SRS is a radiation therapy procedure. This commenter contended that the indirect costs of operating a radiation therapy department are considerably higher than that of a surgery department, when factoring in the cost of a radiation physicist and therapist. The commenter further indicated that the cost-to-charge ratio (CCR) for the radiation therapy cost center more accurately reflects the costs of providing this service relative to a surgical designation. Another commenter objected to our use of the term ''radiosurgery'' and asserted that this term is a misleading nomenclature because surgery is not involved, except for the placement of an externally attached coordinate reference frame. The commenter explained that this treatment usually consists of one or more high dose radiation treatments delivered by either a linear accelerator or a cobalt 60-based unit and, therefore, should be referred to as ''stereotactic radiation therapy.''

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter urged that CMS not attempt to label stereotactic radiosurgery as either neurosurgery or external beam radiotherapy, and explained that stereotactic radiosurgery is a unique procedure that combines elements of both neurosurgery and external beam radiotherapy. This commenter recommended that we recognize CPT codes specifically designed for stereotactic radiosurgery.

Response: Considering the wide range of conflicting recommendations we received from commenters, we believe that appropriate coding for Cobalt 60-based multisource photon SRS remains a highly contentious and unsettled area of interest among hospitals, neurosurgeons, radiation oncologists, and non-Medicare payors. Based upon our reading of the comments and the observations of CMS staff, we do not believe that Cobalt 60-based multisource photon SRS can be easily classified as either a neurosurgical or radiation therapy procedure specifically. Rather, for the safe and effective delivery of Cobalt 60-based multisource photon SRS to typical patients with brain lesions, the contributions of hospital physician and nonphysician staff with expertise in neurosurgery and radiation therapy are essential for both the planning of the treatment and its delivery.

In the OPPS November 30, 2001 final rule in which we first established payment rates for stereotactic radiosurgery planning and treatment using G-codes in lieu of CPT codes, we noted that, for historical hospital claims for CPT code 61793 (Stereotactic radiosurgery), other combinations of codes from the radiation oncology CPT code section were billed most of the time as well. This confirmed our recognition of the multidisciplinary nature of the service. However, we note that the classification of stereotactic radiosurgery as either neurosurgery or radiation therapy is not relevant to payment for the service under the OPPS. Therefore, for purposes of the OPPS, we have not attributed the service to one specialty or the other.

While we consider the adoption of CPT codes that describe this service, we will continue to maintain HCPCS codes G0242 and G0243 as separate codes in their respective new technology APCs 1516 and 1528 for CY 2005. Although we recognize that the single claims data we collect from these codes may include aberrant claims due to the necessity of billing both HCPCS codes G0242 and G0243 on the same date of service for a correctly coded claim, the adoption of CPT code 61793 to replace HCPCS codes G0242 and G0243, as recommended by some commenters, would not resolve the multiple procedure claims dilemma due to the fact that typically hospitals would need to bill additional CPT codes along with CPT code 61793 to report the full range of services that are currently bundled into HCPCS codes G0242 and G0243. For example, in our November 30, 2001 final rule in which we described our determination of the total cost for stereotactic radiosurgery, to model costs for planning, we added the median costs of CPT codes 77295 (the most typical simulation code billed with CPT code 61793), 77300, 77370 (the most common physics consult billed with CPT code 61793), and 77315 (the most common dose plan billed with CPT code 61793). Furthermore, the descriptor for CPT code 61793 describes multiple forms of stereotactic radiosurgery (that is, stereotactic radiosurgery, one or more lesions; particle beam, gamma ray or linear accelerator), rather than Cobalt 60-based multisource photon SRS alone. The adoption of CPT code 61793 under the OPPS would have the effect of nullifying all of the stereotactic radiosurgery G–codes, which we are unwilling to do without cost data supporting an equal payment for all forms of stereotactic radiosurgery. In light of all the above-mentioned reasons, we believe that any stereotactic radiosurgery code changes for CY 2005 would be premature without cost data to support a code restructuring. In the meantime, we will continue to pay HCPCS codes G0242 and G0243 under their current respective new technology APCs 1516 and 1528 for CY 2005, as we continue to analyze new methods for resolving the issue of multiple procedure claims.

Comment: In response to the OPPS final rule with comment period published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, several commenters urged CMS to recognize the surgical nature of Cobalt 60-based multisource photon SRS by mapping the procedure to a surgical revenue code. The commenters claimed that some Medicare fiscal intermediaries continue to reject claims in which HCPCS codes G0242 and G0243 are reported with a surgery revenue code, and encouraged CMS to issue national instructions on the correct billing for stereotactic radiosurgery procedures. The commenters believed that revenue codes are established by the general APC in which the procedure resides. Another commenter stated that the placement of HCPCS codes G0242 and G0243 in new technology APCs labeled as radiation therapy has misled Medicare fiscal intermediaries to assume that a radiation revenue code must be reported with these claims. This commenter indicated that, as a result of providers reporting a radiation revenue code when billing HCPCS codes G0242 and G0243 and Medicare applying a radiation CCR ratio to these codes, the median costs for HCPCS codes G0242 and G0243 were understated, as the CCR for radiation is around 33 percent compared to a 45-percent to 55-percent CCR for surgery cost centers.

In response to the OPPS final rule with comment period published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, two commenters objected to the

assignment of HCPCS codes G0243 and G0173 to the same new technology APC 1528. The commenters argued that these two procedures should not be grouped into the same APC because they are clinically dissimilar and do not share the same level of resource intensity. The commenter believed that an APC grouping should be determined by the clinical nature of the procedure, its resource cost, the type of physician necessary to perform the procedure, the clinical setting in which the procedure is performed, and the clinical outcomes of the procedure. Another commenter indicated that the cost of Cobalt 60-based SRS multisource photon SRS delivery is 2.45 times the cost of linear accelerator-based SRS delivery, which the commenter believed to be an unacceptable violation of the 2 times rule. In contrast, one commenter reported that its facility has experienced no delays or claims rejections as a result of the current coding structure for stereotactic radiosurgery. The commenter urged CMS to maintain the current coding structure for Cobalt 60-based multi-source photon SRS planning and delivery, asserting that providers who carefully review the code descriptors should experience no delays or claims rejections.

Response: We believe the commenter's concerns regarding the clinical similarity and the application of the 2 times rule to a new technology APC reflect a misunderstanding of the purpose of the new technology APCS. We assign procedures to a new technology APC when we do not have adequate claims data upon which to determine the relative median cost of performing a procedure, and must rely on other sources of information (that is, external data that have been made publicly available) to determine its appropriate payment. New technology APCs do not carry clinical descriptors, such as radiation therapy; rather, the descriptor for each new technology APC represents a particular cost band (for example, $1,400 to $1,500). Payment for items assigned to a new technology APC is the mid-point of the band (for example, $1,450). As we stated in our proposed rule, we have worked together with some of the commenters to identify specific fiscal intermediaries who may be rejecting claims in which HCPCS codes G0242 and G0243 are reported. However, to date, we have been unable to identify any such local edits. Nor have we received examples of rejected claims from providers to enable us to determine why payment was not made for the claims. CMS will continue to work with providers and contractors to clarify coding and billing for all stereotactic radiosurgery procedures through program instructions, Medlearn Matters articles, and other outreach activities.

Comment: One commenter understood that the Advisory Panel on APC Groups is invested with the responsibility of providing correct coding for hospitals, and contended that the Panel should address in more detail the coding issues for stereotactic radiosurgery procedures. This commenter further indicated that the Panel is composed almost entirely of physicians rather than hospital financial personnel or hospital coders, to which the commenter objected as creating a direct conflict with hospital interests.

Response: We do not agree with the commenter's concerns regarding the Advisory Panel on APC Groups. The Panel is governed by the provisions of Pub. L. 92–463, which set forth standards for the formation and use of advisory panels (42 U.S.C. 13951 (t); section 1833(t) of the Act). According to the Charter, the function of the Panel is to review the APC groups and their associated weights and advise the Secretary of Health and Human Services and the Administrator of CMS concerning the clinical integrity of the APC groups and their weights. The subject-matter of the Panel includes to the following issues and related topics: addressing whether procedures are similar both clinically and in terms of resource use; assigning new CPT codes to APCs; reassigning codes to different APCs; and reconfiguring the APCs into new APCs. Responsibility for providing correct coding for hospitals does not fall within the purview of the Panel. Furthermore, we wish to reassure the commenter about the makeup of the Panel. The commenter's understanding that the Panel is almost entirely composed of physicians and lacks representation from hospital financial personnel or hospital coders is not accurate. As required by the Charter, all of the Panel members are currently employed in a full-time status by a hospital and serve as representatives of their hospital employer. Furthermore, only approximately half of the Panel members hold a medical degree, while the other half of the Panel members hold a hospital coding certification or nursing, pharmacy, or business degree(s), or both, or serve as hospital reimbursement officers, or both.

Comment: We received numerous comments suggesting various simplifications of the coding structure for SRS planning and delivery. Some commenters urged that CMS develop one uniform series of treatment codes for the various types of stereotactic radiation therapy, based on the process of care rather than a vendor-specific technology. One commenter suggested that CMS eliminate HCPCS codes G0338 (Linear accelerator-based SRS planning) and G0242 (Multi-source Cobalt 60-based photon SRS planning) and recognize existing CPT codes 77295 or 77301 to describe stereotactic radiation therapy planning, which the commenter believed would more accurately describe the process of care and reduce duplication in codes. Another commenter recommended that CMS eliminate HCPCS code G0242, and recognize HCPCS code G0338 for describing all forms of stereotactic radiosurgery planning by deleting the phrase that restricts the code to linear accelerator-based stereotactic radiosurgery planning.

In contrast, a commenter responding to the OPPS final rule with comment period published on November 7, 2003, suggested that CMS eliminate HCPCS code G0338, and recognize HCPCS code G0242 for all stereotactic radiosurgery planning by deleting the phrase that restricts the code to multisource Cobalt 60-based photon SRS planning. Other commenters recommended that CMS simplify the stereotactic radiosurgery delivery codes as well by eliminating HCPCS codes G0173 (SRS delivery, complete session) and G0251 (Linear accelerator-based SRS delivery, fractionated sessions), and recognizing HCPCS codes G0339 (Image guided, robotic linear accelerator-based SRS, complete or first session) and G0340 (Image guided, robotic linear accelerator-based SRS, second through fifth sessions) for all forms of stereotactic radiosurgery delivery by removing the word ''robotic'' from their descriptors. Another commenter suggested an alternative option for simplifying the stereotactic radiosurgery delivery codes by eliminating HCPCS codes G0339 and G0340, and recognizing HCPCS codes G0173 and G0251. This commenter recommended that CMS modify the descriptors for HCPCS codes G0173 and G0251 by deleting the linear accelerator specification so the codes apply to all forms of stereotactic radiosurgery delivery and deleting the maximum number of five sessions per course of treatment from the descriptor of HCPCS code G0251. One commenter suggested that CMS eliminate HCPCS codes G0173, G0251, G0339, and G0340 and recognize HCPCS code G0243 as including all stereostactic radiosurgery delivery procedures by deleting the phrase that restricts its use to

multisource Cobalt 60-based photon stereotactic radiosurgery delivery.

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter indicated that HCPCS code G0340 (Image guided, robotic linear accelerator-based SRS, second through fifth sessions) should not be described by radiosurgery, contending that radiosurgery is defined by a single session treatment. The commenter recommended that the descriptor for HCPCS code G0340 be changed to ''image-guided, robotic, linear accelerator-based radiation therapy-hypofractionated delivery.'' One commenter responded to the OPPS proposed rule by applauding CMS for placing the first fraction of a multiple session treatment delivery of image-guided robotic linear accelerator-based stereotactic radiosurgery (described by HCPCS code G0339) in the same APC as a complete single session treatment delivery of image-guided robotic linear accelerator-based stereotactic radiosurgery, and stated that the resources consumed are identical, regardless of whether additional treatment sessions are delivered. This commenter agreed with CMS' placement of subsequent fractionated sessions in a lower paying APC to reflect the fewer resources consumed during the delivery of subsequent sessions.

In response to the OPPS final rule with comment period published November 7, 2003, several commenters supported CMS' decision to assign HCPCS codes G0338 (Linear accelerator-based stereotactic radiosurgery planning) and G0242 (Cobalt 60-based, multi-source photon stereotactic radiosurgery planning) to the same APC, and stated that the resource costs of both types of stereotactic radiosurgery planning are comparable. Another commenter applauded CMS' creation of HCPCS code G0338 to differentiate linear accelerator stereotactic radiosurgery planning from multisource photon stereotactic radiosurgery planning (HCPCS code G0242), due to the differences in their clinical uses and cost resources.

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter supported the creation of HCPCS codes G0339 and G0340, as long as these codes are used exclusively for extracranial stereotactic radiosurgery treatments, such as those of the spine, lung, and pancreas. Due to limited cost data and clinical efficacy published on image-guided, robotic stereotactic radiosurgery used to treat extracranial indications, the commenter believed that the costs for this new and emerging technology would be more accurately captured by limiting the use of HCPCS codes G0339 and G0340 to extracranial stereotactic radiosurgery treatments.

Several commenters requested that CMS present their recommendations to the Advisory Panel on APC Groups during its next meeting in the event that the stereotactic radiosurgery code descriptors cannot be modified in time for the CY 2005 final rule.

Response: For reasons stated in a previous response, we believe that any stereotactic radiosurgery code changes for CY 2005 would be premature without cost data to support a code restructuring. For instance, in preparation of the CY 2006 OPPS Update, we intend to conduct data analysis for the first time for HCPCS codes G0338, G0339, and G0340, which were newly created G-codes for CY 2004. Therefore, until we have completed any such analysis, we will continue to maintain HCPCS codes G0173, G0251, G0338, G0339, G0242, and G0243 in their respective new technology APCs for CY 2005 as we consider the adoption of CPT codes to describe all stereotactic radiosurgery procedures for CY 2006, including the new CPT tracking codes 0082T (Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day) and 0083T (Stereotactic body radiation therapy, treatment management, per day) that the AMA intends to make effective January 1, 2005. For CY 2005, we will assign a status indicator of ''E'' for CPT code 0082T to reflect the fact that the current G-codes for stereotactic radiosurgery treatment delivery include this service, and a status indicator of ''N'' for CPT code 0083T because we consider the treatment management per session bundled into the current stereotactic radiosurgery treatment delivery G-codes.

In reference to commenters' request that CMS present their recommendations for stereotactic radiosurgery code restructuring to the Advisory Panel on APC Groups, we refer the readers to the discussion above in an earlier response concerning the purview of the Panel's responsibilities. To the extent that the APC assignments for stereotactic radiosurgery codes are an issue, we may bring those to the attention of the Panel.

Comment: In response to the OPPS final rule with comment period published on November 7, 2003, several commenters expressed concern that the placement of HCPCS code G0340 (Image-guided robotic linear accelerator-based SRS delivery, fractionated treatment) in a higher paying new technology APC than G0251 (Non-robotic linear accelerator-based SRS delivery, fractionated treatment) creates a financial incentive to use robotic SRS technology over non-robotic stereotactic radiosurgery technology. The commenters urged that HCPCS codes G0251 and G0340 be placed in the same APC until clinical evidence supports an improved clinical outcome using robotic stereotactic radiosrugery as compared to non-robotic stereotactic radiosurgery and sound financial data supports payment differentiation. In addition to placing G0251 and G0340 in the same APC, one commenter urged that CMS remove the language ''or first session of fractionated treatment'' from the descriptor for G0339 and remove the language ''second through fifth sessions'' from the descriptor for G0340, so that placement of HCPCS codes G0251 and G0340 in the same APC will result in equal payments for the first session of fractionated therapy, regardless of the type of technology used to deliver fractionated stereotactic radiosurgery.

In response to the OPPS final rule with comment published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, several commenters asserted that the creation of HCPCS codes G0339 and G0340 was unnecessary, on the premise that all stereotactic radiosurgery and radiotherapy equipment is image guided and robotic. One commenter expressed concern that the creation of HCPCS codes G0339 and G0340, the limitation of HCPCS code G0340 to five fractionated sessions, and the placement of HCPCS code G0340 in a higher paying APC than other SRS modalities inadvertently amount to an endorsement by CMS of the CyberKnife technology. The commenter believed that the current payment rate for CyberKnife therapy results in excessive copayments for beneficiaries and unfairly advantages a technology that has provided insufficient clinical evidence of an improved outcome above existing stereotactic radiosurgery and radiotherapy modalities, and has provided CMS with no convincing cost data to support such an excessive return on investment. The commenter believed that if CMS had consulted the Medicare Coverage Advisory Committee (MCAC) or the Medical Technology Council (MTC), which advise CMS on whether specific medical treatments and technology should receive coverage, neither the MCAC nor the MTC would have recommended coverage for the CyberKnife technology. Other

commenters urged that CMS eliminate what they believe to be an unfair advantage given to HCPCS code G0339 by modifying the descriptor for HCPCS code G0173 (SRS delivery, complete session) to describe a complete session or first session of linear accelerator-based stereotactic radiosurgery delivery, and modifying the descriptor for HCPCS code G0251 to describe second through fifth sessions of linear accelerator-based stereotactic radiosurgery delivery, so that the first session of a multiple session treatment will be paid equal to that of a complete session, regardless of the type of stereotactic radiosurgery technology used.

Response: We disagree with commenters who believe that the creation of HCPCS codes G0339 and G0340, the limitation of HCPCS code G0340 to five fractionated sessions, and the placement of HCPCS code G0340 in a higher paying APC than other stereotactic radiosurgery modalities amount to an endorsement by CMS of a particular technology. We also note that the code descriptors for HCPCS codes G0339 and G0340 do not limit themselves to the CyberKnife technology. As other commenters indicated, the term ''image-guided robotic'' applies to other types of stereotactic radiosurgery besides CyberKnife. The OPPS payment system establishes payment rates for services based on relative resources utilized by hospitals to provide such services, based primarily on historical claims data if data are available. If hospital claims data are unavailable, we may consider external data to assist us. From 2000 through 2002, the manufacturer of one type of image-guided robotic stereotactic radiosurgery technology (that is, CyberKnife), along with several hospitals, provided CMS with cost data indicating the level of resources utilized in the provision of this form of stereotactic radiosurgery. We believe these data support the current placement of HCPCS codes G0339 and G0340 in their respective new technology APCs 1528 and 1525 for CY 2005.

To date, we have not received such cost data on non-robotic linear accelerator-based stereotactic radoisurgery (that is, on HCPCS codes G0173 and G0251) to aid us in determining if the current payment differentiation is appropriate. Therefore, we will maintain HCPCS codes G0339 and G0340 in APCs 1528 and 1525, respectively, and make no changes to their descriptors for CY 2005. In reference to CMS consulting a medical technology council for advice on new technology coverage, we refer the readers to section II.F.4.,''Public Comments Received Relating to Other New Technology APC Issues,'' of this final rule with comment period for a discussion of the recently established Council on Technology and Innovation.

Comment: A number of commenters, mostly providers of radiation oncology centers or departments, pointed out that stereoscopic kV x-ray guidance using infrared and/or camera technology is a new and important technology that allows for improved precision in radiation therapy targeting. These commenters indicated that kV x-ray guidance is not described by any current HCPCS or CPT code and requested that CMS create a new HCPCS G-code for payment under the OPPS. In addition, one commenter requested that CMS establish a new HCPCS code necessary for target localization in conjunction with intensity modulated radiation therapy, stereotactic radiotherapy, and stereotactic radiosurgery.

Response: The kV x-ray guidance using infrared technology came to our attention by means of an application to be considered for assignment to a new technology APC. We have recently concluded that the kV x-ray guidance should receive a temporary ''C'' code for OPPS payment under certain circumstances described below, and that it should be placed into a new technology APC. Therefore, we are creating the following HCPCS code to describe kV x-ray guidance using infrared technology:

HCPCS code C9722 (Stereoscopic kV x-ray imaging with infrared tracking for localization of target volume)

We are assigning the new HCPCS code C9722 to New Technology APC 1502 at a payment of $75, effective on January 1, 2005.

While we are assigning a C-code and payment for hospital costs, we are not assigning a G-code because we believe that the interested party should seek a CPT code from the AMA. We believe that the CPT Editorial Panel needs to assess the need for a code for the service, and, if a code is granted, evaluate the resources necessary to provide this service. This technology has been available for more than 2 years. We consider this time period to be sufficient for the interested party to request a CPT code from the AMA.

In addition, in our definition and payment instructions for this service, we are limiting additional payment for this service to occasions when kV x-ray is not billed with stereotactic radiosurgery delivery G-codes. As all stereotactic radiosurgery delivery services require guidance, the current payments for the stereotactic radiosurgery delivery G-codes (HCPCS codes G0173, G0243, G0251, G0339, and G0340) bundle payment for guidance services with stereotactic radiosurgery delivery.

4. Final Policy for CY 2005

We are adopting our proposal to maintain HCPCS codes G0173, G0242, G0243, G0251, G0338, and G0339 in their respective new technology APCs for CY 2005. We will consider the adoption of CPT codes to describe all stereotactic radiosurgery procedures in the future.

F. Movement of Procedures From New Technology APCs to Clinically Appropriate APCs

1. Background

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 CY 2002, we retained services within new technology APC groups until we acquired adequate data to enable us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

In the November 7, 2003 final rule with comment period, we implemented a comprehensive restructuring of the new technology APCs to make the payment levels more consistent (68 FR 63416). We established payment levels in $50, $100, and $500 intervals and expanded the number of new technology payment levels.

2. APC Panel Review and Recommendation

During the APC Panel's February 2004 meeting, the APC Panel heard testimony from several interested parties who requested specific modifications to the APCs for the radiation oncology APC. They asked the APC Panel to make several recommendations: (1) That we move CPT code 77418 (Radiation treatment delivery, Intensity-modulated radiation therapy (IMRT)) from APC 0412 (IMR Treatment Delivery) back into a new technology APC; (2) that we dampen, or limit, any possible payment reductions to APC 0301 (Level II Radiation Therapy); (3) that we accept more external data to evaluate costs; and (4) that we identify more claims that are useful for ratesetting.

In response to the testimony presented, the APC Panel recommended that we reassign CPT code 77418 to the new technology APC 1510 for CY 2005 and that we explain to providers any steps we take to limit payment reductions to APC 0301 so that they can better plan for future years during which we may decide not to apply a dampening, or payment reduction limitation, to the rates for APC 0301.

In the August 16, 2004 proposed rule, we did not propose to accept the APC Panel's recommendations because we believe that we have ample claims data for use in determining an appropriate APC payment rate for CPT code 77418. Moreover, we believe that the development of median cost for CPT code 77418 based on those data is representative of hospital bills.

We have over 255,000 claims for this service, and over 95 percent were single claims that we could use for ratesetting. Moreover, the APC medians have been stable for the last 2 years of data. As indicated by our claims data, returning code 77418 to new technology APC 1510 would result in a payment for the service that is significantly higher than the resources utilized to provide it.

We refer the readers to section II.F.4., ''Public Comments Received Relating to Other New Technology APC Issues,'' of this final rule with comment period for a discussion of the public comments and our final policy regarding the APC placement of CPT code 77418 for CY 2005.

Comment: Several commenters objected to the proposed assignment of CPT code 77418 to APC 0412 at a payment rate of $307.78. These commenters disagreed with CMS' conclusion that the significant volume of single claims used to set the payment rate accurately reflects the costs hospitals incur to provide this service, and argued that hospitals are inaccurately coding this service and submitting insufficient charges for delivering this therapy. One commenter raised concerns that some providers are incorrectly billing procedures other than IMRT under CPT code 77418. Commenters urged CMS to accept the recommendation of the Advisory Panel on APC Groups to return CPT code 77418 to a new technology APC with a payment rate comparable to the CY 2003 payment rate of $400.

Response: As we noted previously, we do not accept the Panel's recommendation to move CPT code 77418 back to a new technology APC. We believe the 2 years (that is, CYs 2002 and 2003) that CPT code 77418 was in new technology APC 0710 allowed ample opportunity for providers to receive proper instruction on correctly coding and billing for this service. The proposed payment rate of $307.78 for CY 2005 was set using 96 percent of the total claims (that is, 246,045 single procedure claims out of 255,020 total claims) for CPT code 77418, which deeply supports its current placement in clinical APC 0412. Therefore, we will maintain CPT code 77418 in APC 0412 for CY 2005.

Comment: Several commenters objected to the proposed movement of CPT code 77301 (Radiotherapy dose plan, IMRT) from new technology APC 1510 (New Technology, Level X) with a payment rate of $850 to clinical APC 0310 (Radiation treatment preparation, Level III) with a payment rate of $811.91. The commenters indicated that this procedure is relatively new and that hospitals appear to be inaccurately reporting the costs of providing this service. The commenters recommended that, until more data can be collected and analyzed, CMS retain CPT code 77301 in new technology APC 1510 at a payment rate of $850.

Response: We move a procedure from a new technology APC to a clinical APC when we have adequate claims data for ratesetting. We believe that the proposed movement of CPT code 77301 from new technology APC 1510 to clinical APC 0310 is appropriate, considering that 88 percent of the total claims (66,076 single procedure claims out of 74,911 total claims) were used to set the payment rate of $811.91 for APC 0301. Furthermore, CPT code 77301 has been placed in a new technology APC for the past 3 years (that is, CY 2002 through CY 2004), which we believe to be ample time for providers to receive proper instruction on correctly coding and billing for CPT code 77301. Therefore, as proposed, we are moving CPT code 77301 from new technology APC 1510 to clinical APC 0310 for CY 2005.

Comment: One commenter requested that new CPT 0073T (Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session) be assigned to APC 0412 with an ''S'' status indicator. The commenter believed that the assignment of 0073T should be the same as that for CPT 77418.

Response: We agree with the commenter and are assigning CPT 0073T to APC 0412 with status indicator ''S'' for CY 2005.

3. Proposed and Final Policy for CY 2005

There are 24 procedures currently assigned to new technology APCs for which we have data adequate to support assignment into clinical APCs. Therefore, in the August 16, 2004 proposed rule, we proposed to reassign these procedures to clinically appropriate APCs. We proposed to assign 24 of the procedures that were listed in Table 14 of the proposed rule to clinically appropriate APCs using CY 2003 claims data to set medians on which payments would be based.

As we did in the proposed rule, we present below a further explanation to provide a fuller understanding of the payment rates for several of the procedures that we proposed to move out of new technology APCs and into clinical APCs.

a. Photodynamic Therapy of the Skin

For CPT code 96567 (Photodynamic therapy of the skin), the impact of the payment decrease between CY 2004 and CY 2005 is actually low, as the CY 2004 payment included the topically applied drug required to perform this procedure and the CY 2005 payment does not. We will now pay separately for the drug billed under HCPCS code J7308 in CY 2005. We have adequate claims data on which to base payment for that procedure in a clinically appropriate APC. Payment based on those data in addition to removal of the drug for separate payment resulted in a lower median cost for the APC.

Comment: Several commenters objected to the proposed movement of CPT code 96567 (Photodynamic therapy of the skin) from New Technology APC 1540 (New Technology, Level III) with a payment rate of $150 to clinical APC 0013 (Level II Debridement and Destruction) with a proposed payment rate of $66.15. The commenters recognized that the drug (that is, HCPCS code J7308) used with this procedure is no longer bundled into the payment for CPT code 96567, and agreed that some payment reduction is appropriate. However, the commenters indicated that the proposed payment rate for APC 0013 would not cover the costs of providing this service even after excluding the costs of the drug.

Response: We believe that the resources and the clinical nature of CPT code 96567 are consistent with other codes that are placed in APC 0013. Therefore, in this final rule with comment period, we are finalizing our proposal to move CPT code 96567 from New Technology APC 1540 to clinical APC 0013 for CY 2005.

Comment: One commenter brought to our attention that CPT code 96571 (Photodynamic therapy, additional 15 minutes) may have been moved mistakenly from New Technology APC 1541 to clinical APC 0012 (Level I Debridement and Destruction). The commenter suggested that CPT code 96571 be placed in the same clinical APC 0013 (Level II Debridement and Destruction) as CPT code 96570 (Photodynamic therapy, 30 minutes).

Response: We agree with the commenter that CPT code 96571 was mistakenly moved to APC 0012 in the proposed rule. Because CPT code 96571 is an add-on code for an additional 15 minutes of photodynamic therapy, reported in addition to CPT code 96570, which describes the first 30 minutes of therapy, we believe that both codes, with status indicator ''T,'' should be placed in APC 0015 (Level III Debridement and Destruction). Therefore, in this final rule with comment period, we are moving CPT code 96571 from New Technology APC 1541 to clinical APC 0015 for CY 2005.

b. Left Ventricular Pacing, Lead and Connection

Based on a comparison of payment rates for CY 2004 and CY 2005, it appears that there is a large increase in payment that results from reassigning CPT code 33224 (Insertion of left ventricular pacing, lead and connection) from its new technology APC to a clinical APC. The difference is due to the fact that the CY 2005 APC payment includes the cost of the left ventricular lead that was not included in the CY 2004 new technology APC payment. The left ventricular lead was paid as a pass-through device under HCPCS code C1900 in CY 2004, but is not eligible for pass-through payments in CY 2005, and, as such, is now included in the APC for the procedure.

Similarly, the CY 2005 payment rate for CPT code 33225 (Left ventricular pacing lead add-on) includes the cost of the ventricular lead. However, for code 33225, the data are still somewhat unstable. Therefore, in the proposed rule, we maintained CPT code 33225 in a new technology APC, but at a higher payment level, to reflect the additional cost of the lead.

We received no comments and, therefore, we are reassigning CPT code 33224 to a clinical APC for CY 2005.

c. Positron Emission Tomography (PET) Scans

PET–FDG (Nonmyocardial)

In the proposed rule, we noted that a number of positron emission tomography (PET) scans currently are classified into APC 1516. We recognized that PET is an important technology in many instances and want to ensure that the technology remains available to Medicare beneficiaries when medically necessary. We believe that we have sufficient data to assign PET scans to a clinically appropriate APC. However, we have been told that if the effect of doing so is to reduce payment significantly for the procedure, it may hinder access to this technology. Therefore, as indicated in the August 16, 2004 proposed rule, we considered three options as the proposed payment for these procedures in CY 2005, based on our review of the 2003 claims data for the PET procedures. We specifically invited comments on each of these options.

Option 1: Continue in CY 2005 the current assignment of the scans to New Technology APC 1516 prior to assigning to a clinical APC.

Option 2: Assign the PET scans to a clinically appropriate APC priced according to the median cost of the scans based on CY 2003 claims data. Under this option, we would assign PET scans to APC 0420 (PET Imaging).

Option 3: Transition assignment to a clinical APC in CY 2006 by setting payment in CY 2005 based on a transition payment of a 50–50 blend of the median cost and a New Technology APC payment for CY 2004. We would assign the scans to New Technology APC 1513 for the blended transition payment.

We included the proposed rates for these options in Addendum B of the proposed rule.

Comment: Many commenters supported maintaining a number of PET scans in New Technology APC 1516 for CY 2005, as presented under option 1 of the proposed rule. These commenters expressed concern that options 2 and 3 set forth in the proposed rule would greatly impede patient access to PET technology. They stated that options 2 and 3 fail to account for the significant degree of variation in hospital mark-up practices and capital depreciation methods associated with PET procedures and, therefore, underestimate hospitals' costs for performing PET scans. These commenters further explained that the majority of hospitals report PET procedures under an overall diagnostic radiology revenue code rather than distinguishing PET procedures under a diagnostic nuclear medicine revenue code. The commenters expressed concern that PET claims data, when adjusted using a cost to charge ratio not specific to PET, underestimate the relative costs associated with PET imaging procedures.

Another commenter commissioned a time-and-motion study at nine PET facilities in geographically diverse regions of the United States to estimate hospitals' actual costs for providing PET scans. According to the commenter, this cost study concluded that many hospitals could not afford to provide PET scans at a payment rate below $1,450. In addition, the commenter indicated that the cost study suggested that hospitals need to perform three or more scans per day in order to break even at the current payment rate of $1,450 per scan. The commenter pointed out that using a marketing share-weighted average, the cost study found that PET facilities across the United States are performing an average of 2.63 PET scans per day, translating into a loss of $165.18 per scan for most PET providers at the current payment rate of $1,450 per scan. However, the commenter did not clarify whether this national average of performing 2.63 PET scans per day reflects utilization by both hospitals and freestanding PET centers. The commenter urged that PET remain in new technology APC 1516 for CY 2005, and noted that any reductions in payment, including the proposed blended payment rate of $1,150, would significantly impede patient access to this technology, especially in rural settings where the volume of PET scans tends to be lower. Another commenter that provides FDG to 300 PET imaging centers in geographically diverse regions of the United States reviewed their May, June, and July 2004 data for these PET centers and reported an average number of 1.88 PET scans provided per day and a median of 1.3 PET scans provided per day across the 300 PET centers. Again, the commenter did not clarify whether this national average of performing 1.88 PET scans per day reflects utilization by both hospitals and freestanding PET centers. This commenter expressed concern that any reduction in payment for PET scans, with or without a reduction in payment for FDG, may drive many PET centers into an operating deficit and reduce the availability of PET scans for Medicare beneficiaries.

Response: We appreciate the many comments we received on this topic and the efforts undertaken by several of the commenters to provide us with additional data concerning the costs of providing the scans. We acknowledge variations in hospital markup practices, capital depreciation and other cost allocation methods, although we note that the CCRs in the various reported cost centers (that is, Nuclear Medicine,

Imaging Department, Radiology) for PET procedures are fairly consistent. The median hospital CCR for these cost centers ranges from 0.3118 to 0.3172, and does not vary greatly from the median overall hospital CCR of 0.33. We believe that the robust number of claims (that is, 55,838 single procedure claims out of 61,492 total claims, representing 91 percent of the total claims) provides sufficient data to assign PET scans to a clinically appropriate APC. However, we received numerous comments indicating that any reduction in payment for PET scans would hinder access by Medicare beneficiaries to this technology. Based on our review of the comments, we are setting the CY 2005 payment for PET scans based on a 50–50 blend of the median cost and the CY 2004 new technology APC payment rate, as presented under option 3 in the proposed rule. PET scans will be assigned to new technology APC 1513 for a blended payment rate of $1,150 for CY 2005.

Comment: One commenter pointed out that the CY 2003 hospital claims data may not account for the current shift to PET/CT technology, which the commenter stated has virtually doubled the cost of launching a viable PET operation, from an average cost of $1,200,000 for a dedicated PET scanner to an average cost of $2,400,000 for a PET/CT scanner. The commenter estimated that approximately 90 percent of the PET systems currently being sold are PET/CT scanners and predicted that the current installed base of approximately 35 percent PET/CT and 65 percent dedicated PET will shift to an overwhelming majority of PET/CT scanners within the next 5 years. The commenter argued that investment in a PET/CT scanner is important to be competitive in the marketplace, due to better capability for detecting malignancies. The commenter stated that the higher capital costs of a PET/CT operation require a patient volume of between four and five patients per day to break even compared to a patient volume of between two and three patients for a dedicated PET operation. According to the commenter, the number of claims for PET remains relatively low compared to MRI and CT scans, comprising less than 1 percent of all imaging procedures performed in the United States. Therefore, the commenter argued that providers would be unlikely to recover significant losses through increased patient volume.

Several commenters indicated that the American Medical Association will be creating three new CPT codes 78814, 78815, and 78816 to describe PET with concurrent CT for anatomical localization for CY 2005. One commenter recommended that CMS assign these new CPT codes for PET/CT scans to three different new technology APCs, while another commenter recommended that CMS place these new CPT codes in new technology APC 1516 at a payment rate of $1,450.

Response: The current G code descriptors do not describe PET/CT scan technology, and should not be reported to reflect the costs of a PET/CT scan. At present, we have decided not to recognize the CPT codes for PET/CT scans that the AMA intends to make effective January 1, 2005, because we believe the existing codes for billing a PET scan along with an appropriate CT scan, when provided, preserve the scope of coverage intent of the PET G-codes as well as allow for the continued tracking of the utilization of PET scans for various indications. We plan to issue billing guidance through program instructions and provider education articles for hospitals to use when they provide both a PET and CT scan to patients in their outpatient department. While we acknowledge that PET/CT scanners may be more costly to purchase than dedicated PET scanners, a PET/CT scanner is versatile and may also be used to perform individual CT scans, thereby potentially expanding its use if PET/CT scan demand is limited.

Comment: One commenter supported assigning PET procedures to new technology APC 1513 at a payment rate of $1,150, based on a 50–50 blend of the median cost and the CY 2004 new technology payment, as presented under option 3 of the proposed rule. This commenter stated that option 3 provides the best balance between ensuring continued beneficiary access to this valuable technology and the need for CMS to consistently apply its ratesetting methodology to determine payment rates. Another commenter supported the assignment of PET procedures into a clinically appropriate APC that pays at least $1,200. This commenter believed that a payment of at least $1,200 would compensate adequately for the technology and necessary staffing.

Response: We agree with the commenters that a balance must be reached between ensuring continued beneficiary access to PET scans and the necessity for CMS to apply consistently its rate-setting methodology. Balancing the concern regarding possible adverse effects on patient access that might result from a substantial precipitous reduction in payment with information from thousands of hospital claims and the cost data we received from commenters, we are setting the CY 2005 payment for PET scans based on a 50–50 blend of the median cost and the CY 2004 new technology APC payment rate, as presented under option three in the proposed rule. We believe we have reached this balance for CY 2005 by assigning PET scans to new technology APC 1513 for a blended payment rate of $1,150.

Comment: Another commenter addressed the issue of three new CPT codes 78811, 78812, and 78813 for tumor PET imaging to replace CPT code 78810 (Tumor imaging, positron emission tomography, metabolic evaluation) for CY 2005. The commenter recommended that CMS adopt these new CPT codes in place of the existing G-codes and place them in new clinical APCs, which would result in one level for brain PET scans, two levels for cardiac PET scans, and three levels for tumor PET scans.

Response: At present, we believe that the existing G-codes for PET scans adequately serve the purpose of tracking utilization of PET scans for various indications. Therefore, CMS will continue to recognize the existing G-codes for PET scans.

Comment: One commenter requested that CMS provide the number of single procedure claims that support assigning FDG-PET scans to a clinically appropriate APC according to the median cost of the scans, as presented under option 2 in the proposed rule.

Response: The number of single procedure claims used to create the median of $898.64 discussed in the proposed rule under option 2 for APC 0420 (PET imaging) totaled 55,838 single procedure claims out of 61,492 total claims.

PET (Myocardial)

Comment: One commenter brought to our attention that CPT code 78459 (myocardial imaging, PET, metabolic evaluation) and HCPCS code G0230 (PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study) are both currently paid under OPPS and describe nearly the same procedure, with the exception that HCPCS code G0230 has a more narrow description. The commenter understood that CMS had intended to replace HCPCS code G0230 with CPT code 78459, but was confused by the payable status indicator for both codes. Two commenters recommended that CMS clarify the proper use of these codes and move CPT code 78459 from APC 0285 (Myocardial Positron Emission Tomography), with a payment rate of $690.61 to APC 1516 with a payment rate of $1,450.

Response: We appreciate the commenter bringing to our attention the

duplication of codes for myocardial PET imaging for metabolic assessment. At present, we will change the status indicator for CPT code 78459 (Myocardial imaging, PET, metabolic evaluation) to ''B,'' not payable under the OPPS, and move HCPCS code G0230 (PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study), along with the other PET codes currently assigned to APC 1516, from APC 1516 to APC 1513 for CY 2005. We will seek advice on the APC placement of HCPCS code G0230 from the Advisory Panel on APC Groups during their next meeting.

Comment: Several commenters indicated that the resources, other than the radiopharmaceuticals, required to perform the PET myocardial perfusion imaging studies assigned to APC 0285 (Myocardial Positron Emission Tomography) do not differ significantly from many of the PET tumor imaging procedures contained in new technology APC 1516. These commenters requested an explanation for the payment rate decrease from $1,058.87 in the proposed rule for the CY 2004 update to $772.08 in the final rule for the CY 2004 update, and the further decrease to $690.61 in the proposed rule for the CY 2005 update. The commenters objected to CMS creating an exception to the 2 times rule for APC 0285. The commenters believed that the small volume of these procedures and the complexity of multiple G-codes to describe both single and multiple imaging sessions preclude reasonable conclusions about the cost of providing these services. The commenters recommended that CMS move the 18 G-codes from APC 0285 paying $690.61 to APC 1516 with a payment rate of $1,450. The commenters further recommended that we reduce the complexity of billing for these procedures by collapsing these eighteen G-codes into two CPT codes based on resources for single and multiple studies, replacing HCPCS codes G0030–G0047 with CPT code 78491 (Myocardial imaging, PET, perfusion; single study at rest or stress) and CPT code 78492 (Myocardial imaging, PET, perfusion; multiple studies at rest or stress).

Response: The steady decline of the payment rate for APC 0285 since the CY 2004 proposed rule is attributable to the 153-percent increase in the number of single procedure claims used to set the payment rate for APC 0285, which gave rise to better data to more accurately set the payment rate. In the CY 2004 proposed rule, we used 613 single procedure claims out of 1,584 total claims (39 percent of total claims) to set the CY 2004 proposed payment rate of $1,058.87. In the CY 2004 final rule, we used 1,089 single procedure claims out of 1,778 total claims (61 percent of total claims) to set the CY 2004 final payment rate of $772.08. In the CY 2005 proposed rule, we used 1,451 single procedure claims out of 1,946 total claims (75 percent of total claims) to set the CY 2005 proposed payment rate of $690.61. At present, composition of APC 0285 will be maintained for CY 2005 while we collect claims data on HCPCS codes G0030 through G0047. Based on our CY 2003 data for the specific G-codes, we cannot identify a predictable pattern of increased hospital costs associated with multiple studies as compared with single studies. We will present before the Advisory Panel on APC Groups during their next meeting the commenters' recommendation to recognize CPT codes 78491 and 78492 as representing single and multiple myocardial PET studies and movement of these codes from APC 0285 to APC 1516. We note that we will be moving the PET scans currently in APC 1516 to APC 1513 for CY 2005, and will bring that to the Panel's attention as they consider potential APC movement of the myocardial PET studies.

d. Bard Endoscopic Suturing System

For CY 2005, we proposed to create APC 0422 for Level II Upper GI Procedures and to assign HCPCS code C9703 (the Bard Endoscopic Suturing System), as well as other procedures to APC 0422 based on clinical and resource homogeneity. Currently, HCPCS code C9703 is assigned to New Technology APC 1555, with a payment of $1,650. Our examination of CY 2003 claims data for HCPCS code C9703 revealed that 137 of the 171 single claims were from a single institution with an extremely low and consistent cost per claim. We do not believe that those 137 claims represent the service described by HCPCS code C9703, which includes an upper gastrointestinal endoscopy along with suturing of the esophagogastric junction. Therefore, in establishing the median for APC 0422, we did not use the 137 claims, which we believe were incorrectly coded.

Comment: Several commenters opposed the movement of HCPCS code C9703 (Bard Endoscopic Suturing System) from New Technology APC 1555 with a payment rate of $1,650 to clinical APC 0422 (Level II Upper GI Procedures) with a proposed payment rate of $1,274. The commenters indicated that the proposed payment under APC 0422 is inadequate to cover even the equipment costs alone. The commenters contended that the claims data are insufficient to support movement of this procedure out of its new technology APC and into a clinical APC, and urged CMS to maintain HCPCS code C9703 in New Technology APC 1555 with a payment rate of $1,650.

Response: As we stated in the proposed rule, our examination of the CY 2003 claims data for APC 0422 revealed that 137 of the 171 single claims for HCPCS code C9703 were incorrectly coded. Therefore, the remaining single claims were used in establishing the median for APC 0422. Considering that HCPCS code C9703 has remained in a new technology APC for 2 years with a relatively modest volume, we are not convinced that maintaining HCPCS code C9703 in a new technology APC will necessarily result in a high volume for future ratesetting. Furthermore, the median cost as calculated for HCPCS code C9703, using the subset of single claims, has been relatively stable over the past 2 years and consistent with the median for APC 0422. In addition, in keeping with our practice to use CPT codes, if possible, we will discontinue HCPCS code C9703 and instruct providers to report service with this technology under CPT code 0008T (Upper gastrointestinal endoscopy with suture), which will be payable under the OPPS for CY 2005. In this final rule with comment period, we are finalizing our proposal to move HCPCS code C9703, which will be replaced with CPT code 0008T, from New Technology APC 1555 to clinical APC 0422 for CY 2005. Code 0008T is assigned status indicator ''NI'' and, as such, is open for public comment during the 60-day comment period associated with this final rule with comment period.

e. Stretta System

Comment: Several commenters objected to the movement of HCPCS code C9701 (Stretta system) from New Technology APC 1557 with a payment rate of $1,850 to clinical APC 0422 (Level II Upper GI Procedures) with a proposed payment rate of $1,274. The commenters indicated that the proposed payment is inadequate to cover even the equipment costs alone, and urged CMS to maintain HCPCS code C9701 in New Technology APC 1557 with a payment rate of $1,850.

Response: The single claims volume for HCPCS code C9701 has remained modest for the past 2 years of its placement in a new technology APC. Therefore, we do not believe that maintaining HCPCS code C9701 in a new technology APC will necessarily result in a high volume for future

ratesetting. Furthermore, the median cost for HCPCS code C9701 has been stable over the past 2 years and consistent with the median for APC 0422. Moreover, we can now discontinue HCPCS code C9701 and will instruct providers to report service with this technology under CPT code 43257 (Upper gastrointestinal endoscopy with delivery of thermal energy), a new CPT code that will be payable under OPPS for CY 2005. We are finalizing our proposal to move HCPCS code C9701, which will be replaced with CPT code 43257, from New Technology APC 1557 to clinical APC 0422 for CY 2005.

f. Gastrointestinal Tract (GI) Capsule Endoscopy

Comment: Several comments opposed our proposal to move CPT code 91110 (GI Capsule Endoscopy) from New Technology APC 1508 with a payment rate of $650 to clinical APC 0141 (Level I Upper GI Procedures) with a proposed payment rate of $464.52 for CY 2005. (CPT code 91110 (Capsule Endoscopy) replaced HCPCS code G0262 in CY 2004. HCPCS code G0262 was mapped to New Technology APC 1508 in CY 2004.) The commenters explained that the cost data for CPT code 91110 are unreliable due to multiple coding changes over the last 3 years and, therefore, believed that the data should not be used to set the payment rate. The commenters indicated that the device costs are $450, and under the proposed payment rate, only $14 would be available to cover the service portion of the procedure. The commenters expressed concern that patient access to care would be hindered by moving the service into clinical APC 0141. The commenters also contended that the proposed assignment of this procedure to APC 0141 is inappropriate because none of the other services that reside in APC 0141 require a device of significant cost and the codes are not clinically homogeneous with CPT code 91110. The commenters urged CMS to maintain CPT code 91110 in New Technology APC 1508 with a payment rate of $650. One commenter suggested that CMS assign a C code to the capsule and instruct providers to bill this C-code along with HCPCS code G0262. One commenter requested that, if CMS does not maintain CPT code 91110 in new technology APC 1508, CMS consider two additional options: (1) Limiting the rate reduction for CY 2005 to 5 percent of the CY 2004 rate; or (2) assign CPT code 91110 to APC 0142 (Small Intestine Endoscopy), which the commenter stated would be a compromise because the payment of $503.20 would still ''underpay'' the hospital for the costs of providing the procedure.

Response: Generally, we do not establish C-codes for devices outside of the pass-through process, so we will not assign a C-code to the capsule. We remind providers that they should include the charges for device costs associated with this capsule within the charges reported for CPT code 91110. We agree with the commenters that CPT code 91110 may not belong in APC 0141 based on clinical homogeneity and resource consumption. We had almost 4,000 single claims, about 90 percent of all CY 2003 claims for capsule endoscopy, available for use in calculating the median cost of the service. We have confidence that our median reflects hospital resources needed to perform the service. As one commenter recommended, we believe that the resource costs and clinical nature of CPT code 91110 are more consistent with other codes that reside in APC 0142. Therefore, in this final rule with comment period, we are moving CPT code 91110 from New Technology APC 1508 to clinical APC 0142 for CY 2005, as the commenter suggested.

g. Proton Beam Therapy

Comment: Several commenters urged CMS to maintain intermediate (CPT code 77523) and complex (CPT code 77525) proton beam therapies in New Technology APC 1511 at a payment rate of $950 for CY 2005. The commenters indicated that the proposed payment rate of $678.31 for CY 2005 does not capture the significant difference in resource consumption and complexity between the simple and the intermediate/complex procedures. These commenters expressed concern that the low volume of claims submitted by only two facilities provides volatile and insufficient data for movement into the proposed clinical APC 0419 (Proton Beam Radiation Therapy) at a payment rate of $678.31. They pointed out that more than four additional centers are currently under construction or in the planning phases in response to the high demand for this technology. The commenters explained that the extraordinary capital expense of between $70–$125 million and high operating costs of a proton beam necessitate adequate payment for this service to protect the financial viability of this emerging technology. They feared that a payment reduction would halt diffusion of this technology and negatively impact patient access to this cancer treatment.

Two commenters explained that the CY 2005 proposed payment rates for CPT codes 77523 (intermediate proton beam treatment) and 77525 (complex proton beam treatment) were based on costs derived by applying CCRs from the most recent Medicare cost reports to charges reported on CY 2003 claims submitted by two hospitals, which were the only two proton therapy centers in operation in the United States at the time. The commenters further indicated that these two hospitals, from which all of the intermediate and complex proton therapies claims were derived, reported the costs and charges of proton therapy along with the costs and charges for all other radiation therapy services on the radiation therapy department line. One commenter calculated an overall radiation therapy department CCR of 0.2442 using CY 2003 data from one of these hospitals. This commenter then calculated a proton beam therapy CCR of 0.4175 by isolating the costs and charges for proton beam therapy from the costs and charges for the overall radiation therapy department. The commenter applied this proton beam therapy CCR of 0.4175 to calculate the costs based on average CY 2003 charges for intermediate and complex proton beam treatments and reported a cost of $1,105.96 for intermediate proton beam treatment and a cost of $1,216.60 for complex proton beam treatment, significantly above Medicare's proposed payment rate of $678.31 for CY 2005.

Commenters believed that this understatement of costs in the Medicare cost reports from these two hospitals is largely responsible for the inadequacy of the proposed payment rates for intermediate and complex proton beam treatments. The commenters requested that CMS apply the proton beam therapy CCR of 0.4175, based on proton beam specific cost data provided by one of these commenters, for determining the median costs of proton beam therapy. The commenters believed that the revised costs support the maintenance of CPT codes 77523 and 77525 in New Technology APC 1511 at a payment rate of $950 for CY 2005. The commenters also noted the recommendation of the Advisory Panel on APC Groups to maintain intermediate and complex proton beam therapies in New Technology APC 1511 at a payment rate of $950 for CY 2005 and urged CMS to adopt that recommendation.

Response: We will not apply the commenter's calculated CCR to determine the median costs of proton beam therapy because we are unable to replicate the commenter's proton beam therapy CCR calculation of 0.4175 by

isolating the costs and charges for proton beam therapy from the costs and charges for the overall radiation therapy department. However, having considered the concerns of numerous commenters that patient access to proton beam therapy may be impeded by a significant reduction in OPPS payment, we are setting the CY 2005 payment for CPT codes 77523 and 77525 by calculating a 50–50 blend of the median cost of $690.45 derived from 2003 claims and the CY 2004 new technology APC payment rate of $950. We will use the result of that calculation ($820) to assign intermediate and complex proton beam therapies (CPT codes 77523 and 77525) to New Technology APC 1510 for a blended payment rate of $850 for CY 2005.

After consideration of these public comments and based upon our review of the latest claims data available, we are moving the procedures listed in Table 14 from their current new technology APCs to the APCs listed, as we have adequate data on these procedures to enable us to make the necessary APC assignment.

BILLING CODE 4120–01–P

Table 14.--APC Reassignment of New Technology Procedures Into Clinical APCs

HCPCS	Descriptor	CY 2004 APC	CY 2005 APC	CY 2004 Payment Amount	CY 2005 Payment Amount
15860	Test for blood flow in graft	1501	0359	$ 25.00	$49.54
96003	Dynamic fine wire EMG	1503	0215	$150.00	$37.61
96000	Motion analyses, video/3D	1503	0216	$150.00	$150.20
96001	Motion test w/ft pressure measure	1503	0216	$150.00	$150.20
96002	Dynamic surface EMG	1503	0218	$150.00	$65.20
91110	GI tract capsule endoscopy	1508	0142	$650.00	$496.15
G0288	Reconstruction, CTA surgical plan	1506	0417	$450.00	$266.72
77301	Radiotherapy dose plan, IMRT	1510	0310	$850.00	$813.57
77523	Proton treatment, intermediate	1511	1510	$950.00	$850.00
77525	Proton treatment, complex	1511	1510	$950.00	$850.00
95250	Glucose monitoring, continuous	1540	0421	$150.00	$106.51
96567	Photodynamic treatment, skin	1540	0013	$150.00	$64.85
96570	Photodynamic treatment, 30 min.	1541	0015	$250.00	$98.28
96571	Photodynamic treatment, 15 min.	1541	0015	$250.00	$98.28
92973	Perc. Coronary thrombectomy	1541	0676	$250.00	$243.48
36595	Mech remov tunneled CV Cath	1541	0187	$250.00	$219.53
36596	Mech remov tunneled CV Cath	1541	0187	$250.00	$219.53
33224	Insert pacing lead and connect	1547	0418	$850.00	$4,246.04
33225	L ventricular pacing lead add-on	1550	1525	$1,150.00	$3,750.00
43257	Stretta System	1520	0422	$1,650.00	$1,264.79
47382	Perc. ablation liver tumor, rf	1557	0423	$1,850.00	$1,753.39
53853	Prostatic water thermometer	1550	0162	$1,150.00	$1,311.65
58356	Endometrial cryoablation	1557	0202	$1,850.00	$2,260.37
0008T	Bard Endoscopic Suturing Sys	1518	0422	$1,650.00	$1,264.79

BILLING CODE 4120–01–C

4. Public Comments Received Relating to Other New Technology APC Issues

a. Computerized Reconstruction CT of Aorta

In the August 16, 2004 proposed rule, we proposed to reassign code G0288 (Reconstruction, CTA of aorta for preoperative planning and evaluation post vascular surgery) from New Technology APC 1506 to clinical APC 0417 (Computerized Reconstruction) for CY 2005.

Comment: Several commenters expressed concern about our proposal to move G0288 from New Technology APC 1506 to clinical APC 0417. The commenter asserted that the reassignment results in a decreased payment amount from $450 to approximately $247, a rate that commenters believe is too low to cover the costs of providing the service.

The commenters suggested that CMS use external data to calculate rates rather than relying on hospital claims data, that CMS maintain G0288 in its current new technology APC assignment until hospital claims are more accurate, or that CMS go ahead with the reassignment to a clinical APC but continue to base payment on a rate that is consistent with the CY 2004 rate. One commenter provided invoices from hospitals across the country to support its assertion that our proposed payment will be to low.

One commenter also requested that CMS change the descriptor for code G0288 to read ''Three-dimensional pre-operative and post-operative computer-aided measurement planning and simulation in accordance with measurements and modeling specifications of the Society for Vascular Surgery'' in order to ensure that the code is only used for true three-dimensional preoperative and postoperative computer-aided measurement planning and simulation technologies.

Response: A predecessor C-code to G0288 had a new technology APC assignment in CY 2002, with a payment level of $625. The C-code was deleted for CY 2003, and G0288, a more general treatment planning code, was then assigned to the same new technology APC for CY 2003, with a payment of $625. For CY 2004, we proposed to move G0288 from a new technology APC to a clinical APC based on over 1,000 claims, with a median cost of $272. Based on hospital data provided by a commenter on the CY 2004 proposed rule and our conclusion that there may have been Medicare claims that understated the costs of the treatment planning software, we placed G0288 in a new technology APC with a payment of $450 for CY 2004, consistent with a 50/50 blend of our data with the analysis of a commenter. For CY 2005, we believe we have adequate claims data on which to base payment for G0288 and to reassign the service to its own clinical APC. We had almost 5,000 total claims for code C9703 (first 3 months of CY 2003 when the C-code was still in the grace period) and G0288, and over half of these were single claims available for APC median calculation. We are confident that the median cost for APC 0417 reflects hospital resource costs, and we are reassured by the consistency of our median cost data over the past several years for this service.

Accordingly, we are adopting as final our proposal to assign code G0288 to APC 0417 for CY 2005.

We are not changing the name of G0288 at this time. However, we will take the commenter's suggestion into consideration in the future if the need arises. We revised the descriptor for the code for CY 2004 to clarify that the service can be used for treatment planning prior to surgery and for postsurgical monitoring. We believe that the current G code descriptor appropriately describes the service.

b. Kyphoplasty

Comment: One commenter, a manufacturer of medical devices used to restore spinal function and treat vertebral compression fractures, suggested that CMS should place kyphoplasty, a new procedure to treat vertebral compression fractures, into New Technology APC 1535. The commenter stated that kyphoplasty is currently billed using code 22899 (Unlisted procedure of the spine). The commenter claimed that, according to our policy, because CMS received its application before June 2004, the procedure is eligible for new technology APC payments in October 2004. The commenter was surprised that it did not see a proposal to place kyphoplasty into a new technology APC in our proposed rule or in the October 2004 OPPS update. The commenter stated that using an unlisted code creates problems concerning billing and payment for hospitals.

Response: We have completed our evaluation of the new technology application for kyphoplasty and have assigned new C-codes that describe the procedure. We have assigned these codes to existing clinical APC 0051 rather than to a new technology APC. We believe that APC 0051 is appropriate for kyphoplasty in terms of clinical characteristics and resource costs. Reasonable placement into an existing APC that is appropriate in terms of clinical characteristics and resource costs is one of our criteria in deciding whether a service should be placed into a new technology APC (66 FR 59900, November 30, 2001).

Concerning the commenter's assertion that because CMS received its application before June 2004, the procedure is eligible for payment status as a new technology APC in October 2004, we remind the public that the timing of eligibility for payment, if any, is not bound to when an application is filed with CMS. As we state on the CMS Web site notice at *http://www.cms.gov,* if an application is filed by a certain date (for example, by June 1), the earliest date that such an item or service can be considered for new payment status is the following quarter (for example, October 1). This means that any additional coding and payment, if warranted, could begin later than the following quarter. Because it is important that our payment and coding systems do not impede access by Medicare beneficiaries to the best available medical care, we review all applications as quickly as possible, given the complexity of the issues and the thoroughness we believe such reviews require. The timing of completion of our evaluation of any specific application depends on such factors as the complexity of the application, the completeness of all materials submitted, whether the review team requires additional information and the amount of time before we receive additional materials and information. Of course, the service needs to be otherwise eligible for assignment to a new technology APC (or as a pass-through assignment in the case of a new device, drug, or biological).

We note that while we consider these new codes as final, the codes and the placement of the services are subject to comment within 60 days of the publication of this final rule with comment period, as stated elsewhere in this rule. Moreover, the public may comment on our placement of services to the APC Panel, which often hears comments and testimony concerning the placement of new services brought to us by interested parties.

Accordingly, the codes for kyphoplasty are:

C9718 Kyphoplasty, one vertebral body, unilateral or bilateral injection

C9719 Kyphoplasty, one vertebral body, unilateral or bilateral injection; each additional vertebral body (list separately in addition to code for primary procedure)

c. Laser Treatment of Benign Prostatic Hyperplasia (BPH)

In the August 16, 2004 proposed rule, HCPCS code C9713 (Non-contact laser vaporization of prostate, including coagulation control of intraoperative and postoperative bleeding) was assigned to New Technology APC 1525 for CY 2005. The assignment of this code to New Technology APC 1525 was a continuation of the new technology APC placement established on April 1, 2004.

Comment: One commenter, the manufacturer of medical equipment used in the treatment of benign prostatic hyperplasia (BPH) stated that its product, the GreenLight Laser, was the only technology available that uses a 532nm or ''green'' wavelength as an energy source and that CMS had assigned code C9713 in response to an application for a new technology APC assignment from Laserscope. The commenter indicated that other technologies that do not employ the same energy wavelength and the same noncontact vaporization technique should not be billed with code C9713. The commenter expressed concern that the costs of the other techniques are less than those for GreenLight Laser and thus the other techniques should not be paid under New Technology APC 1525. The commenter requested CMS to revise the descriptor of code C9713 to describe only 532nm laser technologies such as the GreenLight Laser.

Response: We acknowledge that HCPCS code C9713 was established following our review of the new technology application from Laserscope. We also agree that code C9713 may be used by hospitals to report such procedures using the Laserscope product, the GreenLight PVP, described in the application for new technology assignment. We established code C9713 based on our understanding of the information provided to us that the service may be different from other services used to treat BPH. We look forward to receiving and assessing the medical review, analysis, and evaluation of the service and technology through the usual AMA coding and payment processes. In general, we do not tailor temporary procedure codes in the ''C'' series to particular products and have not been persuaded that a redefinition of code C9713 is necessary at this time. With respect to other techniques for treatment of BPH, we would rely on the hospitals to determine which HCPCS code, whether C9713 or one of the CPT codes, most accurately describes the procedure for treatment of BPH for which they are billing. With regards to the commenter's claim that the costs of other techniques described by code C9713 are less than warranted by the New Technology APC 1525, our policy is to review the costs of services assigned to New Technology APCs each year to determine if an alternate placement in another APC is warranted. We continue to believe that placement of code C9713 in a new technology APC is appropriate for CY 2005.

d. Computerized Tomographic Angiography (CTA)

In the August 16, 2004 proposed rule, we included the APC assignment and the payment rate for computed tomographic angiography (CTA). These procedures, coded using one of several CPT codes, depending on the body region under study, involve acquisition of a CT scan with and without contrast material, as well as image post-processing. The assigned CTA CPT codes under APC 0662 had a proposed payment rate of $320.60. That proposed payment rate was slightly lower than that for a CT scan ($323.21) and significantly lower than the sum of the proposed payment for CT scan and image reconstruction, CPT code 76375 ($98), billed separately.

Comment: A number of commenters were concerned about the lower payment rates for the CTA procedures and asked CMS to review and revise the proposed payment rate.

The commenters pointed out that, prior to 2001, two codes were used to code for the procedure: one for the CT scan and another for the 3-D reconstruction. The commenters indicated that, in 2001, CPT codes were created to enable specific coding for CTA procedures, including image post-processing in the CTA codes, but those codes were still assigned to the same APC (0333) as CT procedures that did not include image reconstruction. They added that, in CY 2003, the CTA procedures were assigned to their own APC (0662). The commenters asserted that in spite of the creation of an APC specific to CTA procedures, the OPPS payment amounts have not reflected the additional costs for CTA compared to CT. They believed that the low payment rates are due to continuing confusion and conflicting information among providers concerning appropriate billing and charging practices associated with CTA procedures.

One commenter performed a number of analyses in an attempt to understand and address the apparent billing problems. In its investigation, the commenter discovered that, in 2002, only 40 percent of all hospitals that performed both CT and CTA charged more for CTA than for CT. The commenter also found in its study of hospital charge structures that there is wide variation in methods employed by hospitals and that only 29 percent of hospitals use costs to set charges.

While all commenters recommended that CMS adjust the payment rate for CTA procedures to equal that for APC 0333 plus APC 0282, one commenter recommended that we do this using the adjustment made under the Medicare Physician Fee Schedule for CY 2003 as a model. That commenter suggested that we should ignore CTA claims and instead rely on CT claims (APC 0333) plus reimbursement for image reconstruction (APC 0282) as a basis for setting the rate for CTA services.

Other alternative suggestions provided by the commenter include: use only CTA claims that are ''logical;'' change coding instructions and edits to allow CTA to be billed in addition to image reconstruction; or make an administrative adjustment to increase CTA payment.

Finally, the commenters encouraged CMS to investigate alternative methods for calculating CCRs in order to achieve more accurate costs on which to base our rates.

Response: Although we understand the commenters' points of view and appreciate the comprehensive analyses they shared with us, we cannot identify any action that would be appropriate for us to take. As the commenters are aware, we rely on hospital claims data to set payment rates and have made clear our intent to rely solely on those claims by CY 2007. If the claims data are inaccurate, especially across a broad spectrum of providers as the commenters believe is evidenced in this case, we have no way to determine which claims are more or less accurate than any others.

To implement the commenters' suggestion that we make the payment rate for CTA (APC 0662) equal to the sum of the rates for CT alone (APC 0333) plus image reconstruction (APC 0282) would require that we have accurate cost information about the cost of image reconstruction for CTA specifically and for CT alone, as utilized with CTA. This is not the case. The image reconstruction code CPT 76375 (coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality) is not limited to image reconstruction performed for CTA and may be used in any number of other procedures. Based on the available CPT codes for CTA, we

would not expect any current utilization of CPT code 76375 to be for CTA post-image processing, unless there was no appropriate CTA code to describe the body region imaged. We believe this would be rare. In addition, our current cost data for CT alone do not necessarily reflect the resources utilized for the CT portion of CTA.

We also do not believe that for the last 3 years there has been conflicting information given to providers concerning appropriate billing and charging practices associated with CTA procedures. The CPT code descriptors clearly include image post-processing for CTA procedures. In response to previous comments, we did provide a separate APC for CTA procedures beginning in CY 2003 in recognition that hospital resources might be different for CTA procedures as compared with CT procedures. From the over 100,000 claims for CTA procedures from CY 2003, we were able to use about 50 percent of the claims to determine hospitals' costs for the services. Our number of claims for CTA procedures increased significantly between CY 2002 and CY 2003. From the 2003 full year of data, we have calculated that median hospital costs for the APCs for CT and CTA services were approximately equal, at $329. Because hospitals set their own charges for services, which we then convert to costs, we see no reason why adding the costs for CT alone plus the costs for image reconstruction would necessarily provide a better estimate of costs for CTA than our analysis of our specific CTA claims.

Similarly, in order to make an adjustment akin to that made for the Medicare Physician Fee Schedule for CY 2003, we would need to have accurately coded cost data for the individual components of CTA, performed in the context of CTA, on which to base that change. We do not have that data, and the OPPS system, unlike the Medicare Physician Fee Schedule, relies upon historical hospital claims data to develop relative costs of services.

Lastly, we do not agree that we should provide coding guidance that differs from that embodied in the CPT code descriptors in this case. Our current edits that do not allow CTA to be billed in addition to image reconstruction are consistent with the CPT code descriptors for CTA procedures.

We created a separately paid, specific APC for those procedures in an attempt to provide an accurate payment for CTA. Moreover, by creating a unique APC for the procedures, we provided the means for hospitals to bill for all of the costs associated with CTA, entirely separate from their billing for CT. We cannot now assume that the claims billed for that APC are incorrect and that those billed for CT alone are correct.

We acknowledge the commenters' belief that the claims are flawed and that hospitals' divergent charge structures do not result in consistent charging for CT scans, CTAs or image reconstruction, but note that those claims comprise the data on which the OPPS relies for payment of a wide variety of hospital outpatient services. We must rely on hospitals to manage their charge structures in a manner that accurately and best reflects the services provided.

For the reasons stated above, we will not alter the payment rates for CTA, APC 0662, for CY 2005. Once again, we encourage hospitals to take all actions necessary to assure that they are billing accurately and including all resources utilized to deliver services. As discussed in detail in section III. of this preamble, we are continuing our work to refine the CCRs used for ratesetting.

e. Acoustic Heart Sound Services

Comment: Several commenters addressed the need to assign a recently created code for acoustic heart sound services for recording and computer analysis to an APC. One of the commenters indicated that the acoustic heart sound recording can be performed in the first 5 minutes of an emergency department service, together with an ECG, to enable the earliest possible detection of acute cardiac conditions. The commenter related that AMA's CPT Editorial Panel created three new Category III codes for acoustic heart sound recording that correspond to performing the procedure, physician interpretation of results, and recording and interpretation in combination. The commenter contended that one of these codes, CPT Category III code 0069T (Acoustic heart sound recording and computer analysis only) could be payable under the OPPS. The commenters noted that we did not propose an APC assignment for code 0069T in our proposed rule, and they requested an APC assignment effective January 1, 2005. One of the commenters believed that the most appropriate clinical APC to assign this code is APC 0099 (Electrocardiograms).

Response: One of the commenters, a manufacturer of the acoustic heart sound system, had previously applied for assignment of these codes to new technology APCs and we have previously evaluated the three acoustic heart sound services. We agree that only code 0069T could be payable under the OPPS. The comment that acoustic heart sound recording can be performed in the first 5 minutes of a visit by an ECG technician, together with an ECG, to enable the earliest possible detection of acute cardiac conditions, demonstrates that there are limited additional facility resources associated with the acoustic heart sound recording in conjunction with an ECG. It is also our understanding that the AMA's coding advice indicates that the acoustic heart sound services are to be used in conjunction with electrocardiography services. We believe it is worthwhile to recognize code 0069T under the OPPS to track its utilization and develop cost data. However, because the service may be performed quickly and is always accompanied by an ECG, we are assigning a packaged status to code 0069T for CY 2005. Although not separately payable under the OPPS, charges for the acoustic heart sound service will be packaged with charges for the separately payable services with which it is performed. With regards to the comment that we did not assign an APC in our proposed rule, we note that we do not recognize under the OPPS new CPT codes on a mid-year basis, even though the AMA may assign new tracking codes mid-year, as it did in this case. We assign new CPT codes on an annual basis, effective with our January 1 updates to the OPPS. Because this is a new code assignment that was not proposed in the CY 2005 proposed rule, interested parties will be able to comment on this new payment assignment in response to this final rule with comment period. This code is included in Addendum B.

f. Laparoscopic Ablation Renal Mass

Comment: Commenters asked that we move CPT code 50542 (Laparoscopic ablation renal mass) out of APC 0131 (Level II Laparoscopy) and place it in new technology APC 1574 (New Technology, Level XXXVII ($9,500–$10,000) until meaningful data can be obtained for the procedure. The commenter indicated that the procedure, including required devices, might cost approximately $10,000 because of the cost of the cryosurgery device. The commenter indicated that because they did not find any claims for this code that contained the device code for cryoablation probes (C2618), CMS should discard the data as being valid to set the weight for this code.

Response: Code 50542 represents a service that may or may not be performed with cryoablation equipment. Therefore, the absence of the device code for cryoablation probes on the

claims may be an accurate reflection of the service as it was performed. The median cost for the service appears to be appropriately placed in APC 0131 and the service is clinically coherent with other services in APC 0131. Therefore, we are retaining its placement in APC 0131 for CY 2005.

g. Intrabeam Intra-Operative Therapy

Comment. One commenter, the manufacturer of the Intrabeam Intra-Operative Therapy System, commented that this procedure, a treatment for women diagnosed with early-stage breast cancer, which is currently assigned to APC 0312 (Radioelement Applications) and is billed using CPT code 77776, is currently underpaid in APC 0312. The commenter claimed that there is no current APC mechanism to capture the cost information specific to this technology, and there are insufficient Medicare claims data at this time to make an appropriate clinical APC assignment. The commenter requested that CMS assign the Intrabeam procedure to a new technology APC. In addition, the commenter requested that CMS create two new level II HCPCS codes with the following descriptors: (1) Surgical placement and removal of intra-operative direct application x-ray source using surgical closure techniques; and (2) Administration of radiation therapy by intra-operative direct application of x-ray source.

Response. We recently received from the manufacturer of the Intrabeam Intra-Operative Radiation Therapy procedure an application for assignment of this procedure to a new technology APC. We are currently engaged in review of that application.

h. New Technology Process Issues

Comment: In response to the OPPS final rule with comment period published November 7, 2003, one commenter asserted that CMS had failed to establish an acceptable method for evaluating the costs and clinical efficacy of therapeutic medical technologies before assigning a code and New Technology APC payment under the OPPS. The commenter urged CMS to propose evaluation criteria for determining costs and clinical efficacy. In developing such criteria, the commenter encouraged CMS to require that all filings with the FDA be submitted to CMS for review and for CMS to rely heavily on the predicated device in the FDA application, require all privately held companies to provide CMS with a list of investors/owners, utilize generally accepted accounting principles, seek advice from the Medicare Coverage Advisory Committee (MCAC) or the Medical Technology Council (MTC), consider evaluation methods used by other health insurers, and consider recommendations from experts in the field. The commenter believed that if CMS had consulted the MCAC or the MTC, which advise CMS on whether specific medical treatments and technology should receive coverage, neither the MCAC nor the MTC would have recommended coverage for the CyberKnife technology, as an example.

In response to our August 16, 2004 proposed rule, one commenter, a device manufacturer, urged CMS to make changes to the pass-through and new technology application and evaluation processes to provide disclosure of applications filed with CMS and to create an opportunity for the public to comment on the disposition of proposed or final actions on applications. The commenter believed that public processes can be adopted, while retaining CMS' quarterly update capability for coding and payment.

Response: As required by section 942(a) of Pub. L. 108–173, we recently established the Council on Technology and Innovation (CTI) which brings together CMS senior leadership to better coordinate coverage, coding and payment policy to support the goal of high quality, high value care. The CTI aims to provide CMS with improved methods for developing practical information about the clinical benefits of new medical technologies to aid in achieving more efficient coverage and payment of these medical technologies. The CTI will also help identify and develop study methods for gathering reliable evidence about the risks and benefits of new and existing medical technologies that can be carried out more easily on a regular basis, such as simple protocols, registries, and other study methods.

The CTI will support CMS' efforts to develop better evidence on the safety, effectiveness, and cost of new and approved technologies to help promote their more effective use. As directed in section 942(a) of Pub. L. 108–173, the CMS Council coordinates the activities of Medicare coverage, coding, and payment for new technologies and the exchange of information on new technologies between CMS and other entities charged with making similar considerations and decisions.

G. Changes to the Inpatient List

At the APC Panel's February 2004 meeting, we advised the APC Panel of a request that we had received to move four codes for percutaneous abscess drainage 44901 (Drain append. abscess, percutaneous), 49021 (Drain abdominal abscess), 49041 (Drain percutaneous abdominal abscess), 49061 (Drain, percutaneous, retroper. abscess)) from the inpatient list and to assign them to appropriate APCs. The APC Panel also recommended that we evaluate other codes on the inpatient list for possible APC assignment and that we consider eliminating the inpatient list.

In the August 16, 2004 proposed rule, we proposed to remove the four above-cited codes and assign them to clinically appropriate APCs, as recommended by the APC Panel. We also proposed to assign code 44901 to APC 0037, code 49021 to APC 0037; code 49041 to APC 0037; and code 49061 to APC 0037. We discuss in section VII.E. of this final rule with comment period our response to the APC Panel's recommendation that we either abolish the inpatient list or evaluate it for any appropriate changes, the public comments we received on our proposal, and our responses to those public comments.

H. Assignment of ''Unlisted'' HCPCS Codes

1. Background

Some HCPCS codes are used to report services that do not have descriptors that define the exact service furnished. They are commonly called ''unlisted'' codes. The code descriptors often contain phrases such as: ''unlisted procedure,'' ''not otherwise classified,'' or ''not otherwise specified.'' The unlisted codes typically fall within a clinical or procedural category, but they lack the specificity needed to describe the resources used in the service. For example, CPT code 17999 is defined as ''Unlisted procedure, skin, mucous membrane and subcutaneous tissue.'' The unlisted codes provide a way for providers to report services for which there is no HCPCS code that specifically describes the service furnished. However, the lack of specificity in describing the service prevents us from assigning the code under the Medicare OPPS to an APC group based on clinical homogeneity and median cost.

In the August 16, 2004 proposed rule, we listed in Table 15 our proposed APC reassignments of unlisted HCPCS codes. In most cases, the unlisted codes are assigned to the lowest level, clinically appropriate APC group under the Medicare OPPS. This creates an incentive for providers to select the appropriate, specific HCPCS code to describe the service if one is available. In addition, if there is no HCPCS code that accurately describes the service, placing the unlisted code in the lowest level APC group provides an incentive

for interested parties to secure a code through the AMA's CPT process that will describe the service. Once a code that accurately describes the service is created, we can collect data on the service and place it in the correct APC based on the clinical nature of the service and its median cost.

We do not use the median cost for the unlisted codes in the establishment of the weight for the APC to which the code is assigned because, by definition of the code, we do not know what service or combination of services is reflected in the claims billed using the unlisted code.

Our review of HCPCS code assignments to APCs has revealed that there are a number of unlisted codes that are not assigned to the lowest level APC.

2. Proposed and Final Policy for CY 2005

In the August 16, 2004 proposed rule, we proposed to reassign specified unlisted HCPCS codes for CY 2005 OPPS to the lowest level APC in the clinical grouping in which the unlisted code is located. We displayed a listing of our proposed reassignment of the unlisted HCPCS codes in Table 15 of the proposed rule.

We received a number of public comments on our proposals.

Comment: Some commenters supported placing all unlisted codes in the lowest paid APC and noted that they believed that there are others, such as CPT code 43999 (Unlisted procedure stomach), which is now in APC 0141, that should be added to the list of those to be placed in the lowest APC. They recommended that CMS review the entire list of CPT codes to find others that should be moved to the lowest level APC.

Some commenters opposed placing ''unlisted'' or ''not otherwise classified'' codes in the lowest APC applicable to the category of service. They believed that it is inappropriate for CMS to develop payment policies aimed at forcing stakeholders to seek new HCPCS codes for the services being performed. They indicated that moving these codes to the lowest paying APC would decrease payment for 18 of the 20 procedures by more than 70 percent and would create a barrier to new technology. They indicated that CMS should analyze the costs associated with particular unlisted codes and assign them to APCs that appropriately reflect the cost to perform the services but in the meantime, should retain them in the existing APCs in which they are placed. One commenter urged us to follow the process that is followed for physician payment when unlisted codes are used, with fiscal intermediaries negotiating payment for the unlisted code depending on the actual service provided each time. One commenter indicated that putting the unlisted codes in the lowest level APC provides a disincentive for facilities to adopt new technology because it will not be paid adequately.

Response: We appreciate the support of the commenters who agreed with placing unlisted codes in the lowest APC for the clinical category. With respect to the comment that CPT code 43999 should be moved out of APC 0141 and should be placed in the lowest APC for gastrointestinal procedures, we have not moved it from APC 0141 because we believe that APC 0141 is the lowest APC appropriate to the clinical category of services for CPT code 43999.

We have reviewed again the proposed list of unlisted or ''not otherwise classified'' codes being moved to the lowest APC and based on that re-review have determined that we do not need to make any additional changes to that proposed list in this final rule with comment period.

By definition, ''unlisted'' or ''not otherwise classified'' codes do not describe the services being performed, and the services coded using ''unlisted'' codes vary over time as new CPT and HCPCS codes are developed. Therefore, it is impossible for any level of analysis of past hospital data to result in appropriate placement of the service for the upcoming year in an APC in which there is clinical integrity of the groups and weights. Therefore, we believe that the appropriate default, in the absence of a code that describes the service being furnished, is placement in the lowest level APC within the clinical category in which the unlisted code falls. We see no need to expand the process that is followed for physician payment of unlisted codes to the outpatient hospital setting. The assignment of the unlisted codes to the lowest level APC in the clinical category specified in the code provides a reasonable means for interim payment until such time as there is a code that specifically describes what is being paid. It encourages the creation of codes where appropriate and mitigates against overpayment of services that are not clearly identified on the bill. For new technologies that are complete services but may not have yet been granted a specific CPT code, the new technology payment mechanism is available under OPPS. Outlier payments may also be available under the OPPS in a case of an expensive new technology for which a specific code is not available and for which the costs of the new procedure exceed the outlier threshold.

Comment: One commenter indicated that the principal problem behind the use of unlisted or not otherwise classified codes is the AMA's bias against giving CPT codes for new services and technologies unless a physician group requests the code to provide a mechanism for increased physician payment for the service. The commenter asked that CMS, as the largest and most powerful licensee of CPT, influence the AMA to reduce the amount of time it takes to release new CPT codes for use in the OPPS so that the need for use of unlisted codes will diminish and the new services can be paid appropriately more quickly after they come onto the market. The commenter also asked that CMS reduce its ''barriers'' to placement of new services that require new technologies into new technology APCs or to granting of pass through payment status. The commenter indicated that lowering these ''barriers'' also would eliminate much of the use of the unlisted codes.

Response: An individual, a physician group, or a manufacturer may submit a request for a new CPT code. CMS works collaboratively with the AMA to establish new CPT codes, recognizing that the process is governed and controlled by the AMA. The AMA CPT process involves methodical consideration of new coding proposals, which may be time consuming. In addition, the payment system changes required by new codes take some time to implement. Under the OPPS, we make available the pass-through and new technology payment mechanisms, using C-codes and G-codes to allow new services, devices, and technologies to be available to clinicians and providers to facilitate appropriate payment for such services. The commenter did not indicate what ''barriers'' to placement of new services exist. However, to assist the public, we provide further guidance in section IV.C. of the preamble concerning additional comments on the topic of the surgical insertion or implantation criterion for the pass-through device payment mechanism.

In this final rule with comment period, we are adopting as final, without modification, the proposed reassignment of unlisted HCPCS codes to move all unlisted or ''not otherwise classified'' codes to the lowest level APC that is appropriate to the clinical nature of the service, as displayed in Table 15.

Table 15.--Reassignments of Unlisted HCPCS Codes

HCPCS Short Description	CY 2004 APC Assignment	CY 2005 APC Assignment
15999	0022	0019
21089	0253	0251
21299	0253	0251
21499	0253	0251
21899	0252	0251
22999	0022	0019
31299	0252	0251
31599	0254	0251
40799	0253	0251
40899	0252	0251
41899	0253	0251
42699	0253	0251
42999	0252	0251
47399	0037	0002
48999	0005	0004
49659	0131	0130
67599	0239	0238
67999	0240	0238
68399	0239	0238
68899	0699	0230
69799	0253	0251
69949	0253	0251

I. Addition of New Procedure Codes

During the first two quarters of CY 2004, we created 85 HCPCS codes that were not addressed in the November 7, 2003 final rule with comment period that updated the CY 2004 OPPS. We have designated the payment status of those codes and added them to the April and July updates of the 2004 OPPS (Transmittals 3144, 3154, 3322, and 3324). We showed these codes in Table 16 of the proposed rule. Thirty of the new codes were created to enable providers to bill for brand name drugs and to receive payments at a rate that differs from that for generic equivalents, as mandated in section 1833(t)(14)(A)(i) of the Act as added by Pub. L. 108–173. In the August 16, 2004 proposed rule, we solicited comment on the APC assignment of these services. Further, consistent with our annual APC updating policy, we proposed to assign the new HCPCS codes for CY 2005 to the appropriate APCs.

We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are adopting as final our proposal to assign the new HCPCS codes for CY 2005 to the appropriate APCs, as shown in Addendum B of this final rule with comment period, without modification.

J. OPPS Changes Relating to Coverage of Initial Preventive Physical Examinations and Mammography Services Under Pub. L. 108–173

1. Payment for Initial Preventive Physical Examinations (Section 611 of Pub. L. 108–173)

a. Background

Section 611 of Pub. L. 108–173 provides for coverage under Medicare Part B of an initial preventive physical examination for new beneficiaries, effective for services furnished on or after January 1, 2005. This provision applies to beneficiaries whose coverage period under Medicare Part B begins on or after January 1, 2005, and only for an initial preventive physical examination performed within 6 months of the beneficiary's initial coverage date.

Current Medicare coverage policy does not allow for payment for routine physical examinations (or checkups) that are furnished to beneficiaries. Before the enactment of Pub. L. 108–173, all preventive physical examinations had been excluded from coverage based on section 1862(a)(7) of the Act, which states that routine physical checkups are excluded services. This exclusion is specified in regulations under § 411.15(a). In addition, preventive physical examinations had been excluded from coverage based on section 1862(a)(1)(A) of the Act. This section of the Act provides that items and services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (as implemented in regulations under § 411.15(k)).

Coverage of initial preventive physical examinations is provided only under Medicare Part B. As provided in the statute, this new coverage allows payment for one initial preventive physical examination within the first 6 months after the beneficiary's first Part B coverage begins, although that coverage period may not begin before

January 1, 2005. We also note that Pub. L. 108–173 did not make any provision for the waiver of the Medicare coinsurance and Part B deductible for the initial preventive physical examination. Payment for this service would be applied to the required Medicare Part B deductible, which is $110 for CY 2005, if the deductible has not been met, and the usual coinsurance provisions would apply.

b. Amendments to Regulations

In the August 16, 2004 proposed rule, we proposed to amend our regulations to add a new § 410.16 that would provide for coverage of initial preventive physical examinations in various settings, including the hospital outpatient department, as specified in the statute, and specify the condition for coverage and limitation on coverage. In addition, we proposed to conform our regulations on exclusions from coverage under § 411.15(a)(1) and § 411.15(k) to the provisions of section 611 of Pub. L. 108–173. Specifically, we proposed to specify an exception to the list of examples of routine physical checkups that are excluded from coverage under § 411.15(a) and to add a new exclusion under § 411.15(k)(11).

We proposed to amend § 419.21 of the OPPS regulations to add a new paragraph (e) to specify payment for an initial preventive physical examination as a Medicare Part B covered service under the OPPS if the examination is furnished within the first 6 months of the beneficiary's first Medicare Part B coverage.

We noted that the initial preventive physical examination was also addressed in detail in our proposed rule to update the Medicare Physician's Fee Schedule for CY 2005 (69 FR 47487, August 5, 2004). However, because we believe the same elements of the initial physical examination furnished in a physician's office would also apply when the examination is performed in a hospital outpatient clinic, we proposed to revise the applicable regulations to reflect this requirement.

Section 611(b) of Pub. L. 108–173 defines an ''initial preventive physical examination'' to mean physicians'' services consisting of—

(1) A physical examination (including measurement of height, weight, blood pressure, and an electrocardiogram (EKG), but excluding clinical laboratory tests) with the goal of health promotion and disease detection; and

(2) Education, counseling, and referral with respect to screening and other preventive coverage benefits separately authorized under Medicare Part B, excluding clinical laboratory tests.

Specifically, section 611(b) of Pub. L. 108–173 provides that the education, counseling, and referral services with respect to the screening and other preventive services authorized under Medicare Part B include the following:

(1) Pneumococcal, influenza, and hepatitis B vaccine and their administration;

(2) Screening mammography;

(3) Screening pap smear and screening pap smear and screening pelvic examination;

(4) Prostate cancer screening tests;

(5) Colorectal cancer screening tests;

(6) Diabetes outpatient self-management training services;

(7) Bone mass measurements;

(8) Screening for glaucoma;

(9) Medical nutrition therapy services for individuals with diabetes and renal disease;

(10) Cardiovascular screening blood tests; and

(11) Diabetes screening tests.

Section 611(d)(2) of Pub. L. 108–173 amended sections 1861(s)(2)(K)(i) and (s)(2)(K)(ii) of the Act to specify that the services identified as physicians' services and referred to in the definition of initial preventive physical examination include services furnished by a physician assistant, a nurse practitioner, or a clinical nurse specialist. We refer to these professionals as ''qualified nonphysician practitioners.''

Based on the language of the statute, our review of the medical literature, current clinical practice guidelines, and United States Preventive Services Task Force recommendations, we proposed (under proposed new § 410.16(a), Definitions) to interpret the term ''initial preventive physical examination'' for purposes of this new benefit to include all of the following services furnished by a doctor of medicine or osteopathy or a qualified nonphysician practitioner:

(1) Review of the beneficiary's comprehensive medical and social history. We proposed to define ''medical history'' to include, as a minimum, past medical and surgical history, including experience with illnesses, hospital stays, operations, allergies, injuries, and treatments; current medications and supplements, including calcium and vitamins; and family history, including a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk. We proposed to define ''social history'' to include, at a minimum, history of alcohol, tobacco, and illicit drug use; work and travel history; diet; social activities; and physical activities.

(2) Review of the beneficiary's potential (risk factors) for depression (including past experiences with depression or other mood disorders) based on the use of an appropriate screening instrument that the physician or qualified nonphysician practitioner may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is defined through the national coverage determination (NCD) process.

(3) Review of the beneficiary's functional ability and level of safety (that is, at a minimum, a review of the following areas: Hearing impairment, activities of daily living, falls risk, and home safety), based on the use of an appropriate screening instrument, which the physician or qualified nonphysician practitioner may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is further defined through the NCD process.

(4) An examination to include measurement of the beneficiary's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's comprehensive medical and social history and current clinical standards.

(5) Performance of an electrocardiogram and interpretation.

(6) Education, counseling, and referral, as deemed appropriate, based on the results of elements (1) through (5) of the definition of the initial preventive physical examination.

(7) Education, counseling, and referral, including a written plan for obtaining the appropriate screening and other preventive services, which are also covered as separate Medicare Part B benefits; that is, pnuemococcal, influenza, and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic exams, prostate cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, screening for glaucoma, medical nutrition therapy services, cardiovascular screening blood tests, and diabetes screening tests.

As we indicated in the OPPS proposed rule, we are addressing the public comments that we received on our proposal to revise our regulations to include specific coverage of initial preventive physical examinations under Medicare Part B and finalizing our coverage policy for initial preventive physical examinations in the final rule for the CY 2005 Medicare Physician Fee

Schedule published elsewhere in this issue.

c. Assignment of New HCPCS Codes for Payment of Initial Preventive Physical Examinations

There was no CPT code that contained the specific elements included in the initial preventive physical examination. Therefore, in the August 16, 2004 proposed rule, we proposed to establish a new HCPCS code to be used to bill for the new service under both the Medicare Physician Fee Schedule and the OPPS. We proposed a code, GXXXX, for the full service, including an EKG, but not including the other previously mentioned preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they should be billed using the existing appropriate HCPCS and CPT codes.

For payment under the Medicare Physician Fee Schedule, relative value units were proposed for the new HCPCS code for the initial preventive physical based on equivalent resources and work intensity to those contained in CPT evaluation and management code 99203 (New patient, office or other outpatient visit) and CPT 93000 (Electrocardiogram, complete) (69 FR 47487, August 5, 2004). The ''technical component'' of the Medicare Physician Fee Schedule (the costs other than those allocated for the physician's professional services and professional liability insurance which are billed and paid for separately, when appropriate) is the portion of the fee schedule payment that is most comparable to what Medicare pays under the OPPS. The estimated ''technical component'' of the Medicare Physician Fee Schedule payment for GXXXX was between $50 and $100.

d. APC Assignment of Initial Preventive Physical Examination

Given our lack of cost data to guide assignment of the new code to a clinically appropriate APC, in our proposed rule, we proposed assignment of the new code GXXXX (Initial preventive physical examination) to New Technology APC 1539 (New Technology, Level II) with a payment level between $50 and $100. We believed that the proposed temporary assignment to a new technology APC would allow us to pay for the new benefit provided in the OPD while we accrued claims data and experience on which to base a clinically relevant APC assignment in the future.

We received a number of public comments regarding the proposed payment for the initial preventive physical examination and its proposed APC placement.

Comment: A number of commenters highlighted billing and operational concerns with the definition of a single HCPCS code, GXXXX, for the initial preventive physical examination. The commenters explained that, in hospitals where the EKG was performed in a separate department from the location of the physical examination, the technician charging for the service would have no way of distinguishing an EKG related to the initial preventive physical examination from other EKG tracings performed for diagnostic purposes, for which the hospital would bill for that specific service. The commenters noted that physicians often send their patients to hospitals for the EKG tracing, and if hospitals performed the EKG associated with the initial preventive physical examination in this context, they would have no way to bill for the EKG. The commenters presented various alternative coding possibilities for our consideration to address these situations.

Response: Section 611 of Pub. L. 108–173 does require a screening EKG to be performed as part of the initial preventive physical examination visit. In view of the different circumstances that may occur when performing the full initial preventive physical examination, we are establishing four new G codes for the initial preventative physical examination for CY 2005.

- G0344: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare Part B enrollment. This code is assigned a status indicator ''V'' for the OPPS.
- G0366: Electrocardiogram, routine EKG with at least 12 leads; performed as a component of the initial preventive physical examination with interpretation and report. This code is assigned a status indicator ''B'' for the OPPS.
- G0367: Electrocardiogram, tracing only, without interpretation and report, performed as a component of the initial preventive physical examination. This code is assigned status indicator ''S'' for the OPPS.
- G0368: Electrocardiogram, interpretation and report only, performed as a component of the initial preventive physical examination. This code is assigned status indicator ''A'' for the OPPS.

In the hospital, performance of the complete initial preventive physical examination service would be coded using both the G0344 and G0367 codes. As required by the statute, the new codes describe the visit and the EKG, but not the other previously mentioned preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they should be billed using the existing appropriate HCPCS and CPT codes.

To comply with Pub. L. 108–173, the initial preventive physical examination must include the EKG, regardless of whether a diagnostic EKG had previously been performed. Both components of the initial preventive physical examination, the examination and the EKG, must be performed to fulfill the statutory benefit for either of the components to be paid. Billing instructions for providers will be issued.

In addition to our decision to create two codes for hospitals to report for performance of the initial preventive physical examination service, we are assigning the codes to appropriate APCs as follows: G0344 is assigned to APC 0601 (Mid Level Clinic Visits), and G0367 is assigned to APC 0099 (Electrocardiograms). These APC assignments result in a total payment of approximately $78, slightly more than the $75 payment rate proposed for the comprehensive initial preventive physical examination service in the proposed rule.

Comment: A few commenters requested that CMS increase the payment for the initial preventive physical examination benefit and stated that the payment rate set is too low to cover the required clinical resources.

Response: As stated in our proposed rule, the payment rate for the comprehensive initial preventive physical examination service under the OPPS was based on the rate proposed under the Medicare Physician Fee Schedule, which utilized estimates of necessary resources for the initial preventive physical examination benchmarked against the resources required to deliver existing evaluation and management and electrocardiogram services in the physician office. Based on comments concerning the adequacy of our proposed payment for the comprehensive initial preventive physical examination service and our decision to separate the examination service from the EKG for coding and payment purposes, we explicitly compared the resources we anticipated for the examination service delivered in the hospital to the OPPS median cost for the existing new office or other outpatient visit service which was used as a crosswalk. CPT code 99203 (Office

or other outpatient visit for a new patient) is in APC 0601, which has a median cost of $57.66. The AMA/Specialty Society RVS Update Committee survey data for code 99203 showed 51 minutes of staff time, and we believe the initial preventive physical examination will reflect comparable time and consumption of hospital resources. As we expect the hospital resources utilized for code G0344 to be similar to those needed for clinic visits for which we have historical hospital cost data, we will place G0344 in APC 0601 rather than in a new technology APC as we proposed for the initial preventive physical examination comprehensive service. We expect the hospital resources utilized for the screening EKG tracing, code G0367, to be very similar to those necessary for a diagnostic EKG tracing, code 93005 and assigned to APC 0099. Together these APCs (0601 and 0099) will pay approximately $78, several more dollars than we proposed for the comprehensive service. We will monitor our claims data for the initial preventive physical examination services as hospitals gain experience delivering the services. We are finalizing our placement of code G0344 in APC 0601 for CY 2005 and code G0367 in APC 0099 for 2005.

Comment: Several commenters asked that CMS provide explicit instructions and guidelines, respectively, to providers and beneficiaries regarding the details of what will be included in the new initial preventive physical examination benefit, the eligibility requirements, and how providers should bill Medicare for the new service. One commenter asked if the preventive physical examination will be subject to the evaluation and management guidelines.

Response: We will release appropriate manual and transmittal instructions and information from the CMS educational components for the medical community, including a MedLearn Matters article and fact sheets such as the ''2005 Payment Changes for Physicians and Other Providers: News From Medicare for 2005''. The medical community can join this effort in educating physicians and beneficiaries by their own communications, bulletins, or other publications. In addition, we have specifically included information on the new initial preventive physical examination benefit in the 2005 version of the *Medicare and You Handbook* and revised booklet, *Medicare's Preventive Services*. A new 2-page fact sheet on all of the new preventive services, including the initial preventive physical examination benefit, will be available this Fall, and a bilingual brochure for Hispanic beneficiaries will also be available in the near future. Information will be disseminated by CMS regional offices, State Health Insurance Assistance Programs (SHIPs), and various partners at the national, State, and local levels. Information on the new benefit will also be made available to the public through Web site, *http://www.medicare.gov*, the partner Web site to *http://www.cms.hhs.gov*, the toll free number 1–800–MEDICARE, numerous forums hosted by CMS, and conference exhibits and presentations.

The initial preventive physical examination will not be subject to each hospital's internal set of evaluation and management guidelines that hospitals were instructed to develop at the implementation of the OPPS in the August 7, 2000 final rule (65 FR 18451) because we have defined one explicit service, without levels.

Comment: Several commenters asked how providers of initial preventive physical examination services will know if a particular beneficiary is eligible to receive the new benefit due to the statutory time and coverage frequency (one-time benefit) limitations.

Response: The statute provides for coverage of a one-time initial preventive physical examination that must be performed for new beneficiaries by qualified physicians or certain specified nonphysician practitioners within the first 6 month period following the effective date of the beneficiary's first Medicare Part B coverage. Because physicians or qualified nonphysician practitioners may not have the complete medical history for a particular new beneficiary, including information on possible use of the one-time benefit, these clinicians are largely relying on their own medical records and the information the beneficiary provides to them in establishing whether or not the initial preventive physical examination benefit is still available to a particular individual and has not been performed by another qualified practitioner. Because a second initial preventive physical examination will always fall outside the definition of the new Medicare benefit, an advance beneficiary notice (ABN) need not be issued in those instances where there is doubt regarding whether the beneficiary has previously received an initial preventive physical examination. The beneficiary will always be liable for a second initial preventive physical examination, no matter when it is conducted. However, for those instances where there is sufficient doubt as to whether the statutory 6-month period has lapsed, the physician or qualified nonphysician practitioner should issue an ABN to the beneficiary that indicates that Medicare may not cover and pay for the service. If the physician or qualified nonphysician practitioner does not issue an ABN to the beneficiary and Medicare denies payment for the service because the statutory time limitation for conducting the initial preventive physical examination has expired, the physician or qualified nonphysician practitioner may be held financially liable.

Comment: One commenter recommended that CMS compare the requirements of the initial preventive physical examination to the contemplated requirements for similar but not-yet-disclosed facility-specific evaluation and management level definitions. The commenter wanted to ensure that the technical requirements are comparable between the new benefit and similar evaluation and management service definitions being contemplated by CMS.

Response: We will take the commenter's recommendation into consideration in our ongoing work to develop new evaluation and management codes for the OPPS.

2. Payment for Certain Mammography Services (Section 614 of Pub. L. 108–173)

Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to provide that screening mammography and diagnostic mammography services are excluded from payment under the OPPS. This amendment applies to screening mammography services furnished on or after December 8, 2003 (the date of the enactment of Pub. L. 108–173), and in the case of diagnostic mammography, to services furnished on or after January 1, 2005. As a result of this amendment, both screening mammography and diagnostic mammography will be paid under the Medicare Physician Fee Schedule.

In the August 16, 2004 proposed rule, we proposed to amend § 419.22 of the regulations by adding a new paragraph(s) to specify that both screening mammography and diagnostic mammography will be excluded from payment under the OPPS, in accordance with section 614 of Pub. L. 108–173. We received a few public comments on our proposal.

Comment: A few commenters expressed support for the movement of payment for diagnostic mammograms from the OPPS to the Medicare Physician Fee Schedule.

Response: We appreciate the commenters' support. Additional

discussion of section 614 of Pub. L. 108–173 can be found in the final rule for the CY 2005 Medicare Physician Fee Schedule published elsewhere in this issue.

Comment: A few commenters recommended that the payment rates for mammography be increased. The commenters stated that beneficiary access to mammography is being limited due to a growing number of radiologists who refuse to read mammograms due to low payment and high malpractice rates and recent closure of a large number of centers across the country.

Response: We set the payment rates for diagnostic mammography based on hospital claims data, consistent with the payment methodology for OPPS services. In fact, in accordance with section 614 of Pub. L. 108–173, which requires that diagnostic mammography be paid now under the Medicare Physician Fee Schedule, payment is set using an entirely different process. This statutory change in the payment process results in a somewhat increased payment for mammography procedures from that under the OPPS.

Comment: One commenter asked CMS to clarify that the increase in payment for diagnostic mammography furnished in the hospital outpatient department does not ''come out of the [Medicare Physician Fee Schedule] budget.''

Response: The increase in payment for diagnostic mammography furnished in the hospital outpatient department has no effect on payment for Medicare Physician Fee Schedule services. We are using the Medicare Physician Fee Schedule rate to set Medicare payment for diagnostic mammography furnished in the hospital outpatient department, as required by statute. Further, we are not including diagnostic mammography in our model for setting the relative weights under the OPPS. Thus, the increase in payment for diagnostic mammography furnished in the hospital outpatient department also has no effect on payment for any other OPPS services.

In this final rule, we are adopting, as final without modification, our proposed revision of § 419.22 to incorporate the provisions of section 614 of Pub. L. 108–173.

III. Recalibration of APC Relative Weights for CY 2005

A. Database Construction

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 CY 2001 for application in CY 2002. In the April 7, 2000 OPPS 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. This policy is discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827).)

In the August 16, 2004 OPPS proposed rule, we proposed to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the relative APC weights for services furnished on or after January 1, 2005, and before January 1, 2006. That is, we proposed to recalibrate the weights based on claims and cost report data for outpatient services. We proposed to use the most recent available data to construct the database for calculating APC group weights. We provide a complete description of the data processes we proposed to use for the creation of the CY 2005 OPPS payment rates in the August 16, 2004 proposed rule (69 FR 50448).

For the purpose of recalibrating APC relative weights for CY 2005 displayed in this final rule with comment period, we used the most recent available claims data, which were the approximately 132 million final action claims for hospital OPD services furnished on or after January 1, 2003, and before January 1, 2004. Of the 132 million final action claims for services provided in hospital outpatient settings, 106 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 106 million claims, we were able to use 51 million whole claims (from which we created 84 million single procedure claim records) to set the final OPPS CY 2005 APC relative weights. We used claims from this period that had been processed before June 30, 2004, to calculate the APC weights and payments contained in Addenda A and B of this final rule with comment period.

We received one general public comment on our proposed OPPS database construction for CY 2005 discussed in the August 16, 2004 proposed rule.

Comment: One commenter suggested that CMS use a nationally representative sample of hospitals from which cost data could be collected for purposes of setting relative weights. The commenter suggested that such a sample could be used to validate findings from the larger claims data set or to establish median costs that more accurately reflect the costs of providing device-related procedures and other outpatient services, or both. As an alternative, the commenter suggested conducting a demonstration project using a sample of hospitals that would receive small grants for set up and training to test the feasibility of collecting a valid reliable and manageable data set from which to develop payment rates.

Response: We believe that the Medicare hospital outpatient claims and hospital cost reports are the best, nationally representative database of such information at present. Nevertheless, we acknowledge that an approach that would involve the collection of additional hospital data from a representative sample could have some merit. However, in addition to the resources that would be required for us to pursue such an approach, we also are concerned about the costs to hospitals associated with such an additional data collection effort. Nevertheless, we remain interested and invite additional suggestions from hospitals and other stakeholders on ways to enhance the data we now use to set relative weights for services paid under the OPPS.

1. Treatment of Multiple Procedure Claims

For CY 2005, we proposed to continue to use single procedure claims to set the medians on which the weights would be based (69 FR 50474). As indicated in the August 16, 2004 proposed rule, we received many requests that we ensure that the data from claims that contain charges for multiple procedures were included in the data from which we calculate the CY 2005 relative payment weights (69 FR 50474). Requesters believe that relying solely on single procedure claims to recalibrate APC relative weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that, by depending upon single procedure claims, we base relative payment weights on the least costly services, thereby introducing downward bias to the medians on which the weights are based.

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. As discussed in the explanation of single procedure claims below, we have used the date of service on the claims and a list of codes to be bypassed to create ''pseudo'' single claims from multiple procedure claims. We refer to these newly created single procedure claims

as ''pseudo'' singles because they were submitted by providers as multiple procedure claims.

2. Use of Single Procedure Claims

We use single procedure claims to set the median costs for APCs because we are, so far, unable to ensure that packaged costs can be correctly allocated across multiple procedures performed on the same date of service. However, bypassing specified codes that we believe do not have significant packaged costs enables use of more data from multiple procedure claims. For CY 2003, we created ''pseudo'' single claims by bypassing HCPCS codes 93005 (Electrocardiogram, tracing), 71010 (Chest x-ray), and 71020 (Chest x-ray) on a submitted claim. However, we did not use claims data for the bypassed codes in the creation of the median costs for the APCs to which these three codes were assigned because the level of packaging that would have remained on the claim after we selected the bypass code was not apparent and, therefore, it was difficult to determine if the medians for these codes would be correct.

For CY 2004, we created ''pseudo'' single claims by bypassing these three codes and also by bypassing an additional 269 HCPCS codes in APCs. We selected these codes based on a clinical review of the services and because it was presumed that these codes had only very limited packaging and could appropriately be bypassed for the purpose of creating ''pseudo'' single claims. The APCs to which these codes were assigned were varied and included mammography, cardiac rehabilitation, and level I plain film x-rays. To derive more ''pseudo'' single claims, we also broke claims apart where there were dates of service for revenue code charges on that claim that could be matched to a single procedure code on the claim on the same date.

As in CY 2003, we did not include the claims data for the bypassed codes in the creation of the APCs to which the 269 codes were assigned because, again, we had not established that such an approach was appropriate and would aid in accurately estimating the median cost for that APC. For CY 2004, from about 16.3 million otherwise unusable claims, we used about 9.5 million multiple procedure claims to create about 27 million ''pseudo'' single claims. For the CY 2005 OPPS rates in this final rule with comment period, from about 24 million otherwise unusable claims, we used about 18 million multiple procedure claims to create about 52 million ''pseudo'' single claims.

For CY 2005, we proposed to continue using date of service matching as a tool for creation of ''pseudo'' single claims and take a more empirical approach to creating the list of codes that we would bypass to create ''pseudo'' single claims. The process we proposed for CY 2005 OPPS resulted in our being able to use some part of 89 percent of the total claims eligible for use in OPPS ratesetting and modeling in developing this final rule with comment period. In CY 2004, we used some part of the data from 82 percent of eligible claims. This process enabled us to use, for CY 2005, 84 million single bills for ratesetting: 52 million ''pseudo'' singles and 33 million ''natural'' single bills.

We proposed to bypass the 383 codes, which we published in Table 17 of the proposed rule (69 FR 50476 through 50486), to create new single claims and to use the line-item costs associated with the bypass codes on these claims in the creation of the median costs for the APCs into which they are assigned (69 FR 50474 through 50486). Of the codes on this list, only 123 (32 percent) were used for bypass in CY 2004.

We developed the proposed bypass list using four criteria:

a. We developed the following empirical standards by reviewing the frequency and magnitude of packaging in the single claims for payable codes other than drugs and biologicals. We proposed to use these standards to determine codes that could be bypassed to create ''pseudo'' single claims for median setting. (More explanation regarding the use of these standards is provided in our August 16, 2004 OPPS proposed rule (69 FR 50475).)

- There were 100 or more single claims for the code.
- Five percent or fewer of the single claims for the code had packaged costs on that single claim for the code.
- The median cost of packaging observed in the single claim was equal to or less than $50.
- The code is not a code for an unlisted service.

b. We examined APCs relying on a low volume of single claims, and it became apparent that several radiological supervision and interpretation codes were commonly billed with the procedural codes in the APCs. We then reviewed all radiological supervision and interpretation codes to assess their viability as bypass codes. For the codes included on the proposed list published in Table 17, we determined that, generally, the packaging on claims, including these radiological supervision and interpretation codes, should be associated with the procedure performed.

c. We examined radiation planning and related codes provided by a professional organization. In the organization's opinion, the codes could safely be bypassed and used without packaging to set medians for the APCs into which these codes are assigned. Many of the codes the organization recommended met our criteria under item a., and the remaining codes were close. Therefore, after reviewing such codes, we proposed to adopt as bypass codes all radiation planning and related codes as provided by the organization.

d. We included HCPCS codes 93005 and 71010. These codes have been bypassed for the past 3 years and generate a significant amount of new single claims because they are very commonly done on the same date of surgery. They have low median packaged costs and a low percentage of single claims with any packaged costs, 6 percent and 18 percent, respectively.

In the August 16, 2004 proposed rule, we invited public comment on the ''pseudo'' single process, including the bypass list and the criteria. We received a number of public comments on our proposals.

Comment: Some commenters stated that CMS should provide an impact analysis by medical specialty and APC for the bypass list. Commenters indicated that 26 radiation oncology codes, which represent over 40 percent of the radiation oncology codes, are on the proposed list and that it is not clear what impact the inclusion of these codes will have on payment for radiation oncology procedures.

Response: The OPPS pays hospitals for the hospital services they furnish and, therefore, we focus our impact analysis on the providers who provide services and to whom the payment is made. It is impractical to do an impact analysis by hospital category, much less medical specialty and APC, for each and every step of the process we use to establish medians on which we base our payment rates.

However, to facilitate the public's ability to do specialized detailed analyses beyond what is practical for us to do, we make available the claims we use to set median costs. Specifically, the claims we used to set the payment rates for CY 2004 OPPS and CY 2005 OPPS are available to the public for public use in extended and focused analysis at any level of interest. Moreover, exhaustive discussion of our process is contained in both the CY 2004 and CY 2005 OPPS final rule with comment period claims accounting documents that are available on *www.cms.hhs.gov/providers/*

hopps.asp, to facilitate the use of such claims for further analysis. Therefore, we provide to the public the data needed for a focused exhaustive analysis of impact by medical specialty or on any basis on which any party with a special interest has a particular concern.

The 383 bypass codes presented in Table 17 of the proposed rule represent the result of an empirical and clinical analysis that identified HCPCS codes for which we could not observe significant packaged costs in the CY 2003 claims data and for which there was no clinical reason that a procedure or service should have significant packaged costs. These criteria are detailed in the proposed rule and were carefully chosen to avoid the inaccurate redistribution of packaged costs (69 FR 50474 through 50475). Inclusion of a HCPCS code on the bypass list is not predicated on the median impact, but rather empirical evidence or clinical arguments that these procedures do not contain significant packaged costs that would call into question their appropriateness for inclusion on the bypass list.

Comment: Most commenters supported the use of a bypass list and date of service matching as a way to use more data from multiple claims. One commenter was concerned that the bypass list may inappropriately break multiple claims into single procedure claims by assuming that the amount and frequency of packaging on procedures found on single bills was the same as would exist on multiple procedure claims. The commenter stated that claims involving multiple APCs are by their nature the most complex combinations of services requiring many more resources than if they were performed singly and that, therefore, CMS may be incorrect to generalize that the packaging found on single bills would also be present for the same procedure done as a multiple procedure. Another commenter opposed the use of the bypass list, citing it as a ''bandaid'' and as not a satisfactory way to deal with the presence of multiple procedure claims over the long run. The commenter indicated that, given the OPPS experience gained over the past years, CMS should be able to perform a study of multiple procedure claims that provides a mechanism for using them.

Response: We have retained and used the proposed bypass methodology in creating the median costs used to set the CY 2005 OPPS relative payment weights in this final rule with comment period. We believe that the use of the bypass list gives us considerably more single claims for ratesetting than had we not used it and that it is a valid representation of codes for which there is seldom any packaging and for which the packaging that exist, is minimal. Given the inability of any concrete processes that provide a way to attribute packaging on multiple bill claims, we believe that the best and only alternative available is for us to use the packaging on single bill claims to determine whether a code can be safely bypassed in the creation of ''pseudo single'' claims for median setting. We continue to examine the means by which we could use all multiple procedure claims and to invite additional recommendations from the public on how we might do so.

Comment: One commenter strongly objected to any method of using multiple procedure claims that would rely in any way on payment weights because the commenter believed that any such method would compound problems in the data by carrying them forward into future years.

Response: We expect to examine a number of different ways of using the data from multiple procedure claims and will evaluate each carefully before we discard any particular process. As we have in the past for updating the OPPS, if we decide to pursue any particular process change, we will discuss our findings and any proposed changes to the OPPS median development process in the proposed rule and consider public comments on the proposal before we change the process.

Comment: Some commenters indicated that the use of single procedure claims means that the most typical correctly coded claims are not used for many services. They added that many of the procedures that implant a device are actually replacing an existing device, which means that the removal of the device is billed with one code while the implant is billed with another code on the same claim on the same date of service, thereby creating a multiple procedure claim that will become two ''pseudo'' single claims under the CMS process. The commenters also stated that services that are provided only in addition to other services, such as noncoronary intravascular ultrasound, can never be correctly coded as a single procedure claim. They contended that such correctly coded claims will be multiple major procedure claims and thus will not be used for median cost setting. The commenters stated that the nature of some services being routinely performed in combination with other services means that, under the current CMS methodology, only small percentages of the claims will be used to set the medians and that those claims are likely to be the incorrectly coded claims.

Response: We recognize that there are categories of service that are typically done in combination with other services at such frequency that acquiring valid single procedure claims is very difficult, if not impossible. We are planning to explore these services for which the medians are set based on a small percentage of the claims that are submitted with the APC Panel in the future to determine what methods may be available to deal effectively with these situations.

In the August 16, 2004 proposed rule, we also discussed suggestions that we had received for creating ''pseudo'' single claims, which included recommendations that the costs in packaged revenue codes and packaged HCPCS codes be allocated separately to paid HCPCS codes based on the prior year's payment weights or payment rates for the single procedures. Still other suggestions recommended that we allocate the packaged costs in proportion to the charges or to the costs for the major procedures based on the current year's claims. We are concerned that using a prior year's median costs, relative weights or payment rates as the basis to allocate current year's packaged costs to current year costs for payable HCPCS codes may not be appropriate. For example, if two procedures are performed and one uses an expensive device, this methodology would split the costs of the device between the service that uses the device and a service that does not use the device, thus resulting in an incorrect allocation of the packaged costs. For this reason, we did not propose to incorporate these suggestions in our ratesetting methodology. However, we stated in our proposed rule that we intended to examine them more thoroughly.

We did not propose a methodology beyond use of dates of service and the expanded bypass list. However, we solicited specific proposals that would be provided as comments on how multiple procedure claims can be better used in calculating the relative payment weights.

Comment: One commenter asked that CMS clarify whether the ''pseudo'' single claims data for CPT codes 93307 (Echo exam of heart), 93303 (Echo transthoracic), and 93320 (Doppler echo exam, heart) were used in setting APC relative weights and, if so, the impact of this proposal. Another commenter asked that CMS clarify whether HCPCS codes for drugs, radiopharmaceuticals, and blood products were bypassed to create ''pseudo'' singles. The commenter

believed that packaged costs are never associated with these items; therefore, they should always be bypassed.

Response: The claims data for the three referenced CPT codes were used in setting the APC relative weights for these services. They were included in the list of bypass codes because they met the criteria for inclusion, which focused on selecting only claims that often did not include packaged services and for which packaging on the single bills was very modest.

We agree with the commenter that drugs, radiopharmaceuticals, and blood products would rarely be expected to have associated packaged costs. Presence of codes for these items on a claim does not result in a multiple claim, as we do not consider the items to be major procedures.

Comment: One commenter asked that CMS add CPT codes 76362 (Computed tomography guidance for, and monitoring of, visceral tissue ablation), 76394 (Magnetic resonance guidance for, and monitoring of, visceral tissue ablation), and 76940 (Us guide, tissue ablation) to the bypass list because they are often billed with CPT code 47382 (Radiofrequency ablation procedures of the liver) and CPT code 20982 (Radiofrequency ablation procedures of the bone). The commenter believed that this approach would create more single claims for those codes.

Response: The three CPT codes that the commenter requested we add to the bypass list did not have sufficient claims volume at the time the bypass list was created to meet the criteria for inclusion. When we next review the bypass list, we will examine these codes for inclusion on any future bypass list.

Comment: One commenter objected to use of data-based criteria as the only determinant of whether services are included on the bypass list. Specifically, the commenter objected to the inclusion of CPT evaluation and management codes 99213 and 99214 on the bypass list even though CPT codes 99211, 99212, and 99215 are not included on the list. The commenter believed that CMS should not assume that these codes do not typically have packaged costs associated with them because less than 5 percent of the claims with the code appeared on a claim with packaged charges. The commenter believed that all codes that ''meet the 5 percent data test'' should be qualitatively reviewed to determine whether clinical practice and charging methods support the assertion that packaged dollars are not related to the service proposed for the bypass list. The commenter also recommended that CMS include on the bypass list ''add-on'' CPT codes that have a status indicator of ''N'' so that the remaining packaged services on the claim would be packaged to the main procedure if that were the only other APC reported on the claim. The commenter recommended that ''add-on'' CPT codes with APC payment should be accepted as bypass codes if the only other CPT code on the claim is the main procedure.

Response: The commenter is incorrect in believing that the only criterion used to determine if a code were suitable for inclusion on the bypass list was whether 5 percent of the claims for the code appeared with packaged charges. As we discussed above, there were a number of criteria that had to be met which were focused on ensuring that packaging did not occur often or in significant amounts when it did occur. We reviewed the clinical appropriateness of the codes that were derived from applying the criteria, and did not remove any as a result of the review. Given the large volume of evaluation and management services, we believe that the evaluation and management codes we included on the bypass list were appropriate for inclusion. As we discussed with regard to the radiological supervision and evaluation codes and the simple EKG and chest x-ray codes, clinical practice and charging methods were also factors in determining inclusion on the bypass list.

With respect to the add-on codes, those that have a status indicator of ''N'' would not cause a claim to be a multiple procedure claim (because they are not separately paid). Thus it would not be useful to add them to the bypass list (which is intended to break multiple procedure claims into two single claims). Those add-on codes that are paid separately may or may not have packaging associated with them. Thus, it would be incorrect to assume that all packaging on the claim would be associated with the core procedure to which the add-on code is an appendage. For example, insertion of a left ventricular pacing lead as an add-on procedure to the insertion of a cardioverter-defibrillator carries considerable packaged costs with the add-on service, such as the device, significant additional operating room time, and extra drugs and medical supplies, and, therefore, it would not be suitable for inclusion on the bypass list.

After carefully reviewing all public comments received, we are adopting as final the bypass codes listed in Table 16 below.

BILLING CODE 4120–01–P

Table 16.—HCPCS Bypass Codes for Creating "Pseudo" Single Claims for Calculating Median Costs

HCPCS Code	Short Description
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
31579	Diagnostic laryngoscopy
54240	Penis study
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70130	X-ray exam of mastoids
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70250	X-ray exam of skull
70260	X-ray exam of skull
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70371	Speech evaluation, complex
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70544	Mr angiography head w/o dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/ chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine

HCPCS Code	Short Description
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72192	Ct pelvis w/o dye
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees

HCPCS Code	Short Description
73590	X-ray exam of lower leg
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74000	X-ray exam of abdomen
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74235	Remove esophagus obstruction
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74350	X-ray guide, stomach tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74742	X-ray, fallopian tube
75894	X-rays, transcath therapy

HCPCS Code	Short Description
75898	Followup angiography
75900	Arterial catheter exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75945	Intravascular us
75946	Intravascular us add-on
75952	Endovasc repair abdom aorta
75953	Abdom aneurysm endovas rpr
75954	Iliac aneurysm endovas rpr
75960	Transcatheter intro, stent
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast x-ray exam bile duct
75982	Contrast x-ray exam bile duct
75984	X-ray control catheter change
75992	Atherectomy, x-ray exam
75993	Atherectomy, x-ray exam
75994	Atherectomy, x-ray exam
75995	Atherectomy, x-ray exam
75996	Atherectomy, x-ray exam
75998	Fluoroguide for vein device
76012	Percut vertebroplasty, fluor
76013	Percut vertebroplasty, ct
76040	X-rays, bone evaluation
76061	X-rays, bone survey
76062	X-rays, bone survey
76066	Joint survey, single view
76075	Dexa, axial skeleton study
76076	Dexa, peripheral study
76078	Radiographic absorptiometry
76090	Mammogram, one breast
76091	Mammogram, both breasts
76095	Stereotactic breast biopsy

HCPCS Code	Short Description
76096	X-ray of needle wire, breast
76100	X-ray exam of body section
76101	Complex body section x-ray
76360	Ct scan for needle biopsy
76380	CAT scan follow-up study
76393	Mr guidance for needle place
76511	Echo exam of eye
76512	Echo exam of eye
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76830	Transvaginal us, non-ob
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76941	Echo guide for transfusion
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76977	Us bone density measure
77280	Set radiation therapy field
77285	Set radiation therapy field
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77315	Teletx isodose plan complex
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)

HCPCS Code	Short Description
77336	Radiation physics consult
77370	Radiation physics consult
77399	External radiation dosimetry
77403	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77470	Special radiation treatment
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
80502	Lab pathology consultation
85060	Blood smear interpretation
86585	TB tine test
86850	RBC antibody screen
86870	RBC antibody identification
86880	Coombs test, direct
86885	Coombs test, indirect, qual
86886	Coombs test, indirect, titer
86890	Autologous blood process
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86905	Blood typing, RBC antigens
86906	Blood typing, Rh phenotype
86930	Frozen blood prep
86970	RBC pretreatment
88104	Cytopathology, fluids
88106	Cytopathology, fluids
88107	Cytopathology, fluids
88108	Cytopath, concentrate tech
88160	Cytopath smear, other source
88161	Cytopath smear, other source
88172	Cytopathology eval of fna
88180	Cell marker study

HCPCS Code	Short Description
88182	Cell marker study
88300	Surgical path, gross
88304	Tissue exam by pathologist
88305	Tissue exam by pathologist
88311	Decalcify tissue
88312	Special stains
88313	Special stains
88321	Microslide consultation
88323	Microslide consultation
88325	Comprehensive review of data
88331	Path consult intraop, 1 bloc
88342	Immunohistochemistry
88346	Immunofluorescent study
88347	Immunofluorescent study
90801	Psy dx interview
90805	Psytx, off, 20-30 min w/e&m
90806	Psytx, off, 45-50 min
90807	Psytx, off, 45-50 min w/e&m
90808	Psytx, office, 75-80 min
90809	Psytx, off, 75-80, w/e&m
90810	Intac psytx, off, 20-30 min
90818	Psytx, hosp, 45-50 min
90826	Intac psytx, hosp, 45-50 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90853	Group psychotherapy
90857	Intac group psytx
90862	Medication management
92002	Eye exam, new patient
92004	Eye exam, new patient
92012	Eye exam established pat
92014	Eye exam & treatment
92082	Visual field examination(s)
92083	Visual field examination(s)
92135	Opthalmic dx imaging
92136	Ophthalmic biometry
92225	Special eye exam, initial

HCPCS Code	Short Description
92226	Special eye exam, subsequent
92230	Eye exam with photos
92250	Eye exam with photos
92275	Electroretinography
92285	Eye photography
92286	Internal eye photography
92520	Laryngeal function studies
92546	Sinusoidal rotational test
92548	Posturography
92552	Pure tone audiometry, air
92553	Audiometry, air & bone
92555	Speech threshold audiometry
92556	Speech audiometry, complete
92567	Tympanometry
92582	Conditioning play audiometry
92585	Auditor evoke potent, compre
93005	Electrocardiogram, tracing
93225	ECG monitor/record, 24 hrs
93226	ECG monitor/report, 24 hrs
93231	ECG monitor/record, 24 hrs
93232	ECG monitor/report, 24 hrs
93236	ECG monitor/report, 24 hrs
93270	ECG recording
93278	ECG/signal-averaged
93303	Echo transthoracic
93307	Echo exam of heart
93320	Doppler echo exam, heart
93731	Analyze pacemaker system
93733	Telephone analy, pacemaker
93734	Analyze pacemaker system
93736	Telephonic analy, pacemaker
93743	Analyze ht pace device dual
93797	Cardiac rehab
93798	Cardiac rehab/monitor
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study

HCPCS Code	Short Description
93888	Intracranial study
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study
93926	Lower extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93990	Doppler flow testing
94015	Patient recorded spirometry
95115	Immunotherapy, one injection
95165	Antigen therapy services
95805	Multiple sleep latency test
95807	Sleep study, attended
95812	EEG, 41-60 minutes
95813	EEG, over 1 hour
95816	EEG, awake and drowsy
95819	EEG, awake and asleep
95822	EEG, coma or sleep only
95864	Muscle test, 4 limbs
95872	Muscle test, one fiber
95900	Motor nerve conduction test
95921	Autonomic nerv function test
95926	Somatosensory testing
95930	Visual evoked potential test
95937	Neuromuscular junction test
95950	Ambulatory EEG monitoring
95953	EEG monitoring/computer
96000	Motion analysis, video/3d
96100	Psychological testing
96105	Assessment of aphasia
96115	Neurobehavior status exam

HCPCS Code	Short Description
96900	Ultraviolet light therapy
96910	Photochemotherapy with UV-B
96912	Photochemotherapy with UV-A
96913	Photochemotherapy, UV-A or B
98940	Chiropractic manipulation
99213	Office/outpatient visit, est
99214	Office/outpatient visit, est
99241	Office consultation
99243	Office consultation
99244	Office consultation
99245	Office consultation
99273	Confirmatory consultation
99274	Confirmatory consultation
99275	Confirmatory consultation
C9708	Preview Tx Planning Software
D0473	Micro exam, prep & report
G0005	ECG 24 hour recording
G0006	ECG transmission & analysis
G0015	Post symptom ECG tracing
G0101	CA screen;pelvic/breast exam
G0127	Trim nail(s)
G0131	CT scan, bone density study
G0132	CT scan, bone density study
G0166	Extrnl counterpulse, per tx
G0175	OPPS Service,sched team conf
G0195	Clinicalevalswallowingfunct
G0196	Evalofswallowingwithradioopa
G0198	Patientadapation&trainforspe
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0236	Digital film convert diag ma
Q0091	Obtaining screen pap smear

BILLING CODE 4120–01–C

B. Calculation of Median Costs for CY 2005

In this section of the preamble, we discuss the use of claims to calculate the OPPS payment rates for CY 2005. (The hospital outpatient prospective payment page on the CMS Web site on which this final rule with comment period is posted provides an accounting of claims used in the development of the final rates: *http://www.cms.hhs.gov/hopps.)* The accounting of claims used in the development of the final rule with comment period is included under supplemental materials for this final rule with comment period. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, we note that below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/providers/hopps* includes information about purchasing the following two OPPS data files: ''OPPS limited data set'' and ''OPPS identifiable data set.''

In this final rule with comment period, we are using the same methodology as proposed in the August 16, 2004 proposed rule to establish the relative weights that we used in calculating the OPPS payment rates for CY 2005 shown in Addenda A and B to this final rule with comment period. This methodology is as follows:

We used outpatient claims for full CY 2003 to set the relative weights for CY 2005. To begin the calculation of the relative weights for CY 2005, we pulled all claims for outpatient services furnished in CY 2003 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (for example, critical access hospital (CAH) claims, and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

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

We divided the remaining claims into the three groups shown below. Groups

2 and 3 comprise the 106 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X, 14X (hospital bill types), or 76X (CMHC bill types). Other bill types, such as ASCs, bill type 83, are not paid under the OPPS and, therefore, these claims were not used to set OPPS payment.

2. Bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims.

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

In previous years, we have begun the CCR calculation process using the most recent available cost reports for all hospitals, irrespective of whether any or all of the hospitals included actually filed hospital outpatient claims for the data period. However, in developing the proposed rule and this final rule with comment period, we first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2003 before determining whether the CCRs for such hospitals were valid. This initial limitation changed the distribution of CCRs used during the trimming process discussed below.

We then calculated the CCRs at a departmental level and overall for each hospital for which we had claims data. We did this using hospital specific data from the Hospital Cost Report Information System (HCRIS). As indicated in the proposed rule, we used the same CCRs as those used in calculating the relative weights that we used in developing the proposed rule. We did not recalculate CCRs to reflect updated cost report data.

We then flagged CAHs, which are not paid under the OPPS, and hospitals with invalid CCRs. These included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the departmental level by removing the CCRs for each cost center as outliers if they exceeded +/−3 standard deviations of the geometric mean. In prior years, we did not trim CCRs at the departmental level. However, for CY 2005, as proposed, we trimmed at the departmental CCR level to eliminate aberrant CCRs that, if found in high volume hospitals, could skew the medians. We used a four-tiered hierarchy of cost center CCRs to match a cost center to a revenue code with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's departmental CCR was deleted by trimming, we set the departmental CCR for that cost center to ''missing,'' so that another departmental CCR in the revenue center hierarchy could apply. If no other departmental CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question.

We then converted the charges on the claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. (We discussed in greater detail the allowed revenue codes in the proposed rule (69 FR 50487).) If a hospital did not have a CCR that was appropriate to the revenue code reported for a line-item charge (for example, a visit reported under the clinic revenue code but the hospital did not have a clinic cost center), we applied the hospital-specific overall CCR, except as discussed in section V.H. of this final rule with comment period, for calculation of costs for blood.

Thus, we applied CCRs as described above to claims with bill types 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, or the U.S. Virgin Islands, and flagged hospitals with invalid CCRs. We excluded claims from all hospitals for which CCRs were flagged as invalid.

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

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

We next copied line-item costs for drugs, blood, and devices (the lines stay on the claim but are copied off onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate the per unit median for drugs, radiopharmaceuticals, and blood and blood products. The line-item costs were also used to calculate the per administration cost of drugs, radiopharmaceuticals, and biologicals (other than blood and blood products) for purposes of determining whether the cost of the item would be packaged or paid separately. Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, requires the Secretary to lower to $50 the threshold for separate payment of drugs and biologicals and the per administration cost derived using these line-item cost data would be used to make that decision for CY 2005. As discussed in the November 7, 2003 OPPS final rule with comment period (68 FR 63398), we had also applied a $50 threshold to these items for the CY 2004 update to the OPPS.

We then divided the remaining claims into five groups.

1. *Single Major Claims:* Claims with a single separately payable procedure, all of which would be used in median setting.

2. *Multiple Major Claims:* Claims with more than one separately payable procedure or multiple units for one payable procedure. As discussed below, some of these can be used in median setting.

3. *Single Minor Claims:* Claims with a single HCPCS code that is not separately payable. These claims may have a single packaged procedure or a drug code.

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are not separately payable without examining dates of service. (For example, pathology codes are packaged unless they appear on a single bill by themselves.) The multiple minor file has claims with multiple occurrences of pathology codes, with packaged costs that cannot be appropriately allocated across the multiple pathology codes. However, by matching dates of service for the code and the reported costs through the ''pseudo'' single creation process discussed earlier, a claim with multiple pathology codes may become several ''pseudo'' single claims with a unique pathology code and its associated costs on each day. These ''pseudo'' singles for the pathology codes would then be considered a separately payable code and would be used like claims in the single major claim file.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS are excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory.

We note that the claims listed in numbers 1, 2, and 4 above are included in the data files that can be purchased as described above.

We set aside the single minor claims and the non-OPPS claims (numbers 3 and 5 above) because we did not use either in calculating median cost.

We then examined the multiple major and multiple minor claims (numbers 2 and 4 above) to determine if we could convert any of them to single major claims using the process described previously. We first grouped items on the claims by date of service. If each major procedure on the claim had a different date of service and if the line-items for packaged HCPCS and packaged revenue codes had dates of service, we broke the claim into multiple ''pseudo'' single claims based on the date of service.

After those single claims were created, we used the list of ''bypass codes'' in Table 16 of this final rule with comment period to remove separately payable procedures that we determined contain limited costs or no packaged costs from a multiple procedure bill. A discussion of the creation of the list of bypass codes used for the creation of ''pseudo'' single claims is contained in section III.A.2. of this preamble.

When one of the two separately payable procedures on a multiple procedure claim were on the bypass code list, the claim was split into two single procedure claims records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure retained the packaged revenue code charges and the packaged HCPCS charges.

We excluded those claims that we were not able to convert to singles even after applying both of the techniques for creation of ''pseudo'' singles. We then packaged the costs of packaged HCPCS (codes with status indicator ''N'' listed in Addendum B to this final rule with comment period) and packaged revenue codes into the cost of the single major procedure remaining on the claim. The list of packaged revenue codes is shown in Table 17 below.

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, 56 million claims were left. This subset of claims is roughly one-half of the 106 million claims for bill types paid under the OPPS. Of these 56 million claims, we were able to use some portion of 52 million (91 percent) whole claims to create the 84 million single and ''pseudo'' single claims for use in the CY 2005 median payment ratesetting.

We also excluded claims that either had zero costs after summing all costs on the claim or for which CMS lacked an appropriate provider wage index. For the remaining claims, we then wage adjusted 60 percent of the cost of the claim (which we determined to be the labor-related portion), as has been our policy since initial implementation of the OPPS, to adjust for geographic variation in labor-related costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As proposed, we used the final pre-reclassified wage indices for IPPS and any subsequent corrections. We used the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-reclassification wage indices, and would result in the most accurate adjusted median costs.

We then excluded claims that were outside 3 standard deviations from the geometric mean cost for each HCPCS code. We used the remaining claims to calculate median costs for each separately payable HCPCS code; first, to determine the applicability of the ''2 times'' rule, and second, to determine APC medians as based on the claims containing the HCPCS codes assigned to each APC. As stated previously, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (''the 2 times rule''). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs as deemed appropriate. Section III.B. of this preamble includes a discussion of the HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes.

A detailed discussion of the medians for blood and blood products is provided at section V.I. of this preamble. We provide a discussion of the medians for APC 0315 (Level II Implantation of Neurostimulator), and APC 0651 (Complex Interstitial Radiation Application), at sections III.C.2.a. and III.C.2.b., respectively, of this preamble.

A discussion of the medians for APCs that require one or more devices when the service is performed is provided at section III.C. of this preamble. A discussion of the median for observation services is provided at section VII.D. of this preamble and a discussion of the median for partial hospitalization is provided at section X.C. of this preamble.

We received a number of public comments concerning our proposed data processes for calculating the CY 2005 OPPS relative weights and median costs.

Comment: Some commenters requested that CMS provide specialty-specific and APC-specific impact tables that provide additional information and analysis of its proposal to trim CCRs on a departmental basis. The commenters stated that CMS should justify why it trimmed departmental CCRs at ±3 standard deviations from the geometric mean and explain the impact of the change.

Response: We chose to trim at ±3 standard deviations from the geometric mean because cost and charge data are traditionally log normal distributed and because the 3 standard deviations threshold is standard policy for identifying outliers in CMS' payment systems. We do not believe that an impact analysis for the departmental-level CCR trim is necessary because the overall number of cost-centers trimmed were minimal relative to the number of hospitals and because this trim only removed extreme department CCRs, both low and high. We fully expect that, had we chosen not to trim at the department-level, extreme cost estimates would have been removed during our trim at the HCPCS-level performed later in the data development process.

For example, we trimmed the most department CCRs, 68, from cost center 5500, Medical Supplies Charged to Patients. The low CCRs that were trimmed ranged from 0.00008 to 0.0281. The high CCRs that were trimmed ranged from 0.39530 to 6069.17. Even after the department-level trim, only 7 percent of the hospitals in our data set defaulted to the overall CCR for services mapped to this cost center.

Comment: One commenter stated that the CCRs fell between 1996 and 2002 because charges were increasing faster than costs and that this change resulted in a significant payment decrease for hospitals for which we used the default CCR. The commenter urged CMS to instruct fiscal intermediaries to work with these hospitals in determining

CCRs that will provide accurate cost estimates.

Response: The commenter misunderstood the source of the CCRs used to adjust hospital costs to charges for OPPS median setting. We do not use the CCRs that fiscal intermediaries calculate for purposes of outlier payments, and cost reimbursement. Instead, we use hospital specific data from the health care cost reporting information system and independently calculate CCRs for each standard and nonstandard cost center in which the costs of outpatient services are to be found as well as an overall CCRs for the costs of outpatient care. Hence, intermediaries have no role in the calculation of the CCRs used to reduce charges to approximate costs for OPPS median cost setting.

Comment: One commenter asked that CMS justify why did it not use cost-to-charge data from all hospitals for CY 2005 OPPS calculations when, in the past, CMS used cost report data from all hospitals without regard to whether the hospital had filed data during a specified period.

Response: In the past, we first calculated CCRs for all providers, trimmed the overall hospital CCRs, and then compared the providers for which we had valid CCRs to the providers for which we had claims data. For CY 2005 OPPS, we first determined the providers for which we had claims data and we then calculated the CCRs for those hospitals so that the trimming would occur only across the hospitals for which we had claims data because a CCR is of value only if there are claims to which to apply it.

Comment: One commenter urged CMS to greatly expand the outpatient code editor (OCE) edits to return to providers claims that fail edits that are appropriate to the type of service being billed. The commenter cited as examples, the creation of edits that return claims for chemotherapy administration procedures if anti-neoplastics (cancer chemotherapy) are not also billed on the same day and edits that return claims for services that require the use of contrast agents if no contrast agent were billed. The commenter believed that this would greatly improve the data on which median costs are set.

Response: We do not intend, at this time, to greatly expand the OCE edits to force correct coding as the commenter recommends beyond the edits for correct coding of device procedures that are discussed in section III.C.4 of this final rule with comment period. While we recognize that these kinds of edits would likely result in better coding, they would also impose a significant burden on hospitals. We do, however, encourage hospitals to review their claims completion processes carefully and to edit their claims before they are submitted to maximize the likelihood that the claims are correct and complete. Such a practice would both assist us in developing better OPPS rates, but more importantly, ensure that hospitals are being correctly paid for all of the services they furnish to our beneficiaries.

Comment: One commenter noted the prevalence of drug billing and charging errors and recommended that CMS revise its median trimming methodology for drugs from ±3 standard deviations from the geometric mean to a trim by provider by drug based on the correlation of units and charges. This approach assumes that hospitals engaged in accurate and consistent unit coding and billing will demonstrate a strong correlation between units and per unit charges. The commenter noted that CMS' current trim is very conservative, especially for low costs per unit because it will only eliminate negative cost values, which do not exist in the data. The commenter further suggested that CMS' trim of department-level CCR's and the use of C-code only claims to set device medians are comparable to this proposal.

Response: We agree that billing accurate units has proven challenging for some hospitals in light of various differences in packaged versus delivered units, changing drug pricing, and unit changes in HCPCS codes. Clearly, our goal in conducting the current trim at ±3 standard deviations from the geometric mean is to remove aberrant per unit costs, or costs that are so far removed from the geometric mean that the probability of their occurrence is less than 1 percent. However, even after this trim is conducted, we remain concerned about the per unit cost estimates for some drug codes.

We believe, however, that the current trim of drug costs, while conservative, is not as limiting as suggested in the comment. The natural logarithm of costs per unit less than $1 will be negative. The trim compares the natural logarithm of the cost to the geometric mean, ±3 standard deviations and removes low and high cost observations. The low trim threshold may also be negative if costs are less than $1. In addition to using a trim, we also rely on a median cost rather than an average cost. Averages are subject to the influence of extreme outliers. Using a median instead of a mean eliminates this concern. Assuming most line-items for any given drug are coded correctly, using a trim and the median should provide a robust per unit cost estimate. Nonetheless, we do recognize that for selected low-volume or complex products, this approach is still not sufficient to remove all errors.

We are concerned, however, about implementing systematic trimming at the provider-level as suggested by the commenter for several reasons. First, this approach would remove the data for multiple providers from any given median calculation, making the assumption that their data were inaccurate, when, in fact, a few instances of poor coding may adversely impact the provider's correlation coefficient. Thus, a provider may actually be coding and charging accurately in many cases. In rare instances, we have removed a specific provider when it is more than obvious that the data are erroneous, but we only do this after a careful review of the provider's claims data. It is our preference to remove aberrant line-items rather than a provider's entire data for any given drug. Second, correlation coefficients for a provider may fluctuate if they are based on very low-volume, even if the majority of line-items appear accurate. Third, the commenter's proposed correlation coefficient approach lacks a generally accepted threshold when a providers' data should be removed, unlike the widely accepted trim of 3 standard deviations from the mean. Finally, this approach assumes that a negative correlation coefficient implies that a provider erred in setting its charging practices.

While we agree that the proposed trim seeks to improve the accuracy of the claims data, which is the goal of all trimming, we disagree that the commenter's proposed trim is necessarily comparable to the use of a department-level CCR trim and the limitation of claims to those with C-codes for estimating medians for device-dependent APCs. The department-level trim does not eliminate a provider entirely, it eliminates the department-level CCR for a specific hospital and replaces this CCR with the overall CCR for that hospital. Relying on C-coded claims to calculate device-dependent medians assures us that the device was used with the device-dependent procedure. The specific cost associated with the device code is not considered in subsetting claims and the subsetting is done by claim, not by provider. While the commenter's proposed methodology is not appropriate for use at this time, we nonetheless believe that the commenter's suggested approach can serve as a useful tool in helping us begin the process of identifying providers

Comment: One commenter indicated that using the overall CCR where the

departmental CCR cannot be used may skew the costs derived from application of CCRs to charges. The commenter suggested that CMS develop a method for replacing departmental CCRs similar to that used for blood and blood products whereby the CCR that would apply would not be the overall CCR but a national CCR calculated based on the departmental CCRs of hospitals that do report the more pertinent specific cost centers on their cost reports.

Response: We will consider whether doing so is practical and whether it would yield more accurate cost estimates. However, there were very specific characteristics of the reporting of blood such as a very specific cost center and very specific revenue codes that may not exist for other services.

Comment: One commenter asked that CMS undertake a study to improve the reporting of costs in conjunction with the CCR development. The commenter stated that a more timely process should be implemented so that currently accurate CCRs are used to translate hospital charges to costs and that consideration should be given to attaining greater detail from the hospitals to calculate the CCRs to better reflect the full line of services being offered by hospitals.

Response: We study means by which we could improve the development of cost-to-charge ratios annually. We also use the most current cost report data from the HCRIS system to calculate the cost to-charge-ratios and we use charges from the most current claims data. However, hospitals have great latitude in the way they organize their costs and complete their cost reports. We have no plans to alter the existing instructions to require cost report detail that is not currently provided. We will, instead, continue to examine how the data currently submitted by hospitals can be used to secure the most accurate estimates of cost for the full range of services furnished by hospitals.

After carefully reviewing all comments, we are adopting as final, for OPPS services furnished on or after January 1, 2005, the process for calculating median costs that we described in this section and the list of packaged services shown in Table 17 below. This table contains the list of packaged services by revenue code that we used in developing the APC weights and medians listed in Addenda A and B of this final rule with comment period.

BILLING CODE 4120–01–P

Table 17.--Packaged Services by Revenue Code

Revenue Code	Description
250	PHARMACY
251	GENERIC
252	NONGENERIC
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
343	DIAGNOSTIC RADIOPHARMS
344	THERAPEUTIC RADIOPHARMS
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)
681	TRAUMA RESPONSE, LEVEL I
682	TRAUMA RESPONSE, LEVEL II
683	TRAUMA RESPONSE, LEVEL III

Revenue Code	Description
684	TRAUMA RESPONSE, LEVEL IV
689	TRAUMA RESPONSE , OTHER
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
819	OTHER ORGAN ACQUISITION
942	EDUCATION/TRAINING

BILLING CODE 4120–01–C

C. Adjustment of Median Costs for CY 2005

1. Device-Dependent APCs

Table 19, which we published in the proposed rule (69 FR 50492), contains a list of APCs consisting of HCPCS codes that cannot be provided without one or more devices. For CY 2002 OPPS, we used external data in part to establish the medians used for weight setting. At that time, many devices were eligible for pass-through payment. For that year, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through items, we packaged 75 percent of the cost of the devices (using external data furnished by commenters on the August 24, 2001 proposed rule) into the median cost for the APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass-through payment. (Section VI. of this preamble includes a discussion of the pro rata adjustment.)

For CY 2003 OPPS, which was based on CY 2001 claims data, we found that the median costs for certain device-dependent APCs when all claims were used were substantially less than the median costs used for CY 2002. We were concerned that using the medians calculated from all claims would result in payments for some APCs that would not compensate the hospital even for the cost of the device. Therefore, we calculated a median cost using only claims from hospitals that had separately billed the pass-through device in CY 2001 (that is, hospitals whose claims contained the C-code for the pass-through device). Furthermore, for any APC (whether device-dependent or not) where the median cost would have decreased by 15 percent or more from CY 2002 to CY 2003, we limited decreases in median costs to 15 percent plus half of the amount of any reduction beyond 15 percent (68 FR 47984). For a few particular device-dependent APCs for which we believed that access to the service was in jeopardy, we blended external data furnished by commenters on the August 9, 2002 proposed rule (67 FR 57092) with claims data to establish the median cost used to set the payment rate. For CY 2003, we also eliminated the HCPCS C-codes for the devices and returned to providers those claims on which the deleted device codes were used. (The November 1, 2002 OPPS final rule (67 FR 66750) and section III.C.4 of this preamble contain a discussion regarding the required use of C-codes for specific categories of devices.)

For CY 2004 OPPS, which was based on CY 2002 claims data, we used only claims on which hospitals had reported devices to establish the median cost for the device-dependent APCs in Table 18. We did this because we found that the median costs calculated when we used all claims for these services were inadequate to cover the cost of the device if the device was not separately coded on the claim. Using only claims containing the code for the device (a C-code) provided costs that were closer to those used for CY 2002 and CY 2003 for these services. For a few particular APCs in which we believed that access to the service was in jeopardy, we used external data provided by commenters on the August 12, 2003 proposed rule in a 50 percent blend with claims data to establish the device portion of the median cost used to set the payment rate (68 FR 63423). We also reinstated for CY 2004, but on a voluntary basis, the reporting of C-codes for devices.

Thus, in developing the median costs for device-dependent APCs for CYs 2002, 2003, and 2004, we applied certain adjustments to our claims data as provided under the authority of section 1833(t)(9)(A) of the Act to ensure equitable payments to the hospitals for the provision of such services. As stated in the August 16, 2004 proposed rule, we have continued to receive comments from interested parties as part of the APC Panel process urging us to determine whether the claims data that would be used in calculating the median costs for device-dependent APCs for payment in CY 2005 would represent valid relative costs for these services (69 FR 50490). Careful analysis of the CY 2003 data that we used in calculating the median costs for the CY 2005 OPPS payment rates revealed problems similar to those discussed above in calculating device-dependent APC median costs based solely on claims data. Calculation of the CY 2005 median costs for the device-dependent APCs indicated that some of the medians appeared to appropriately reflect the costs of the services, including the cost of the device, and others did not. Of the 41 device-dependent APCs analyzed, 27 have median costs that are lower than the medians on which the OPPS payments were based in CY 2004. In contrast, 14 device-dependent APCs have median costs that are higher than the medians on which OPPS payments were based in CY 2004.

The differences between the CY 2004 payment medians and the proposed CY 2005 median costs using CY 2003 claims data are attributable to several factors. As discussed above, the CY 2004 payment medians were based on a subset of claims that contained the codes for the devices without which the procedures could not be performed, and several APCs were adjusted using external data. The CY 2005 OPPS median costs on which the proposed payment rates in the August 16, 2004 proposed rule were based, were calculated based on all single bills, including ''pseudo'' single bills, for the services in the APCs and (not a subset

of claims containing device codes) and were not adjusted using external data. In fact, as stated previously, we eliminated device coding requirements for hospitals in CY 2003. Consequently, there were no device codes reported for almost all devices in the CY 2003 claims data. Thus, it was not possible to use only the CY 2003 claims data containing device codes to calculate APC device-dependent medians as was done in CY 2004. Similarly, it was not possible to calculate a percentage of the APC cost attributed to device codes based on CY 2003 claims data.

In light of these data issues for CY 2005, we examined several alternatives to using CY 2003 claims data to calculate the proposed median costs for device-dependent APCs. As discussed in the August 16, 2004 proposed rule, we considered using CY 2004 OPPS medians with an inflation factor, as recommended by the APC Panel and by several outside organizations. We rejected this option because it would not recognize any changes in relative costs for these APCs and would not direct us towards our goal of using all single claims data as the basis for payment weights for all OPPS services.

We also considered using the medians we calculated from all single bills with no adjustments. However, the results of using this approach without increasing the payments for some important high cost services for CY 2005 could result in the closing of hospital programs that provide these services thus, jeopardizing access to needed care. Therefore, we did not adopt this approach.

In addition, we considered subsetting claims based on the presence of charges in certain revenue codes. These revenue codes include: 272, sterile supplies; 275, pacemakers; 278, other implants; 279, other supplies/devices; 280, oncology; 289, other oncology; and 624, investigational devices. We determined that the medians increased for some device-dependent APCs when we used only claims with a charge in at least one of these revenue codes, but our analysis provided no reliable evidence that the charges that would be found in these revenue codes were necessarily for the cost of the device.

Further, we considered using CY 2002 claims to calculate a ratio between the median calculated using all single bills and the median calculated using only claims with HCPCS codes for devices on them, and applying that ratio to the median calculated using all single bills from CY 2003 claims data. We rejected this option because it assumes that the relationship between the costs of the claims with and without codes for devices is a valid relationship not only for CY 2002 but CY 2003 as well. It also assumes no changes in billing behavior. We have no reason to believe either of these assumptions is true and, therefore, we did not choose this option.

In summary, we considered and rejected all of the above options. We have given special treatment to the device-dependent APCs for the past 3 years, recognizing that, in a new payment system, hospitals need time to establish correct coding processes and, considering the need to ensure continued access to these important services. After 3 years of such consideration, we believe that it is time to begin a transition to the use of pure claims data for these services (reflected in these APCs) to ensure the appropriate relativity of the median costs for all payable OPPS services. Our goal is to establish payment rates that provide appropriate relative payment for all services paid under the OPPS without creating payment disincentives that may reduce access to care.

Therefore, we proposed to base median costs for device-dependent APCs in CY 2005 on the greater of (1) median costs calculated using CY 2003 claims data, or (2) 90 percent of the APC payment median for CY 2004 for such services. We proposed this adjustment because we believe that some variation in median costs is to be expected from year to year, and we believe that recognizing up to a 10 percent variation in our payment approach is a reasonable limit. In the August 16, 2004 proposed rule, we solicited comments on all aspects of theses issues and particularly on steps that can be taken in the future to transition from the historic payment medians to claims based median costs for OPPS ratesetting for these important services. In addition, we discussed this issue with the APC Panel at its September 1 through 2, 2004 meeting. The Panel recommended that we base median costs for these APCs on no less than 95 percent of the CY 2004 median not to exceed 105 percent of the CY 2004 payment median.

We received numerous public comments on our proposals.

Comment: A number of commenters objected to the proposal to set the payment medians for device APCs at 90 percent of the CY 2004 payment median for the APC. They indicated that many of these APCs had already been reduced substantially over the past few years and that permitting them to be reduced another 10 percent would mean that some hospitals may close their programs and send patients to other hospitals for these services. Some commenters recommended that the median costs for these APCs be set at 100 percent of the CY 2004 payment median. Some commenters recommended that CMS use the CY 2004 payment median plus an update amount as the median cost for the CY 2005 OPPS. Commenters also recommended that instead of using median costs from claims data with any adjustment, that we collect actual hospital acquisition data or use cost data provided by manufacturers and other stakeholders and substitute that data for the device portion of the median costs. They indicated that we used external data in the past and that we should do so this year also. They cited APCs 0081, 0107, 0108, 0225, 0229, 0259, 0385, and 0386 as cases in which the proposed APC payment rates were less than the cost of the devices and as those for which CMS should use external data in setting the payment rates for CY 2005. A commenter supported the proposal to pay the greater of the CY 2005 claims based median or 90 percent of the CY 2004 payment median.

Response: For the reasons discussed below, we set the adjusted CY 2005 OPPS device-dependent median at the greater of the CY 2005 OPPS unadjusted median or 95 percent of the CY 2004 OPPS adjusted final payment median rather than the greater of the CY 2005 unadjusted median or 90 percent of the CY 2004 OPPS adjusted final median as we proposed in the August 16, 2004 proposed rule. We view this as a transition to the full use of claims data to set the medians for these services. The integrity of a prospective payment system lies heavily in its reliance on a standardized process applied to a standardized data source. The use of external data can, as some commenters point out, unfairly unbalance the payments and result in inequities in payment. (Section III.C.5. of this preamble includes a discussion on the use of external data.)

We considered setting the medians at the CY 2004 adjusted final payment medians with and without further inflation, but we think a certain amount of fluctuation in costs from year to year is to be expected as the costs of services decline after they have been on the market for some time. Moreover, we considered our proposal to pay the greater of the CY 2005 unadjusted median or 90 percent of the CY 2004 OPPS adjusted final payment median, but acknowledged the concerns of the commenters who believe that setting the comparison at 95 percent of the CY 2004 OPPS final adjusted payment median was more appropriate and less likely to impede access to these important services. We recognize that adjustments

to median costs derived from claims data may be necessary yet again in the CY 2006 OPPS due to the voluntary nature of the reporting of device codes in CY 2004. However, as discussed further below at section III.C.4. of this preamble in our discussion of mandatory coding for devices, we expect that reporting of device codes in the CY 2005 claims will enable us to rely upon the claims data for setting the median costs without adjustment in CY 2007.

Comment: Some commenters opposed the APC Panel's recommendation to limit increases in median costs for device APCs to 5 percent over the CY 2004 payment median because the commenters believe such a limit would be arbitrary and would be a hindrance to the improvement of cost data.

Response: We agree and we have not limited the extent to which the median costs for device-dependent APCs may increase for the CY 2005 OPPS. We believe that in a number of cases, providers are reporting the charges for the devices and have otherwise greatly improved coding of their services, resulting in increases in median costs that appear to appropriately reflect the costs of the services furnished. We have no indication that the increases do not otherwise properly reflect the costs of services and, therefore, see no reason to constrain the increases that have resulted.

Comment: Some commenters stated that CMS should look long term to determining a factor through regression analysis that enables CMS to adjust the charges for high cost devices so that the methodology will result in more accurate costs for high cost devices.

Response: We will review and consider the results of credible studies of the possible compression of all charges, both for high cost services and low cost services. Studies that focus only on part of the spectrum of hospital charges, for example, those which look at low markup of high cost items but not at high markup of low cost items, would not be useful in a relative weight system.

Comment: Some commenters indicated that hospitals typically markup high cost items and services less than they markup low cost items and services and that CMS' cost finding methodology does not recognize this because it applies a uniform cost-to-charge ratio (for the department or hospital overall) to the charges, which then yields distorted costs. They recommended that CMS resolve this problem using external data from manufacturers and other stakeholders until such time that CMS can comply with the GAO study that recommended that CMS ''analyze variation in hospital charge setting to determine if the OPPS payment rates uniformly reflect hospitals' costs of provided outpatient services and if they do not, to make appropriate changes to the methodology.'' The commenters asked that CMS provide explicit instructions to hospitals regarding how to adequately capture and charge for high cost devices.

Response: As we discussed previously, we have decided not to use external data to adjust the APC payment rates for CY 2005 OPPS. We do, however, reassess our existing methodology each year to determine how we can best create rates that uniformly reflect hospitals' cost of providing outpatient services. We will not provide instructions to hospitals regarding how to capture and charge for high cost devices. As a matter of policy, we do not tell hospitals how to set their charges for their services. However, we will continue to inform hospitals of the importance of their charge data in future ratesetting and encourage them to include all appropriate charges on their Medicare claims.

Comment: One commenter objected to us applying the wage index adjustment to the cost of a device in a device-dependent APC because, as the commenter stated, the wage index is intended to address the identified differential in wages across localities. The commenter contends that there is no demonstration of a similar differential in the costs of devices across localities.

Response: Previous studies have shown that across the entirety of all services paid under OPPS, approximately 60 percent of total cost is labor related. Therefore we believe it is appropriate to apply the wage index to 60 percent of the payment for each service. The application of the wage index to the payment for the device-dependent APC can either inflate the total payment for the device-dependent APC or reduce it depending on whether the hospital is in a high cost or low cost area. In many cases, if we ceased to apply the wage index adjustment to 60 percent of the APC payment, the payment to the hospital for the APC would be significantly reduced. We will, however, consider whether it is appropriate to continue to apply the wage index adjustment as we currently do.

Comment: One commenter asked that we add CPT codes 47382, (Radiofrequency ablation procedures of the liver) and CPT code 20982, (Radiofrequency ablation procedures of the bone) to the list of device-dependent APCs because they require the use of devices.

Response: We will consider whether these services should be added to the list of device-dependent APCs in the future. However, it is unclear to us what proportion of total cost of each of these procedures is the cost of the device because codes are not reported for the devices. We do not agree that the cost of the devices could be derived from charges reported in particular revenue codes because there is no identification of the items charged under any revenue code.

Comment: Some commenters indicated that the reductions in APC payments following termination of pass-through status for devices have resulted in the elimination of programs at hospitals that have chosen to no longer implant prosthetic devices.

Response: We share the concern that beneficiaries should have access to services covered under Medicare and believe that our payment policies under OPPS have consistently taken this concern into account.

Comment: Some commenters indicated that the proposed payment rates for APCs 0081, 0107, 0108, 0222, 0229, 0385, and 0386 are inadequate and do not cover the cost of the device; therefore, they do not provide payment for the facility services. The commenters stated that hospitals have taken a loss on these services for several years and cannot continue to provide the services at a loss. The commenters developed alternative cost estimates using external data and urged CMS to use these data rather than its claims data as the basis for developing median costs.

Response: As stated, for device-dependent APC in general, we have not used external data to adjust any median costs for CY 2005 OPPS. Instead, we set the medians for these APCs at the greater of the median cost for CY 2005 derived using claims data or 95 percent of the CY 2004 OPPS adjusted payment median. Beginning in CY 2005, we will also require that the claims containing codes assigned to these APCs also contain a code for an appropriate device for the claim to be paid, so that in CY 2007 we will have correctly coded claims to help us in setting the payment weights.

Comment: Some commenters stated that the proposed payment for cryoablation of the prostate (CPT code 55873) is insufficient to cover the cost for the procedure. They further stated that CMS should factor in external data that shows hospital costs to exceed $9,000, eliminate or adjust claims for APC 0674 in which the charges for

cryoablation probes are less than $7500, or discard all claims containing CPT code 55873 in the Medicare database for which the total hospital costs are less than $6500. The commenters indicated that access to this care would be impeded if the APC payment is not sufficient to pay the full cost of the service. The commenters believed that APC payment at less than full costs for the service will give rise to the use of alternative means of treating prostate cancer. These commenters indicated that the charges hospitals report on their claims are seldom sufficient to result in the full cost of all of the supplies and equipment needed to furnish the service. The commenters also indicated that when the only claims used to set the median are those for which the code for cryoablation probes is found, the median increases significantly.

Response: The codes for the cryoablation probes used in providing cryoablation of the prostate were billed in CY 2003 because they were paid as pass-through payments in CY 2003. Therefore, they exist in the claims data and we used them to screen for correctly coded claims in setting the median cost for APC 0674. The median derived using the subset of claims is $6,562.69, a decrease of 5.10 percent from the CY 2004 final payment median for APC 0674. Therefore, based on the device-dependent APC policy that we are finalizing for CY 2005, we set the median for APC 0674 at 95 percent of the CY 2004 final payment median, or $6,569.33.

Comment: Some commenters supported the increased payment for cochlear implant services (CPT code 69930 in APC 0259) even though they indicated that they believe that the Medicare payment continues to be insufficient to fully pay for the costs of both the device and the procedure. One commenter provided an independent statistical analysis of the Medicare claims data and invoice data that the commenter indicated revealed hospital costs of $27,954 based on a screen of claims that contained HCPCS code L8614 and asked that CMS set the payment at that amount. Some commenters stated that they believe that some hospitals are using the cochlear implant codes to code implantation of less expensive implantable hearing aid devices. The commenter also asked that CMS provide education and develop a guidance document for hospitals specific to coding and billing for cochlear implant surgery.

Response: The device code for cochlear implants remained active in CY 2003 because Medicare uses it for purposes other than the OPPS. In developing the CY 2005 OPPS medians, we created a subset of claims for implantation of cochlear implants that contained the device code and calculated the median for the CY 2005 OPPS using only those correctly coded claims. This yielded a median cost of $26,006.74, which we used as the basis for the APC 0259 payment weight for the CY 2005 OPPS. While it is certainly possible that some hospitals are misusing the code for cochlear implantation to bill for less costly implanted hearing aid devices, we have no way to make that determination using the claims data. However, we note that hospitals billing in such a manner do so at their own risk of being found to have filed a false claim. We will consider what general education activities we need to undertake with regard to all devices but we are disinclined to focus on specific devices to the exclusion of others.

Comment: One commenter indicated that the proposed decrease in payment rates for APC 0039 (Level I Implantation of Neurostimulator) is not acceptable as it would not enable hospitals to cover the cost of the service. Moreover, the commenter stated that hospitals have failed to code and bill correctly for this service and that there are no disincentives for incorrect coding and billing. The commenter further stated that the only diagnosis on the claims for APC 0039 should be that for epilepsy because that is the fundamental reason for implanting the device. However, according to the commenter, examination of the claims for APC 0039 revealed that only 12 percent of those claims contained an epilespsy diagnosis; therefore, the remaining claims caused the median to incorrectly represent the implantation of the device for treatment of epilepsy. The commenter recommended that CMS use external data to ensure that the costs of the device and procedure are adequate to avoid discouraging hospitals from providing the care.

Response: As with other device-dependent APCs, the absence of device codes on the claims for CY 2003 means that we were unable to screen the claims to positively identify which claims include the neurostimulator device costs and we are not confident that screening only for the diagnosis of epilepsy will resolve the coding problem. Therefore, we have set the median for APC 0039 at 95 percent of the CY 2004 final adjusted payment median.

Comment: Some commenters objected to the assignment of status indicator ''T'' to APC 0229 (Transcatheter Placement of Intravascular Stent) because they believe it should not be subject to the multiple procedure reduction due to its dependence on a device. They believed that the payment for the services is undervalued because it is typically done with other procedures and that it is further underpaid by the application of the multiple procedure reduction.

Response: We have not changed the status indicator for APC 0229 because the cost of the device for services in this APC is less than 50 percent of the total cost of the service. Therefore, the multiple procedure reduction of 50 percent does not result in the APC payment being less than the device cost. Moreover, there are efficiencies when multiple services are performed on the same day that we believe justify applying the multiple procedure reduction to the services in this APC.

Comment: One commenter asked that CMS require hospitals to show the actual acquisition cost for devices on the bill using a UB92 value code and the amount. The commenter recommended that where 50 percent or more of the APC is attributable to packaged device cost, CMS should obtain actual device information and use it to determine if APC cost calculations are reasonable.

Response: We do not believe the imposition of an additional reporting requirement would be effective. Such a requirement would be both burdensome and unlikely to provide the actual hospital acquisition cost because hospitals have the ability to reflect general rebates and discounts on a per device basis.

Comment: One commenter asked that we make separate payments for CRT–Ds (pacemaker-defibrillators) for which there was a new technology add-on payment under the IPPS for FY 2005, so that payment for this service under the IPPS and the OPPS would be better aligned.

Response: CRT–Ds were paid on a pass-through basis under the OPPS in CYs 2001 and 2002. Their OPPS pass-through status expired in CY 2003 and their component services were packaged into clinical APC 0107 (Insertion of Cardioverter-Defibrillator) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads) and. Accordingly, no separate additional payment is appropriate for these devices.

After carefully reviewing the comments, considering the APC Panel recommendations and examining the claims data, we are adjusting the medians for device-dependent APCs based on comparison of the CY 2005 median costs and the CY 2004 final payment median costs. Specifically, we decided to set the median costs for these

APCs at the higher of the CY 2005 median cost from our claims data or 95 percent of the CY 2004 final adjusted median cost used to set the payment in CY 2004 rather than 90 percent of the CY final adjustment median cost as we proposed.

We believe that this adjustment methodology provides an appropriate transition to eventual use of all single bill claims data without adjustment, and that the methodology moves us towards the goal of using all single bill data without adjustment by CY 2007. It is a simple and easily understood methodology for adjusting median costs. Where reductions occur compared to CY 2004 OPPS, we believe that, under this methodology, the reductions will be sufficiently modest that providers will be able to accommodate them without ceasing to furnish services that Medicare beneficiaries need.

In addition, beginning in CY 2005, as proposed, we are requiring hospitals to bill all device-dependent procedures using the appropriate C-codes for the devices. We believe that this approach mitigates against the reduction of access to care while encouraging hospitals to bill correctly for the services they furnish. We intend this requirement to be the first step towards use of all available single bill claims data to establish medians for device-dependent APCs. Our goal is to use all single bills for device-dependent APCs in developing the CY 2007 OPPS, which we expect to base on data from claims for services furnished in CY 2005. We further discuss our coding requirement in section III.C.4. of this preamble.

Table 18 below, which is sorted by APC, contains the CY 2004 OPPS payment medians, the CY 2005 OPPS final adjusted medians using single bill claims from January 1, 2003, through December 31, 2003), and the medians derived from the adjustment processes discussed further below.

BILLING CODE 4120–01–P

Table 18.-- Median Costs for Device-Dependent APCs

APC	Description	SI	Final CY 2004 OPPS APC Median	Unadjusted CY 2005 OPPS APC Median Cost	Percentage Change from CY 2004 to CY 2005	Adjusted Final CY 2005 OPPS Median	CY 2005 Total Frequency
0032	Insertion of Central Venous/Arterial Catheter	T	$662.31	$475.76	-28.17%	$629.19	79,381
0039	Implantation of Neurostimulator (new for 2004 OPPS; breakout of APC 222)	S	$13,555.80	$10,015.34	-26.12%	$12,878.01	1,833
0040	Level II Implantation of Neurostimulator Electrodes (new for 2004 OPPS; breakout of APC 225)	S	$3,002.98	$2,885.37	-3.92%	$2,885.37	10,657
0080	Diagnostic Cardiac Catheterization	T	$2,075.91	$2,123.65	2.30%	$2,123.65	396,154
0081	Non-Coronary Angioplasty or Atherectomy	T	$2,018.99	$1,782.44	-11.72%	$1,918.04	127,156
0082	Coronary Atherectomy	T	$6,352.89	$4,546.84	-28.43%	$6,035.25	632
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	$3,412.47	$2,920.81	-14.41%	$3,241.85	8,364
0085	Level II Electrophysiologic Evaluation	T	$2,041.13	$2,034.82	-0.31%	$2,034.82	19,113
0086	Ablate Heart Dysrhythm Focus	T	$2,590.21	$2,637.96	1.84%	$2,637.96	8,792
0087	Cardiac Electrophysiologic Recording/Mapping	T	$2,294.94	$559.11	-75.64%	$2,180.19	11,859
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	$6,754.63	$6,279.62	-7.03%	$6,416.90	5,016
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	$5,581.04	$4,996.52	-10.47%	$5,301.99	8,148
0104	Transcatheter Placement of Intracoronary Stents	T	$4,765.05	$4,750.06	-0.31%	$4,750.06	21,614
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	$3,399.05	$1,649.73	-51.46%	$3,229.10	4,355
0107	Insertion of Cardioverter-Defibrillator	T	$19,431.68	$12,119.59	-37.63%	$18,460.10	7,224
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	$26,092.91	$18,077.80	-30.72%	$24,788.26	5,281
0115	Cannula/Access Device Procedures	T	$1,478.06	$1,502.71	1.67%	$1,502.71	106,398
0119	Implantation of Infusion Pump (we proposed to remove 49419 from APC 119 and place it in 115); the 2005 median was calculated from 25 claims after examination of all single bills and removal of erroneously coded claims	T	$7,765.02	$5,320.82	-31.48%	$7,376.77	385
0122	Level II Tube changes and Repositioning	T	$510.80	$473.64	-7.27%	$485.26	18,775

APC	Description	SI	Final CY 2004 OPPS APC Median	Unadjusted CY 2005 OPPS APC Median Cost	Percentage Change from CY 2004 to CY 2005	Adjusted Final CY 2005 OPPS Median	CY 2005 Total Frequency
0167	Level III Urethral Procedures	T	$1,730.23	$1,664.80	-3.78%	$1,664.80	10,194
0202	Level X Female Reproductive Proc	T	$2,246.87	$2,322.83	3.38%	$2,322.83	13,526
0222	Implantation of Neurological Device (APC 39 was part of 222 in 2003)	T	$13,383.79	$9,056.69	-32.33%	$12,714.60	5,224
0225	Level I Implementation of Neurostimulator Electrodes	S	$11,873.72	$12,327.52	3.82%	$12,327.52	1,482
0227	Implantation of Drug Infusion Device	T	$9,270.36	$8,542.64	-7.85%	$8,806.84	3,408
0229	Transcatherter Placement of Intravascular Shunts	T	$3,572.98	$3,638.52	1.83%	$3,638.52	41,858
0259	Level VI ENT Procedures (Cochlear implants; median uses device code only single bills)	T	$22,643.98	$26,006.74	14.85%	$26,006.74	945
0313	Brachytherapy	S	$795.83	$812.60	2.11%	$812.60	15,859
0384	GI Procedures with Stents	T	$1,669.39	$1,232.28	-26.18%	$1,585.92	20,108
0385	Level I Prosthetic Urological Procedures	S	$3,870.60	$4,080.56	5.42%	$4,080.56	843
0386	Level II Prosthetic Urological Procedures	S	$6,699.79	$6,674.53	-0.38%	$6,674.53	4,817
0418	Left ventricular lead In new tech 1547 at $850 for 2004; device coming off pass through for 2005	T		$4,363.37		$4,363.37	530
0425	Level II Arthroplasty with prosthesis (new for 2005; broken out of APC 48; data 2004 is from APC 48)	T	$2,966.13	$5,715.97	92.71%	$5,715.97	795
0648	Breast Reconstruction with Prosthesis	T	$3,113.43	$2,875.96	-7.63%	$2,957.76	1,329
0652	Insertion of Intraperitoneal Catheters	T	$1,558.34	$1,626.29	4.36%	$1,626.29	5,473
0653	Vascular Reconstruction/Fistula Repair with Device	T	$1,731.08	$1,638.33	-5.36%	$1,644.53	29,776
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	$6,495.61	$6,060.94	-6.69%	$6,170.83	21,197
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	$8,225.23	$7,913.85	-3.79%	$7,913.85	15,152
0656	Transcatheter Placement of Intracoronary Drug Eluting Stents	T	$5,965.05	$6,156.14	3.20%	$6,156.14	5,759
0670	Intravenous and Intracardiac Ultrasound	S	$1,582.08	$1,779.08	12.45%	$1,779.08	4,335
0674	Prostate Cryoablation (device was on pass through in 2003; 2003 claims median for 2005 is based on C-code claims)	T	$6,915.08	$6,562.69	-5.10%	$6,569.33	1,516
0680	Insertion of Patient Activated Event Recorders	S	$3,621.15	$3,744.69	3.41%	$3,744.69	2,067
0681	Knee Arthroplasty	T	$5,657.87	$5,353.66	-5.38%	$5,374.98	788

BILLING CODE 4120–01–C

We also note that as a result of our initial data analysis for device-dependent APCs, we proposed to make the following additional adjustments to specific device-dependent APCs for the reasons specified:

a. APC 0226: Implantation of Drug Infusion Reservoir

We proposed to remove APC 0226 (Implantation of Drug Infusion Reservoir) from the list of device-dependent APCs and to use its unadjusted single bill median of $2,793.30 as the basis for the payment weight. CPT code 62360 (Implantation or replacement of device for intrathecal or epidural drug infusion, subcutaneous reservoir) is assigned to APC 0226. In CY 2002, when we packaged 75 percent of the cost of the device into the payment for the procedure with which the device was billed to reduce the pro rata adjustment, we inadvertently packaged the cost of an implantable infusion pump (C1336 and C1337) rather than that of a drug reservoir. Our data indicated that the reservoir used in performing CPT code 62360 costs considerably less than an implantable infusion pump, and we believe that the median cost for APC 0226 appropriately reflects the relative cost of the service and the required device.

We did not receive any public comments on this proposal. Accordingly, we have removed APC 0226 from the device-dependent APC list and used its unadjusted single bill median of $2,541.43 as the basis for its CY 2005 relative payment weight.

b. APC 0048: Arthroscopy With Prosthesis

In addition, we proposed to delete APC 0048 (Arthroplasty with Prosthesis) from the list of device-dependent APCs for CY 2005 and to not adjust the median costs for this APC because we believe that the CY 2005 median cost for this APC as restructured is reasonable and appropriate. Based on our careful analysis of the CY 2003 claims data for this APC, we believe the difference between the CY 2004 and CY 2005 median cost is attributable to the migration of certain high cost CPT codes (23470, 24361, 24363, 24366, 25441, 25442, 25446) from APC 0048 to new APC 0425 (Level II Arthroplasty with Prosthesis) and, as such, this change would not adversely limit beneficiary access to this important service. Therefore, we did not propose to apply a device-dependent adjustment to the median cost for APC 0048.

We did not receive any public comments on this proposal. Accordingly, for CY 2005 we are removing APC 0048 from the device-dependent list and are not adjusting the median cost for this APC.

c. APC 0385: Level I Prosthetic Urological Procedures

We proposed to move CPT code 52282 (Cystourethroscopy, insert urethral stent), from APC 0385 (Level I Prosthetic Urological Procedure) and assign it to APC 0163 (Level IV Cystourethoscopy and other Genitourinary Procedures), for clinical homogeneity. As titled, APC 0385 was intended for the assignment of certain urological procedures that require the use of prosthetics. However, CPT code 52282 requires the use of a stent rather than a urological prosthetic. Therefore, we proposed to reassign CPT code 52282 to APC 0163. Recalculation of the median cost for APC 0385 after reassigning CPT code 52282 yielded a median cost for that APC that is consistent with its CY 2004 median payment. Thus, we did not propose a device-dependent adjustment for the median cost for APC 0385.

Comment: Some commenters asked that we keep CPT code 52282 in APC 0385 and not move it to APC 0163. These commenters believed that placement of CPT code 52282 in APC 0385 would maintain clinical coherence and resource similarity. They also supported the APC Panel's recommendation that all three codes, which we proposed to move from APC 0385 to 0386 (CPT codes 53440, 53444, and 54416) should be retained in APC 0385 for CY 2005 OPPS because they are dissimilar in terms of the nature of the surgical procedure and the sophistication of the prosthetic urology device that is implanted.

Response: We have moved CPT code 52282 from APC 0385 to APC 0163 because we believe that this service is more compatible from a clinical and resource perspective with the other cystourethroscopy services assigned to APC 0163 than with services assigned to APC 0385. We have retained CPT codes 53440 and 53444 to APC 0385 because the median costs for these procedures in the CY 2003 data that were used to develop this final rule with comment period indicate that the resources required for them are similar to those for CPT code 54400, which is also assigned to APC 0385. However, we have placed CPT code 54416 in APC 0386 because the median cost shows that the resources are much more like those for services assigned to APC 0386 than the median costs for services in APC 0385. CPT code 54416 requires removal and replacement of a non-inflatable or inflatable prosthesis and our resource data demonstrate relatively high costs for the service, most typically associated with replacement of an inflatable prosthesis. Thus, the nature of the services are sufficiently similar such that CPT code 54416 is clinically coherent with the services in APC 0386.

d. APC 0119: Implantation of Infusion Device and APC 0115: Cannula/Access Device Procedures

We proposed to remove CPT code 49419 (Insert abdom cath for chemo tx), from APC 0119 (Implantation of Infusion Pump) and assign it to APC 0115 (Cannula/Access Device Procedures) to achieve clinical homogeneity within APC 0115. Unlike all the other codes assigned to APC 0115, HCPCS code 49419 does not require the use of an infusion pump. Rather, this code is used when inserting an intraperitoneal cannula or catheter with a subcutaneous reservoir. Thus, we believed it would be more appropriate clinically to reassign HCPCS code 49419 to APC 0115 that includes procedures that require the use of devices similar to that required for CPT code 49419.

Comment: One commenter recommended that we move the CPT code 36260 (Insertion of infusion pump) and CPT code 36563 (Insert tunneled cv catheter) from APC 0119 to APC 0227 (Implantation of Drug Infusion Device), which is also for implantation of infusion pumps. The commenter indicated that all of these services are for implantation of infusion pumps and that the external cost data on the pumps are not dissimilar.

Response: We have not combined the codes in these APCs because they are not clinically homogeneous. Specifically, the services in APC 0227 are for the insertion of spinal infusion pumps and those in APC 0119 are for insertion of vascular infusion pumps. We see no clinical reason to move these codes as suggested by the commenter.

2. Treatment of Specified APCs

a. APC 0315: Level II Implantation of Neurostimulator

As stated in the August 16, 2004 proposed rule, CPT code 61866 (Implant neurostim arrays) was brought to our attention by means of an application for a new device category for transitional pass-through payment for the Kinetra® neurostimulator, a dual channel neurostimulator currently approved and used for Parkinson's disease. We denied approval for a new device category for the Kinetra® neurostimulator because the device is described by a previously

existing category, C1767 (Generator, neurostimulator (implantable)).

The manufacturer of Kinetra® stated that the AMA created CPT 61886 to accommodate implantation of the Kinetra® neurostimulator and that no services other than implantation of the Kinetra® are currently described by that CPT code. Even though the Kinetra® did not receive full FDA pre-market approval until December 2003, hospital outpatient claims were reported in CYs 2002 and 2003 (289 total claims in CY 2003) for this device. The manufacturer asserted that these claims must have been miscoded because the Kinetra® could not have been used in performing CPT code 61886 before obtaining FDA approval in December 2003. Therefore, the manufacturer did not believe that the device cost could be included in the median for CPT code 61886, which has been assigned to APC 0222.

In examining the CY 2003 claims for CPT code 61866, we noted that many of the claims also contained codes for procedures related to treatment with cranial nerve stimulators, including the placement of electrodes for cranial nerve stimulation. The placement of the cranial neurostimulator electrodes used with the Kinetra® is currently an inpatient rather than outpatient procedure. Therefore, we would not expect patients being prepared for cranial nerve stimulation to also have a Kinetra® neurostimulator for deep brain stimulation for Parkinson's disease placed at the same time. Thus, it seems possible that the CY 2003 claims for CPT code 61886, generally, are incorrectly coded and do not include the dual chamber neurostimulator in the reported charges.

Prior to the availability of the dual channel neurostimulator Kinetra® for bilateral deep brain stimulation, it is our understanding that patients diagnosed with Parkinson's disease had two single channel neurostimulator generators implanted in the same operative session. According to the Kinetra® manufacturer, this device will now replace the insertion of two single channel neurostimulators and the cost of the Kinetra® is equivalent to the cost of two single channel neurostimulators. Given this information, we examined our CY 2003 claims data and found that 69 single claims were reported for patients with a diagnosis of Parkinson's disease and that 2 single channel neurostimulator pulse generators (CPT code 61885) were implanted on the same day. The median cost for these claims was $20,631. Other than the device costs, we believe the procedural costs for the insertion of two single channel devices or one dual channel device should be roughly comparable. Therefore, we proposed to establish a new APC 0315, Level II Implantation of Neurostimulator, for CPT code 61886, and assign it a median cost of $20,631. Because of our concern that hospitals correctly code OPPS claims for CPT code 61886, we also proposed to require device coding (C-code) for APC 0315 to improve the coding on all claims for placement of a dual channel cranial neurostimulator pulse generator or receiver, as we proposed for APC 0039, Implantation of Neurostimulator, for placement of a single channel cranial neurostimulator, discussed in section III. C. of this preamble.

Comment: We received one comment in support of our proposed median cost for APC 0315.

Response: We appreciate the commenter's support. Accordingly, we are finalizing our CY 2005 proposal to assign CPT code 61886 to APC 0315 with an assigned median cost of $20,633.70.

b. APC 0651: Complex Interstitial Radiation Application

For CY 2003, APC 0651 included CPT code 77778 (Complex interstitial radiation source application). This code was not to be used for prostate brachytherapy because we created HCPCS codes G0256 (Prostate brachytherapy with palladium sources) and G0261 (Prostate brachytherapy with iodine sources) in which we packaged the cost for placement of needles or catheters and sources into a single APC payment for each G code (67 FR 66779). When we calculated the median from all single bills for CPT code 77778 from CY 2003 data for CY 2005 OPPS, we found that 73 percent of the single bills for this APC were for prostate brachytherapy and, therefore, were miscoded. The median for APC 0651, using all single bills, including those miscoded for prostate brachytherapy, was $2,641.67. When we removed the incorrectly coded claims for prostate brachytherapy, which we believed to contain brachytherapy sources and which are paid separately for CY 2004 and will be paid separately for CY 2005, the median was $1,491.39. This is the amount that we proposed for payment for CY 2005 OPPS for APC 0651. The proposed median was considerably higher than the median cost of $589.72 for CY 2004 OPPS (from CY 2002 claims data).

We believed that this adjusted median was appropriate for APC 0651 when used for prostate brachytherapy because the service described by CPT code 77778 is only one of several components of the payment for the service in its entirety. When it is used for prostate brachytherapy, hospitals should also bill for the placement of the needles and catheters using CPT code 55859 and should also bill the brachytherapy sources separately. Hospitals will be paid for both APCs and for the cost of sources.

Section 621(b)(1) of Pub. L. 108–173 specifically provides separate payment in CY 2005 "* * * for a device of brachytherapy, consisting of a seed or seeds (or radioactive source) * * *" at the hospital's charge adjusted to cost. We proposed to package the cost of other services such as the needles or catheters into the payment for the brachytherapy APCs and not to pay on the same basis as the brachytherapy sources because the law does not include needles and catheters in its definition of brachytherapy sources to be paid on charges adjusted to cost.

We also recognized that APC 0651 is used for brachytherapy services other than prostate brachytherapy and that, in some of those cases, there are no other separate procedure codes for placement of the needles or catheters. In those cases, which are represented in the claims we used to calculate the proposed median (once the miscoded claims for prostate brachytherapy were excluded), we believed that the charges for CPT code 77778 may have included the placement of the needles or catheters and, therefore, the median may be somewhat overstated when used as the basis for payment for prostate brachytherapy and the other forms of brachytherapy that have procedure codes for placement of needles and catheters. Similarly, we believed that the median may be understated when used to pay for brachytherapy services for which there are no separate HCPCS codes for needle or catheter placement. We considered whether to create new G codes for the placement of catheters and needles for the brachytherapy services for which such codes do not exist, but we were concerned that doing so might create unneeded complexity and that the existing data may not support establishing medians for the new codes. We requested comments on how to address those services for which there are currently no HCPCS codes for placement of needles and catheters for brachytherapy applications.

Comment: Commenters indicated that the absence of codes for brachytherapy needle/catheter placement is problematic because hospitals are forced to use existing "not otherwise classified" codes that makes claims analysis difficult for ratesetting. They asked that we create three "not otherwise classified" HCPCS codes for the placement of needles and catheters

for application of brachytherapy sources other than prostate brachytherapy so that they can be billed and paid appropriately. Specifically, they asked (1) that CMS create a code for 1–4 needles/catheters and place it in APC 1507; (2) that CMS create a code for placment of 5–10 catheters and place it in New Technology APC 1513; and (3) that CMS create a new code for more than 10 needles/catheters and place it in New Technology APC 1522.

Response: We have not created HCPCS codes for needle/catheter placement for CY 2005 as suggested by the commenters. We do not believe that the requested new, ''not otherwise classified'' codes would be any more meaningful for OPPS ratesetting than the existing ''not otherwise classified'' codes.

As explained in the November 30, 2001 final rule (66 FR 59897), new Technology APCs are for complete procedures, not devices or drugs or biologicals, but such items may be part of the cost of the complete service. To qualify for OPPS payment under the new technology APCs, a service must meet the following criteria:

- Service must be a complete service.
- Service must not be described by an existing HCPCS code or combination of codes.
- Service could not have been adequately represented in the claims data used for the most current annual OPPS payment update.
- Service does not qualify for additional payment under pass-through payment provisions.
- Service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs.
- Service is medically reasonable and necessary.
- Service falls within scope of Medicare benefits.

Processes and requirements for pass-through and new technology service APC applications are provided in more detail on the OPPS Web site: *http://www.cms.hhs.gov/poviders/hopps/.*

Implicit in the criteria is that there exists a meaningful description of the services for which new technology status is being requested. We do not believe the ''not otherwise classified'' codes proposed by the commenters are sufficiently specific that they could satisfy the criteria. We believe that CPT already contains sufficient ''not otherwise classified'' codes for the coding of placement of brachytherapy needles and catheters in locations of the body for which specific codes do not now exist. We are unable to specify the ''not otherwise classified'' codes that should be used because the ''not otherwise classified'' codes are generally categorized by body part or function, and, therefore, the code that would apply depends on the location in the body in which the needles and catheters are being placed. For example, placement of needles or catheters in a shoulder muscle would be coded differently from placement of needles or catheters in the pancreas.

Comment: Some commenters supported the proposed payment for APC 0651 (Complex Interstitial Radiation Source Application). They indicated that, together with separate payment for the brachytherapy sources and the placement of needles and catheters, the proposed payment would provide adequate payment for these important services.

Response: We appreciate the commenters' support. Further discussion regarding the payment for APC 0651 is provided at III.C.2.b.

Comment: One commenter indicated that there are many supplies and devices other than needles and catheters that are used in providing brachytherapy and asked that CMS develop codes for them so that they could be billed as coded items because such coding would facilitate capture of all the costs associated with performing the services.

Response: We have not created new device codes for the supplies and equipment that the commenter requested because such items are incidental to the service. We do not believe that such incidental items justify development of new device codes.

In this final rule with comment period, the median cost for APC 0651 is $1,283.44, resulting in a national unadjusted payment rate of $1,248.93. There were fewer CY 2003 final action claims for this service in the database that was constructed from the most current claims data and used to develop the weights and median costs for this final rule with comment period. Twelve hospitals whose claims had appeared in the CY 2003 claims data used to calculate the proposed weights and median costs withdrew their claims before we pulled the data for this final rule with comment period. This may have been because they realized that they had billed incorrectly and withdrew the claims to bill correctly.

Our examination of the claims data set for this final rule with comment period reveals that the claims largely appear to not include charges for brachytherapy sources. The unadjusted median cost that resulted from use of these claims is $1,283.44, a 117 percent increase over the median cost for CY 2004 for this APC. As we noted previously, the median should reflect accurately the appropriate claims for the APC. We have no reason to believe that this median is flawed. Therefore, we have used it as the basis for the CY 2005 OPPS unadjusted payment rate of $1,248.93.

c. APC 0659: Hyperbaric Oxygen Therapy

In the August 16, 2004 proposed rule, we stated that over the past year, we have received a number of questions about billing and payment for HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval). In light of these issues, we carefully examined the CY 2003 single procedure claims data that we proposed to use to calculate the CY 2005 median for APC services. Based on our examination of single procedure claims filed for HCPCS code C1300 in CY 2003, we believe that the claims for these services were either miscoded or the therapy was aborted before its completion. The claims that we examined reflected a pattern that is inconsistent with the clinical delivery of this service. Hyperbaric oxygen therapy (HBOT) is prescribed for clinical conditions such as promoting the healing of chronic wounds. It is typically prescribed on average for 90 minutes and, therefore, you would expect hospitals to bill multiple units of HBOT to achieve full body hyperbaric oxygen therapy. In addition to the therapeutic time spent at full hyperbaric oxygen pressure, treatment involves additional time for achieving full pressure (descent), providing air breaks to prevent neurological and other complications from occurring during the course of treatment, and returning the patient to atmospheric pressure (ascent). Our examination of the claims data revealed that providers who billed multiple units of C1300 reported a consistent charge for each ''30 minute'' unit. Conversely, providers who billed only a single unit of C1300, suggesting either a miscoded or aborted service, reported a charge that was 3 to 4 times greater than the per ''30 minute'' unit reported by providers billing multiple units of HCPCS code C1300. While it appears that many of the single procedure HBOT claims that we examined represented billing for a full 90 to 120 minutes of HBOT (including ascent, descent, and air break time), they were improperly billed as 1 unit rather than as 3 or 4 units of HBOT. Consequently, this type of incorrect coding would result in an inappropriately high per 30 minute median cost for HBOT or a median cost

for HBOT of $177.96 derived using single service claims and ''pseudo'' single service claims. This is a significant issue because HBOT is the only procedure assigned to APC 0659.

Our initial analysis of the HBOT claims data further revealed that about 40 percent of all HBOT claims included packaged costs. To confirm our belief that these packaged costs were not associated with HBOT, we examined the other major payable procedures billed in conjunction with HBOT. As a result, we identified billed services such as drug administration and wound debridement that we would typically expect to have associated packaged services. We also looked at the magnitude of packaged costs in our single bills and found the majority of these costs were small, less than $30, and concentrated in revenue codes 25X, Pharmacy, and 27X, Medical/Surgical Supplies.

As a result of these coding anomalies, we proposed to calculate a ''30 minute'' median cost for APC 0659, using a total of 30,736 claims containing multiple units or multiple occurrences of HBOT, about 97 percent of all HBOT claims. Based on our finding, we proposed to exclude claims with only one unit of HBOT. We estimated costs on these claims using the respiratory therapy cost center CCR when one was available. Otherwise we used the hospital's overall CCR. Using this proposed methodology, the proposed median cost per unit of C1300 was $82.91. Based on hospitals' charges on correctly coded claims, we believe this estimate is much more accurate for 30 minutes of HBOT. Thus, we proposed a median cost for APC 0659 of $82.91 for CY 2005.

We received many public comments on this proposal.

Comment: Overall, commenters expressed concern about the proposed reduction in payment for HBOT. There also was great consistency in the comments. Almost all the commenters cited a recent research report by The Lewin Group (Lewin) that examined our methodology for calculating a payment rate for APC 0659 and offered us several alternatives for identifying a median for HBOT. In their evaluation of our proposed change for calculating a median for HBOT, The Lewin Group ultimately concluded that, while our proposed use of claims with multiple units of C1300 in lieu of the clams with a single unit of C1300 was appropriate for calculating the median cost, we used an inappropriate cost-to-charge ratio to estimate costs from charges on those multiple unit claims.

Lewin surveyed the majority of hospitals billing Medicare for HBOT, requesting specific pages from each hospital's cost report to determine where HBOT services are reported and the associated CCR. Lewin received completed responses from 120 hospitals, a 30 percent response rate. The majority of responding hospitals, 63 percent, frequently broke out the costs of hyperbaric/wound care in a subscripted cost center on their cost report. In addition, 24 percent included their costs in the respiratory therapy cost center, and the remainder included their costs in disparate cost centers including emergency room and physical therapy. For those hospitals reporting separate line-items for hyperbaric/wound care, Lewin used CMS claims data to estimate a median CCR of 0.400 as compared with the median CCR for respiratory therapy of 0.248. Lewin also sought to establish the generalizability of their sample findings by demonstrating that responding hospitals were geographically diverse and that the respiratory therapy CCR for the responding hospitals was comparable to that observed in the claims data. Finally, Lewin used their survey findings to estimate a proportional difference in CCRs between respiratory therapy and the observed, hyperbaric-related CCRs of 1.411 and, applying this adjustment to the CMS claims data, they calculated a payment rate of $118.21.

Practically all commenters offered four possible alternatives to our proposed methodology. First, commenters suggested that CMS leave HBOT reimbursement at its CY 2004 level until CMS can accurately estimate costs and charges for HBOT. Second, commenters suggested that CMS apply The Lewin Group methodology in estimating median cost. Third, commenters suggested that CMS adopt The Lewin Group's estimated median of $118.21 per 30 minutes. With regard to this specific recommendation, several commenters stated that they thought that the $118 rate was appropriate, and one commenter believed a rate of $120 or greater would be acceptable. Finally, commenters suggested that CMS default to the overall CCR of 0.47 in lieu of using the respiratory therapy CCR.

Response: We agree with the commenters that The Lewin Group analysis provides sufficient evidence that the CCR for HBOT is not reflected solely in the respiratory therapy cost center. With regard to the first recommended alternative, we do not believe it is appropriate to maintain the CY 2004 HBOT payment rate for CY 2005. We have clearly demonstrated that the single procedure claims are inappropriate for calculating a median cost, and the submitted research did not dispute our median calculation methodology. We cannot undertake the recommended second alternative and replicate The Lewin Group's methodology because the hyperbaric/wound care cost report cost center line-items are neither standard nor non-standard cost centers. We presume that these line-items for hyperbaric/wound care are subscripted cost centers that are ultimately rolled-up in to a standard cost center on the electronic cost report data. Without the specific subscripted information, we cannot calculate a cost-to-charge ratio specific to HBOT.

We also do not believe it is appropriate to adopt the $118.21 estimate made by Lewin using its survey results and our data, the third recommended alternative. The Lewin survey indicates diversity among hospitals in the subscripted location of reported hyperbaric oxygen costs on the cost report. In addition, the $118.21 is based on an adjustment to the CCR that assumes all nonresponding hospitals report their costs in the hospital-specific hyperbaric oxygen-related cost centers, even though roughly one-fourth of hospitals in the Lewin sample were demonstrated to report costs in the respiratory therapy cost center and 13 percent reported costs in other cost centers. The submitted research further indicates fairly substantial variation in the CCRs for the responding hospitals in the HBOT-related cost centers. In light of this, we agree to adopt the last recommended alternative, which is to calculate the median using the overall CCR. As several commenters noted, defaulting to the hospital's overall CCR is standard OPPS policy when an appropriate cost center cannot be assigned to a revenue code. We estimate an overall, hospital-weighted, median CCR for all hospitals of 0.33 and a hospital-weighted, median CCR for respiratory therapy for all hospitals of 0.27. Using the overall CCR to estimate costs from charges associated with HCPCS code C1300, we calculated a median cost of $93.26 using 38,505 claims in the final rule data. We used this median to set the final CY 2005 payment for APC 0659.

Comment: One commenter conducted an internal study of 11 member hospitals and reported a median total cost of $126.42. The study findings acknowledged that we found billing anomalies in the claims with single units, but noted that our proposed approach will have unintended financial consequences. The commenter requested that we review our claims data to ensure HBOT rates that reflect the full cost of providing HBOT services.

Response: As discussed above, we agree that the proposed cost for HBOT was too low because it relied solely on the respiratory therapy CCR. However, based on the volume and consistency of claims for HBOT, we still believe that the claims data are correct. As already discussed, we will base payment for HBOT on a median calculated using the overall hospital CCR. Further, the purpose of OPPS is not to pay the full cost of a service for any given hospital, but rather to proportionally redistribute total OPPS dollars in a manner that reflects relative resource use. APC payment rates are based on the median cost of a group of services, or in this case, one service, to achieve the averaging effect of a prospective payment system and are not intended to reimburse the full cost to a specific hospital. The costs for these 11 member hospitals may fall above the median cost for all hospitals billing HBOT.

Comment: One commenter reviewed CMS claims with multiple units and found an overall average of 15 units of HBOT per claim. This commenter recommended that CMS review a sample of medical records.

Response: We expect that this finding is the result of outlier claims and unit coding errors. In our analyses of HBOT claims for the proposed rule, we found that the vast majority of claims, 93 percent, were for 3 to 5 units of service. Further, The Lewin Group analysis reviewed above did not dispute the appropriateness of using claims with multiple units for calculating a median cost. As discussed above, we believe that the appropriate concern in estimating a median cost for HBOT is the disparity in charging and cost reporting practices among hospitals and not with the claims themselves, a finding that mitigates the need for medical record review.

Comment: One commenter recommended that CMS continue to compile claims data on HBOT and refer this issue to the APC Panel before making changes.

Response: By using claims with multiple units, we believe that we have ample claims data. However, the APC Panel is an official public forum designed to consider and advise us on APC-related issues. If this is a particular concern to the public, the public is invited to present this concern at the next APC Panel meeting.

After carefully reviewing all comments received, we are basing payment for HBOT on a median calculated using the overall hospital CCR rather than the respiratory therapy CCR as proposed. As discussed above, using the overall CCR to estimate costs from charges associated with HCPCS code C1300, we calculated a final CY 2005 payment for APC 0659 of $90.75.

3. Other APC Median Cost Issues

a. APC 0312 Radioelement Applications

Comment: Some commenters stated that the payment rate for APC 0312 (Radioelement Applications) is inadequate to pay for the staff, supplies and appliances that are needed to furnish the service. The commenters further stated that the APC payment should be similar to that for APC 0651.

Response: The median for APC 0312 has increased significantly from the CY 2004 payment median of $199.90 to the CY 2005 OPPS final rule with comment period median of $326.65. Moreover, we were able to use 28 percent of the total claims in CY 2003 for this APC to set the median cost for the CY 2005 OPPS. Therefore, we see no reason to adjust the median for this APC to the level of APC 0651.

b. Percutaneous Radiofrequency Ablation of Liver Tumors

Comment: Some commenters objected to the proposal to move CPT code 47382 (Percutaneous radiofrequency of liver tumors), from a New Technology APC to clinical APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures) because they believe that there is an inadequate number of claims on which to base median costs, and that median costs are inappropriately low because device costs associated with performing this procedure are underreported. They indicated that the proposed reimbursement does not cover the costs of the single use catheters used in performing the service. The commenters stated that revenue codes should be used to screen for appropriately coded claims. They contended that if CMS cannot complete this analysis for this final rule with comment period, CMS should retain CPT code 47382 in a new technology APC at the CY 2004 payment rate until more representative cost data are available. They argued that this latter approach is consistent with how CMS has handled APC payments for PET services since CY 2001. The commenters also recommended that CPT codes 76362 (CT guidance for and monitoring of visceral tissue ablation), 76394 (Magnetic resonance imaging for and monitoring of visceral tissue ablation), and 76940 (Ultrasound guidance for and monitoring of visceral tissue ablation) be added to the bypass list so that more single bills could be used to set the median for CPT code 47382.

Response: We believe that the claims volume is sufficiently adequate to remove CPT code 47382 from New Technology APC 1557 and place it in a clinical APC. Moreover, the median cost, $1,801.84, derived from the CY 2003 claims data for APC 0423, is very close to the payment that was made for New Technology APC 1557 of $1,850. Therefore, as proposed, this service will be placed in clinical APC 0423 and paid based on its historic claims data for services furnished for the CY 2005 OPPS.

In addition, the three CPT codes that the commenter recommended we add to the bypass list do not meet the CY 2005 criteria for inclusion on the list. However, we will consider their inclusion when we next review items for inclusion in CY 2006.

c. Heparin Coated Stents

Comment: One commenter objected to CMS' policy that heparin coated stents should be coded under C1874 (Stent, coated/cov w/del sys) because the commenter believes that to do so will adversely affect the median cost of the stents. The commenter urged us to create a unique C-code if HCPCS codes G0290 and G0291, which are used for placement of drug eluting stents, are retired.

Response: HCPCS codes G0290 and G0291 will remain active codes for CY 2005 and we see no reason to create another C-code at this time. We will determine whether there is a need for another C-code to differentiate between stents if and when HCPCS codes G0290 and G0291 are retired.

d. Aqueous Drainage Assist Device

Comment: One commenter asked that CMS ensure that the costs of code C1783 (Aqueous drainage assist device) are packaged with the costs of the procedures with which the device is most commonly billed. The commenter stated that codes C1783, L8610 and L8612 would usually be billed with procedures that are in APC 0673.

Response: We package the costs of devices that are billed on the same claim with the procedural APCs into the cost of the procedural APC. Thus, the extent to which the costs of these devices are packaged into the median cost for the procedure depends upon the extent to which the hospitals include the charges for the devices on the claim, with or without including the code for the device. To the extent that hospitals included charges for these devices on the claims for the procedures in which they were used, those charges would be converted to costs and packaged into the median cost for the procedure.

4. Required Use of C-Codes for Devices

An important ancillary issue in regard to using hospital outpatient claims data to calculate median costs for a device-dependent APC is whether to require that hospitals bill the HCPCS codes for the devices that are required for use in the provision of the services in these APCs. We deleted HCPCS codes for devices in CY 2003 because hospitals objected to the complexity of this coding, and we believed that hospitals would charge for the devices in appropriate revenue codes. Our review of the claims data does not support this belief. Hospitals do not appear to routinely include the charges for the devices they use when they bill for all of the related services in the device-dependent APCs. Therefore, as discussed in the August 16, 2004 proposed rule, we proposed requiring hospitals to code devices for APCs to improve the quality of the claims data in support of our transition to the use of all single claims to establish payment rates for those APCs. We made this proposal cautiously, as we realize that it imposes a burden on hospitals to code the devices.

For the CY 2005 OPPS, we proposed to require coding of devices required for APCs for which we proposed to adjust the median costs for the CY 2005 OPPS. The APCs and the devices that were proposed for device coding were published in Table 20 of the August 16, 2004 proposed rule (69 FR 50497 through 50499). Specifically, if one device is shown for one APC, that device would have to be billed on the claim for a service in that APC or the claim would be returned to the provider for correction. If more than one device is shown for one APC, the provider would be required to bill one of the device codes shown on the same claim with the service in that APC for the claim to be accepted.

We also proposed to require coding of C1900 (Left ventricular lead) required to perform the service described in APC 0418, Left Ventricular Lead, because the service cannot be done without the lead, and because the device has been billed separately for pass-through payment in CYs 2003 and 2004. We believe that continued coding of the device would not impose a burden on hospitals. Similarly, because of our concerns regarding the correct coding of claims for CPT code 61886 (Implant neurostim arrays), assigned to APC 0315 (discussed in greater detail in section III.C.2.a. of this preamble), we proposed to require device coding for APC 0315 (Level II Implantation of Neurostimulator) to improve the coding on claims for placement of a dual channel cranial neurostimulator pulse generator or receiver, just as we proposed to require device coding for APC 0039 (Implantation of Neurostimulator) for placement of a single channel cranial neurostimulator as noted below.

We solicited comments on the proposed C-code requirements.

In addition, we announced in the proposed rule that we are considering expanding the device coding requirements in the future. We believed that, by requiring device coding for a small subset of device-dependent APCs each year, we would minimize the marginal annual coding burden on hospitals and begin to improve data for these APCs, which have consistently proven to be problematic. We believed coding of devices was essential if we were to improve the accuracy of claims data sufficiently to better calculate the correct relative costs of device-dependent APCs in relation to the other services paid under the OPPS.

We asked that the public inform us of the device codes that are essential to the procedures contained in the device-dependent APCs listed in Table 20 of the proposed rule. The alphanumeric HCPCS codes for devices that were reactivated for CY 2004 OPPS can be found on the CMS Web site at *http://www.cms.hhs.gov/providers* under coding. They are in the section of alphanumeric codes that begin with the initial letter ''C.''

We received a number of comments regarding our request.

Comment: In general, commenters supported a requirement for mandatory device coding for all devices, not only those for which CMS proposed mandatory reporting. However, they had different views regarding what the requirement should contain and how it should be enforced. Some commenters asked that we require that all procedures for device-dependent APCs contain a C-code to identify the device used in the procedure. They indicated that they believed that this requirement is crucial to acquiring valid cost data for these services. Some commenters were concerned about the administrative burden that required C-coding imposes on hospitals and urged CMS to reassess the burden within 2 years if it imposes mandatory C-coding for devices. Other commenters urged CMS to implement a grace period of no less than 90 days after implementation of the CY 2005 OPPS to enable hospitals to be sure that they are prepared for device code edits. During this period, the commenters wanted intermediaries to accept the codes and not return incorrectly coded claims. The commenters indicated that the edits should be included in this final rule with comment period so that hospitals can begin to work on them as soon as possible. Those commenters suggested that the device codes for which edits will not be implemented in CY 2005 should not be required until CY 2006. The commenters indicated that both OCE and intermediary systems must be ready to handle this change, and that no edits should be implemented if they are not and if providers have not had at least 30 days notice. Some commenters urged CMS to base any edits or list of required device codes on CPT codes, not APCs, because in some cases, not all codes in an APC require the same device. One commenter objected to the use of edits to return to providers claims that contain a procedure code that cannot be done without a device but which contain no device code. The commenter indicated that CMS has been inconsistent in its policies governing coding of devices since the inception of the OPPS and should provide some greater period of stability in coding before it edits for the presence of the device codes.

Response: We appreciate the comments, but continue to believe coding of devices is vital to enhancing the device-dependent APC claims data. Therefore, as proposed, effective for services provided on or after January 1, 2005, we will require hospitals to include device category codes on claims when such devices are used in conjunction with procedures billed and paid for under the OPPS. While we are requiring use of these device codes for reporting all such devices effective January 1, 2005, we will not implement the edits contained in Table 19 until April 1, 2005, to provide time for further review and for hospitals to prepare for them. The edits will not apply to claims that contain a procedure code reported with a modifier 73 or 74 to signify an interrupted procedure because we recognize that in those cases, the procedure might have been interrupted before the device was implanted.

We will apply the edits at the CPT/HCPCS code level to be as precise as possible. Table 19 includes the edits that we expect to go into effect April 1, 2005. The table of edits and the definitions of the C-codes (Table 20 of this preamble) will be posted on the CMS Web site on the OPPS page. As noted on Table 19, there are some CPT codes for which edits cannot be established, for example, because of the optional nature of the use of a device when performing the service. Although there is no official comment period

associated with implementation of the edits, we welcome comments on the edits to be implemented on April 1, 2005, particularly from hospitals to whose claims the edits will apply and from medical specialties whose physicians use the devices in the procedures performed in hospital outpatient settings. Comments may be sent to *OutpatientPPS@cms.hhs.gov* if possible, by December 1, 2004.

In the future, we will consider edits for additional procedure codes in other device-dependent APCs. We will post all final edits on the CMS Web site with an announcement of the calendar quarter in which we expect to implement them. We will also provide them in a Medlearn Matters article. Any future edits will be implemented as always as part of the quarterly OCE release. We intend to expand the editing of device-dependent procedure codes for appropriate device C-codes as expeditiously but also as carefully as possible. The next group of device procedures for which we will consider edits will include those procedures in APCs for which we set the median cost at 95 percent of the CY 2004 payment median but for which we did not propose edits in the August 16, 2004 proposed rule.

Comment: One commenter asked that CMS encourage manufacturers to put the applicable HCPCS device C-code on the device package and that CMS work with FDA to expedite placement of C-codes on device packages. The commenter also urged CMS to simplify the C-codes to be consistent with the information routinely reported by physicians in operative reports. The commenter gave, as an example, the seven device codes used with APC 0087 (Noncoronary Angioplasty or Atherectomy), all of which could be reported using only one code for ''transluminal catheter''. The commenter stated that such simplification would greatly improve the likelihood that the device is coded on the claim because the description that distinguishes one of the seven codes from another is typically not documented in the hospital's record and is not information the coder would know. Other commenters asked that CMS actively undertake a program designed to educate providers on how to bill for devices and how to set charges for high cost devices so that future updates to the OPPS will more accurately reflect the costs of these services. Some commenters urged CMS to create and maintain a file on the CMS Web site that contains a complete crosswalk of devices codes to CPT codes in the device APCs. Some commenters asked that CMS provide a detailed revenue code to device code crosswalk so that hospitals will promote more uniformity in billing for devices.

Response: We will carefully examine how we can facilitate correct coding of devices, including possible communication with the FDA. We will also consider the extent to which we can simplify the HCPCS codes for devices to facilitate straightforward coding. Finally, we will determine the extent to which we can improve provider education regarding correct coding for devices. However, we will not undertake any activity designed to advise hospitals on how to set charges for their services or to designate what revenue codes hospitals should use on a device-specific basis.

The edits that we created to ensure the coding of devices for the selected APCs that are listed in Table 19 of this preamble are also available as an Excel file in the supporting documentation of this final rule with comment period that will be posted on the CMS Web site and will also be contained in the transmittals for the January 2005 OPPS update and OCE release. Moreover, as described above, we will post any added edits for device coding on the OPPS page of the CMS Web site so that providers can have ready access to them.

Comment: Some commenters asked that we add particular device and procedure combinations to the table of edits. Specifically, a commenter asked that we add APC 0259 (Cochlear Implant Surgery) as paired with device code L8614 (Cochlear implant), and APC 0040 paired with both device codes C1778 (Lead neurostimulator) and C1883 (Adapter/extension packing lead or neurostimulator lead). Another commenter asked that we add code C1787 (Patient programmer, neurostimulator) to the required devices for APC 0222. Another commenter asked that the same device codes be required for the CPT codes in APC 0087 as we proposed to require for APC 0085 because the commenter believes that the same devices are used in both APCs. Other commenters asked that we include edits for other APCs, for example, APC 0385 (Level I Prosthetic Urological Procedures) and APC 0386 (Level I Prosthetic Urological Procedures).

Response: Except as discussed below, we have not added any APCs to the list that we proposed be edited for device codes at this time. Although our policy to require hospitals to code all devices is effective January 1, 2005, we will not implement edits until April 1, 2005. We will consider the comments regarding additional edits for later implementation. We believe that it is preferable to focus first on the APCs most affected and to add subsequent edits after careful deliberation. In this manner we can minimize the potential for adverse effects on claims processing and hospitals' cash flow.

However, we have added one CPT code to the list of codes that will be edited for device codes. We inadvertently omitted a proposed edit for CPT code 33225 (Left ventricular pacing lead add-on), which we proposed to place in New technology APC 1525. This procedure uses the device code C1900 (Left ventricular lead), whose pass-through status expires in January 2005. We proposed that when the lead is implanted as a stand-alone procedure using CPT code 33224 (Insert pacing lead and connect), we would edit for the presence of the device code for the lead on the claim. However, we believe that it is also appropriate to edit for the presence of the lead on a claim for the add-on code, CPT code 33225, and that it should pose no additional burden on hospitals because hospitals have been required to bill the device code C1900 for pass-through payment since CY 2004.

Summary of provisions related to required use of C-codes for devices that we are making final beginning in CY 2005:

1. Hospitals are required to report device category codes on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS in order to improve the claims data used annually to update the OPPS payment rates.

2. Beginning April 1, 2005, the OCE will include edits to ensure that certain procedure codes are accompanied by an associated device category code.

3. CMS will post the OCE edits that are to be implemented beginning April 1, 2005 on the CMS Web site to give hospitals and the provider community ample opportunity to review them and provide feedback prior to implementation.

4. Edits will apply at the CPT/HCPCS code level rather than the APC level.

5. Edits will not apply when a procedure code is reported with a modifier −73 or −74 to designate an incomplete procedure.

6. CMS will add edits as needed in future quarterly updates of the OCE to ensure that hospitals are reporting device category codes appropriately with associated procedure codes. CMS will post future device category and procedure code edits on the CMS Web site to give hospitals and the provider

community ample opportunity for input prior to implementation.

BILLING CODE 4120–01–P

Table 19.—Device Codes Required for Select Device-Dependent APCs

HCPCS	SI	Short Description	APC	Allowed Device Codes
36557	T	Insert tunneled cv cath	0032	C1751
36558	T	Insert tunneled cv cath	0032	C1751
36570	T	Insert tunneled cv cath	0032	C1751 C1788
36571	T	Insert tunneled cv cath	0032	C1751 C1788
36581	T	Replace tunneled cv cath	0032	C1751
36585	T	Replace tunneled cv cath	0032	C1751 C1788
36640	T	Insertion catheter, artery	0032	C1751
61885	S	Implant neurostim one array	0039	C1767
35458	T	Repair arterial blockage	0081	C1885 C1725
35459	T	Repair arterial blockage	0081	C1885 C1725
35460	T	Repair venous blockage	0081	C1885 C1725
35470	T	Repair arterial blockage	0081	C1885 C1725
35471	T	Repair arterial blockage	0081	C1885 C1725
35472	T	Repair arterial blockage	0081	C1885 C1725
35473	T	Repair arterial blockage	0081	C1885 C1725
35474	T	Repair arterial blockage	0081	C1885 C1725
35475	T	Repair arterial blockage	0081	C1885 C1725
35476	T	Repair venous blockage	0081	C1885 C1725

HCPCS	SI	Short Description	APC	Allowed Device Codes
35484	T	Atherectomy, open	0081	C1714 C1724
35485	T	Atherectomy, open	0081	C1714 C1724
35490	T	Atherectomy, percutaneous	0081	C1714 C1724
35491	T	Atherectomy, percutaneous	0081	C1714 C1724
35492	T	Atherectomy, percutaneous	0081	C1714 C1724
35493	T	Atherectomy, percutaneous	0081	C1714 C1724
35494	T	Atherectomy, percutaneous	0081	C1714 C1724
35495	T	Atherectomy, percutaneous	0081	C1714 C1724
61626	T	Transcath occlusion, non-cns	0081	C2628 C1887
92997	T	Pul art balloon repr, percut	0081	C1885 C1725
92998	T	Pul art balloon repr, percut	0081	C1885 C1725
92995	T	Coronary atherectomy	0082	C1714 C1724
92996	T	Coronary atherectomy add-on	0082	C1714 C1724
92982	T	Coronary artery dilation	0083	C1725 C1885
92984	T	Coronary artery dilation	0083	C1725 C1885
92986	T	Revision of aortic valve	0083	No edit; no suitable device code
92987	T	Revision of mitral valve	0083	No edit; no suitable device code
92990	T	Revision of pulmonary valve	0083	No edit; no suitable device code
93600	T	Bundle of His recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894

HCPCS	SI	Short Description	APC	Allowed Device Codes
93602	T	Intra-atrial recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93603	T	Right ventricular recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93609	T	Map tachycardia, add-on	0087	C1730 C1731 C1733
93610	T	Intra-atrial pacing	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93612	T	Intraventricular pacing	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93613	T	Electrophys map 3d, add-on	0087	C1732
93615	T	Esophageal recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93616	T	Esophageal recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894

HCPCS	SI	Short Description	APC	Allowed Device Codes
93618	T	Heart rhythm pacing	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93623	T	Stimulation, pacing heart	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93631	T	Heart pacing, mapping	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
33212	T	Insertion of pulse generator	0090	C1786 C2620
33210	T	Insertion of heart electrode	0106	No edit; no device code for some procedure options
33211	T	Insertion of heart electrode	0106	C1779
33216	T	Revise eltrd pacing-defib	0106	C1779 C1777 C1895 C1896 C1899
33217	T	Insert lead pace-defib, dual	0106	C1779 C1777 C1895 C1896 C1899
33218	T	Repair lead pace-defib, one	0106	No edit; code is for repair only
33220	T	Repair lead pace-defib, dual	0106	No edit; code is for repair only
G0297	T	Insert single chamber/cd	0107	C1722 C1882
G0298	T	Insert dual chamber/cd	0107	C1721 C1882
G0299	T	Inser/repos single icd+leads	0108	C1722 C1882

HCPCS	SI	Short Description	APC	Allowed Device Codes
G0300	T	Insert reposit lead dual+gen	0108	C1721 C1882
36260	T	Insertion of infusion pump	0119	C1772 C1891 C2626
36563	T	Insert tunneled cv cath	0119	C1772 C1891 C2626
36583	T	Replace tunneled cv cath	0119	C1772 C1891 C2626
63685	T	Implant neuroreceiver	0222	C1767
64590	T	Implant neuroreceiver	0222	C1767
61886	T	Implant neurostim arrays	0315	C1767
43219	T	Esophagus endoscopy	0384	No edit; no device code for some procedure options
43256	T	Uppr gi endoscopy w stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
43268	T	Endo cholangiopancreatograph	0384	No edit; no device code for some procedure options
43269	T	Endo cholangiopancreatograph	0384	No edit; device optional
44370	T	Small bowel endoscopy/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
44379	T	S bowel endoscope w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
44383	T	Ileoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877

HCPCS	SI	Short Description	APC	Allowed Device Codes
44397	T	Colonoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
45327	T	Proctosigmoidoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
45345	T	Sigmoidoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
45387	T	Colonoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
33224	T	Insert pacing lead & connect	0418	C1900
55873	T	Cryoablate prostate	0674	C2618
33225	S	L ventricular pacing lead add-on	1525	C1900

Table 20.—Device Code Descriptors for Select Device-Dependent APCs

Device code	Descriptor
C1714	Catheter, transluminal atherectomy, directional
C1721	Cardioverter-defibrillator, dual chamber (implantable)
C1722	Cardioverter-defibrillator, single chamber (implantable)
C1724	Catheter, transluminal atherectomy, rotational
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)
C1730	Catheter, electrophysiology, diagnostic, other than 3d mapping (19 or fewer electrodes)
C1731	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)
C1732	Catheter, electrophysiology, diagnostic/ablation, 3d or vector mapping
C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3d or vector mapping, other than cool-tip
C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)
C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away
C1767	Generator, neurostimulator (implantable)
C1772	Infusion pump, programmable (implantable)
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)
C1779	Lead, pacemaker, transvenous vdd single pass
C1786	Pacemaker, single chamber, rate-responsive (implantable)
C1788	Port, indwelling (implantable)
C1874	Stent, coated/covered, with delivery system
C1875	Stent, coated/covered, without delivery system
C1876	Stent, non-coated/non-covered, with delivery system
C1877	Stent, non-coated/non-covered, without delivery system
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)
C1885	Catheter, transluminal angioplasty, laser
C1887	Catheter, guiding (may include infusion/perfusion capability)
C1891	Infusion pump, non-programmable, permanent (implantable)
C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away
C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away
C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)
C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)
C1900	Lead, left ventricular coronary venous system
C2617	Stent, non-coronary, temporary, without delivery system
C2618	Probe, cryoablation
C2620	Pacemaker, single chamber, non rate-responsive (implantabe)
C2625	Stent, non-coronary, temporary, with delivery system
C2626	Infusion pump, non-programmable, temporary (implantable)
C2628	Catheter, occlusion

BILLING CODE 4120–01–C

5. Submission of External Data

In the August 16, 2004 proposed rule, we stated that we would consider external data submitted with respect to any APC to the extent that such data enable us to verify or adjust claims data where we are convinced that such an adjustment to the median cost is appropriate. Further, we stated that all comments and any data we use would be available for public inspection and commenters should not expect that any data furnished as part of the comment

would be withheld from public inspection. We also stated that parties who submit external data for devices should also submit a strategy that can be used to determine what part of the median cost represents the device to which the external data applies. We stated in the proposed rule that external data that are likely to be of optimal use should meet the following criteria:

- Represent a diverse group of hospitals both by location (for example, rural and urban) and by type (for example, community and teaching). We preferred that commenters identify each hospital, including location with city and State, nonprofit vs. for profit status, teaching vs. nonteaching status, and the percent of Medicare vs. non-Medicare patients receiving the service. A pseudo identifier could be used for the hospital identification. Data should be submitted both ''per hospital'' and in the aggregate.
- Identify the number of devices billed to Medicare by each hospital as well as any rebates or reductions for bulk purchase or similar discounts and identify the characteristics of providers to which any such price rebates or reductions apply.
- Identify all HCPCS codes with which each item would be used.
- Identify the source of the data.
- Include both the charges and costs for each hospital for CY 2003.

Meeting the criteria would help enable us to compare our CY 2003 claims data to the submitted external data and help us determine whether the submitted data are representative of hospitals that submit claims under the OPPS.

We noted in the proposed rule that information containing beneficiary-specific information (for example, medical records, and invoices with beneficiary identification on it) must be altered, if necessary, to remove any individually identifiable information, such as information that identifies an individual, diagnoses, addresses, telephone numbers, attending physician, medical record number, and Medicare or other insurance number. Moreover, individually identifiable beneficiary medical records, including progress notes, medical orders, test results, and consultation reports must not be submitted to us. Similarly, photocopies of checks from hospitals or other documents that contain bank routing numbers must not be submitted to us.

We received a number of public comments concerning the submission of external data.

Comment: Some commenters supported use of claims data and strongly opposed use of data from external sources to set the OPPS payment rates. They believed that claims data more accurately reflects the costs hospitals incur to provide outpatient services. They strongly opposed use of external data because they believe that item specific adjustments will make OPPS unduly complex and result in unfair imbalances in payments. They believed that CMS should remain committed to the principles of prospective payment and the use of the averaging process rather than seeking to pay actual cost for one element of costs (for example, new technology) at the expense of all other items, which would result after application of mandated budget neutrality adjustments. Conversely, other commenters indicated that CMS should rely on external data in lieu of claims data for procedures that require high cost devices because the CMS methodology of applying a cost-to-charge ratio to charges to acquire costs will always result in costs that are below the actual acquisition cost of the device and that, barring a significant change in CMS' cost finding process, external data are the only means by which valid cost data for high cost devices can be introduced into the OPPS. Some commenters provided external data on the devices of interest to them and some provided specific amounts calculated using external data, which they asked that we substitute for claims data in setting the weight for the APC of interest to them.

Response: We have not applied numbers from external data in our adjustments of median costs for the CY 2005 OPPS. While recognizing that external data aids in our general analysis of determining payment rates, we believe that generally such use of external data is not the optimal way to set payment rates for services in a relative weight system. As we discussed in section III.C.5. of this preamble, we believe that using external data has a significant potential for creating an unfair imbalance in a prospective payment system. However, we appreciate the efforts of some commenters in providing us with external data.

Comment: Some commenters urged us to use external data in the construction of APC rates and urged us to use confidential data for this purpose. Some commenters are concerned about the criteria CMS proposed for external data and urged us to expand the use of confidential external data to calculate future payment rates whenever such data are indicated and proven reliable based on the data's merits. The commenter did not suggest criteria for determining if confidential proprietary external data are reliable.

Response: As we indicated in the August 16, 2004 proposed rule, all information sent in response to comments will be made available to the public for review. We believe that all parties who are affected by the payment rates set under this system should have access to the information on which the rates are set.

Comment: One commenter indicated that CMS should use external data for all device APCs in which the device cost exceeds 5 percent of the total APC cost because to do otherwise would unfairly benefit some categories of services compared to other categories of services.

Response: We have not used external data to adjust any medians for the CY2005 OPPS. As discussed above, we applied the same adjustment rules to all device medians.

After carefully reviewing all public comments received, we have decided not to use any external data to adjust the median costs for the CY 2005 OPPS for the reasons discussed above.

D. Calculation of Scaled OPPS Payment Weights

Using the median APC costs discussed previously, we calculated the relative payment weights for each APC for CY 2005 shown in Addenda A and B to this final rule with comment period. 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 CY 2003 data, the median cost for APC 0601 is $57.32 for CY 2005.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2005 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2004 relative weights to aggregate payments using the CY 2005 proposed relative weights. Based on this comparison, we proposed to make an adjustment to the weights for purposes of budget neutrality. The unscaled weights were adjusted by 0.984667135 for budget neutrality. The CY 2005

relative weights, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B to this final rule with comment period.

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) provides the payment rates for certain specified covered outpatient drugs. Therefore, the incremental cost of those specified covered outpatient drugs (as discussed in section II.J. of this final rule with comment period) is excluded from the budget neutrality calculations but the base median cost of the drugs continues to be a factor in the calculation of budget neutrality. Accordingly, we calculated median costs for the specified covered outpatient drugs to which this section applies and used those medians and the frequencies in the calculation of the scaler for budget neutrality.

Under section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108–173, payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) is to be made at charges adjusted to cost for services furnished on or after January 1, 2004 and before January 1, 2006. As we stated in our January 6, 2004 interim final rule, charges for the brachytherapy sources will not be used in determining outlier payments and payments for these items will be excluded from budget neutrality calculations, consistent with our practice under the OPPS for items paid at cost. (We provide a discussion of brachytherapy payment issues at section VII.G. of this final rule with comment period.)

IV. Payment Changes for Devices

A. Pass-Through Payments for Devices

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

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. In our November 7, 2003 final rule with comment period (68 FR 63437), we specified six device categories currently in effect that would cease to be eligible for pass-through payment effective January 1, 2005.

The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, we paid for pass-through devices under the OPPS on a brand-specific basis. All of the initial category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002 and 2 categories expired after CY 2003. All of the categories listed in Table 21, along with their expected expiration dates, were created since we published the criteria and process for creating additional device categories for pass-through payment on November 2, 2001 (66 FR 55850 through 55857). We based the expiration dates for the category codes listed in that table on the date on which a category was first eligible for pass-through payment.

There are six categories for devices that would have been eligible for pass-through payments for at least 2 years as of December 31, 2004. In our November 7, 2003 final rule with comment period, we finalized the December 31, 2004 expiration dates for these six categories. (Three other categories listed in Table 21, as proposed, C1814, C1818, and C1819, will expire on December 31, 2005.) As indicated in Table 21, as proposed, the six categories that will expire as of December 31, 2004, are: C1783, C1884, C1888, C1900, C2614, and C2632. Each category includes devices for which pass-through payment was first made under the OPPS in CY 2002 or CY 2003.

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). For CY 2003, we packaged the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in CY 2001. There were few exceptions to this established policy (brachytherapy sources for other than prostate brachytherapy, which is now also separately paid in accordance with section 621(b)(2) of Pub. L. 108–173). For CY 2004, we continued to apply this policy for categories that expired on January 1, 2004.

2. Proposed and Final Policy for CY 2005

In the August 16, 2004 proposed rule, we proposed to continue to base the expiration date for a device category on the earliest effective date of pass-through payment status of the devices that populate the category. This basis for determining the expiration date of a device category is the same as that used in CY 2003 and CY 2004.

We also proposed that payment for the devices that populate the six categories that would cease to be eligible for pass-through payment after December 31, 2004, would be made as part of the payment for the APCs with which they are billed. This methodology for packaging device cost is consistent with the packaging methodology that we describe in section III. of this final rule with comment period. To accomplish this, we proposed to package the costs of devices that would no longer be eligible for pass-through payment in CY 2005 into the HCPCS codes with which the devices are billed.

In the proposed rule, we noted that category C1819 (Tissue localization excision device) was added subsequent to our proposed rule for CY 2004. We first announced the start date and the proposed expiration date for this device category in our November 7, 2003 final rule with comment period. Therefore, we proposed to maintain the category's December 31, 2005 expiration date. We invited specific comments on the proposed expiration date for category C1819.

We received a number of public comments on our proposals relating to the expiration dates for transition pass-through devices.

Comment: One commenter noted that C1884 (Embolization protection system) is used for carotid stenting. The commenter recommended that CMS continue paying pass-through payment for C1884 until carotid stenting APC costs are established.

Response: Carotid stenting procedures are on the inpatient list for the OPPS and, therefore, are not paid by Medicare when performed in the outpatient hospital setting. To the extent that C1884 has been used with other procedures payable under the OPPS, we packaged the costs of C1884 into the APCs that include the procedures with which this device code was billed.

Comment: One commenter objected to our proposal to remove HCPCS code C1884 from pass-through status, effective January 1, 2005. The commenter believed that the service had been unfairly subjected to the device offset because it was totally new and did not replace any existing device. The commenter claimed that, for CY 2003, code C1884 inappropriately received very little pass-through payment when the device was used. The commenter indicated that CMS subsequently recognized its error by changing the offset policy for CY 2004, the second year of the device's pass-through status,

and, therefore should give the device a third year of pass-through payment.

Response: We disagree with the commenter that we inappropriately made little pass-through payments for C1884. The commenter is correct that, for CY 2004, following notice and comment rulemaking, we changed the policy for applying offsets. As of January 1, 2004, we apply offsets, on a device-category-specific basis, when we determine that an APC contains costs associated with the device. Under the policy in effect prior to CY 2004, we applied offsets when a device category was billed with any of the APCs on our device offset list. This policy change affected all the categories in effect in CYs 2003 and 2004, including C1884. Some of these categories went into effect as of January 1, 2003; thus their pass-through status will expire after exactly 2 years. Other categories began receiving pass-through payments in the middle of 2002. Therefore, their categories will have more than 2, but less than 3 years with pass-through payment. We would not be able to extend pass-through payment for the second group of categories for an additional year, because they would then have greater than the statutory maximum of 3 years of pass-through payment.

We see no reason to adopt the commenter's suggestions to only change the status for code C1884. In CY 2003, C1884, like all our other pass-through categories, was subject to the same offset policy. Therefore, we are not changing the expiration date of device category C1884.

This device will cease to be a pass-through device effective January 1, 2005, at which time it will have had 2 years of pass-through payment.

We note that the expiration dates of C1884 and most other categories (the exception being C1819, discussed below) that were in effect at the time of our final rule for CY 2004 (68 FR 63437) were made final in that same rule, having been proposed in the proposed rule for CY 2004. We are now merely reaffirming that policy.

A few commenters supported our proposal to remove the six device categories from further pass-through payments and our proposal to package the costs of these devices into the cost of the APCs with which they are billed. The commenters indicated that incorporating these technologies into the APC system will minimize special payment incentives to use certain devices over others.

Comment: One commenter was concerned that pass-through payment for a brachytherapy-related solution (C2632, Brachytherapy solution, Iodine-125, per mCi) would expire from pass-through payment after December 31, 2004, under our proposal, and requested a third year of pass-through payment, until December 31, 2005, because pass-through payment has been made only since January 1, 2003. The commenter claimed that this category still qualifies for another year of pass-through payment.

Response: Because the brachytherapy solution in question, C2632, is a brachytherapy source separately payable under the OPPS according to section 621(b) of Pub. L. 108–173, it will continue to receive cost-based payment as of January 1, 2005, based on those statutory provisions, rather than on the pass-through payment provisions. Section VII.G. of this final rule with comment period explains those provisions and includes code C2632 for cost-based payment in CY 2005. As indicated, in regard to other comments concerning expired categories, this brachytherapy device will have had 2 years of pass-through status on January 1, 2005. Our policy is that pass-through devices are removed from pass-through status as soon as permitted under the statute. Therefore, this device will cease to be a pass-through device effective January 1, 2005, at which time it will have had 2 years of pass-through payment.

Comment: A few commenters were concerned that pass-through payment for C2614 (Probe, percutaneous lumbar diskectomy) in APC 0220 (Level I Nerve Procedures) would expire from pass-through payment after December 31, 2004, under our proposal, and requested that CMS continue to pay for this device category separately on a pass-through basis. The commenters were under the impression that the methodology used to determine whether or not a device category would continue to be eligible for payment in CY 2005 was if it showed ''that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them.''

One commenter indicated that the payment for APC 0220 is not sufficient to cover the cost of the high end disposable RF lumbar probe coded under C2614. The commenter was also concerned that this device, which is used in performing CPT code 62287 (Percutaneous diskectomy), and which costs $1,150, will cease to be eligible for pass-through payments effective January 2005. The commenter stated that the device has increased effectiveness and reduced recovery time for patients but unless CMS increases the payment for APC 0220 for which we proposed to pay $996.69, hospitals will be forced to cease using it in 2005. The commenter urged that CMS continue pass-through payment for C2614 until such time as the payment rate for APC 0220 is adequate to cover the cost of the probe.

Response: The commenters are incorrect in their understanding of our criteria for proposing to expire device categories. We proposed to expire C2614 because it has received pass-through payment for at least 2 years, which is also the basis for our proposal to expire the other five device categories listed for expiration in CY 2005 in our proposed rule. A device with no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them is actually a factor in determining whether to apply an offset, which would reduce the pass-through payment amount, as explained in the August 16, 2004 proposed rule (69 FR 50501). As indicated, similar to other responses in regard to other comments concerning other categories due to expire, this disc decompression device will have had 2 years of pass-through status on January 1, 2005. Our policy is that pass-through devices are removed from pass-through status as soon as permitted under the statute. Therefore, this device will cease to be a pass-through device effective January 1, 2005, at which time it will have had 2 years of pass-through payment.

We have considered the commenter's concern regarding placement of code C2614, the code for a device that is used in performing CPT code 62287, in APC 0220 and find that the resource costs for CPT code 62287 may be more appropriate for APC 0221 (Level II Nerve Procedures). Therefore, we have reassigned CPT code 62287 to APC 0221, for which the CY 2005 payment rate is $1,635.87.

Comment: One commenter recommended that CMS continue to pay for C2614 as a pass-through device category until CMS determines how the procedure, percutaneous lumbar diskectomy, is coded for determination of accurate APC cost weighting.

Response: As explained previously, we packaged costs of the C-code devices into the APCs that include the procedures with which the device codes were billed. We are packaging the costs related to code C2614 in this manner.

Comment: One commenter, a device manufacturer, recommended that CMS extend the expiration date for pass-through payment of C1819 (Tissue localization excision device) until December 31, 2006, instead of ending pass-through payment after CY 2005. The commenter claimed that CMS will have only a partial year of data for the

CY 2006 year, unless it extends the date that the category is effective for pass-through payment. This commenter claimed that the proposed payment for APC 0028, in which therapeutic breast cancer procedures, CPT codes 19125 and 19160, are placed, increased by only $100 and does not represent any device codes. The commenter asserted that CMS needs to collect data over 2 years and increase payment for APC 0028 to at least $1,345 starting in CY 2007. The commenter also pointed out that two categories set to expire after December 31, 2005, C1814 (Retinal tamonade device, silicone oil) and C1818 (Integrated keratoprosthesis), would be paid as pass-through devices several months longer than C1819, resulting in a greater amount of data for ratesetting than will be available for C1819.

Response: We believe it is premature to make any conclusions and recommendations concerning the payment rate for APC 0028 for CY 2006 or CY 2007. Presumably, after the pass-through period ends, the device costs of category code C1819 will be included in the median costs of APC 0028 if the device is billed with procedures that are included in that APC. We reiterate that, as with other categories due to expire, this tissue localization device will have had 2 years of pass-through status on January 1, 2006. Our policy is that pass-through devices are removed from pass-through status as soon as permitted under the statute. Therefore, this device will cease to be a pass-through device effective January 1, 2006.

In this final rule with comment period, we are finalizing the proposed expiration dates for device categories as specified in the proposed rule, as indicated in Table 21 below.

Table 21.--List Of Current Pass-Through Device Categories By Expiration Date

HCPCS Codes	Category Long Descriptor	Date(s) Populated	Expiration Date
C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
C1888	Catheter, ablation, noncardiac, endovascular (implantable)	7/1/02	12/31/04
C1900	Lead, left ventricular coronary venous system	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

B. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups

1. Background

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 the associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the CY 2002 OPPS update (April 1, 2002), we deducted from the pass-through payments for the identified devices an amount that reflected the portion of the APC payment amount that we determined was associated with the cost of 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 CY 2003 (67 FR 66801).

For the CY 2002 and CY 2003 OPPS updates, to estimate the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device eligible for pass-through payment, we used claims data from the period used for recalibration of the APC rates. Using those 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 the associated device category C-codes that were billed with the APC packaged into the median. Comparing the median APC cost without device packaging to the median APC cost including device packaging enabled us to determine the percentage of the median APC cost that is attributable to the associated pass-through devices. By applying those percentages to the APC payment rates, we determined the applicable amount to be deducted from the pass-through payment, the ''offset'' amount. We created an offset list comprised of any APC for which the device cost was at least 1 percent of the APC's cost.

As first discussed in our November 1, 2002 final rule (67 FR 66801) the offset list that we publish each year is a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not know in advance which procedures and APCs may be billed with new categories. Therefore, an offset amount is applied only when a new device category is billed with an APC appearing on the offset list. The list of potential offsets for CY 2004 is currently published on the CMS Web site: *http://www.cms.hhs.gov,* as ''Device-Related Portions of Ambulatory Payment Classification Costs for 2004.''

For CY 2004, we modified our policy for applying offsets to device pass-through payments. Specifically, we indicated that we would apply an offset to a new device category only when we could determine that an APC contains costs associated with the device. We continued our existing methodology for determining the offset amount, described above. We were able to use this methodology to establish the device offset amounts for CY 2004 because providers reported device codes (C-codes) on the CY 2002 claims used for CY 2004 OPPS. However, for the CY 2005 update to the OPPS, we proposed to use CY 2003 claims that do not include device coding. (Section III. of this final rule with comment period contains a fuller discussion of our proposed and final requirement for use

of C-codes for CY 2005.) In the CY 2004 OPPS update, we reviewed the device categories eligible for continuing pass-through payment in CY 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. Based on our review of the data for the categories existing in CY 2004, we determined that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them. Therefore, for those device categories, we set the offset to $0 for CY 2004.

2. Proposed and Final Policy for CY 2005

As we proposed in the August 16, 2004 proposed rule, in this final rule with comment period for CY 2005, we are continuing to review each new device category on a case-by-case basis as we did in CY 2004 to determine whether device costs associated with the new category are packaged into the existing APC structure. We are setting the offsets to $0 for the currently established categories that would continue for pass-through payment into CY 2005. If, during CY 2005, we create a new device category and determine that our data contain identifiable costs associated with the devices in any APC, we will adjust the APC payment if the offset is greater than $0. If we determine that device offsets greater than $0 are appropriate for any new category that we create during CY 2005, we will announce the offset amounts in the program transmittal that announces the new category.

Further, as we proposed, in this final rule with comment period for CY 2005, we are using the device percentages (portion of the APC median cost attributable to the packaged device) that we developed for potential offsets in CY 2004 and apply these percentages to the CY 2005 payment amounts to obtain CY 2005 offset amounts, in cases where we determine that an offset is appropriate. As proposed, we are using the device percentage developed for CY 2004 because, as noted above, for the CY 2005 update to the OPPS, we are using CY 2003 claims that do not include device codes. Therefore, we are not easily able to determine the device portions of APCs for CY 2003 claims data. We have posted the list of device-dependent APCs and their respective device portions on the CMS Web site: *http://www.cms.hhs.gov* for CY 2004 We will update the device portions as a percentage of final CY 2005 APC payments and post these on the CMS Web site.

We did not receive any public comments on our proposed policy for reducing transitional pass-through payments to offset costs packaged into APC groups.

C. Criteria for Establishing New Pass-Through Device Categories

Comment: Several commenters from the medical device community asked that CMS revise the criteria under which it evaluates applications for pass-through status for new device categories. The commenters specifically requested that CMS eliminate the current requirement that items that are included in new pass-through device categories must be surgically inserted or implanted through a surgically created incision. The commenters expressed concern that the current requirement may prevent access to innovative and less invasive technologies, particularly in the areas of gynecologic, urologic, colorectal and gastrointestinal procedures. These commenters asked that CMS change the surgical insertion or implantation criterion to allow pass-through payment for potential new device categories that include items introduced into the human body through a natural orifice, as well as through a surgically created incision.

Several of the commenters recommended that CMS allow the creation of a new pass-through category for items implanted or inserted through a natural orifice, as long as the other existing criteria are met. The commenters do not believe that such an expansion of the criteria would significantly increase the amount spent on pass-through device categories and asked that CMS implement this change in January 2005. A few commenters predicted that this modification would result in expenditures of less than one quarter of the total amount available for pass-through payments. A few commenters further asked that CMS allow new categories, even if the name or terminology associated with the requested category resembles an expired category, even if that entails modifying the description of the expired category. One commenter claimed that manufacturers of technologies that are implanted through a surgically created opening have two options for incremental payment: (1) Pass-through payment; and (2) new technology APC, and that those not requiring a surgical incision have only one option for additional payment (the new technology APC).

Response: We share the views of the commenters about the importance of ensuring access for Medicare beneficiaries to new technologies that offer substantial clinical improvement in the treatment of their medical conditions. We also recognize that, since the initial implementation of the OPPS, there have been beneficial changes in the methods by which some conditions are treated. These are issues that the agency takes very seriously and considers in the context of both pass-through device categories and payment for new, complete procedures through assignment to either a new technology APC or an existing clinical APC.

We note that other payment mechanisms exist within the OPPS for complete procedures that use new technology. These other payment mechanisms (establishment of a new code, where appropriate, and assignment to either a new technology APC or to a clinical APC) are already available, and do not require the implantation of a device through a surgical incision.

We are also interested in hearing the views of other parties and receiving additional information on these issues. While we appreciate and welcome additional comments on these issues from the medical device makers, we are also interested in hearing the views of Medicare beneficiaries, of the hospitals that are paid under the OPPS and of physicians and other practitioners who attend to patients in the hospital outpatient setting. For that reason, we are soliciting additional comments on this topic within the 60-day comment period for this final rule with comment period. (See the **ADDRESSES** section of this preamble for information on submitting comments. When submitting comments on this issue, please include the caption ''Device Categories'' at the beginning of your comment.) In framing their comments, commenters are asked to consider the following questions:

1. The comments discussed above refer to devices introduced into the body through natural orifices. We are seeking comments on whether this includes orifices that are either naturally or surgically created, as in the case of ostomies? If you believe this includes only natural orifices, why do you distinguish between natural and surgically created orifices?

2. How would you define ''new,'' with respect to time and to predecessor technology? What additional criteria or characteristics do you believe distinguish ''new'' devices that are surgically introduced through an existing orifice from older technology that also is inserted through an orifice?

3. What characteristics do you consider to distinguish a device that might be eligible for a pass-through category even if inserted through an

existing orifice from materials and supplies such as sutures, clips or customized surgical kits that are used incident to a service or procedure?

4. Are there differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope?

Concerning the request that we allow new categories for new devices by modifying the descriptors of existing categories, we note there are systems difficulties with changing a descriptor of an existing HCPCS code, such as payment considerations of claims prior to when a modification would be made. Moreover, both hospitals and manufacturers have informed us in the past that coding changes have led to confusion on the part of hospital coders. Modifying established device category C-codes would only exacerbate any such coding confusion. Therefore, we note that we are not inclined to change the descriptors of existing C-codes at this time.

Comment: One commenter recommended that CMS revise the cost significant criterion for establishing new device categories for pass-through payment. The commenter stated that medical devices are sometimes used as part of procedures that are secondary to a primary procedure, and in these cases the cost significance threshold of at least 25 percent of the APC rate associated with the services performed with the device should be adjusted downward to reflect the lower APC payment made for the secondary service. The commenter provided as an example those cases when the secondary procedure would be subject to the multiple procedure discount, thus lowering the APC payment associated with the procedure by 50 percent. The commenter indicated that this scenario happens infrequently.

Response: We disagree that our cost significance criterion for a proposed new device category for pass-through payment requires revision or adjustment. The criterion commented on requires that the estimated average reasonable cost of devices in a proposed new device category exceeds 25 percent of the applicable APC payment amount for the service associated with the device category (67 FR 66785). Very few new device category applications are denied for pass-through payment because they do not meet this cost criterion. If the proposed category of devices can be billed with more than one APC, we generally use the lowest APC payment rate applicable for use with the nominated device when we test against this cost criterion, thus increasing the probability the device will pass the cost significance criterion. We do not believe any further adjustment is needed for this cost criterion.

Therefore, we are not making any additional changes to our policy for CY 2005.

V. Payment Changes for Drugs, Biologicals, Radiopharmaceutical Agents, and Blood and Blood Products

A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs and biological agents. As originally enacted by the 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 and biological agents and brachytherapy used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of BIPA (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' drugs, devices and biological agents that were not being paid for as a hospital OPD 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 drug, device, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. In Addenda A and B to this final rule with comment period, pass-through drugs and biological agents are identified by status indicator ''G.''

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

2. Expiration in CY 2004 of Pass-Through Status for Drugs and Biologicals

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. The drugs whose pass-through status will expire on December 31, 2004, meet that criterion. In the August 16, 2004 proposed rule, Table 22 listed the 13 drugs and biologicals for which we proposed that pass-through status would expire on December 31, 2004.

Comment: One commenter, a national hospital association, supported our proposal to remove these 13 drugs from the pass-through status on December 31, 2004.

Response: We appreciate the commenters' support for our proposal.

For this final rule with comment period, in Table 22 below, we are specifying the drugs and biologicals for which pass-through status will expire on December 31, 2004. This listing is the same as that published in the proposed rule.

Table 22.--List of Drugs and Biologicals for Which Pass-Through Status Expires December 31, 2004

HCPCS	APC	Long Descriptor	Trade Name
J0583	9111	Injection, Bivalirudin, per 1 mg	Angiomax Inj (single source)
C9112	9112	Injection, Perflutren lipid microsphere, per 2 ml	Definity (single source)
C9113	9113	Injection, Pantoprazole sodium, per vial	Protonix (single source)
J1335	9116	Injection, Ertapenem sodium, per 500 mg	Invanz (single source)
J2505	9119	Injection, Pegfilgrastim, per 6 mg single dose vial	Neulasta (single source)
J9395	9120	Injection, Fulvestrant, per 25 mg	Faslodex (single source)
C9121	9121	Injection, Argotroban, per 5 mg	Acova (single source)
C9200	9200	Orcel, per 36 square centimeters	Orcel (single source)
C9201	9201	Dermagraft, per 37.5 square centimeters	Dermagraft (single source)
J2324	9114	Injection, Nesiritide, per 0.5 mg	Natrecor (single source)
J3315	9122	Injection, Triptorelin pamoate, per 3.75 mg	Trelstar depot Trelstar LA (single source)
J3487	9115	Injection, Zoledronic acid, per 1 mg	Zometa (single source)
Q0137	0734	Injection, Darbepoetin Alfa, 1 mcg (non-ESRD use)	Aranesp® (single source)

3. Drugs and Biologicals With Pass-Through Status in CY 2005

As we proposed in the August 16, 2004 proposed rule, we are continuing pass-through status for CY 2005 for 18 drugs and biologicals listed in Table 23 of this final rule with comment period. The APCs and HCPCS codes for drugs and biologicals that will have pass-through status in CY 2005 are assigned status indicator ''G'' in Addendum A and Addendum B, respectively, to this final rule with comment period.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act. Section 303(c) of Pub. L. 108–173 amended Title XVIII of the Act by adding new section 1847A. This new section establishes the use of the average sales price (ASP) methodology for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act furnished on or after January 1, 2005. Therefore, as we proposed in the August 16, 2004 proposed rule, in CY 2005, we will pay under the OPPS for drugs and biologicals with pass-through status consistent with the provisions of section 1842(o) of the Act as amended by Pub. L. 108–173 at a rate that is equivalent to the payment these drugs and biologicals will receive in the physician office setting, and established in accordance with the methodology described in the CY 2005 Physician Fee Schedule final rule published elsewhere in this issue.

Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between the amount authorized under section 1842(o) of the Act, and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological.

In this final rule with comment period, we are adopting as final our proposal to amend § 419.64 of the regulations to conform this section to these changes. Specifically, we are revising paragraph (d) to provide that, subject to any reduction determined under § 419.62(b), the payment for a drug or biological with pass-through status equals the amount determined under section 1842(o) of the Act, minus the portion of the APC payment amount that we determine is associated with the drug or biological.

As we explained in the August 16, 2004 proposed rule, we will make separate payment, beginning in CY 2005, for new drugs and biologicals with an HCPCS code consistent with the provisions of section 1842(o) of the Act, as amended by Pub. L. 108–173, at a rate that is equivalent to the payment they would receive in a physician office setting, whether or not we have received a pass-through application for the item. Accordingly, beginning in CY 2005, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status equals zero. That is, when we subtract the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act, as amended by Pub. L. 108–173, from the portion of the otherwise applicable fee schedule amount, or the APC payment rate associated with the drug or biological that would be the amount paid for drugs and biologicals under section 1842(o) of the Act as

amended by Pub. L. 108–173, the resulting difference is equal to zero.

We have used the second quarter ASP numbers for budget neutrality estimates, impact analysis, and for completing Addenda A and B because those were the most recent numbers available to us in time for publication. Changes in program payments due to quarterly updates of ASP for pass-through drugs are factored into our budget neutrality estimates. To be consistent with the ASP-based payments that will be made when these drugs and biologicals are furnished in physician offices, we plan to make any appropriate adjustments to the amounts shown in Addendum A and B if later quarter ASP submissions indicate that adjustments to the payment rate are necessary. We will announce such changes in our program instructions to implement quarterly releases and post any revisions to the Addenda on the *http://cms.hhs.gov* Web site.

In the proposed rule, we listed in Table 23 the drugs and biologicals for which we proposed pass-through status continuing in CY 2005. We also included in Addendum B to the proposed rule the proposed CY 2005 rates for these pass-through drugs and biologicals based on data reported to CMS as of April 30, 2004. Since publication of the proposed rule on August 16, 2004, we have approved two additional drugs and biologicals for pass-through payment beginning on or after October 1, 2004. These products are Vidaza that has been assigned HCPCS code C9218 (Injection, azacitidine, per 1 mg) and Myfortic that has been assigned HCPCS code J7518 (Mycophenolic acid, oral, per 180 mg). (*See* Change Request 3420, Transmittal 290 issued August 27, 2004.) In addition, three more products have been approved for pass-through status beginning or after January 1, 2005. They are Orthovice (HCPCS code C9220, Sodium Hyaluronate per 30 mg dose, for intra-articular injection), GraftJacket (Repair)(HCPCS code C9221, Acellular dermal tissue, matrix per 16cm2), and GraftJacket (Soft Tissue)(HCPCS code C9222, Decellularized Soft Tissue Scaffold, per 1 cc). These new eligible pass-through items are listed in Table 23 below.

We received several public comments on the proposed listing and payment rates for drugs and biologicals for pass-through status continuing in CY 2005.

Comment: Two commenters stated that the proposed payment rate for HCPCS code C9203 (Injection, Perflexane lipid microsphere, per single use vial) is inappropriate and should be re-examined. They state that the methods used to price the drug are inconsistent with the Pub. L. 108–173, which requires that payments for pass-through drugs be based at either 106 percent of reported average sales price (ASP) or 83 percent of the average wholesale price (AWP). Pricing at 95 percent of AWP for C9203 creates a competitive disadvantage for contrast agents no longer being paid as pass-through drugs.

One commenter suggests that CMS create a class of echocardiography contrast agents similar to the class established for anti-emetic drugs. This allows for a uniform methodology to price drugs and ensures patient access to all drugs in the same therapeutic class. An alternative proposal identified by the commenter, is to base the payment for Imagent on the method applicable to the pricing for all other specified covered outpatient drugs (that is, 83 percent of the AWP). Yet another proposal included either maintaining pass-through status for all contrast agents or removing Imagent from pass-through designation. Another commenter recommended that the payment rate for all contrast agents be based on median costs reflected in hospital outpatient claims data.

Response: Whereas separate payment was already being made for the contrast agents, either as a pass-through item or as a ''specified covered outpatient drug,'' the 5HT3 anti-emetic products varied in their payment status, that is, some were packaged and some were paid separately. Although we are making final our proposal to pay separately for the 5HT3 anti-emetic products in CY 2005 in this final rule with comment period, the intent of this policy discussed in section IV.B.2. of this preamble is not to standardize payment for already separately payable drugs. For this reason, the policy does not apply to the echocardiography contrast agents. Therefore, we are not accepting the commenter's recommendation that we create a class of echocardiography contrast agents similar to the class for anti-emetic drugs.

Other proposals to: (1) Change the pass-through payment status for Imagent to a ''specified covered outpatient drug,'' (2) extend the pass-through payment status for other contrast agents, or (3) use hospital claims data to establish payment for Imagent are not provided for under the statute. Imagent obtained pass-through status effective on April 1, 2003, and will remain a pass-through drug for CY 2005.

Since the ASP for contrast agents was not reported in time for use in developing the APC payments for this final rule with comment period, the CY 2005 first quarter APC payment for Imagent is based on 95 percent of the AWP reported as of May 1, 2003. As previously stated, we plan to update payments for pass-through drugs on a quarterly basis. Beginning in April 2005, payment for Imagent will be based on 106 percent of the reported ASP.

Comment: Several commenters wrote in support of our proposal to remove 13 drugs and biologic agents from the pass-through table as the pass-through period for these items will end on January 1, 2005. Many commenters were very much in favor of our proposal for setting the pass-through payment portion of drugs. They wrote that zero pass-through payments ensures pass-though drugs and biologicals receive the full payment while at the same time eliminates the risk of a pro-rata reduction from occurring. Other commenters urged CMS to update ASP based payment rates for therapies with transitional pass-through status on a quarterly basis as is done for the drugs and biologicals administered in physician offices and paid for in accordance with the same statutory requirements as the drugs and biologicals with pass-through status under the OPPS. Otherwise, they argued, patient access to innovative drug and biological therapies in appropriate outpatient settings could be jeopardized.

Response: We appreciate the comments that support our decision to remove 13 drugs pass-through and biologicals for which pass-through status expires at the end of CY 2004 from the table. With respect to those drugs and biologicals that will continue to be on pass-through status or that may be granted pass-through status in CY 2005, we agree that our payment rules and amounts should be consistent with the ASP-based payments that will be made when these drugs and biologicals are furnished in physician offices since payment for both settings is governed by the same provisions of the Act. Therefore, we plan to make any appropriate adjustments to the amounts shown in Addendum A and B if later quarter ASP submissions indicate that adjustments to the payment rate are necessary. Changes in total payments due to quarterly updates of ASP for pass-through drugs are factored into our budget neutrality estimates.

In this final rule with comment period, we are not making any changes to the listing as a result of public comments. Table 23 below lists the drugs and biologicals that will have pass-through status in CY 2005. Addendum B of this final rule with

comment period lists the final CY 2005 rates for these pass-through drugs and biologicals, which are assigned status indicator "G" based on data reported to CMS as of July 30, 2004.

BILLING CODE 4120–01–P

Table 23.-- List of Drugs and Biologicals With Pass-Through Status in CY 2005

HCPCS Code	APC	Long Descriptor	Trade Name
C9123	9123	TransCyte, per 247 sq. cm	TransCyte
C9205	9205	Injection, Oxaliplatin, per 5 mg	Eloxatin
C9203	9203	Injection, Perflexane lipid microspheres, per single use vial	Imagent
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg	Geodon
C9211	9211	Injection, IV, Alefacept, per 7.5 mg	Amevive
C9212	9212	Injection, IM, Alefacept, per 7.5 mg	Amevive
J9041	9207	Injection, IV, Bortezomib, per 0.1 mg	Velcade
J0180	9208	Injection, IV, Agalsidase beta, per 1 mg	Fabrazyme
J1931	9209	Injection, IV, Laronidase, per 0.1 mg	Aldurazyme
J2469	9210	Injection, IV, Palonosetron HCI per 0.025 mg (25 microgram)	Aloxi
J0878	9124	Injection, daptomycin, per 1 mg	Cubicin
J2794	9125	Injection, risperidone, per 0.5 mg	Risperdal Consta
J2783	0738	Injection, rasburicase, 0.5 mg	Elitek
J9305	9213	Injection, Pemetrexed, per 10 mg	Alimta
J9035	9214	Injection, Bevacizumab, per 10 mg	Avastin
J9055	9215	Injection, Cetuximab, per 10 mg	Erbitux
J0128	9216	Abarelix for Injectable Suspension, per 10 mg	Plenaxis
J2357	9300	Injection, Omalizumab, per 5 mg	Xolair
C9218	9218	Injection, azacitidine, per 1 mg	Vidaza[1]
J7518	9219	Mycophenolic acid, oral, per 180 mg	Myfortic[1]
C9220	9220	Sodium Hyaluronate per 30 mg dose, for intra-articular injection	Orthovisc
C9221	9221	Acellular dermal tissue, matrix, per 16cm2	GraftJacket (Repair)
C9222	9222	Decellularized Soft Tissue Scaffold, per 1 cc	GraftJacket (Soft Tissue)

[1]Approved for pass-through payment beginning on or after October 1, 2004

BILLING CODE 4120–01–C

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

1. Background

Under the OPPS, we currently pay for drugs, biologicals including blood and blood products, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs). We explained in the April 7, 2000 final rule (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated

procedure or service. (Program Memorandum Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs, biologicals, and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services. As discussed in the November 7, 2003 OPPS final rule with comment period (68 FR 63445), in CY 2004 we packaged payment for drugs, biologicals, and radiopharmaceuticals into the APCs with which they were billed if the median cost per day for the drug, biological, or radiopharmaceutical was less than $50. We established a separate APC payment for drugs, biologicals, and radiopharmaceuticals for which the median cost per day exceeded $50. Our rationale for establishing a $50 threshold was also discussed in the November 7, 2003 OPPS final rule with comment period (68 FR 63444 through 63447).

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

Section 621(a)(2) of Pub. L. 108–173 amended section 1833(t)(16) of the Act by adding a new subparagraph (B) to require that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CYs 2005 and 2006. For CY 2005, we proposed to continue our policy of paying separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds $50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per day is less than $50 into the procedures with which they are billed.

We calculated the median cost per day using claims data from January 1, 2003, to December 31, 2003, for all drugs, biologicals, and radiopharmaceuticals that had an HCPCS code during this time period and were paid (via packaged or separate payment) under the OPPS. Items such as single indication orphan drugs, certain vaccines, and blood and blood products were excluded from these calculations and our treatment of these is discussed separately in sections V.F., E., and I., respectively, of this preamble. In order to calculate the median cost per day for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2005, in the August 16, 2004 proposed rule, we proposed to use the methodology that was described in detail in the CY 2004 OPPS proposed rule (68 FR 47996 through 47997) and finalized in the CY 2004 final rule with comment period (68 FR 63444 through 63447). We requested comments on the methodology we proposed to continue to use to determine the median cost per day of these items.

We proposed to apply an exception to our packaging rule to one particular class of drugs, the injectible and oral forms of anti-emetic treatments. The HCPCS codes to which our exception to the packaging rule for CY 2005 would apply were listed in Table 24 of the proposed rule (69 FR 50506). Our calculation of median cost per day for these products showed that, if we were to apply our packaging rule to these items, two of the injectible products would be packaged and one would be separately payable. In addition, two of the oral products would be separately payable and one would be packaged. Chemotherapy is very difficult for many patients to tolerate as the side effects are often debilitating. In order for beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We wanted to ensure that our payment rules did not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician. Therefore, we proposed to pay separately for all six injectible and oral forms of anti-emetic products in CY 2005.

We received several public comments on our proposed criteria for packaging payment for drugs, biologicals, and radiopharmaceuticals.

Comment: Many commenters supported our proposal to continue paying separately for drugs, biologicals, and radiopharmaceuticals whose median costs per day exceed $50. The commenters encouraged CMS to continue to maintain the threshold at $50 after CY 2006 and recommended that any additional packaging threshold be examined carefully prior to future implementation so that beneficiary access to therapies will not be compromised as a result. One of the commenters, however, remained concerned about the packaging of other drugs and biologicals that fell below the $50 threshold and recommended that CMS make separate payments for drugs and biologicals that meet one or both of the following criteria: products with median cost per day of at least $50; or products that are eligible for separate payment in other outpatient sites of care and that received a separate payment previously under the OPPS. Another commenter expressed concern about the site of service incentives presented by some drugs being paid when furnished in the physicians' offices, while being packaged in the hospital setting. The commenter urged CMS to consider several options, including: Making separate payment for all drugs in CY 2005 that were separately paid under a previous OPPS payment rate and are separately paid for in physicians' offices; lowering the packaging threshold, for example, to $10 or $20; paying separately for all drugs for which the 106 percent of ASP payment amount in the physicians' office is at least $10; or establishing procedures to ensure that drugs used for similar indications (including off-label uses) are either all packaged or all paid separately. MedPAC, to the contrary, expressed concern about the use of an arbitrary cut-off of $50 per administration for separate payment of drugs. It stated that separate payment for certain more expensive drugs gave hospitals an incentive to use those drugs rather than those that are packaged, and the threshold also gave manufacturers an incentive to price their drugs to ensure that they are above $50 per administration. MedPAC recommended that CMS should carefully analyze alternative thresholds or the creation of larger bundles to allow for alternative approaches once the MMA provision requiring a $50 threshold expires in CY 2007.

Response: We appreciate the support of many commenters for our packaging policy for CY 2005. Section 621(a)(2) of Pub. L. 108–173 requires that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CYs 2005 and 2006. Therefore, we cannot change the threshold amount for CY 2005 as some of the commenters have suggested. We will take all of the commenters' recommendations into consideration as

we work on our packaging proposal for the CY 2007 OPPS.

However, in light of the commenters' concerns, we have decided to apply our equitable adjustment authority to establish several exceptions to the packaging threshold. We note that there were seven drugs and biologicals that we proposed to pay separately for in our proposed rule. However, when we recalculated their median costs per day using all of the hospital claims used for this final rule with comment period, their median costs per day were less than $50. We considered several payment options for these drugs and biologicals, such as packaging all of the items in CY 2005 or paying separately for all of them as we had proposed. However, after evaluating these drugs carefully, we decided to finalize the following payment policy for these items:

- Drugs and biologicals that were paid separately in CY 2004 and have median costs per day less than $50 based on the hospital claims data being used for the CY 2005 final rule with comment period would continue to receive separate payment in CY 2005.
- Those drugs and biologicals that are packaged in CY 2004 and that have median costs per day less than $50 based on the hospital claims data being used for the CY 2005 final rule with comment period would remain packaged in CY 2005.

We believe these policies are the most equitable for this particular set of drugs given the fluctuations in median hospital cost relative to the $50 threshold and their status in CY 2004.

Table 24 lists the seven drugs and biologicals to which this policy will apply along with their CYs 2004 and 2005 payment status indicator. The four items that will be separately paid under this policy meet the definition of sole source ''specified covered outpatient drugs'' and will be paid between 83 percent and 95 percent of their AWP in CY 2005.

Table 24.-- Drugs and Biologicals with Median Costs Per Day Less than $50[1] (Proposed for separate payment)

HCPCS	Description	CY 2004 Status Indicator	CY 2005 Status Indicator
J1450	Inj Fluconazole, 200 mg	N	N
J1730	Inj, Diazoxide, up to 300 mg	N	N
J3400	Inj, Triflupromazine, Hcl, up to 20 mg	N	N
J0350	Inj, Anistreplase, per 30 units	K	K
J1830	Inj, Interferon beta-1B, 0.25 mg	K	K
J8510	Busulfan, oral, 2 mg	K	K
J9151	Daunorubicin citrate, liposomal formulation, 10 mg	K	K

[1]Median costs are based on CY 2003 final rule claims.

Comment: One commenter indicated that CMS was proposing a packaging policy that appeared to be different from the MMA requirement because a particular drug may be administered more than once per day. Therefore, the commenter added, a drug with a cost per administration of less than $50 that is administered more than once per day would qualify for separate payment under CMS' proposed policy, but would not qualify for separate payment under the MMA requirement. The commenter indicated that the overall impact of this discrepancy is that there will be less packaging of drugs under the OPPS than Congress intended. The commenter was unclear as to whether CMS had the authority to deviate from the statute in this way.

Response: We note that the hospital claims data do not indicate whether there were multiple administrations of the same drug on a single day. Accordingly, we must assume that for all cases there was only a single administration of each drug per day. For packaging purposes, the median cost per day for each drug and biological must, therefore, serve as a proxy for its cost per administration. We will, however, continue to explore ways to distinguish single versus multiple drug administrations for future OPPS updates.

Comment: Numerous commenters, including several manufacturers of pharmaceutical products, individual hospitals, and hospital associations, strongly supported CMS' proposed exception to exclude the six injectible and oral forms of 5HT3 anti-emetic products from the packaging threshold and allow separate payment for all of them. One commenter indicated that CMS' claims data used to determine median cost per day may not be a reliable source for accurate median costs for these products and may understate their actual acquisition and related costs. Another commenter stated that if the $50 threshold were applied to this class of drugs, it would have created an incentive for hospitals to choose therapies based on the opportunity for payment and not their appropriateness for each individual patient. The commenters agreed that this policy would help to ensure beneficiary access to the most appropriate anti-emetic drug for cancer care. Several commenters also urged CMS to give careful thought to the effects of packaging on patient access to other types of drugs and biological therapies. However, one commenter indicated that, in recent months, the

wholesale acquisition cost for one of the injectible anti-emetic drugs specified in the proposed exception was reduced by the manufacturer by seventy-three percent. If the proposed exception were applied to this drug, the payment would provide a margin of over one hundred dollars for each dose administered and the outcome would be contrary to the stated intent of the proposal. The commenter believed that CMS could not have anticipated the perverse payment situation that would result under such an exception and recommended that CMS reconsider and withdraw the exception to the packaging rule for this class of drugs.

Response: We appreciate the commenters' support of our proposal to pay for the six 5HT3 products separately. We also recognize the concerns raised by a commenter informing us of the price reduction for one of the injectible products. However, we firmly believe that packaging some of the 5HT3 anti-emetic products and paying separately for others may negatively impact a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician. Therefore, we are finalizing our policy to pay separately for all six injectible and oral forms of anti-emetic products in CY 2005. We note that this policy only affects drugs of a particular class (in this case, 5HT3 anti-emetic products) that vary in their payment status (that is, packaged or paid separately), and our intent is not to generally standardize payment methodologies for separately payable drugs of the same class.

Comment: One commenter expressed operational concerns about billing for oral anti-emetics associated with chemotherapy. The commenter indicated that it will be extremely difficult to bill for these drugs when the same HCPCS codes are used for the drugs' use in nausea not associated with chemotherapy and requested that CMS consider establishing a separate HCPCS code or an edit that will only allow payment when a cancer diagnosis is on the claim.

Response: The following HCPCS codes are those hospitals use to report the six 5HT3 products irrespective of their use: J1260 (Injection, Dolasetron, Mesylate, 10 mg), Q0180 (Dolasetron Mesylate, 100 mg, oral), J1626 (Injection, Graniestron Hydrochloride, 100 mcg), Q0166 (Granisetron Hydrochloride, 1 mg, oral), J2405 (Injection, Ondansetron Hydrochloride, per 1 mg), and Q0179 (Ondansetron Hydrochloride 8 mg, oral). The policy discussed above applies only to the packaging status of these products, not to their coverage status. Hospitals should continue billing in accordance with existing coverage rules.

Comment: We received comments on the packaging status of several drugs, biologicals, and radiopharmaceutical agents where the commenters indicated that the items were incorrectly packaged and should be paid separately as sole source ''specified covered outpatient drugs.'' Specific items mentioned in the comments were HCPCS codes A9524, Q3010, J2790, and J7525. The commenters asserted that the median cost per day calculations for these products were based on inaccurate and incomplete hospital claims data because the hospitals were not likely to have been charging appropriately for the products or billing the correct number of units. One of the commenters also cited changes in HCPCS code descriptors and the lag time in hospitals updating their charge masters to reflect revised code descriptors as possible reasons for why the hospital claims data may be skewed and may not be reflective of hospitals' actual acquisition costs. Another commenter asserted that since many of these drugs were packaged in CY 2003, the claims data did not capture the drugs' actual costs. Commenters urged CMS to review only the ''correctly coded'' claims when determining median cost per day for these products, use external data to help determine appropriate payment rates, or pay for the drugs separately as sole source ''specified covered outpatient drugs'' since these items meet that definition. Another commenter requested that CMS retain the CY 2004 payments until there is enough data to accurately determine payment rates.

Response: We understand commenters' concerns about the median cost per day for these particular items. To determine which claims for drugs, biologicals and radiopharmaceuticals are ''correctly coded'' would require that we attempt to assess which claims indicate that the number of units billed were or were not clinically reasonable. Given variations among patients with respect to the appropriate doses, the variety of indications with different dosing regimens for some agents, our lack of information about how many doses were administered on a given day, the possibility of off-label uses, and our desire not to question the clinical judgment of the prescribing providers on these issues, we do not believe that an approach that attempts to identify and use only ''correctly coded'' claims is feasible. The hospital claims database is the best and most complete source of data we have for establishing median hospital costs for the services and items paid for under the OPPS.

In section III.B. of this final rule with comment period, we discuss comments concerning our methodology for units trimming. It is possible that some other approaches to units trimming could increase the derived cost per day for some drugs but could also result in decreases for some. For others, it could result in no difference for the drug in relation to the $50 threshold. As a test, we applied several different unit trim approaches to one of the codes for which we received comments and still did not achieve a median cost per day above $50. Nevertheless, we appreciate the thoughtful comments we have received on this topic and will consider the issue of units trimming in later development of our OPPS payment rates. For our final policy for CY 2005, however, we retain the methodology that we proposed. We will also encourage hospitals to carefully consider the descriptions of each HCPCS code when determining the number of units to bill for drugs, biologicals and radiopharmaceuticals. We will consider special efforts related to particular items. We would note, also, that the payment hospitals receive for a particular drug is based on the number of units billed. If a hospital underreports the number of units administered to a patient due to a misunderstanding about the definition of the code, the hospital will not receive the full amount to which it is entitled. Conversely, hospitals should not report more units than appropriate based on the coding description and the amount required to treat the patient.

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

a. Payment for Specified Covered Outpatient Drugs

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

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not

included in the definition of ''specified covered outpatient drugs.'' These exceptions are:

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

Section 1833(t)(14)(A)(i) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, specifies payment limits for three categories of specified covered outpatient drugs in CY 2004. Section 1833(t)(14)(F) of the Act defines the three categories of specified covered outpatient drugs based on section 1861(t)(1) and sections 1927(k)(7)(A)(ii), (k)(7)(A)(iii), and (k)(7)(A)(iv) of the Act. The categories of drugs are ''sole source drugs,'' ''innovator multiple source drugs,'' and ''noninnovator multiple source drugs.'' The definitions of these specified categories for drugs, biologicals, and radiopharmaceutical agents under Pub. L. 108–173 were discussed in the January 6, 2004 OPPS interim final rule with comment period (69 FR 822), along with our use of the Medicaid average manufacturer price database to determine the appropriate classification of these products. Because of the many comments received on the January 6, 2004 interim final rule with comment period, the classification of many of the drugs, biologicals, and radiopharmaceuticals changed from that initially published. These changes were announced to the public on February 27, 2004, Transmittal 112, Change Request 3144. Additional classification changes were implemented in Transmittals 3154 and 3322.

We received 25 public comments associated with the January 6, 2004 interim final rule with comment period. These public comments are summarized under section V.B.4. of this preamble.

Section 1833(t)(14)(A) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, also provides that payment for these specified covered outpatient drugs is to be based on its ''reference average wholesale price,'' that is, the AWP for the drug, biological, or radiopharmaceutical as determined under section 1842(o) of the Act as of May 1, 2003 (section 1833(t)(14)(G) of the Act). Section 621(a) of Pub. L. 108–173 also amended the Act by adding section 1833(t)(14)(A)(ii), which requires that:

- A sole source drug must, in CY 2005, be paid no less than 83 percent and no more than 95 percent of the reference AWP.
- An innovator multiple source drug must, in CY 2005, be paid no more than 68 percent of the reference AWP.
- A noninnovator multiple source drug must, in CY 2005, be paid no more than 46 percent of the reference AWP.

Section 1833(t)(14)(G) of the Act defines ''reference AWP'' as the AWP determined under section 1842(o) as of May 1, 2003. We interpreted this to mean the AWP set under the CMS single drug pricer (SDP) based on prices published in the Red Book on May 1, 2003.

For CY 2005, we proposed to determine the payment rates for specified covered outpatient drugs under the provisions of Pub. L. 108–173 by comparing the payment amount calculated under the median cost methodology as done for procedural APCs (described previously in the preamble) to the AWP percentages specified in section 1833(t)(14)(A)(ii) of the Act.

Specifically, for sole source drugs, biologicals, and radiopharmaceuticals, we compared the payments established under the median cost methodology to their reference AWP. We proposed to determine payment for sole source items as follows: If the payment falls below 83 percent of the reference AWP, we would increase the payment to 83 percent of the reference AWP. If the payment exceeds 95 percent of the reference AWP, we would reduce the payment to 95 percent of the reference AWP. If the payment is no lower than 83 percent and no higher than 95 percent of the reference AWP, we would make no change.

Comment: A few commenters strongly opposed the decrease in the payment floor for sole source specified covered outpatient drugs from 88 percent of AWP in CY 2004 to 83 percent of AWP in CY 2005. The commenters believed that the decrease was inappropriate and lacked sound policy justification. The commenters recommended that for CY 2005 the payment floor for sole source specified covered outpatient drugs be maintained at 88 percent of AWP. One commenter, however, was concerned about the proposed payment rate for HCPCS code J9395 (Injection, Fulvestrant, 25 mg), which is based on 83 percent of AWP instead of 85 percent of AWP that is the CY 2004 payment level. The commenter asserted that CMS's use of median cost data to establish appropriate payment rates for specified covered outpatient drugs is faulty for this drug because of concerns about the accuracy of the hospital median cost data. The commenter also indicated that several payment changes affecting this drug were likely to have created a significant degree of confusion among hospitals that may have negatively skewed hospital median cost data and led CMS to correlate the data to an AWP-based payment percentage that is too low. Another commenter urged CMS to create an exceptions process that would provide for appropriate adjustments within the MMA-specified payment corridor upon submission of data documenting potential access problems or a payment rate significantly lower than the acquisition cost of the drug. The commenter indicated that creating such an approach would help to minimize disruption to patient access to drugs in the hospital outpatient setting. To the contrary, several commenters were pleased with the payment rates for certain products at 83 percent of their AWPs.

Response: Section 621(a) of Pub. L. 108–173 is very specific in requiring that a sole source drug must be paid no less than 83 percent and no more than 95 percent of the reference AWP in CY 2005. We used the 83 percent of AWP as the payment floor to set payment rates for sole source drugs, unless payments based on median costs were higher, as we lack any data to determine what would be the appropriate payment level between 83 percent and 95 percent of AWP for all sole source drugs. We set up a payment floor to avoid paying for these drugs at different arbitrarily determined payment levels. We note that if data show that the payment rate for a drug falls between the 83 percent floor and 95 percent ceiling, the drug is paid at the payment rate.

We have responded to comments about the relative hospital data from our claims above and in other sections of this preamble. While we certainly share the desire to provide beneficiaries with access to the drugs that are reasonable and necessary for the treatment of their conditions, we do not agree with the comments that we should pay above the 83 percent floor established by the MMA for sole source drugs if the median hospital cost falls below this floor. We believe the intent of the law is to use hospital cost data as the best available information in setting the payment rates for most items paid for under the OPPS. In the case of sole source specified covered outpatient drugs, the MMA provides for a floor of 83 percent of the reference AWP for those items for which the payment based on relative hospital costs would fall below 83 percent of the AWP and a ceiling of 95 percent of the reference AWP for items where the relative

hospital costs from our claims data exceed that amount. We are not convinced that the 83 percent AWP floor is a barrier to appropriate treatment.

Comment: One commenter, the manufacturer of AGGRASTAT®, requested that CMS convert the current temporary outpatient HCPCS code C9109 (Injection, Tirofiban HCl, 6.25 mg) to a permanent national HCPCS code with a base dose of 5 mg and continue to maintain the permanent national HCPCS code J3245 (Injection, Tirofiban HCl, 12.5 mg). The commenter asserted that HCPCS codes with units of 5 mg and 12.5 mg would properly reflect the actual doses of AGGRASTAT® that currently exist in the market.

Response: For 2005, the National HCPCS Panel decided to delete HCPCS codes C9109 and J3245 and create a new HCPCS code J3246 (Injection, Tirofiban HCl, 0.25 mg). We hope that the creation of this new HCPCS code will ameliorate the commenter's concerns about appropriate coding for this product.

Comment: We received a number of comments on the packaging status of HCPCS codes J7505 (Muromonab-CD3, parenteral, 5 mg) and J9266 (Pegaspargase, single dose vial). The commenters stated that these two products were incorrectly packaged because the data used to determine packaging status were flawed and requested that both products be paid separately as sole source drugs at a rate between 83 percent and 95 percent of their AWPs.

Response: There were several drugs and biologicals that we proposed to package in the proposed rule, including the two products mentioned in the comments. However, when we recalculated their median costs per day using all of the hospital claims from CY 2003 used for this final rule with comment period, we determined that their median costs per day were greater than $50. Therefore, for CY 2005, we will pay for these drugs and biologicals separately. Items that meet the definition of ''specified covered outpatient drugs'' (SCOD) will be paid according to the payment methodologies established in the MMA, and payment for items that do not meet the definition will be based on their median unit cost. Table 25 lists the drugs and biologicals that were proposed as packaged drugs and biologicals but will be paid separately in CY 2005. The table also indicates the methodology that will be used to determine their APC payment rates in CY 2005.

Table 25. - Drugs and Biologicals with Packaging above $50 Threshold (Proposed as packaged items but will be paid separately in CY 2005)

HCPCS	Description	CY 2005 Payment Methodology
J0743	INJ, CILASTATIN SODIUM; IMIPENEM, PER 250 MG	Median based
J0900	INJ, TESTOSTERONE ENANTHATE AND ESTRADIOL VALERATE, UP TO 1 CC	Median based
J1455	INJ, FOSCARNET SODIUM, PER 1000 MG	Median based
J2760	INJ, PHENTOLAMINE MESYLATE, UP TO 5 MG	Median based
J1325	INJ, EPOPROSTENOL, 0.5 MG	SCOD
J7505	MUROMONAB-CD3, PARENTERAL, 5 MG	SCOD
J9050	CARMUSTINE, 100 MG	SCOD
J9165	DIETHYLSTILBESTROL DIPHOSPHATE, 250 MG	SCOD
J9266	PEGASPARGASE, PER SINGLE DOSE VIAL	SCOD

Comment: One commenter was concerned about the proposed payment rates for HCPCS codes A9502 (Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin, per unit dose) and Q3005 (Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m mertiatide, per mci). The commenter indicated that payment corrections made for these two products in the February 27, 2004 CMS Transmittal 113 resulted in significant payment reductions. The commenter was concerned that significant payment fluctuations and reductions were counter-productive to the provision of quality care and will negatively impact the operational viability of nuclear medicine departments. Therefore, the commenter urged CMS to reconsider their proposed payments for these two products.

Response: We understand the commenter's concern about the impact of fluctuations in payment rates for HCPCS codes A9502 and Q3005. However, we note that the payment rates that were listed in the January 6, 2004 interim final rule with comment period for these products were calculated using incorrect reference AWPs as indicated in the February 27, 2004 CMS Transmittal 113. Therefore, we made corrections to the AWPs for these products and recalculated their payment rates according to the payment methodology required by the MMA for sole source ''specified covered outpatient drugs''.

Comment: One commenter requested that CMS support a decision by the HCPCS Alpha-Numeric Editorial Panel to issue separate permanent and universal drug codes for echocardiography contrast agents for which applications have been submitted. Specifically, the commenter recommended that CMS support the application submitted for the creation of a J-code for Definity, which is currently being reported as HCPCS code C9112 (Injection, perflutren lipid microsphere, per 2 ml vial).

Response: Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. Comments related to the HCPCS code creation process and decisions made by the National HCPCS Panel are

outside the scope of this rule; therefore, we will not respond to this comment. We note that until a J-code is established for this product, hospitals can continue to bill for this product using the HCPCS code C9112.

Comment: Several commenters expressed concern about the proposed payment for intravenous immune globulin. They were concerned that CMS calculated the reference AWP for this code using AWPs for one or more products that were no longer commercially available. For example, Carimune and Panglobulin were removed from the market and replaced with Carimune NF and Panglobulin NF, respectively. The commenters requested that CMS review the current pricing data on the brand products that are currently in the market place and recalculate payment for IVIG as a sole source specified covered outpatient drug. Another commenter was concerned about the proposed payment rate for HCPCS code J7198 (Anti-inhibitor, per IU). The commenter indicated CMS calculated the reference AWP for this code using an AWP for a product called Autoplex that was discontinued from the market in May 2004 and recommended that CMS calculate payment for this HCPCS code using cost data associated with the product Feiba VH that currently exists in the market.

Response: We agree with the comments and accordingly recalculated the base AWP for HCPCS code J1563 (Immune globulin, intravenous, 1 g) excluding AWPs for the two discontinued products, Panglobulin and Carimune. Similarly, we excluded the AWP for the discontinued product, Autoplex, when redetermining the base AWP for HCPCS code J7198 (Anti-inhibitor, per IU). We then recalculated their payment rates as sole source ''specified covered outpatient drugs.'' We note that these changes resulted in an increase in the base AWPs for both products.

Comment: One commenter, the maker of the product billed under HCPCS code C9201 (Dermagraft, 37.5 cm2), requested that CMS set its CY 2005 payment rate under the OPPS identical to the payment rate in the physician office setting. The commenter anticipated a payment rate of $574.41 (third quarter ASP plus 6 percent) when it is used in the physician office setting during CY 2005; however, the proposed payment rate as a sole source drug under the OPPS was $529.54. The commenter indicated that Dermagraft's cost to all customers is identical regardless of the site of service and establishing a payment rate under the OPPS below the cost of the product to hospitals would hinder their access to medical technologies for which they will not recover their costs. Additionally, we received comments from an association representing a group of specialty hospitals and a professional association expressing concern about the proposed payment level for HCPCS code J3395 (Injection, verteporfin, 15 mg). The commenters indicated that the payment rate for this product is significantly less than the acquisition cost for outpatient facilities and requested that CMS pay for it at a rate that covers the cost of acquiring the drug. The commenter also stated that accurate pricing information for the drug should be available when CMS receives final data from the manufacturer on October 31, 2004 and that the final OPPS payment rate should be reflective of the pricing data.

Response: The products described by HCPCS codes C9201 and J3395 meet the definition of sole source ''specified covered outpatient drugs.'' The MMA specifies the methodology that determines payment for this group of drugs under the OPPS where, for CY 2005, sole source drugs must be paid between 83 percent and 95 percent of their reference AWP. Since payments for these two products based on the median cost methodology were less than 83 percent of their AWPs, their CY 2005 payment levels were established at 83 percent of their AWP. In these cases, we believe the statute specifically addresses the payment methodology for these drugs.

Comment: A few commenters were concerned about the proposed payment rates for some separately payable drugs and biologicals that did not fall under the category of ''specified covered outpatient drugs.'' These products would be either paid as pass-through items or their payment rates were based on median cost data; however, the commenters requested that the products be paid as sole source ''specified covered outpatient drugs.'' One of the commenters requested that external data be used to correct the payment rate for their product. Several rationales were cited for this request to change the payment methodology, such as the use of inaccurate and incomplete hospital claims data to determine payment rates that are lower than actual hospital acquisition costs and eliminating payment differentials between drugs of the same class.

Response: We believe that the MMA defines the items that are to be considered ''specified covered outpatient drugs'' for payment purposes under the OPPS, and these drugs do not meet the definition. We also recognize that classifying these products as sole source ''specified covered outpatient drugs'' would increase their payments; however, we are not convinced that the payment rates for these products calculated under current methodologies are insufficient.

In developing our August 16, 2004 proposed rule, there was one sole source item, Co 57 cobaltous chloride (HCPCS code C9013), for which we could not find a reference AWP amount. However, we had CY 2003 claims data for HCPCS code C9013, and therefore, we proposed to derive its payment rate using its median cost per unit. We requested comments on our proposed methodology for determining the payment rate for HCPCS code C9013. We received a few comments in response to our proposal.

Comment: The manufacturer of the product billed under HCPCS code C9013 (Supply of Co 57 cobaltous chloride, radiopharmaceutical diagnostic imaging agent), Rubatrope, along with other commenters, indicated that Rubatrope is an FDA-approved radiopharmaceutical and a sole source drug that meets the definition of a ''specified covered outpatient drug;'' therefore, it should be paid between 83 percent and 95 percent of AWP. The manufacturer of Rubatrope indicated that it had experienced problems with the production of this product in the past 2 years and thus production was discontinued. However, the product will be commercially available from November 2004. The commenter also indicated that it would send CMS an AWP for this product once it becomes available. Therefore, for CY 2005, the commenters strongly urged CMS to establish payment for C9013 as a sole source drug at 83 percent of AWP.

Response: We understand the commenters' concern about the payment rate for this product and note that HCPCS code C9013 was considered a sole source ''specified covered outpatient drug'' in the proposed rule. However, as we were not able to determine a reference AWP for this product, we based its proposed payment rate on its median cost from the claims data. At the time of the publication of this final rule, we were still unable to find an AWP for this product, and thus, in the absence of an AWP for this product, as proposed we will use the product's median cost to base its CY 2005 payment rate. However, if we determine an AWP for HCPCS code C9013, we will issue a change to its payment accordingly in a quarterly update of the OPPS.

We note that there are three radiopharmaceutical products for which

we proposed a different payment policy in CY 2005. These products are represented by HCPCS codes A9526 (Ammonia N–13, per dose), C1775 (FDG, per dose (4–40 mCi/ml), and Q3000 (Rubidium–Rb–82). Radiopharmaceuticals are classified as a ''specified covered outpatient drug'' according to section 1833(t)(14)(B)(i)(I) of the Act and their payment is dependent on their classification as a single source, innovator multiple source, or noninnovator multiple source product as defined by sections 1927 (k)(7)(A)(iv), (ii), and (iii) of the Act. Upon further analysis of these items, we determined that these three products do not meet the statutory definition of a sole source item or a multiple source item. Pub. L. 108–173 requires us to pay for ''specified covered outpatient drugs'' using specific payment methodologies based on their classification and does not address how payment should be made for items that do not meet the definition of a sole source or multiple source item. Therefore, in the August 16, 2004 proposed rule, we proposed to set the CY 2005 payment rates for these three products based on median costs derived from CY 2003 hospital outpatient claims data, which would reflect hospital costs associated with these products. With regard to HCPCS code A9526, we have no hospital outpatient cost data for this HCPCS code. We received correspondence from an outside source stating that Rubidium–Rb–82 (HCPCS code Q3000) is an alternative product used for procedures for which Ammonia N–13 is also used and these two products are similar in cost. Therefore, we proposed to establish a payment rate for Ammonia N–13 that is equivalent to the payment rate for Rubdium Rb–82.

We listed the proposed CY 2005 payment rates for these three items in Table 25 of the proposed rule (69 FR 50507), requested comments on the proposed payment rates and invited commenters to submit external data if they believe the proposed CY 2005 payment rates for these items do not adequately represent actual hospital costs.

We received many public comments on the proposed payment rates for the three items.

Comment: Many commenters were concerned about the proposed reduction in the payment rate for FDG in CY 2005. They stated that FDG meets the definition of ''specified covered outpatient drugs,'' and the MMA requires that ''specified covered outpatient drugs'' be classified as sole source drugs, innovator multiple source drugs, or noninnovator multiple source drugs, and be reimbursed according to a percentage of the reference AWP during CY 2005. Several commenters understood the difficulty CMS had in classifying FDG into one of the three categories of ''specified covered outpatient drugs.'' However, one of the commenters was concerned that CMS abandoned the methodology prescribed by the MMA and created another payment category for ''specified covered outpatient drugs,'' which the commenter believed is outside the scope of the MMA.

A commenter suggested that CMS assign FDG to the category that most closely reflects the underlying regulatory and economic environment for the production of FDG, which is the innovator multiple source drug category. The commenter explained that the production and sale of FDG is unusual in that the FDA does not yet require an approved New Drug Application (NDA) or Abbreviated New Drug Application (ANDA). The commenter also stated that the FDA is currently drafting special criteria to govern NDAs and ANDAs for the production and marketing of FDG, and eventually, manufacturers will be required to submit either an NDA or ANDA in order to sell FDG. Right now, there are no approved ANDAs or ''generics'' for FDG, and none of the FDA approved products is therapeutically equivalent. The commenter indicated that FDG is sold commercially by at least three manufacturers and is produced by numerous hospitals and academic medical centers for their own use, thus making it a multiple source drug. However, until the FDA finalizes its requirements for NDAs and ANDAs for FDG and all manufacturers have an opportunity to comply with those regulations, all FDG marketed in the United States should be considered a ''brand'' version. Although the different FDG products distributed are not rated as equivalent by the FDA, FDG was originally marketed under an NDA, and currently there are multiple distributors. Thus, although FDG does not meet all aspects of the multiple source innovator drug definition, given the inaccuracies of the hospital outpatient claims data, this commenter, along with several others, recommended that FDG be paid under the MMA at 68 percent of its AWP. Alternatively, some commenters requested that CMS keep the CY 2005 payment for FDG at its CY 2004 level until the completion of the GAO hospital acquisition cost survey, which will allow for a more reliable basis for setting payment based on average acquisition cost. One commenter stated that CMS should use external data submitted by hospitals to determine the true costs of this product. External data from a survey of 2002 nuclear medicine costs reported by hospitals were submitted, and the results indicated that median cost to hospitals for one dose of FDG is $425. Another commenter stated that their current cost for administering one dose of FDG to patients receiving PET scans is $450 and that CMS should research real market costs for this product before reducing payment by $126 from the current CY 2004 payment rate

The commenters all agreed that CMS should not use CY 2003 hospital claims data to calculate payment for FDG in CY 2005 because the reported data fails to accurately capture the actual acquisition cost to hospitals along with all the reasonable costs needed to safely prepare, store, administer, and dispose of the product. Commenters indicated that the HCPCS code descriptor for C1775 is written in a way that requires hospitals to use the same code to report FDG with a concentration of 4mci/ml as they use to report FDG with a concentration of 40 mci/ml, thus making the claims data unreliable, and also, hospitals did not have clear billing and charging guidance. Thus, the commenters claimed that the FDG data from CY 2003 are a flawed basis upon which to make a payment determination and would significantly underpay hospitals. Commenters noted that a reduction in payment for FDG to the proposed payment rate would limit utilization and access to FDG PET because of the financial losses the providers will suffer.

Response: We appreciate these thoughtful comments on our proposed payment rate for FDG. Based on the unique regulatory processes that affect the manufacturing and marketing of FDG, we believe that it is reasonable for us to classify FDG as an innovator multiple source drug. Therefore, we will not reinstate the HCPCS code C9408 (FDG, brand, per dose), which we inadvertently deleted as stated in the October 2004 Update of the OPPS (CMS Transmittal 290). In CY 2005, hospitals should use C1775 to bill for all FDG products.

With respect to calculating payment for FDG in CY 2005, the MMA requires that an innovator multiple source drug must be paid no more than 68 percent of the reference AWP. The MMA sets forth a payment ceiling for the brand innovator multiple source drugs, but does not provide a payment floor for them. We believe that the intent of the statute is to use available hospital

claims to set payment rates for most items paid under OPPS; therefore, we apply the ceiling only when the payment for an item based on the median hospital cost for the drug exceeds the ceiling. As we described in section V.A.3.a. of this final rule with comment period, for innovator multiple source drugs, we set the payment rate at the lower of the payment rate calculated under the standard median cost methodology or 68 percent of the AWP. We have applied this methodology to all of the other innovator multiple source drugs; therefore, we do not believe that it would be appropriate for us to exempt FDG from this methodology and pay for it at 68 percent of AWP, the ceiling for innovator products. We believe that basing payment for this item on relative hospital costs, with the application as appropriate of the previously mentioned ceiling, not only meets the intent but also the requirements of the MMA. The payment rate for C1775 in CY 2005 will be $221.11.

Comment: The manufacturer of CardioGen–82, also known as Rubidium Rb–82, along with other commenters asserted that this product does meet the classification of a sole source drug as defined by the MMA. The commenters indicated that FDA approval for this product was received under an NDA, and there is currently only one manufacturer of the Cardiogen–82 generators used to produce Rubidium Rb–82. Also, there is no FDA-approved generic product for Rubidium Rb–82. One of the commenters indicated that a survey was conducted to obtain data on actual hospital costs for Rubidium Rb–82, which showed that the median per dose cost to hospitals was $244.73. Thus, the commenter believed that CMS hospital cost data were flawed and do not represent true hospital costs; therefore, the hospital claims cost data should not be used to set the payment rate for Rubidium Rb–82 in CY 2005. Other commenters indicated that median cost data used by CMS to calculate the payment rate for Rubidium Rb–82 underreport the actual and reasonable hospital costs needed to safely prepare, store, administer, and dispose of the product. The commenters urged CMS to recognize HCPCS code Q3000 (Supply of radiopharmaceutical diagnostic imaging agent, Rubidium Rb–82, per dose) as a sole source drug and set its payment at 83 percent of its AWP, or at minimum, retain the CY 2004 payment rate.

Response: We appreciate these comments. Based on further evaluation of the appropriate classification for this product, we agree with the commenters that Rubidium Rb–82 should be classified as a sole source product. Therefore, payment for Q3000 will be made at 83 percent of AWP as its payment based on the median cost methodology is less than 83 percent of AWP. The payment rate for Rubidium Rb–82 in CY 2005 will be $153.39 per dose.

Comment: Numerous commenters were concerned about the proposed payment rate for HCPCS code A9526 (Ammonia N–13, per dose). Some of the commenters stated that CMS proposed to treat HCPCS codes Q3000 (Rubidium Rb–82, per dose) and A9526 under a ''presumptive functional equivalence'' in setting the same payment rate for these products when they are not functionally equivalent. It was also stated that Rubidium Rb–82 and Ammonia N–13 are used for similar procedures, but they have different costs, clinical composition, and utilization patterns. Another commenter indicated that Rubidium Rb–82 significantly differs from the other PET radiopharmaceuticals as it is produced by a radionuclide generator system, compared to FDG and Ammonia N–13 that are made in cyclotrons. A commenter also stated that Ammonia N–13 has no commercial vendors; whereas, Rubidium Rb–82 is produced and distributed by one commercial vendor. Some commenters suggested that CMS pay for A9526 separately, similar to other ''specified covered outpatient drugs.'' On the other hand, other commenters recommended that, in the absence of reliable cost data or a published AWP, CMS should use the cost of FDG as a proxy for the cost of Ammonia N–13, since these products have equivalent production costs.

Response: We recognize the concerns raised by commenters about our proposal to pay for Ammonia N–13 at the same payment rate as Rubidium Rb–82. We acknowledge that Ammonia N–13 meets the definition of ''specified covered outpatient drugs;'' however, we have not been able to determine an AWP for this product. Thus, we cannot set a payment rate for this product based on a percentage of its AWP. While some of the commenters recommended that we set the payment rate for Ammonia N–13 at the same level as that for FDG, we are aware this would give rise to the same concerns raised by commenters regarding payment for Ammonia N–13 and Rubidium Rb–82. Therefore, we are not adopting our proposed payment policy for Ammonia N–13. Based on the complete CY 2003 hospital claims data that were used for this final rule with comment period, we were able to identify claims submitted for Ammonia N–13; therefore, for CY 2005, we will use median cost derived from the claims data to set the payment for this product. The CY 2005 payment rate for A9526 will be $109.86 per dose.

Comment: A number of commenters, including several cancer research centers and trade associations representing the radionuclide and radiopharmaceutical industry, biomedical science, and the biotechnology industry, as well as the manufacturers of Bexxar (billed using HCPCS codes C1080, C1081, and G3001) and Zevalin (billed using HCPCS codes C1082 and C1083), expressed concern that 83 percent of AWP is insufficient to reimburse hospitals for the cost of acquiring Zevalin and Bexxar. Several commenters, including the manufacturer of Zevalin, were concerned that the proposed payment rates for Zevalin are inadequate to facilitate patient access to this critical therapy. One commenter stated that, because Zevalin is a radioimmunotherapy, its purchase and use are subject to state regulatory safeguards that limit its availability in the oncology practices; therefore, its access in the hospital outpatient setting is crucial. The commenter urged CMS to maintain the 2004 payment rates for Zevalin, which are at 88 percent of AWP, into CY 2005, and indicated that this stability would make treatment with Zevalin more economically feasible for hospitals.

One commenter, the manufacturer of Bexxar, expressed concern about what they identified as several ''inequities'' in the coding and proposed payments for Bexxar and Zevalin. Specifically, the commenter pointed out that the payment proposed for Bexxar in CY 2005 is more than $1500 less than the payment proposed for Zevalin. This commenter further recommended that payment for Bexxar be set at its wholesale acquisition cost, which is $19,500, or 95 percent of the RAWP, which would be $22,230. Several commenters indicated that CMS has the option to exceed the floor of 83 percent of AWP established under the MMA for sole source specified covered outpatient drugs, which would enable CMS to set a rate for Bexxar and Zevalin commensurate with their cost.

Two commenters recommended that CMS consider external data where available to supplement its payment determinations for Bexxar and Zevalin.

Response: We share the commenters' concerns that Medicare payment rates not be a barrier to beneficiary access to radioimmunotherapy for the treatment of non-Hodgkins lymphoma. However, we do not agree with the comments that we should set the OPPS payment rates

for Zevalin and Bexxar based on their CY 2004 payment levels, on external data, on their WAC, or on any payment amount other than that which is consistent the designation of radiopharmaceuticals in the MMA as specified covered outpatient drugs.

Zevalin and Bexxar are radiopharmaceuticals, and the MMA includes them as ''specified covered outpatient drugs'' for the OPPS payment purposes. Each meets the definition of a sole source drug. We believe the intent of the law is that we set payment rates for most items paid for under the OPPS using hospital cost data from the best and most recent information available, unless the statute directs otherwise, as in the case of drugs with pass-through status or new drugs without HCPCS codes. The MMA provides a floor of 83 percent of the reference AWP in CY 2005 for sole source specified covered outpatient drugs for which payment based on relative hospital costs would be less. Similarly, the MMA provides a cap of 95 percent of the reference AWP in CY 2005 for sole source specified covered outpatient drugs for which payment based on relative hospital costs would be higher. The statute provides a payment floor and ceiling for sole source ''specified covered outpatient drugs,'' at no lower than 83 percent of AWP or higher than 95 percent of AWP; the statute does not require a payment at some intermediate level that falls between 83 percent and 95 percent of AWP.

Payment for Zevalin based on relative hospital costs drawn from CY 2003 claims data would fall below 83 percent of the reference AWP. As we did in the case of other sole source drugs for which payment based on hospital claims would be lower than 83 percent of AWP, we proposed to set payment for Zevalin at 83 percent of the reference AWP. We also proposed to set payment for Bexxar in CY 2005 as a sole source radiopharmaceutical at 83 percent of AWP because, like Zevalin, it is a radiopharmaceutical and, therefore, a sole source specified covered outpatient drug under the MMA. We discuss in section V.G. of this final rule with comment period that we are making final our proposal to treat radiopharmaceuticals the same as we treat drugs and biologicals for purposes of ratesetting, with two exceptions: We will set payment for new radiopharmaceuticals for which we have no claims data, and for new radiopharmaceuticals with pass-through status effective on or after January 1, 2005, based on the MMA CY 2005 payment requirements for specified covered outpatient drugs. We have no ASP for Bexxar because it is a radiopharmaceutical, and manufacturers have not been required to submit ASP for radiopharmaceuticals. We have no claims data from which to calculate relative hospital costs for Bexxar because of the newness of the product. Therefore, we are setting payment for Bexxar in accordance with the MMA requirement that a sole source specified covered outpatient drug be paid no less than 83 percent of AWP in CY 2005.

Comment: A number of commenters, including several cancer centers and a nuclear medicine trade association, asked that CMS provide payment to hospitals for the cost of compounding each patient-specific dose of Bexxar, noting that the compounding costs amount to several thousand dollars in addition to the cost of the drug itself. One of these commenters recommended that the cost of compounding Bexxar be included in the payment for the product and that C1080 and C1081 be assigned to a new technology APC to reflect the total cost of the product plus compounding. One commenter, the manufacturer of Bexxar, is concerned because the payment proposed for Bexxar in CY 2005 does not include payment for the cost of compounding that is required to prepare patient specific doses of diagnostic and therapeutic I–131 tositumomab, whether done by the hospital's own radiopharmacy or by a commercial radiopharmacy. The commenter estimates that hospitals incur a compounding cost of $2,000–$3,000 to furnish Bexxar to a single patient when a commercial radiopharmacy does the compounding. The commenter recommends that CMS either base payment for Bexxar on 95 percent of AWP, continue payment for Bexxar at the CY 2004 level, or establish a new code to enable hospitals to bill separately for Bexxar compounding costs.

Response: Because Zevalin and Bexxar are radiopharmaceuticals that fall under the category of sole source specified covered drugs established by the MMA, the payment rates for these products are based on AWP, as required by the MMA. To the extent that compounding costs are reflected in the AWP, the payment rate includes these costs. If hospitals incur additional compounding costs for the radiolabeled monoclonal antibodies, those costs could be reported as a separate line item charge with an appropriate revenue code or packaged into the charge for CPT codes 78804 and 79403, which could result in an outlier payment if the outlier threshold for those services was exceeded. The MMA requires that MedPAC submit a report to the Secretary by July 1, 2005 on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. We look forward to receiving this report in anticipation that the data collected by MedPAC will enable us to address drug-related overhead costs in future OPPS updates.

Comment: Several commenters expressed concerns that the payment rates proposed for Bexxar could result in clinicians having to make treatment decisions based upon payment considerations rather than medical considerations, and could result in physicians having to deny patients a potential life-saving therapy. The same commenters were concerned that the payment proposed for Zevalin and Bexxar does not recognize all of the additional costs associated with the provision of radiolabeled antibody therapy or radioimmunotherapy (RIT) for the treatment of non-Hodgkins lymphoma. These commenters urged CMS to consider all of the costs associated with this therapy when setting payment rates for each component of the regimen and recommended that CMS ensure that total payment to hospitals be commensurate with all of the actual costs that hospitals incur to acquire, prepare, and administer radiolabeled antibodies and to perform all of the additional procedures associated with RIT, thereby ensuring that patient access to these vital therapies will not be jeopardized.

Response: We share the commenters' concerns about the extent to which payment considerations influence treatment decisions. However, we believe that to the extent that radioimmunotherapy proves to be an efficacious treatment for patients with certain forms of non-Hodgkins lymphoma, payment in the aggregate for the full array of procedures and services associated with this new form of treatment affords hospitals sufficient flexibility to ensure that payment is not a barrier to beneficiary access when it is deemed reasonable and necessary.

Table 26 below lists the final APC payment rates for sole source drugs, biologicals, and radiopharmaceuticals effective January 1, 2005 to December 31, 2005.

BILLING CODE 4120–01–P

Table 26. – CY 2005 APC Payment Rates for Sole Source Drugs, Biologicals, and Radiopharmaceuticals

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
A4642	K	0704	Satumomab pendetide per dose	$1,390.25
A9500	K	1600	Technetium TC 99m sestamibi	$106.32
A9502	K	0705	Technetium TC99M tetrofosmin	$104.58
A9504	K	1602	Technetium tc 99m apcitide	$415.00
A9507	K	1604	Indium/111 capromab pendetid	$1,915.23
A9508	K	1045	Iobenguane sulfate I-131, pe	$996.00
A9511	K	1095	Technetium TC 99m depreotide	$37.79
A9521	K	1096	Technetiumtc-99m exametazine	$778.13
A9605	K	0702	Samarium sm153 lexidronamm	$907.33
C1079	K	1079	CO 57/58 per 0.5 uCi	$221.78
C1080	K	1080	I-131 tositumomab, dx	$2,241.00
C1081	K	1081	I-131 tositumomab, tx	$19,422.00
C1082	K	9118	Indium111ibritumomabtiuxetan	$2,419.78
C1083	K	9117	Yttrium90ibritumomabtiuxetan	$20,948.25
C1091	K	1091	IN111 oxyquinoline,per0.5mCi	$373.50
C1092	K	1092	IN 111 pentetate per 0.5 mCi	$224.10
C1122	K	1122	Tc 99M ARCITUMOMAB PER VIAL	$1,079.00
C1178	K	1178	BUSULFAN IV, 6 Mg	$24.35
C1201	K	1201	TC 99M SUCCIMER, PER Vial	$118.52

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
C1305	K	1305	Apligraf	$1,130.88
C9003	K	9003	Palivizumab, per 50 mg	$576.51
C9008	K	9008	Baclofen Refill Kit-500mcg	$10.21
C9009	K	9009	Baclofen Refill Kit-2000mcg	$37.64
C9013	K	9013	Co 57 cobaltous chloride	$142.45
C9105	K	9105	Hep B imm glob, per 1 ml	$118.32
C9112	K	9112	Perflutren lipid micro, 2ml	$129.69
C9200	K	9200	Orcel, per 36 cm2	$991.85
C9201	K	9201	Dermagraft, per 37.5 sq cm	$529.54
C9202	K	9202	Octafluoropropane	$129.48
J0130	K	1605	Abciximab injection	$448.22
J0207	K	7000	Amifostine	$395.75
J0287	K	9024	Amphotericin b lipid complex	$19.09
J0288	K	0735	Ampho b cholesteryl sulfate	$15.20
J0289	K	0736	Amphotericin b liposome inj	$31.27
J0350	K	1606	Injection anistreplase 30 u	$2,353.53
J0583	K	9111	Inj, bivalirudin, 1 mg	$1.52
J0585	K	0902	Botulinum toxin a per unit	$4.32
J0587	K	9018	Botulinum toxin type B	$7.68
J0637	K	9019	Caspofungin acetate	$28.78
J0850	K	0903	Cytomegalovirus imm IV /vial	$622.13
J1260	K	0750	Dolasetron mesylate	$14.38
J1325	K	7003	Epoprostenol injection	$15.78
J1327	K	1607	Eptifibatide injection	$11.21
J1438	K	1608	Etanercept injection	$135.56
J1440	K	0728	Filgrastim 300 mcg injection	$162.41
J1441	K	7049	Filgrastim 480 mcg injection	$274.40
J1563	K	0905	IV immune globulin	$80.68
J1564	K	9021	Immune globulin 10 mg	$0.75
J1565	K	0906	RSV-ivig	$16.55
J1626	K	0764	Granisetron HCl injection	$16.20
J1745	K	7043	Infliximab injection	$57.40
J1830	K	0910	Interferon beta-1b / .25 MG	$58.73
J1950	K	0800	Leuprolide acetate /3.75 MG	$451.98
J2020	K	9001	Linezolid injection	$32.15
J2324	K	9114	Nesiritide	$132.47
J2353	K	1207	Octreotide injection, depot	$69.44
J2354	K	7031	Octreotide acetate injection, 25 mcg	$3.72
J2405	K	0768	Ondansetron hcl injection	$5.54
J2505	K	9119	Injection, pegfilgrastim	$2,448.50

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
J2788	K	9023	Rho d immune globulin 50 mcg	$30.38
J2792	K	1609	Rho(D) immune globulin h, sd	$17.95
J2820	K	0731	Sargramostim injection	$25.39
J2941	K	7034	Somatropin injection	$280.87
J2993	K	9005	Reteplase injection	$1,192.09
J3100	K	9002	Tenecteplase injection	$2,350.98
J3246	K	7041	Tirofiban hydrochloride	$8.24
J3305	K	7045	Inj trimetrexate glucoronate	$142.50
J3396	K	1203	Verteporfin injection	$8.49
J3487	K	9115	Zoledronic acid	$197.87
J7190	K	0925	Factor viii	$0.76
J7191	K	0926	Factor VIII (porcine)	$1.78
J7192	K	0927	Factor viii recombinant	$1.10
J7193	K	0931	Factor IX non-recombinant	$0.98
J7194	K	0928	Factor ix complex	$0.32
J7195	K	0932	Factor IX recombinant	$0.98
J7198	K	0929	Anti-inhibitor	$1.29
J7320	K	1611	Hylan G-F 20 injection	$203.70
J7504	K	0890	Lymphocyte immune globulin	$243.50
J7505	K	7038	Monoclonal antibodies	$747.31
J7507	K	0891	Tacrolimus oral per 1 MG	$3.05
J7511	K	9104	Antithymocyte globuln rabbit	$312.41
J7517	K	9015	Mycophenolate mofetil oral	$2.46
J7520	K	9020	Sirolimus, oral	$6.23
J8510	K	7015	Oral busulfan	$2.08
J8520	K	7042	Capecitabine, oral, 150 mg	$2.96
J8700	K	1086	Temozolomide	$6.42
J9001	K	7046	Doxorubicin hcl liposome inj	$343.78
J9020	K	0814	Asparaginase injection	$54.71
J9031	K	0809	Bcg live intravesical vac	$139.90
J9045	K	0811	Carboplatin injection	$129.96
J9151	K	0821	Daunorubicin citrate liposom	$56.44
J9170	K	0823	Docetaxel	$312.69
J9178	K	1167	EPIRUBICIN HCL, 2 mg	$24.14
J9185	K	0842	Fludarabine phosphate inj	$311.09
J9201	K	0828	Gemcitabine HCl	$105.73
J9202	K	0810	Goserelin acetate implant	$390.09
J9206	K	0830	Irinotecan injection	$127.33
J9213	K	0834	Interferon alfa-2a inj	$30.48
J9214	K	0836	Interferon alfa-2b inj	$13.00

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
J9215	K	0865	Interferon alfa-n3 inj	$8.17
J9217	K	9217	Leuprolide acetate suspnsion	$543.72
J9219	K	7051	Leuprolide acetate implant	$4,717.72
J9245	K	0840	Inj melphalan hydrochl 50 MG	$367.03
J9266	K	0843	Pegaspargase/singl dose vial	$1,247.08
J9268	K	0844	Pentostatin injection	$1,683.24
J9270	K	0860	Plicamycin (mithramycin) inj	$93.80
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$313.96
J9310	K	0849	Rituximab cancer treatment	$437.83
J9350	K	0852	Topotecan	$697.76
J9355	K	1613	Trastuzumab	$50.79
J9390	K	0855	Vinorelbine tartrate/10 mg	$95.23
J9600	K	0856	Porfimer sodium	$2,274.78
Q0136	K	0733	Non esrd epoetin alpha inj	$11.09
Q0137	K	0734	Darbepoetin alfa, 1 mcg[1]	$3.66
Q0166	K	0765	Granisetron HCl 1 mg oral	$39.04
Q0179	K	0769	Ondansetron HCl 8mg oral	$26.12
Q0180	K	0763	Dolasetron mesylate oral	$63.28
Q0187	K	1409	Factor viia recombinant	$1,410.34
Q2002	K	7022	Elliotts b solution per ml	$1.50
Q2003	K	7019	Aprotinin, 10,000 kiu	$12.51
Q2005	K	7024	Corticorelin ovine triflutat	$353.70
Q2006	K	7025	Digoxin immune fab (ovine)	$332.00
Q2007	K	7026	Ethanolamine oleate 100 mg	$63.29
Q2008	K	7027	Fomepizole, 15 mg	$10.04
Q2009	K	7028	Fosphenytoin, 50 mg	$5.31
Q2011	K	7030	Hemin, per 1 mg	$6.47
Q2013	K	7040	Pentastarch 10% solution	$131.99
Q2017	K	7035	Teniposide, 50 mg	$224.94
Q2018	K	7037	Urofollitropin, 75 iu	$56.59
Q2021	K	9057	Lepirudin	$130.30
Q2022	K	1618	VonWillebrandFactrCmplxperIU	$0.83
Q3000	K	9025	Rubidium-Rb-82	$153.39
Q3002	K	1619	Gallium ga 67	$27.10
Q3003	K	1620	Technetium tc99m bicisate	$370.60
Q3005	K	1622	Technetium tc99m mertiatide	$31.13
Q3007	K	1624	Sodium phosphate p32	$94.98
Q3008	K	1625	Indium 111-in pentetreotide	$1,079.00
Q3011	K	1628	Chromic phosphate p32	$147.25
Q3012	K	1089	Cyanocobalamin cobalt co57	$85.49
Q3025	K	9022	IM inj interferon beta 1-a	$74.44

[1] Equitable adjustment applied to payment rate

In order to determine the payment amounts for innovator multiple source and noninnovator multiple source forms of the drug, biological, or radiopharmaceutical, we compared the payments established under the median cost methodology to their reference AWP. For innovator multiple source items, we proposed to set payment rates at the lower of the payment rate calculated under our standard median cost methodology or 68 percent of the reference AWP. For noninnovator multiple source items, we proposed to set payment rates at the lower of the

payment rate calculated under our standard median cost methodology or 46 percent of the reference AWP. We followed this same methodology to set payment amounts for innovator multiple source and noninnovator multiple source ''specified covered outpatient drugs'' that were implemented by the January 6, 2004 interim final rule with comment period. We listed the proposed payment amounts in Table 26 of the proposed rule.

Comment: One commenter, an association of cancer centers, indicated that CMS proposed the same payment rate for both the brand name and generic versions of a drug. Given that CMS does not have separate HCPCS code level data for brand versus generic drugs in the CY 2003 claims data, the commenter indicated that it did not understand how CMS could use claims data to justify equivalent payment levels for both brand and generic versions of a drug. The commenter was also concerned about the adequacy of using the CY 2003 claims data to calculate the costs of these products and making comparisons to the payment rate ceilings set forth by the MMA for multi-source drugs, especially for the brand name drugs. Therefore, the commenter requested that CMS pay for all brand name drugs at 68 percent of AWP and pay for generics by comparing the calculated cost using the claims data to the 46 percent of AWP threshold and selecting the lower of the two as the payment rate.

Response: For CY 2005, as for the current year, the MMA sets forth different payment ceilings for the brand and generic versions of the drug. The MMA does not provide a payment floor for either the brand or generic versions of such items. Only sole source drugs have a payment floor and ceiling. As stated elsewhere in this final rule with comment period, the CY 2005 payment rate for innovator multiple source (brand name) drugs may not exceed 68 percent of the reference AWP. The payment for noninnovator multiple source (generic) drugs may not exceed 46 percent of the reference AWP. In determining payment rates, we apply those ceilings only when the payment for an item based on the median hospital cost for the drug exceeds one of these ceilings. In some cases, the payment based on the median hospital cost falls below the 46 percent ceiling for generic drugs. In such cases, the payment rate would be the same for brand and generic versions. However, we believe that basing payment for these items on relative hospital costs, with the application as appropriate of the previously mentioned ceilings not only meets the intent but also the requirements of the MMA.

Comment: A few commenters indicated that the proposed payment rate of $410.45 for HCPCS code A9600 (Supply of therapeutic radiopharmaceutical, Strontium-89, per mci) would underpay hospitals for this product since the payment rate was based on flawed CMS median cost data that do not accurately reflect the real acquisition cost of this drug by hospitals. The commenters believed that hospital costs for A9600 are approximately $800 per mci and requested that CMS adjust the payment accordingly. One commenter, who was the manufacturer of this product, asserted that the product is expensive and difficult to manufacture since it is produced in small quantities. The commenter also indicated that the reduction in the payment rate for this product is driving the underutilization of this product and increasing the use of costly narcotic analgesics, thus resulting in a decrease in quality of life and a rise in the cost of health care. Another commenter stated that the HCPCS codes for diagnostic and therapeutic iodine products (C1064, C1065, C1188, C1348, A9528, A9529, A9530, A9531, A9517 and A9518) all describe in various years and forms diagnostic and therapeutic Iodine 131 and that these codes have had varying descriptions that have resulted in flawed cost data. The commenter submitted data indicating that the cost for I–131 in the capsule form is higher than for solution, and recommended that CMS use external data to restore and correct payment rates for the Iodine 131 product so that the payment more accurately reflects actual hospital costs.

Response: We understand the commenters' concerns about establishing appropriate payment rates for these products. We believe that the intent of the statute is to use available hospital claims to set payment rates for most items paid under the OPPS. In the case of multiple source drugs such as these products, the MMA requires that innovator and noninnovator multiple source drugs be paid no more than 68 percent and 46 percent of their AWP, respectively.

As previously stated, for innovator multiple source drugs, we set the payment rate at the lower of the payment rate calculated under the standard median cost methodology or 68 percent of the AWP; and for noninnovator multiple source drugs, we set the payment rate at the lower of the payment rate calculated under the standard median cost methodology or 46 percent of the AWP. Using the most recent available data, we determined that the payment rates based on median cost for these drugs were lower than both 68 percent and 46 percent of their AWPs; therefore, the payment rates for both the innovator and noninnovator forms of these products were based on their median costs.

Comment: One commenter, the maker of one of the viscosupplement drugs, was concerned that the proposed payment rates for the four competitive products are inequitable and will harm beneficiary access to these therapies. The commenter indicated that currently two of the products, Hyalgan and Supartz, are billed using HCPCS code J7317 (Sodium Hyaluronate, per 20 to 25 mg dose for intra-articular injection), and this HCPCS code has been classified as a multi-source drug. The commenter assumed that another product, Orthovisc, would also be billed under HCPCS code J7317. However, the fourth product, Synvisc, is classified as a sole source drug and billed under HCPCS code J7320 (Hylan G–F20, 16 mg, for intra-articular injection). The commenter strongly believed that classifying these products differently resulted in payment rates that will create significant payment inequities and unjustified market distortions. To correct the payment inequity across the class of viscosupplements, the commenter recommended that CMS create separate HCPCS codes for these products and treat each product as a sole source drug. Another commenter strongly recommended that Orthovisc, a new product, be recognized as a pass-through under the OPPS, and be assigned a separate C-code for payments under that system.

Response: We recognize the commenter's concern about payment for these viscosupplement drugs under the OPPS. The National HCPCS Panel coordinates decisions regarding the creation of permanent HCPCS codes; therefore, comments related to the HCPCS creation process and decisions made by the National HCPCS Panel are outside the scope of this rule. However, we note that the product Orthovisc received approval for pass-through status under the OPPS effective January 1, 2005, and a new temporary C-code has been established to allow hospitals to receive pass-through payments for this product.

Comment: A commenter requested that CMS show three separate tables for the nonpass-through drugs; that is, one for sole source drugs, one for innovator multiple source drugs, and one for noninnovator multiple source drugs.

Response: We have accepted the commenter's suggestion and created three distinct tables listing the sole source drugs, innovator multiple sources drugs, and noninnovator multiple source drugs.

Tables 27 and 28 below list the final payment amounts for innovator and noninnovator multiple source drugs, biologicals, and radiopharmaceuticals, respectively, effective January 1, 2005 to December 31, 2005.

BILLING CODE 4120–01–P

Table 27. – CY 2005 APC Payment Rates for Multiple Source Innovator Drugs, Biologicals, and Radiopharmaceuticals

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
C1775	K	1775	FDG, per dose (4-40 mCi/ml)	$221.11
C9400	K	9400	Thallous chloride, brand	$21.19
C9401	K	9401	Strontium-89 chloride, brand	$406.16
C9402	K	9402	Th I131 so iodide cap, brand	$6.57
C9403	K	9403	Dx I131 so iodide cap, brand	$6.57
C9404	K	9404	Dx I131 so iodide sol, brand	$9.73
C9405	K	9405	Th I131 so iodide sol, brand	$9.73
C9410	K	9410	Dexrazoxane HCl inj, brand	$123.93
C9411	K	9411	Pamidronate disodium, brand	$160.65
C9413	K	9413	Sodium hyaluronate inj, brand	$53.94
C9414	K	9414	Etoposide oral, brand	$25.71
C9415	K	9415	Doxorubic hcl chemo, brand	$6.94
C9417	K	9417	Bleomycin sulfate inj, brand	$130.56
C9418	K	9418	Cisplatin inj, brand	$11.42
C9419	K	9419	Inj cladribine, brand	$36.72
C9420	K	9420	Cyclophosphamide inj, brand	$4.10
C9421	K	9421	Cyclophosphamide lyo, brand	$3.50
C9422	K	9422	Cytarabine hcl inj, brand	$2.28
C9423	K	9423	Dacarbazine inj, brand	$8.15
C9424	K	9424	Daunorubicin, brand	$53.14
C9425	K	9425	Etoposide inj, brand	$1.22
C9426	K	9426	Floxuridine inj, brand	$97.92
C9427	K	9427	Ifosfomide inj, brand	$90.80
C9428	K	9428	Mesna injection, brand	$23.79
C9429	K	9429	Idarubicin hcl inj, brand	$66.58
C9430	K	9430	Leuprolide acetate inj, brand	$21.41
C9431	K	9431	Paclitaxel inj, brand	$93.50
C9432	K	9432	Mitomycin inj, brand	$45.70
C9433	K	9433	Thiotepa inj, brand	$66.98
C9435	K	9435	Gonadorelin hydroch, brand	$17.08
C9436	K	9436	Azathioprine parenteral,brnd	$44.61
C9437	K	9437	Carmus bischl nitro inj	$79.42
C9438	K	9438	Cyclosporine oral, brand	$1.78
C9439	K	9439	Diethylstilbestrol injection	$10.32

Table 28. – CY 2005 Payment Amounts for Noninnovator Multiple Source Drugs, Biologicals, and Radiopharmaceuticals

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
A9505	K	1603	Thallous chloride TL 201/mci	$18.29
A9517	K	1064	Th I131 so iodide cap millic	$6.57
A9528	K	1064	Dx I131 so iodide cap millic	$6.57
A9529	K	1065	Dx I131 so iodide sol millic	$9.73
A9530	K	1065	Th I131 so iodide sol millic	$9.73
A9600	K	0701	Strontium-89 chloride	$406.16
J1190	K	0726	Dexrazoxane HCl injection	$113.28
J1620	K	7005	Gonadorelin hydroch/ 100 mcg	$17.08
J2430	K	0730	Pamidronate disodium /30 MG	$128.74
J7317	K	7316	Sodium hyaluronate injection	$53.94
J7501	K	0887	Azathioprine parenteral	$30.18
J7502	K	0888	Cyclosporine oral 100 mg	$1.78
J8560	K	0802	Etoposide oral 50 MG	$21.91
J9000	K	0847	Doxorubic hcl 10 MG vl chemo	$4.69
J9040	K	0857	Bleomycin sulfate injection	$88.32
J9050	K	0812	Carmus bischl nitro inj	$65.94
J9060	K	0813	Cisplatin 10 MG injection	$7.73
J9065	K	0858	Inj cladribine per 1 MG	$24.84
J9070	K	0815	Cyclophosphamide 100 MG inj	$2.77
J9093	K	0816	Cyclophosphamide lyophilized	$2.36
J9100	K	0817	Cytarabine hcl 100 MG inj	$1.55
J9130	K	0819	Dacarbazine 100 mg inj	$6.14
J9150	K	0820	Daunorubicin	$35.94
J9165	K	0822	Diethylstilbestrol injection	$6.98
J9181	K	0824	Etoposide 10 MG inj	$0.83
J9200	K	0827	Floxuridine injection	$66.24
J9208	K	0831	Ifosfomide injection	$72.81
J9209	K	0732	Mesna injection	$17.66
J9211	K	0832	Idarubicin hcl injection	$66.58
J9218	K	0861	Leuprolide acetate injeciton	$14.48
J9265	K	0863	Paclitaxel injection	$79.04
J9280	K	0862	Mitomycin 5 MG inj	$30.91
J9340	K	0851	Thiotepa injection	$45.31

BILLING CODE 4120–01–C

b. Treatment of Three Sunsetting Pass-Through Drugs as Specified Covered Outpatient Drugs

As we discussed in the August 16, 2004 proposed rule, there are 13 drugs and biologicals whose pass-through status will expire on December 31, 2004. Table 29 below lists these drugs and biologicals.

Pass-through payment was made for 10 of these 13 items as of December 31, 2002. Therefore, these 10 items now qualify as specified covered outpatient drugs under section 1833(t)(14) of the Act, as added by section 621(a) of Pub. L. 108–173, as described above. However, pass-through status for three of the pass-through drugs and biologicals that will expire on December 31, 2004 (C9121, Injection, Argatroban; J9395, Fulvestrant; and J3315, Triptorelin pamoate), was first made effective on January 1, 2003. These items are specifically excluded from the definition of ''specified covered outpatient drugs'' in section 1833(t)(14)(B)(ii) of the Act, because they are not drugs or biologicals for which pass-through payment was first made on or before December 31, 2002. Pub. L. 108–173 does not address how

to set payment for items whose pass-through status expires in CY 2004, but for which pass-through payment was not made as of December 31, 2002.

Therefore, we proposed to pay for the three expiring pass-through items for which payment was first made on January 1, 2003, rather than on or before December 31, 2002 using the methodology described under section 1833(t)(14) of the Act for specified covered outpatient drugs. We believed that this methodology would allow us to determine appropriate payment amounts for these products in a manner that is consistent with how we pay for drugs and biologicals whose pass-through status was effective as of December 31, 2002, and that does not penalize those products for receiving pass-through status beginning on or after January 1, 2003 and expiring December 31, 2004. In Table 27 in the proposed rule, we listed the CY 2005 OPPS payment rates that we proposed for these three drugs and biologicals.

Of the 13 products for which we proposed that pass-through status expire on December 31, 2004, we proposed to package two of them (C9113, Inj. Pantoprazole sodium and J1335, Ertapenum sodium) because their median cost per day falls below the $50 packaging threshold. We proposed to pay for the remaining 11 drugs and biologicals as sole source items according to the payment methodology for sole source products described above.

We note that darbepoetin alfa (Q0137) will be considered a ''specified covered outpatient drug'' in CY 2005. Payment for these drugs is governed under section 1833(t)(14) of the Act. Specifically, we proposed that darbepoetin alfa would be paid as a sole source drug at a rate between 83 percent and 95 percent of its reference AWP. Accordingly, we specifically solicited comments on whether we should again apply an equitable adjustment, made pursurant to section 1833(t)(2)(E) of the Act, to the price for this drug.

Comment: Numerous commenters applauded CMS for proposing a fair and consistent payment methodology for drugs and biologicals whose pass-through status expires on December 31, 2004, and supported the proposal to treat these three therapies as specified covered outpatient drugs. They also encouraged CMS to expand this treatment to all separately paid drugs and biologicals in the future. A few commenters, including MedPAC, disagreed with our proposal to pay for the three expiring pass-through items for which payment was first made on January 1, 2003, as ''specified covered outpatient drugs.'' One commenter indicated that because these three drugs were excluded from the statutory definition of ''specified covered outpatient drug,'' it did not believe that CMS had the authority to treat newer drugs expiring out of pass-through status as specified covered outpatient drugs. Therefore, the commenter believed that CMS should pay for newer drugs expiring from pass-through status at 106 percent ASP, the rate applicable to the physician setting. MedPAC expressed concern about treating these 3 expiring pass-through drugs differently from the older, historically packaged drugs that are now eligible for separate payment and whose payments will be based on the median cost from the claims data. MedPAC indicated that the purpose of the pass-through payments is to allow time to accumulate data on costs and that there seemed to be no reason to believe that claims data are more accurate for one category of drugs that the other. Therefore, the drugs coming off pass-through, which do not fall under the SCOD category, and the older drugs should be paid consistently.

Response: We appreciate the commenters' support for our proposal to treat the three items for which pass-through status expires on December 31, 2004, but that were approved for pass-through status effective January 1, 2003, similar to the other drugs and biologicals whose pass-through status expires December 31, 2004, but that were approved for pass-through status on or before December 31, 2002. The statute does not address payment for drugs and biologicals that had pass-through status effective on January 1, 2003, but not on or before December 31, 2002. These items are newer drugs than the older products that never received pass-through status. We have accumulated cost data for these three drugs throughout the same 2-year period during which we accumulated cost data for the other drugs and biologicals whose pass-through status expires on December 31, 2004. Therefore, noting that the statute does not address drugs whose pass-through status likewise expires on December 31, 2004, but was approved on January 1, 2003, we believe it is reasonable to pay for these three drugs in a manner consistent with how we pay for the other drugs whose pass-through status likewise sunsets on December 31, 2004.

Comment: We received a number of comments concerning our proposal to pay for both epoetin alfa (marketed under trade name of Procrit) and darbepoetin alfa (marketed under the trade name of Aranesp®) based on 83 percent of their individual reference AWPs. A number of commenters also wrote in response to our solicitation for comments concerning the application of our equitable adjustment authority in determining the payment rate for darbepoetin alfa. Commenters acknowledged that both biologicals meet the MMA definition of specified covered outpatient drug (SCOD) and that the pass-through status of darbepoetin alfa ends on January 1, 2005. One of the commenters supported the proposal to establish payment for darbepoetin alfa as a SCOD, to base CY 2005 payment on its reference AWP, and to discontinue the application of an equitable adjustment to reduce the statutorily mandated payment for any product paid under the OPPS in CY 2005. This commenter stated the proposed payment for darbepoetin alfa as a sole source SCOD is fully consistent with section 621 of the MMA and that this is consistent with the method of payment for all other sole source SCODs. The commenter further stated that when drafting the language for section 622 of the MMA, Congress intended to ensure that considerations of functional equivalence were not applied to darbepoetin alfa after its pass-through status expired. This commenter acknowledges that section 1833(t)(2)(E) of the Act permits CMS to make ''adjustments as determined to be necessary to ensure equitable payments.'' However, this commenter stated that payments for the two products are already inherently equitable at the proposed rates because they are comparably priced and because CMS proposed to set the payment rates for the two products using the same methodology. The commenter noted that when CMS first applied the equitable adjustment for darbepoetin alfa, in CY 2003, CMS had only three choices for establishing drug payments under the OPPS: (1) Packing payment with related services; (2) using charges from outpatient claims to derive median cost; and (3) paying separately under the pass-through provisions, at 95 percent of AWP. The commenter notes the new payment methodology for all sole source ''specified covered outpatient drugs'' and argues that by applying this methodology to both of these biologicals, CMS would establish a level playing field and assure that market-based forces remain operable. This commenter also provided data concerning the clinical efficacy of darbepoetin alfa.

Many of the other commenters stated that CMS' application of its equitable adjustment authority deviated from the MMA's intent to pay for sole source

products and multi-source products under separate payment methodologies. The commenters were concerned about the significant impact that application of such authority may have on a company's decision to continue developing innovator products. The commenters also argued that applying such a policy could inject CMS into clinical decisions based solely on economic considerations and create payment incentives that distort patient decisions properly entrusted to treating physicians. One commenter recommended that if CMS plans to utilize this authority again, then CMS should hold a public forum and provide interested parties with an opportunity to submit written comments about the standards that will be used to determine equitable adjustment. Other commenters argued that CMS should comply with the MMA and protect patient access to innovative therapies by not applying functional equivalence or a similar standard to any drug in 2005 or future years.

One commenter on this topic also provided detailed results of clinical studies that the commenter believes support the necessity of a continuation of the equitable payment adjustment. This commenter further stated that the clinical data support the use of a particular conversion ratio in making such an adjustment. The commenter noted that without an equitable adjustment policy, both drugs would be paid at 83 percent of each product's AWP. The commenter estimated weekly payments for the two drugs under four scenarios: an equitable adjustment based on three different conversion ratios and the proposed policy of treating each drug independently without application of an equitable adjustment. According to this commenter, overall Medicare expenditures and beneficiary coinsurance payments would increase for the treatment of chemotherapy-induced anemia in the absence of an equitable payment adjustment. The commenter's estimates assume a 50 percent market share for each of the two drugs and estimated 2005 spending based on 2003 OPPS claims data with anemia market unit growth assumptions of 35 percent in 2004 and 22 percent in 2005. The commenter also noted that the MMA did not remove the Secretary's authority to establish adjustments to ensure equitable payments and that the Secretary retains the authority to determine the CY 2005 payment rate for darbepoetin alfa using the equitable payment policy applied in CY 2003 and CY 2004. This commenter also argued that the MMA prohibition on the use of a functional equivalence standard applies only to pass-through drugs and only to future implementation.

A comment from MedPAC on this issue indicated that as costs to the Medicare program continue to grow, the program will need to examine tools for obtaining value in its purchasing. MedPAC believed that, absent evidence that the CMS' use of its equitable adjustment to set equivalent payment rates for Procrit and Aranesp® denied beneficiaries' access to needed treatments, CMS should pursue value-based purchasing where possible.

Response: As the commenters noted, while we proposed a payment rate for darbepoetin alfa as a sole source SCOD based on its reference AWP, we also specifically solicited comments on whether we should again apply an equitable adjustment, made pursuant to section 1833(t)(2)(E) of the Act, to establish the payment for this drug in CY 2005. After careful consideration of the thoughtful and well-documented comments concerning this issue, we have concluded that it is still appropriate to apply an adjustment to the payment for darbepoetin alfa under our authority in section 1833(t)(2)(E) of the Act to ensure that equitable payments for these two products under the OPPS continue in CY 2005. We agree with those commenters that argued that section 1833(t)(2)(E) of the Act was not affected by the provisions of the MMA and that we retain our authority to make such adjustments to payments under the OPPS. As we have done previously, we will reassess the need to exercise our adjustment authority when we next review the payment rates under the OPPS.

To apply an equitable adjustment for CY 2005, we reviewed the analysis we conducted during 2003 and the additional data we received in 2004. As we discussed in further detail in our November 7, 2003 final rule with comment period for the 2004 update to the OPPS (68 FR 63455) and our November 1, 2002 final rule with comment period for the 2003 update (67 FR 66758), because darbepoetin alfa has two additional carbohydrate side-chains, it is not structurally identical to epoetin alfa. 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 different dosing schedule for darbepoetin alfa by comparison to epoetin alfa. Amgen has FDA approval to market darbepoetin alfa under the trade name ® 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. Epoetin alfa, which is marketed by Ortho Biotech under the trade name Procrit, is approved by FDA for marketing for the following conditions: (1) Treatment of anemia of chronic renal failure (including for 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.

The two 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 differences in the accepted convention at the time of each product's development. At the time epoetin alfa was developed, biologicals (such as those like epoetin alfa that are produced by recombinant DNA technology) were typically dosed in International Units (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 drug dosed by weight.

The process that we used in 2003 to define the payment conversion ratio between the two biologicals for CY 2004 is described in the November 7, 2003 final rule with comment period. We refer readers to that discussion, found at 68 FR 63455, for more complete details on that process and the data received and reviewed by CMS during the process. At the conclusion of the 2003 process, we established a conversion ratio of 330 Units of epoetin alfa to 1 microgram of darbepoetin alfa (330:1) for establishing the CY 2004 payment rate for darbepoetin alfa.

During the comment period, each company presented additional data concerning their products. Based upon our analysis to date, we continue to believe that the conversion ratio used for CY 2004 is appropriate for purposes of establishing equitable payment under the OPPS for both epoetin alfa and darbepoetin alfa for CY 2005. Initial review of new information submitted by the commenters provides no compelling

evidence that the conversion ratio of 330:1 is unreasonable. Therefore, for this final rule with comment period, we have established payment for darbepoetin alfa by applying the conversion ratio of 330:1 to 83 percent of the AWP for epoetin alfa. The resulting payment rate for darbepoetin alfa is $3.66 per microgram. We will continue to assess the data we have received thus far and invite the submission of additional information. In order to fully evaluate and assess this issue in determining whether any further adjustment of the conversion ratio is necessary, additional analysis will be required. If, after additional review and analysis, we determine that a different conversion ratio is more appropriate, we will make a change in the payment rate for darbepoetin alfa to reflect the change in ratio as soon as possible.

We do not believe that our application of an equitable adjustment will create a barrier to treatment for the conditions for which these products are prescribed or to the product of choice of the beneficiary and his or her treating physician. According to the most recent average sales price (ASP) information collected by CMS and available in time for this final rule with comment period, 106 percent of ASP for darbepoetin alfa is $3.69 per microgram. This amount would have been the basis for payment under the OPPS on January 1, 2005 if pass-through status did not expire and if we did not apply an equitable adjustment. Furthermore, as we have emphasized in prior rulemaking on this topic, our conversion of amounts of a biologic dosed in Units to amounts of a drug dosed by weight strictly for the purpose of calculating a payment rate should not in any way be viewed as a statement regarding the clinical use of either product. The method we use to convert Units to micrograms in order to establish equitable payments is not intended to serve as a guide for dosing individual patients in clinical practice. By using a conversion ratio solely for the purpose of establishing equitable payments, CMS is not attempting to establish a lower or upper limit on the amount of either biological that a physician should prescribe to a patient. We expect that physicians will continue to prescribe these biologicals based on their own clinical judgment of the needs of individual patients.

Table 29 below lists the final CY 2005 OPPS payment rates for the three sunsetting pass-through drugs and biologicals that will be treated as specified covered outpatient drugs.

Table 29. -- CY 2005 APC Payment Rates for Three Expiring Pass-Through Drugs and Biologicals That Will Be Treated As Specified Covered Outpatient Drugs

HCPCS Code	Status Indicator	Short Description	APC	CY 2005 Payment Rate
J9395	K	Injection, Fulvestrant	9120	$79.65
J3315	K	Triptorelin pamoate	9122	$362.78
C9121	K	Injection, argatroban	9121	$12.45

c. CY 2005 Payment for Nonpass-through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without the OPPS Hospital Claims Data

Pub. L. 108–173 does not address the OPPS payment in CY 2005 for new drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictates payment for such drugs and biologicals in CY 2005, and because we have no hospital claims data to use in establishing a payment rate for them, we investigated other possible options to pay for these items in CY 2005. Clearly, one option is to continue packaging payment for these new drugs and biologicals that have their own HCPCS codes until we accumulate sufficient claims data to calculate median costs for these items. Another option is to pay for them separately using a data source other than our claims data. The first option is consistent with the approach we have taken in prior years when claims data for new services and items have not been available to calculate median costs. However, because these new drugs and biologicals may be expensive, we are concerned that packaging these new drugs and biologicals may jeopardize beneficiary access to them. In addition, we do not want to delay separate payment for a new drug or biological solely because a pass-through application was not submitted.

Therefore, for CY 2005, we proposed to pay for these new drugs and biologicals with HCPCS codes but which do not have pass-through status at a rate that is equivalent to the payment they would receive in the physician office setting, which would be established in accordance with the methodology described in the CY 2005 Medicare Physician Fee Schedule proposed rule (69 FR 47488, 47520 through 47524). We noted that this payment methodology is the same as the methodology that will be used to calculate the OPPS payment amount that pass-through drugs and biologicals will be paid in CY 2005 in accordance with section 1842(o) of the Act, as amended by section 303(b) of Pub. L. 108–173, and section 1847A of the Act. Thus, we proposed to treat new drugs and biologicals with established HCPCS codes the same, irrespective of whether pass-through status has been determined. We also proposed to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application.

In light of our August 16, 2004 proposal, we understood that manufacturers might be hesitant to apply for pass-through status. However, we did not believe there would be many instances in CY 2005 when we would not receive a pass-through application for a new drug or biological that has an HCPCS code. To avoid delays in setting an appropriate payment amount for new drugs and biologicals and to expedite the processing of claims, we strongly encouraged manufacturers to continue submitting pass-through applications for new drugs and biologicals when FDA

approval for a new drug or biological is imminent to give us advance notice to begin working to create an HCPCS code and APC. The preliminary application would have to be augmented by FDA approval documents and final package inserts once such materials become available. However, initiating the pass-through application process as early as possible would enable us to expedite coding and pricing for the new drugs and biologicals and accelerate the process for including them in the next available OPPS quarterly release.

In the August 16, 2004 proposed rule, we discussed how we proposed to pay in CY 2005 for new drugs and biologicals between their FDA approval date and assignment of an HCPCS code and APC. We shared the desire of providers and manufacturers to incorporate payment for new drugs and biologicals into the OPPS as expeditiously as possible to eliminate potential barriers to beneficiary access and to minimize the number of claims that must be processed manually under the OPPS interim process for claims without established HCPCS codes and APCs, and we solicited public comments on our proposal.

Comment: Several commenters commended CMS's proposal to set payment rates for new drugs with HCPCS codes using the same methodology proposed to set payment for drugs with pass-through status, regardless of whether a pass-through application has been submitted for the new drug. They applauded CMS for acknowledging that packaging payment for these new therapies might jeopardize beneficiary access to them. However, a comment from MedPAC indicated that CMS's proposal to pay 106 percent of ASP for this particular group of drugs and biologicals represented a change in policy where drugs of this nature were previously packaged until sufficient claims data were accumulated to calculate payment rates, unless they received pass-through status via an application process. MedPAC was concerned that the newly approved drugs and biologicals that do not go through the pass-through payment mechanism will be added to the OPPS system without any control on spending since this policy does not have a budget neutrality provision, similar to pass-through payments. Given that the pass-through policy existed as a controlled mechanism for introducing new drugs into the OPPS, these drugs should either be treated through the pass-through process or continue to be packaged under the previous policy.

Response: We appreciate the commenters' support for our proposal to pay for new drugs with HCPCS codes, but without pass-through status and hospital claims data under the same methodology that will be used to pay for them in the physician office setting. We also understand MedPAC's concern about budget neutrality associated with this policy. Our intent in paying for new drugs and biologicals with HCPCS codes, but without pass-through status and hospital claims data, separately, was that we recognized that some of these new products would be important new therapies in treatment of such diseases as cancer. We also believe that the MMA provision that requires CMS to pay for new drugs and biologicals before a code is assigned indicates that Congress intended for us to pay separately for new items until we have hospital claims data that would allow us to determine whether the product should be packaged. We are concerned that packaging their payments may prevent hospitals from acquiring these products and in turn harm beneficiaries' access to them. We do not expect the volume of new drugs and biologicals to which we would apply this policy in CY 2005 to be so significant as to have an effect on budget neutrality. Moreover, we would not expect this policy to have a differential impact on budget neutrality any more than payment for the drugs would affect pass-through spending had the drugs been approved for pass-through status. We also believe (and strongly encourage) that stakeholders will continue to apply for pass-through status for new drugs, biologicals and radiopharmaceuticals as a means of ensuring that we have all of the information required to establish accurate payments for these items as quickly as possible. At the same time, if we were to package all such items, we are concerned that it would provide a disincentive for manufacturers to come forward and request codes for new items. Under the MMA provision described above, we are required to pay for new drugs and biologicals without HCPCS code at 95 percent of AWP, which we would expect to generally be higher than 106 percent of ASP. We also believe the MMA provision regarding drugs without HCPCS codes indicates that Congress clearly intended that we pay separately for new drugs and biologicals. Therefore, for CY 2005 we will finalize the policy that we proposed to pay separately for new drugs and biologicals with HCPCS codes but without pass-through status and hospital claims data based on the payment for the same new products in a physician office.

We will, however, monitor this carefully during the course of CY 2005 and reassess the policy for CY 2006. In CY 2005, payment for these new drugs and biologicals will be based on 106 percent of ASP. In the absence of ASP data, we will use wholesale acquisition cost (WAC) for the product to establish the initial payment rate. If WAC is also unavailable, then we will calculate payment at 95 percent of the May 1, 2003 AWP or the first reported AWP for the product. We have used the second quarter ASP data from CY 2004 because those were the most recent numbers available to us in time for the publication for this rule. To be consistent with the ASP-based payments that will be made when these drugs and biologicals are furnished in the physician offices, we plan to make any appropriate adjustments to the amounts shown in Addendum A and B if later quarter ASP submissions indicate that adjustments to the payment rates are necessary. We will announce such changes in our program instructions to implement quarterly releases and post any revisions to the addenda on the *www.cms.hhs.gov* Web site. We will similarly adjust payment for items for which we used AWP or WAC because ASP was not available if ASP becomes available from later quarter submissions.

For CY 2005, we will apply this policy to three drugs and biologicals that are new effective January 1, 2005 and do not have pass-through status and hospital claims data. These drugs will be separately payable under the OPPS, and thus, we have assigned them to status indicator ''K''. Table 30 below lists these drugs and biologicals and the payment methodologies used to calculate their APC payments listed in Addendum A and B of this rule.

Table 30. -- New CY 2005 HCPCS Codes for Drugs and Biologicals without Pass-Through Status and Hospital Claims Data

HCPCS Code	APC	Short Descriptor	CY 2005 Payment Methodology
J0135	1083	Injection, Adalimumab, 20 mg	95% AWP
J1457	1085	Injection, Gallium nitrate, 1 mg	WAC
J7674	0867	Methacholine Chloride, neb	95% AWP

We have also identified several drugs and biologicals with new HCPCS codes created effective January 1, 2004, that do not meet the definition of ''specified covered outpatient drugs'' and for which we would not have CY 2003 hospital claims data. These items are packaged in CY 2004, and we also proposed to package them for CY 2005 in the proposed rule. To avoid negatively impacting beneficiary access to these new products by packaging them, we will be paying for these drugs in CY 2005 under the same methodology that will be used to pay for them in the physician office setting. The rules for determining payment for these drugs will be the same as the rules for new drugs with HCPCS codes but without pass-through status in CY 2005. In CY 2005, these drugs will be separately payable under the OPPS, and thus, we have assigned status indicator ''K'' to these drugs. Table 31 below lists these drugs and biologicals and the payment methodologies used to calculate their APC payments listed in Addendum A and B of this rule.

We note that CPT 90715 (Tdap vaccine > 7 im) was newly created in 2004; however, we will not apply this payment policy to this code because all of the vaccines similar to this product are packaged in CY 2004 and will remain packaged in CY 2005. This payment policy also will not apply to new radiopharmaceuticals since all radiopharmaceuticals meet the definition of ''specified covered outpatient drugs''. Therefore, payment for new radiopharmaceuticals will be made according to the payment methodologies established for ''specified covered outpatient drugs'' under section 1833(t)(14)(A)(ii) of the Act.

Table 31. - New 2004 HCPCS Codes for Drugs and Biologicals without Pass-Through Status and Hospital Claims Data

HCPCS	APC	Description	CY 2005 Payment Methodology
J0595	0703	Butorphanol tartrate 1 mg	106 % ASP
J2185	0729	Meropenem	106% ASP
J2280	1046	Inj, moxifloxacin 100 mg	WAC
J3411	1049	Thiamine hcl 100 mg	WAC
J3415	1050	Pyridoxine hcl 100 mg	WAC
J3465	1052	Injection, voriconazole	106% ASP
Q4075	1062	Acyclovir, 5 mg	106% ASP
Q4076	1070	Dopamine hcl, 40 mg	106% ASP
Q4077	1082	Treprostinil, 1 mg	106% ASP

Comment: One commenter noted that CMS historically had declined to process pass-through applications prior to FDA approval, consequently many manufacturers have ceased submitting early applications. The commenter stated that manufacturers may be uncomfortable submitting the detailed information required for the pass-through application prior to securing FDA approval. The commenter suggested that a more realistic expectation of the timeframe for pass-through application would be at or subsequent to FDA approval, when the product launch is imminent.

Response: We recognize that some manufacturers may be concerned about submitting detailed information for pass-through application in advance of FDA's approval for their product. However, we reiterate that we strongly encourage manufacturers to continue submitting pass-through applications when FDA approval for a new drug or biological is imminent to give us advance notice to begin working to create a HCPCS code and an APC for their product. While we will not be able to give final approval to the pass-through application prior to FDA approval, early notification about the product prior to FDA approval can expedite the granting of a new product-specific code and implementation of

that code and appropriate payment rate within our system.

d. Payment for Separately Payable NonPass-Through Drugs and Biologicals

As discussed in section V.B.2. of the August 16, 2004 proposed rule, for CY 2005, we used CY 2003 claims data to calculate the proposed median cost per day for drugs, biologicals, and radiopharmaceuticals that have an assigned HCPCS code and are paid either as a packaged or separately payable item under the OPPS. Section 1833(t)(14) of the Act, as added by section 621(a) of Pub. L. 108–173, specified payment methodologies for most of these drugs, biologicals, and radiopharmaceuticals. However, this provision did not specify how payment was to be made for separately payable drugs and biologicals that never received pass-through status and that are not otherwise addressed in section 1833(t)(14) of the Act. Some of the items for which such payment is not specified are (1) those that have been paid separately since implementation of the OPPS on August 1, 2000, but are not eligible for pass-through status, and (2) those that have historically been packaged with the procedure with which they are billed but, based on the CY 2003 claims data, their median cost per day is above the legislated $50 packaging threshold. Because Pub. L. 108–173 does not address how we are to pay for such drugs and biologicals (any drug or biological that falls into one or the other category and that has a per day cost greater than $50), we proposed to set payment based on median costs derived from the CY 2003 claims data. Because these products are generally older or low-cost items, or both, we believe that the payments will allow us to provide adequate payment to hospitals for furnishing these items. In the proposed rule, we listed in Table 28 the drugs and biologicals to which the proposed payment policy would apply.

We received numerous public comments on our proposal.

Comment: A commenter expressed concern about the proposed payment rate for HCPCS code J7342 (Dermal tissue, of human origin, with or without other bio-engineered or processed elements, with metabolically active elements, per square centimeter) when billed by Maryland-based hospitals and comprehensive outpatient rehabilitation facilities (CORFs).

Response: We understand the commenter's concern; however, Maryland-based hospitals and CORFs are excluded from payment under the OPPS and the OPPS payment rates do not apply to them. This final rule with comment period addresses only the providers that are paid under the OPPS. Therefore, this comment is outside the scope of this rule.

Comment: An association for manufacturers of contrast agents supported CMS' proposal to pay separately for certain MRI contrast agents (for example, HCPCS codes A4643 and A4647). However, the commenter was concerned that the payment rates for these products were based on CY 2003 hospital claims data and that the overall accuracy of the hospital median cost data is questionable; therefore, the commenter recommended that CMS review the proposed payment rates for MRI contrast agents and requested that such review include a confirmation that the median cost data used as the basis for calculating the payment rates are correct. The commenter also indicated that the proposed rule did not have unit descriptors for the HCPCS codes A4643 and A4647 and requested that CMS add the unit descriptor, ''up to 20 ml'' to HCPCS codes A4643 and A4647 in order to provide further clarity and facilitate more accurate coding and billing by hospitals.

Response: We understand the commenter's concern about setting appropriate payment rates for these products. These products do not meet the definition of ''specified covered outpatient drugs'' as defined in the MMA; however, we do have a significant number of CY 2003 hospital claims data for these products. It is our general policy under the OPPS to use the most recent available hospital claims data in setting the OPPS payment rates. For CY 2005, both of these products will be separately payable items. The payment rate for A4643 will be based on approximately 14,200 claims for approximately 27,000 services, and payment for A4647 will be based on approximately 87,600 claims for approximately 155,000 services.

We believe that the CY 2003 claims data contain a sufficiently robust set of claims for both products on which to base the payment rates for these items using the methodology that will be used for other separately payable non-pass-through drugs and biologicals. With respect to adding unit descriptors to A4643 and A4647, we suggest that the commenter pursue these changes through the process set up by the National HCPCS Panel.

Comment: A commenter expressed concern that CMS may have inappropriately packaged low osmolar contrast material (LOCM) drugs into APCs based on a determination that the drugs do not meet CMS's packaging rule because they are below the $50 threshold required for separate payment. The commenter questioned the accuracy of the median cost data used as the basis for CMS's decision as CMS' paid claims files for LOCM do not include unit descriptors for the HCPCS codes A4644, A4645, and A4646. The commenter is concerned that this makes it difficult to interpret the data in any meaningful way for purposes of determining what the payment rates for these drugs should be and whether they should be paid separately, in particular, because the dose administered per procedure can range from 10 ml to 200 ml. The commenter also believed that CMS should pay for LOCM drugs separately in the hospital outpatient setting because they are paid as such in the physician office setting. Therefore, the commenter recommended that CMS exercise its discretion to apply an exception to the packaging rule to LOCM as it did with the anti-emetics and allow separate payment for LOCM drugs in CY 2005. The commenter also suggested that CMS assign the unit descriptor ''per 10 ml'' to HCPCS codes A4644, A4645, and A4646.

Response: We recognize that the commenter is concerned about the packaging of the three LOCM products. Based on the methodology used to calculate median cost per day for drugs and biologicals, as explained in section V.B.2. of the preamble, we determined that the per day costs of these products were below $50. Therefore, these items were packaged. We note that the LOCM products are a unique class of drugs that have always been packaged from the beginning of the OPPS in August 1, 2000, and this is the first year that we looked into the cost data for these drugs to determine whether they should be paid separately. We realize that for CY 2005 these drugs will be packaged under the OPPS, but will receive separate payment in the physician office setting. However, based upon the statutory packaging threshold for drugs and biologicals as per administration cost less than $50, we believe that it is appropriate for us to package the LOCM drugs under the OPPS. With respect to adding unit descriptors to HCPCS code A4644, A4645, and A4646, we suggest that the commenter pursue these changes through the process set up by the National HCPCS Panel.

Comment: We received comments concerning the new Part D prescription drug benefit mandated by the MMA and the intersection between drugs covered by Part D and Part B.

Response: Because such issues are not within the scope of this CY 2005 OPPS

final rule with comment period, we will not respond to those comments in this document.

Comment: We received many comments from makers of drug and biological products, national trade associations, and an association for cancer centers suggesting that CMS should expand the future rate-setting methodology for ''specified covered outpatient drugs'' to include all drugs and biologicals that either are or were previously paid separately under the OPPS, regardless of whether the drugs meet or exceed the $50 threshold. The commenters also recommended that CMS also work with GAO and MedPAC to ensure that their respective studies of the acquisition costs and pharmacy service and overhead costs include all of these drugs and biologicals and that the studies are thorough and will contain all the information CMS needs to set proper payment rates in the future. Many of these commenters were concerned about CMS' use of claims, other data, and the methodologies used to establish the OPPS payments for drugs and biologicals that do not meet the definition of ''specified covered outpatient drugs'' and therefore, are not statutorily required to be included in these studies. The commenters suggested that CMS should not implement different methodologies for ''specified covered outpatient drugs'' and other separately paid drugs in CY 2006; instead, CMS should ensure appropriate payment for all Medicare covered drugs by applying the acquisition cost-based payment methodology to all separately paid drugs. One commenter believed that Congress fully intended for all separately paid drugs and biologicals to be paid based on hospital acquisition costs, as informed by these studies. Another commenter recommended that CMS continue to accept external cost data that may be submitted by knowledgeable stakeholders, such as manufacturers, providers, or patients to provide verification of hospital acquisition costs for specific drugs and biologicals. One commenter indicated that it would like to work with CMS as it prepares the hospital acquisition cost survey for the CY 2006 rates.

Response: We appreciate the interest expressed by many of the commenters regarding the MMA-mandated surveys that will be conducted by the GAO and MedPAC of hospital acquisition cost for drugs and biologicals and their overhead and related costs, respectively. However, we note that these provisions of the MMA affect payment for drugs and biologicals in CY 2006, and thus, these comments fall outside the scope of this rule. Therefore, we will not be responding to these comments at this time.

Comment: A commenter requested that CMS examine every HCPCS J-code for drugs to ensure that the dosage definitions for the HCPCS codes are set at the lowest available manufacturers' dosage and match the customary dispensing packaging.

Response: Changes to the HCPCS J-codes are made by the National HCPCS Panel; therefore, this comment is outside the scope of this OPPS final rule. We suggest that the commenter pursue these changes through the process established by the National HCPCS Panel.

BILLING CODE 4120–01–P

Table 32. – CY 2005 APC Payment Rates for Drugs, Biologicals, and Radiopharmaceuticals (Based on Median Cost)

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
A4643	K	9026	High dose contrast MRI	$26.24
A4647	K	9027	Supp- paramagnetic contr mat	$35.59
J0120	K	9028	Tetracyclin injection	$99.99
J0150	K	0379	Injection adenosine 6 MG	$12.33
J0152	K	0917	Adenosine injection	$8.71
J0282	K	9029	Amiodarone HCl	$11.00
J0285	K	9030	Amphotericin B	$20.64
J0395	K	9031	Arbutamine HCl injection	$68.08
J0475	K	9032	Baclofen 10 MG injection	$10.68
J0740	K	9033	Cidofovir injection	$407.58
J0743	K	0846	Cilastatin sodium injection	$11.37
J0900	K	0848	Testosterone enanthate inj	$38.27
J0945	K	9034	Brompheniramine maleate inj	$59.01
J1051	K	9035	Medroxyprogesterone inj	$17.56
J1212	K	9036	Dimethyl sulfoxide 50% 50 ML	$53.34
J1230	K	9037	Methadone injection	$13.32
J1245	K	0380	Dipyridamole injection	$11.70
J1410	K	9038	Inj estrogen conjugate 25 MG	$45.51
J1452	K	9040	Intraocular Fomivirsen na	$939.79
J1455	K	0866	Foscarnet sodium injection	$11.80
J1460	K	9041	Gamma globulin 1 CC inj	$31.63
J1610	K	9042	Glucagon hydrochloride/1 MG	$46.16
J1742	K	9044	Ibutilide fumarate injection	$123.79
J1750	K	9045	Iron dextran	$14.78
J1756	K	9046	Iron sucrose injection	$0.53
J1835	K	9047	Itraconazole injection	$42.10
J2260	K	7007	Inj milrinone lactate / 5 MG	$8.22
J2597	K	9048	Inj desmopressin acetate	$4.52
J2725	K	9049	Inj protirelin per 250 mcg	$40.81
J2760	K	0845	Phentolaine mesylate inj	$20.82
J2916	K	9050	Na ferric gluconate complex	$6.03
J2995	K	0911	Inj streptokinase /250000 IU	$43.41
J2997	K	7048	Alteplase recombinant	$18.04
J3350	K	9051	Urea injection	$69.74
J3365	K	7036	Urokinase 250,000 IU inj	$124.64
J3530	K	9053	Nasal vaccine inhalation	$92.41
J7342	K	9054	Metabolically active tissue	$7.15
J7350	K	9055	Injectable human tissue	$8.05
P9041	K	0961	Albumin (human),5%, 50ml	$18.82
P9045	K	0963	Albumin (human), 5%, 250 ml	$60.54
P9046	K	0964	Albumin (human), 25%, 20 ml	$13.01
P9047	K	0965	Albumin (human), 25%, 50ml	$52.32

BILLING CODE 4120–01–C

e. CY 2005 Change in Payment Status for HCPCS Code J7308

Since implementation of the OPPS on August 1, 2000, HCPCS code J7308 (Aminolevulinic acid HCI for topical administration, 20 percent single unit dosage form) has been treated as a packaged item and denoted as such using status indicator ''N''. Thus, historically we have not allowed separate payment for this drug under the OPPS and it does not meet the statutory definition of a specified covered outpatient drug. For CY 2005, we proposed to allow separate payment for this drug at 106 percent of ASP, which is equivalent to the payment rate that it would receive under the Medicare Physician Fee Schedule. We proposed a CY 2005 ASP and payment under the OPPS for HCPCS code J7308 of $88.86. We solicited comments on our proposed payment methodology for HCPCS code J7308 for CY 2005.

We did not receive any comments on our proposed policy. However, we did receive a comment on this policy in response to the January 6, 2004 interim final rule with comment period, which we discuss below.

Comment: One commenter requested that HCPCS code J7308 be paid separately under the OPPS because its cost is in excess of the $50 median cost per day threshold, and the drug is also paid separately under the Medicare Physician Fee Schedule in CY 2004.

Response: We agree with the commenter and will finalize our policy to pay separately for J7308 at the payment rate that it would receive under the Medicare Physician Fee Schedule. The payment rate listed in Addenda A and B of the August 16, 2005 proposed rule was based on the second quarter ASP submission for CY 2004. As stated in section V.A. 3. of this final rule with comment period, we plan to make any appropriate adjustments to the amount shown in Addenda A and B if later quarter ASP submissions indicate that adjustments to the payment rate for this drug is necessary.

4. Public Comments Received on the January 6, 2004 Interim Final Rule With Comment Period and Departmental Responses

As discussed in section V.B.3. of this final rule with comment period, on January 6, 2004, we published in the **Federal Register** an interim final rule with comment period (69 FR 822) that implemented section 621(a)(1) of Pub. L. 108–173. Section 621(a)(1) specified payment limits on three categories of specific covered outpatient drugs and defined these three categories of drugs.

We received many pieces of correspondence that contained public comments associated with the January 6, 2004 interim final rule with comment period. Many of the comments expressed concerns about the following issues: treating radiopharmaceuticals as ''drugs;'' establishing mechanisms to pay for drugs without HCPCS codes at 95 percent of AWP; correcting the classification of specific items to sole source ''specified covered outpatient drugs;'' eliminating the use of ''equitable adjustments'' to the OPPS payment for drugs and biologicals or applying any functional equivalence standards; paying separately for drugs that are either packaged or whose payment is based on median cost as ''specified covered outpatient drugs''; expanding the list of items that will be studied in the MMA-mandated GAO and MedPAC surveys of certain OPD services; using the cost-to-charge methodology and the hospital outpatient claims data to set payment rates for certain drugs and biologicals; identifying and establishing appropriate payment rates for innovator and noninnovator multiple source drugs; and changing HCPCS code descriptors for radiopharmaceuticals to reflect the products as administered to patients.

We will not address these comments separately in this section because these issues are discussed in detail throughout this entire section (section V.) of this final rule with comment period. However, for those public comments that are not specifically addressed in section V., a summary of them and our responses to those comments follow:

Comment: A commenter suggested that CMS create separate HCPCS codes for Neoral, Sandimmune, and the other cyclosporine products. The commenter indicated that currently all of these products are being billed using HCPCS code J7502 (Cyclosporine, oral, 100 mg). The commenter stated that the payment rates for the brand name products should not be linked to the payment rates for the non-innovator products because this situation creates access issues to the branded products, and CMS should not limit patient access to the specific formulation deemed medically appropriate for the individual needs of the specific patients.

Response: We note that for both CYs 2004 and 2005, hospitals can use HCPCS code C9438 to bill for the brand name forms of oral cyclosporine. As stated V.A.3.a. of this final rule with comment period, the MMA set forth different payment ceilings for the brand and generic versions of a drug where the CY 2005 payment rate for innovator multiple source (brand name) drugs may not exceed 68 percent of the reference AWP and the payment for generic versions may not exceed 46 percent of the reference AWP. We explained previously that we apply those ceilings only where the payment for an item based on the median hospital cost for the drug exceeds one of these ceilings. In some cases, the payment based on the median hospital cost falls below the 46 percent ceiling for generic drugs. In such cases, the payment rate would be the same for brand and generic versions. We believe that basing payment for these items on relative hospital costs, with the application as appropriate of the previously mentioned ceilings not only meets the intent but also the requirements of the MMA.

Comment: A commenter recommended that CMS consider pricing information from several authoritative sources when determining the reference AWP, including Red Book and First Data Bank, on a case-by-case basis since such pricing information can be used to resolve outstanding payment issues and ensure greater accuracy in calculating the OPPS payment rates.

Response: We appreciate this comment and will consider this recommendation when we reassess the OPPS payment rates.

Comment: Several commenters noted that CMS changed the classification for many of the biologicals products to sole source ''specified covered outpatient drugs'' in the February 27, 2004 CMS Transmittal 113 without discussing why the changes were made. One of the commenters indicated that the definition for sole source ''specified covered outpatient drugs'' in the MMA is different from the Medicaid rebate definition. The commenter stated that the MMA defined sole source drugs as: (1) A biological product (as defined under section 1861(t)(1) of the Act); or (2) a single source drug (as defined in section 1927(k)(7)(A)(iv) of the Act). The commenters requested that CMS clarify that it intends to treat all biological products as sole source drugs in the future as the law requires.

Response: We agree with the commenters that biologicals products are defined as sole source ''specified covered drugs'' in the MMA, and we will determine payment rates for these products accordingly.

Comment: We received several comments on the mechanism for establishing payment rates for innovator and noninnovator multiple source drugs. One commenter urged CMS to set the payment rates closer to the actual

costs for all products and services and provide differential reimbursement for innovator multiple source products only if their actual acquisition costs were markedly higher than that for the noninnovator multiple source products. Another commenter indicated that innovator and noninnovator multiple source drugs were discounted very similarly, and therefore, differential payments were not necessary. A commenter also requested that CMS obtain legislative approval to price these innovator and noninnovator multiple source drugs using a blended payment rate set halfway between 46 percent and 68 percent of their reference AWPs.

Response: We appreciate these suggestions and note that the methodology that will be used to determine payment rates for innovator and noninnovator multiple source drugs in CY 2005 is described in detail in section V.A.3.a. of this final rule with comment period.

C. Coding and Billing for Specified Outpatient Drugs

As discussed in the January 6, 2004 interim final rule with comment period (69 FR 826), hospitals were instructed to bill for sole source drugs using the existing HCPCS code, which were priced in accordance with the provisions of newly added section 1833(t)(14)(A)(i) of the Act, as added by Pub. L. 108–173. However, at that time, the existing HCPCS codes did not allow us to differentiate payment amounts for innovator multiple source and noninnovator multiple source forms of the drug. Therefore, effective April 1, 2004, we implemented new HCPCS codes via Program Transmittal 112 (Change Request 3144, February 27, 2004) and Program Transmittal 132 (Change Request 3154, March 30, 2004) that providers were instructed to use to bill for innovator multiple source drugs in order to receive appropriate payment in accordance with section 1833(t)(14)(A)(i)(II) of the Act. Providers were also instructed to continue to use the current HCPCS codes to bill for noninnovator multiple source drugs to receive payment in accordance with section 1833(t)(14)(A)(i)(III). In this manner, drugs, biologicals, and radiopharmaceuticals will be appropriately coded to reflect their classification and be paid accordingly. In the August 16, 2004 proposed rule, we proposed to continue this coding practice in CY 2005 with payment made in accordance with section 1833(t)(14)(A)(ii) of the Act.

We received a few public comments on our proposal.

Comment: Several commenters urged that CMS delete certain newly created C codes (C9400,Thallous Chloride, brand; C9401 Strontium–89 chloride, brand; C9402 Th I131 so iodide cap, brand; C9403 Dx I131 so iodide cap, brand; C9404 Dx So iodide sol, brand; C9405 Th I131 so iodide, sol. brand) because radiopharmaceuticals are better characterized as either sole source or innovator multiple source drugs. The commenters indicated that the creation of the new codes implied that some radiopharmaceuticals are generic products and others are brand, but there was no identification of which product falls within which code. Further, there was no payment difference between some of the radiopharmaceutical brand products versus generics. The commenters believed these products did not fit the conventional brand versus generic distinctions, and should all be recognized as brand drugs until the GAO report provides additional data. Also, the commenters recommended that the current A-codes be retained at the payment levels CMS proposes for ''brand'' drugs and believed that deletion of these codes should result in payment for the corresponding radiopharmaceuticals based on their status as a sole source or innovator multi-source drug and would significantly lessen hospital administrative burden and confusion. Another commenter indicated that hospitals needed further clarification on which manufacturers' products can be billed under the HCPCS codes created for the brand and generic forms of a product.

Response: As stated in section V.A.3.a. of this final rule with comment period, section 621(a) of Pub. L. 108–173 sets forth different payment ceilings for the brand and generic versions of a drug where the CY 2005 payment rate for innovator multiple source (brand name) drugs may not exceed 68 percent of the reference AWP and the payment for generic versions may not exceed 46 percent of the reference AWP. We explained previously that we apply those ceilings only where the payment for an item based on the median hospital cost for the drug exceeds one of these ceilings. In some cases, the payment based on the median hospital cost falls below the 46 percent ceiling for generic drugs. In such cases, as the commenters indicate, the payment rate would be the same for brand and generic versions.

We will not be providing a list of brand name and generic products for hospitals to use in determining whether their product is a brand name or generic product. We believe that hospitals are in the best position to correctly determine which type of products they are using. We refer the commenter to the definitions of innovator and noninnovator multiple source drugs stated in the January 6, 2004 interim final rule with comment period (69 FR 822). Hospitals can also use the FDA's Orange Book in determining whether an item they use is a brand name product.

D. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned

1. Background

Historically, hospitals have used a code for an unlisted or unclassified drug, biological, or radiopharmaceutical or used an appropriate revenue code to bill for drugs, biologicals, and radiopharmaceuticals furnished in the outpatient department that do not have an assigned HCPCS code. The codes for not otherwise classified drugs, biologicals, and radiopharmaceuticals are assigned packaged status under the OPPS. That is, separate payment is not made for the code, but charges for the code would be eligible for an outlier payment and, in future updates, the charges for the code are packaged with the separately payable service with which the code is reported for the same date of service.

Drugs and biologicals that are newly approved by the FDA and for which an HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup could qualify for pass-through payment under the OPPS. An application must be submitted to CMS in order for a drug or biological to be assigned pass-through status, along with a temporary C-code for billing purposes, and an APC payment amount. Pass-through applications are reviewed on a flow basis, and payment for drugs and biologicals approved for pass-through status is implemented throughout the year as part of the quarterly updates of the OPPS.

In the November 7, 2003 final rule with comment period (68 FR 63440), we explained how CMS generally pays under the OPPS for new drugs and biologicals that are assigned HCPCS codes, but that are not approved for pass-through payment, and for which CMS had no data upon which to base a payment rate. These codes do not receive separate payment, but are assigned packaged status. Hospitals were urged to report charges for the new codes even though separate payment is not provided. Charges reported for the new codes are used to determine hospital costs and payment rates in future updates. For CY 2004, we again

noted that drugs that were assigned an HCPCS code effective January 1, 2004, and that were assigned packaged status, remain packaged unless pass-through status is approved for the drug. If pass-through status is approved for these drugs, pass-through payments are implemented prospectively in the next available quarterly release.

2. Provisions of Pub. L. 108–173

Section 621(a)(1) of Pub. L. 108–173 amended section 1833(t) of the Act by adding paragraph (15) to provide for payment for new drugs and biologicals until HCPCS codes are assigned under the OPPS. Under this provision, we are required to make payment for an outpatient drug or biological that is furnished as part of covered OPD services for which a HCPCS code has not been assigned in an amount equal to 95 percent of AWP. This provision applies only to payments under the OPPS, effective January 1, 2004. However, we did not implement this provision in the January 6, 2004 interim final rule with comment period because we had not determined at that time how hospitals would be able to bill Medicare and receive payment for a drug or biological that did not have an identifying HCPCS code.

As stated earlier, at its February 2004 meeting, the APC Panel heard presentations suggesting how to make payment for a drug or biological that did not have a code. The APC Panel recommended that we work swiftly to implement a methodology to enable hospitals to file claims and receive payment for drugs that are newly approved by the FDA. The APC Panel further recommended that we consider using temporary or placeholder codes that could be quickly assigned following FDA approval of a drug or biological to facilitate timely payment for new drugs and biologicals.

We explored a number of options to make operational the provisions of section 1833(t)(15) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, as soon as possible. One of the approaches that we considered was to establish a set of placeholder codes in the Outpatient Code Editor (OCE) and the PPS pricing software for the hospital OPPS (PRICER) that we would instruct hospitals to use when a new drug was approved. Hospitals would be able to submit claims using the new code but would receive no payment until the next quarterly update. By that time, we would have installed an actual payment amount and descriptor for the code into the PRICER, and would mass-adjust claims submitted between the date of FDA approval and the date of installation of the quarterly release. A second option that we considered was to implement an APC, a C-code, and a payment amount as part of the first quarterly update following notice of FDA approval of a drug or biological. Hospitals would hold claims for the new drug or biological until the quarterly release was implemented and then submit all claims for the drug or biological for payment using the new C-code to receive payment on a retroactive basis. We also considered instructing hospitals to bill for a new drug or biological using a ''not otherwise classified'' code for which they would receive an interim payment based on charges converted to cost. Final payment would then be reconciled at cost report settlement. While each of these approaches might enable hospitals to begin billing for a newly approved drug or biological as soon as it received FDA approval, each approach had significant operational disadvantages, such as increased burden on hospitals or payment delays, or the risk of significant overpayments or underpayments that could not be resolved until cost report settlement.

We adopted an interim approach that we believe balances the need for hospitals to receive timely and accurate payment as soon as a drug or biological is approved by the FDA with minimal disruption of the OPPS claims processing modules that support the payment of claims. On May 28, 2004 (Transmittal 188, Change Request 3287), we instructed hospitals to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, Unclassified drug or biological. When C9399 appears on a claim, the OCE suspends the claim for manual pricing by the fiscal intermediary. The fiscal intermediary prices the claim at 95 percent of its AWP using Red Book or an equivalent recognized compendium, and processes the claim for payment. This approach enables hospitals to bill and receive payment for a new drug or biological concurrent with its approval by the FDA. The hospital does not have to wait for the next quarterly release or for approval of a product-specific HCPCS to receive payment for a newly approved drug or biological or to resubmit claims for adjustment. Hospitals would discontinue billing C9399 and the NDC upon implementation of an HCPCS code, status indicator, and appropriate payment amount with the next quarterly update.

In the August 16, 2004 proposed rule, we proposed to formalize this methodology for CY 2005 and to expand it to include payment for new radiopharmaceuticals to which a HCPCS code is not assigned (see section V.G. of this preamble). We solicited comments on the methodology and expressed particular interest in the reaction of hospitals to using this approach to bill and receive timely payment under the OPPS for drugs, biologicals, and radiopharmaceuticals that are newly approved by the FDA, prior to assignment of a product-specific HCPCS code.

We received a number of public comments on our proposal.

Comment: One commenter, a state hospital association, is concerned about the ability of hospitals to correctly code for newly approved drugs and biologicals without HCPCS codes using the NDC codes. The commenter indicates that typically only pharmacy systems within hospitals can properly handle the assignment and reporting of a drug's NDC, not the hospital billing systems. Additionally, the use of the Remarks field to report the NDC creates payment delays as it requires manual review and pricing by the fiscal intermediaries. Several commenters, including a national hospital association and several state hospital associations, recommended that CMS adopt a new revenue code subcategory for hospitals to use when reporting these newly FDA-approved drugs and biologicals on UB–92 paper claims. The hospital could use the new revenue code along with the reported NDC in the revenue-code description field. Establishing a new revenue code field, to be used with the description field, allows clearinghouses to scan the paper UB–92 and then convert the data into the appropriate HIPAA standard for auto adjudication. The FI would then no longer have to suspend these paper claims for manual pricing, because it would build logic into the system to auto-adjudicate these claims. The hospital would then continue to report C9399 (HCPCS code indicating Unclassified drug or biological) in the HCPCS field, the units in the Unit field, the date the drug was administered in the date field, and finally, the price of these drugs in the Total Charges field. These commenters believed that this alternative policy would greatly improve the current process for both hospitals and fiscal intermediaries.

Response: We read the hospital associations' recommendation for an alternative approach to report NDCs on UB–92 paper claims with interest and will explore its feasibility with the different components within CMS that are responsible for claims processing, information technology and systems,

and HIPAA standards. It appears that time-consuming systems changes could be required were we to adopt such an approach, which could delay implementation, but we will consider the proposal carefully.

Comment: A maker of pharmaceuticals commends CMS for implementing the mechanism where hospitals can bill and be paid for new drugs without HCPCS codes. However, the commenter is concerned that the use of a miscellaneous code may result in significant payment delays and potentially prevent patient access to new therapies. The commenter suggests that CMS monitor claims submission, timely processing, and payments more closely so that patient access to new therapies is not impeded. Another commenter suggested that CMS should modify this mechanism if necessary to ensure patients have access to cutting-edge drugs. One commenter suggested that CMS explore with its contractors the feasibility of automating processing of these claims by including the NDC number as a claims processing field when the miscellaneous C code appears on a claim since such a process would eliminate the additional costs of manual claim review and expedite provider payment.

Response: We share the commenters' concerns that claims processing systems not impede beneficiary access to new drug therapies. However, we believe the approach that we implemented in CY 2004 and that we proposed to adopt permanently beginning in CY 2005, which requires the use of HCPCS code C9399 to be reported with an appropriate NDC, will result in hospitals receiving payment for new drugs more quickly compared to the process that we followed previously, even though some manual handling of claims is required. We agree with the commenter who suggested that CMS closely monitor claims submission, timely processing, and payments for new drugs, and we intend to do so.

Comment: One commenter encouraged CMS to reconsider the payment policy that requires the reporting of the NDC for new drugs as ''mandatory'' and consider making the NDC ''optional.'' For providers unable to automate the reporting of the NDC number due to software limitations, it suggested that CMS consider allowing providers the option of listing the NDC number in the detailed drug name as reported on the itemized statement of charges that can be requested along with the UB reporting the C9399 code.

Response: As we have indicated in previous responses to commenters' suggestions regarding ways to implement the payment requirement for new drugs and biologicals that have not been assigned a HCPCS code, we will also consider this commenter's recommendation to determine its feasibility.

Comment: Several commenters urged CMS to reconsider the policy of preloading several new codes into CMS' computer system and assigning them to new drugs and biologicals as the Food and Drug Administration approved them, rather than requiring manual processing of claims using a single miscellaneous code. If CMS determines that the current policy is imposing too great an administrative burden on hospitals and delays in processing claims that harm hospitals' ability to provide new drugs and biologicals to Medicare beneficiaries, the commenters urged CMS to reconsider its proposal and to explore preloading placeholder codes instead.

Response: Preloading placeholder codes was one of the options that we considered before we implemented C9399, but we found that this approach had its disadvantages, most of which stemmed from concerns about delays related to the dissemination of new codes to providers and installing prices into the claims processing modules in a timely manner. We propose to monitor throughout CY 2005 the use of HCPCS code C9399 and NDC codes to evaluate whether this approach is an improvement over how hospitals were previously paid for new drugs to which a HCPCS code had not been assigned and to determine if changes in the process would be beneficial.

Comment: One commenter indicated that requiring hospitals to submit the National Drug Code on claims imposes an enormous administrative burden on hospitals because there is no field for NDCs on the claims form and, therefore, NDCs cannot be entered on the claim automatically. Rather, claims must be flagged and adjusted manually. The commenter suggested that the best solution is to close the lag time between FDA approval and HCPCS assignment of a new drug. By creating a seamless execution of approval and code assignment, CMS can ensure that the MMA mandate is fulfilled in the least burdensome manner and that providers are adequately paid for providing these new drugs.

Response: While the use of NDCs may impose a degree of reporting burden on hospitals, we believe that, in spite of the inconvenience of manual reporting and claims processing, this approach is the most efficient way to expedite payment to hospitals for newly approved drugs to which a HCPCS code has not been assigned.

Comment: One commenter, an association for cancer centers, supported CMS' proposal for reporting new drugs without HCPCS codes using C9399 and any other necessary data. However, the commenter requested clarification from CMS on whether C9399 can only be used for injectible drugs or whether this code can also be used to report all newly approved FDA drugs (including oral drugs). The commenter believed that C9399 can be used for all Medicare-covered drugs, including oral anti-emetics and oral chemotherapeutics with IV equivalents, but requested that CMS clarify this issue to ensure that fiscal intermediaries correctly process this new code.

Response: Our instructions regarding how hospitals may report a new drug using C9399 and NDCs only indicate the method by which hospitals can bill Medicare for payment if the new drug is covered by the Medicare program. These instructions do not represent a determination that the Medicare program covers a new drug for which a hospital submits a bill using C9399. In addition to determining payment, fiscal intermediaries must determine whether a drug billed with C9399 meets all program requirements for coverage. For example, they must assess whether the drug is reasonable and necessary to treat the beneficiary's condition and whether the drug is excluded from payment because it is usually self-administered. The same rules, regulations, and policies that apply to coverage of drugs, biologicals, and radiopharmaceutical agents that already have a HCPCS code also apply to newly approved items for which a HCPCS code has not yet been assigned.

Comment: Two commenters urged CMS to publish the approved drugs and radiopharmaceuticals that may be submitted under HCPCS code C9399, as well as the appropriate units of measure applicable for each drug or biological and the payment amount for the drug based on 95 percent of the AWP. One commenter indicated that hospitals are concerned that they will not identify all of the drugs that are eligible for this payment and are also concerned that they may inappropriately assign the HCPCS code to drugs that are not eligible for this payment. Additionally, there is an administrative burden placed both on providers and the fiscal intermediaries when CMS does not publish the payment rates for these drugs.

Response: We understand that use of C9399 and NDCs is a departure from how hospitals have become accustomed

to preparing Medicare claims for the OPPS services. However, the MMA mandates that hospitals be paid 95 percent of AWP for new drugs until a HCPCS code is assigned to that drug. We believe this MMA provision is intended to ensure that hospitals can receive timely payment for new drugs, biologicals, and radiopharmaceuticals without having to wait for a HCPCS code to be created and disseminated or for an OPPS payment amount to be implemented in a quarterly OPPS update. Generally, CMS learns of FDA approval of a new product at approximately the same time the public learns of the approval. Hospitals may wish to look to their advocacy associations for assistance in monitoring the FDA Web site to identify new products as they are approved, as a supplemental information source. We also intend to explore ways hospitals could systematically receive timely reports of newly approved drugs by means other than checking the FDA Web site. However, how to report a product rests with the hospital, as it does for any drug, biological, radiopharmaceutical agent, procedure, or service, with or without a HCPCS code. Therefore, we are not accepting the commenters' suggestion that we publish the approved drugs and radiopharmaceuticals that may be submitted under HCPCS code C9399, as well as the appropriate units of measure applicable for each drug or biological and the payment amount for the drug based on 95 percent of the AWP. Rather, we prefer to focus our resources on updating the OPPS on a quarterly basis with codes, APC assignments, and payment amounts for drugs, biologicals, and radiopharmaceuticals newly approved by the FDA during the prior quarter.

We have carefully considered commenters' recommendations and concerns, and we believe that our proposed methodology for using C9399 and NDC codes to bill for drugs, biologicals, and radiopharmaceutical agents newly approved by FDA to which a HCPCS code is not assigned is the most efficient and practicable approach at this time to ensure timely, appropriate Medicare payment for these new products. Therefore, we are making final for CY 2005 our proposed methodology, without modification.

E. Payment for Vaccines

Outpatient hospital departments administer large numbers of immunizations 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 the 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 the OPPS rates as a major concern. They indicated 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 with this concern 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, which were paid for these vaccines under the OPPS in CY 2002, have been receiving payment at reasonable cost for these vaccines since CY 2003. We are aware that access concerns continue to exist for these vaccines. However, we continue to believe that payment other than on a reasonable cost basis would exacerbate existing access problems. Therefore, in the August 16, 2004 proposed rule, we proposed to continue paying for influenza and pneumococcal pneumonia vaccines under the reasonable cost methodology in CY 2005.

Comment: Several commenters applauded CMS' proposal to continue to pay for vaccines under the reasonable cost methodology. The commenters indicated that payment on a reasonable cost basis helps ensure that the OPPS rates are adequate to cover hospitals' costs of providing vaccines to Medicare beneficiaries, protecting their health, and reducing Medicare's costs of treating influenza and other preventable illnesses.

Response: We appreciate the commenters' continued support of our policy to pay for influenza and pneumococcal pneumonia vaccines at reasonable cost and finalize our proposal in this final rule with comment period. We note that for CY 2005 a new CPT code for an influenza vaccine was created. The new CPT code 90656 (Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use) will be paid at reasonable cost in CY 2005. We have assigned status indicator ''L'' (Not Paid under OPPS. Paid at reasonable cost) to this new CPT code.

F. Changes in Payment for Single Indication Orphan Drugs

Section 1833(t)(1)(B)(i) of the Act gives the Secretary the authority to designate the hospital outpatient services to be covered. The Secretary has specified coverage for certain drugs as orphan drugs (section 1833(t)(14)(B)(ii)(III) of the Act as added by section 621(a)(1) of Pub. L. 108–173). Section 1833(t)(14)(C) of the Act as added by section 621(a)(1) of Pub. L. 108–173, gives the Secretary the authority in CYs 2004 and 2005 to specify the amount of payment for an orphan drug that has been designated as such by the Secretary.

We recognize that orphan drugs that are used solely for an orphan condition or conditions are generally expensive and, by definition, are rarely used. We believe that if the cost of these drugs were packaged into the payment for an associated procedure or visit, the payment for the procedure might be insufficient to compensate a hospital for the typically high cost of this special type of drug. Therefore, in the August 16, 2004 proposed rule, we proposed to continue making separate payments for orphan drugs based on their currently assigned APCs.

In the November 1, 2002 final rule (67 FR 66772), we identified 11 single indication orphan drugs that are used solely for orphan conditions by applying the following criteria:

- The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan conditions(s).
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

Eleven single indication orphan drugs were identified as having met these criteria and payments for these drugs were made outside of the OPPS on a reasonable basis.

In the November 7, 2003 final rule with comment period (68 FR 63452), we discontinued payment for orphan drugs on a reasonable cost basis and made separate payments for each single indication orphan drug under its own APC. Payments for the orphan drugs were made at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer, unless we were presented with verifiable information that showed that our payment rate did not reflect the price that is widely available to the hospital market. For CY 2004, Ceredase (alglucerase) and Cerezyme (imiglucerase) were paid at 94 percent of AWP because external data

submitted by commenters on the August 12, 2003 proposed rule caused us to believe that payment at 88 percent of AWP would be insufficient to ensure beneficiaries' access to these drugs.

In the December 31, 2003 correction of the November 7, 2003 final rule with comment period (68 FR 75442), we added HCPCS code J9017, arsenic trioxide (per unit) to our list of single indication orphan drugs. As of the time of our August 16, 2004 proposed rule, the following were the 12 orphan drugs that we have identified as meeting our criteria: J0205 Injection, alglucerase, per 10 units; J0256 Injection, alpha 1-proteinase inhibitor, 10 mg; J9300 Gemtuzumab ozogamicin, 5 mg; 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; J9017 Arsenic trioxide, per unit; J9160 Denileukin diftitox, 300 mcg; J9216 Interferon, gamma 1-b, 3 million units and Q2019 Injection, basiliximab, 20 mg. In the August 16, 2004 proposed rule, we did not propose any changes to this list of orphan drugs for CY 2005.

In the proposed rule, we noted that had we not classified these drugs as single indication orphan drugs for payment under the OPPS, they would have met the definition as a single source specified covered outpatient drug and been paid lower payments which could impede beneficiary access to these unique drugs dedicated to the treatment of rare diseases. Instead, for CY 2005, under our authority at section 1833(t)(14)(C) of the Act, we proposed to pay for all 12 single indication orphan drugs, including Ceredase and Cerezyme, at the rate of 88 percent of AWP or 106 percent of the ASP, whichever is higher. However, for drugs where 106 percent of the ASP would exceed 95 percent of AWP, payment would be capped at 95 percent of AWP, which is the upper limit allowed for sole source specific covered outpatient drugs. For example, Ceredase and Cerezyme would each be paid at 95 percent of the AWP because payment at ASP plus 6 percent for these two drugs not only exceeds 88 percent of the AWP but also exceeds 95 percent of the AWP. We proposed to pay the higher of 88 percent of AWP or 106 percent of ASP capped at 95 percent of AWP to ensure that beneficiaries will continue to have access to such important drugs.

We received the following comments to our August 16, 2004 proposed rule on single indication orphan drugs.

Comment: A few commenters recommended that CMS adopt the FDA's definition of an orphan drug as under the Orphan Drug Act. The commenters indicated that CMS should expand the current list of 12 single-indication orphan drugs that receive special treatment to include several other FDA-designated orphan drugs. One commenter requested that CMS adopt a utilization threshold to identify orphan drugs that would receive the special treatment rather than using its current criteria.

Response: Using the statutory authority in 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 single-indication orphan drugs from other drugs designated as orphan drugs by the FDA under the Orphan Drug Act. Our determination to provide special payment for these drugs neither affects nor deviates from FDA's classification of any drugs as orphan drugs. The special treatment given to this subset of FDA-designated orphan drugs is intended to ensure that beneficiaries have continued access to these life-saving therapies given that these drugs have a relatively low volume of patient use, lack any other non-orphan indication and are typically very costly. Although we are not expanding our criteria to identify orphan drugs that will receive special payment for CY 2005, we will consider the commenters' recommendation of a utilization threshold in future changes to the OPPS orphan drug list.

Comment: We received comments from different drug manufacturers separately requesting that Campath (J9010, Alemtuzumab), Elitek (J2783, Rasburicase), Vidaza (C9218, Azacitidine for injectable suspension), and Botox (J0585, Botulinum toxin type A) be included in the list of single-indication orphan drugs that will receive special payment for CY 2005.

Response: After careful review of the requests for these four drugs to be included in the list of single-indication orphan drugs, we have determined that Campath (J9010) and Vidaza (C9218) do meet our criteria for inclusion in the list. Thus, effective for January 1, 2005, J9010 and C9218 will be paid in accordance with the payment policy for single indication orphan drugs for CY 2005. However, we have determined that Elitek (J2783) and Botox (J0585) do not meet the criteria for inclusion in the list because these drugs have an off-label use as indicated by the 2004 United States Pharmacopoeia Drug Information (USPDI).

Comment: Several commenters, including manufacturers of alpha-1 proteinase inhibitor (J0256) sold under the brand names Prolastin, Aralast and Zemaira, submitted comments expressing concern over the decrease in the payment rate for HCPCS J0256 from the CY 2004 level to the CY 2005 proposed rate. The majority of commenters requested that the payment rate for J0256 be frozen at the CY 2004 levels, rather than based on the AWP of Prolastin, the least expensive drug among the three name brands. As some commenters explained, Prolastin has experienced supply shortages in the past and if the payment rate for the alpha-1 therapy did not take into account the higher AWPs of Aralast or Zemaira, it would be inadequate to cover the actual acquisition costs of the drugs to hospitals.

The manufacturer of Aralast requested that CMS exclude pricing information associated with Prolastin when setting the payment rate for J0256. The commenter stated that although Prolastin is currently available and used in greater quantities than either Aralast or Zemaira , it has experienced supply shortages in the past. Therefore, according to the commenter, the payment rate for J0256 needs to be such that patients will have continued access to all three brand names. Alternatively, the commenter recommended that new HCPCS codes could be created so each brand name could be paid appropriately or CMS could freeze the payment rate for J0256 at the CY 2004 levels, as the majority of commenters recommended.

The manufacturer of Zemaira expressed concern that the proposed payment rate does not meet the actual hospital acquisition cost for this brand name, which is the newest of the three brand names to come on the market to be used in alpha-1 therapy.

We received a comment from an organization representing voluntary health organizations and individual patients that stated that the proposed payments for CY 2005 were adequate to avoid problems with access to the orphan drugs that patients with rare diseases need. In addition, the commenter requested that CMS take actions to monitor any changes in beneficiaries' access to orphan drugs as a result of payment changes, to review the claims database for changes in utilization patterns, to seek input from beneficiaries about access problems, and to inform beneficiaries about payment changes and the potential impact of such changes on their access.

We also received recommendations from a patient advocacy organization requesting that CMS work with the manufacturers of the alpha-1 therapy to obtain the data necessary to raise the proposed OPPS rate of $2.46 (per 10 mg) or to establish the ASP rate which may

enhance patient access to care. The commenter also recommended that CMS base the payment rate for J0256 on all available brands.

Response: After careful evaluation of the issues and concerns raised by commenters in response to our proposed rule, we recognize that our proposed payment rate for HCPCS code J0256 may create an unanticipated access problem during periods of short supply. Therefore, in order to ensure continued beneficiaries' access to this important drug, we will base the payment rate for HCPCS code J0256 on all three brands of the alpha-1 proteinase inhibitor currently available on the market. The adjusted AWP of HCPCS code J0256 will be based on the volume-weighted average of the three drugs. The adjusted AWP will be updated each quarter, as necessary, to reflect any changes in the individual AWP or relative weight of each drug in the calculation of the AWP for HCPCS code J0256. We would expect that as the volume and/or individual AWP increases or decreases for a brand, these changes will be captured in its relative weight and will be reflected in the adjusted AWP for HCPCS code J0256.

We share the commenters' concern for protecting beneficiaries' access to these therapies used for rare disease conditions. As part of our process of developing special payment rates for single indication orphan drugs in CY 2005, our analysis of CY 2003 claims data does not indicate a decrease in utilization of any orphan drugs that may signify barriers to beneficiaries' access to these drugs.

Comment: Several commenters recommended that CMS eliminate the 95 percent AWP cap on single-indication orphan drugs whose ASP plus 6 percent would exceed their 88 percent AWP. According to the commenters, these drugs would not be subject to the 95 percent AWP cap when administered in the physician's office. They argued that CMS should pay for these drugs at the same rate, irrespective of the site of service.

We received a request from the drug manufacturer of Ontak to increase the payment rate for the drug from 88 percent of the May 2004 AWP to 92 percent of the current AWP. Alternatively, the commenter requested that CMS remove the 95 percent AWP cap for J9160 (Ontak).

Response: We believe that access to these life-saving therapies is extremely important and after careful consideration, we will not implement the cap of 95 percent of AWP for any of the single-indication orphan drug for those drugs whose 106 percent ASP exceeds 88 percent of AWP. Effective for CY 2005, payment for all single-indication orphan drugs will be set at the higher of 106 percent of the most current ASP or 88 percent of the most current AWP.

Comment: A few commenters recommended that CMS update the payment rates quarterly, based on the latest ASP and AWP data available. They argue that to lock in the rates for a year based on outdated information could impede patient access to these drugs.

Response: We agree with the commenters and will base payments for single-indication orphan drugs on a quarterly comparison of ASP and AWP data. Appropriate adjustments to the payment amounts shown in Addendum A and B will be made if ASP submissions and AWP data in a later quarter indicate that adjustments to the payment rates are necessary. These changes to the Addenda will be announced in our program instructions released on a quarterly basis and posted on our Web site at *http://www.cms.hhs.gov.*

Comment: We also received a comment from the manufacturer of Fabrazyme requesting that CMS consider making payment for Fabrazyme (C9208, agalsidase beta) as a single-indication orphan drug. The commenter believes that by statute, CMS is required to pay for the drug at 106 percent of ASP; however, the commenter stated that if CMS were to somehow reach a different conclusion, it would request to be treated as a single-indication orphan drug.

Response: We agree with the commenter that the statute requires that payment for Fabrazyme (C9208), a drug that currently has pass-through status, be made at 106 percent of ASP for CY 2005.

In summary, we have set payment rates for single-indication orphan drugs according to the following policy, effective January 1, 2005:

- 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; and,
- We are setting payment under the CY 2005 OPPS for single indication orphan drugs at the higher of 88 percent of the AWP or the ASP plus 6 percent, updated quarterly to reflect the most current AWP and ASP data.

While we are not implementing the 95 percent AWP cap on single-indication orphan drugs in CY 2005, we will monitor this decision and may apply the cap in future OPPS updates.

G. Change in Payment Policy for Radiopharmaceuticals

In the November 1, 2002 OPPS final rule (67 FR 66757), we determined that we would classify any product containing a therapeutic radioisotope to be in the category of benefits described under section 1861(s)(4) of the Act. We also determined that the appropriate benefit category for diagnostic radiopharmaceuticals is section 1861(s)(3) of the Act. We stated in the November 1, 2002 final rule that we will consider neither diagnostic nor therapeutic radiopharmaceuticals to be drugs as defined in 1861(t) of the Act (67 FR 66757). Therefore, beginning with the CY 2003 OPPS update, and continuing with the CY 2004 OPPS update, we have not qualified diagnostic or therapeutic radiopharmaceuticals as drugs or biologicals.

As we stated in the August 16, 2004 proposed rule, when we analyzed the many changes mandated by Pub. L. 108–173 that affect how we would pay for drugs, biologicals, and radiopharmaceuticals under the OPPS in CY 2005, we revisited the decision that we implemented in CY 2003 not to classify diagnostic and therapeutic radiopharmaceuticals as drugs or biologicals. In our analysis, we noted that although we did not consider radiopharmaceuticals for pass-through payment in CYs 2003 and 2004, we did apply to radiopharmaceuticals the same packaging threshold policy that we applied to other drugs and biologicals, and which we proposed to continue in CY 2005. In addition, for the CY 2004 OPPS update, we applied the same adjustments to median costs for radiopharmaceuticals that we applied to separately payable drugs and biologicals that did not have pass-through status (68 FR 63441).

In our review of this policy, we noted that section 1833(t)(14)(B)(i) of the Act, as amended by section 621(a) of Pub. L. 108–173, does include ''radiopharmaceutical'' within the meaning of the term ''specified covered outpatient drugs,'' although neither section 621(a)(2) nor section 621(a)(3) of Pub. L. 108–173 includes a reference to radiopharmaceuticals.

In an effort to provide a consistent reading and application of the statute, we proposed to apply to radiopharmaceuticals certain provisions in section 621 of Pub. L. 108–173 which affect payment for drugs and biologicals billed by hospitals for payment under the OPPS. We believed it was reasonable to include radiopharmaceuticals in the general category of drugs in light of their

inclusion as specified covered outpatient drugs in section 1833(t)(14)(B) of the Act, as added by section 621(a)(1) of Pub. L. 108–173.

Section 621(a)(1) of Pub. L. 108–173, which amends section 1833(t) of the Act by adding a new subparagraph (14) affecting payment for radiopharmaceuticals under the OPPS, is unambiguous. This provision clearly requires that separately paid radiopharmaceuticals be classified as ''specified covered outpatient drugs.'' Therefore, in CY 2005, we proposed to continue to set payment for radiopharmaceuticals in accordance with these requirements, which are discussed in detail in section V.B.3. of this preamble.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, requires us to reduce the threshold for the establishment of separate APCs with respect to drugs and biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006. We proposed to apply the $50 packaging threshold methodology discussed in section V.B.2. of this final rule with comment period to radiopharmaceuticals as well as to drugs and biologicals.

Section 1833(t)(15) of the Act, added by section 621(a)(1) of Pub. L. 108–173, requires us to make payment equal to 95 percent of the AWP for an outpatient drug or biological that is covered and furnished as part of covered OPD services for which a HCPCS code has not been assigned. We proposed, beginning in CY 2005, to extend to radiopharmaceuticals the same payment methodology discussed in section V.D. of this preamble for new drugs and biologicals before HCPCS codes are assigned. That is, we proposed to pay for newly approved radiopharmaceuticals, as well as newly approved drugs and biologicals, at 95 percent of AWP prior to assignment of a HCPCS code.

Section 1833(t)(5)(E) of the Act, as added by section 621(a)(3) of Pub. L. 108–173, excludes separate drug and biological APCs from outlier payments. Beginning in CY 2005, we proposed to apply section 621(a)(3) of Pub. L. 108–173 to APCs for radiopharmaceuticals. That is, beginning in CY 2005, radiopharmaceuticals would be excluded from receiving outlier payments.

Consistent with our proposed policy to apply to radiopharmaceutical agents payment policies that apply to drugs and biologicals, we further proposed, beginning in CY 2005, to accept applications for pass-through status for certain radiopharmaceuticals. That is, we proposed on a prospective basis to consider for pass-through status those radiopharmaceuticals to which a HCPCS code is first assigned on or after January 1, 2005. As we explain in section V.A.3. of this final rule with comment period, section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs and biologicals as the amount determined under section 1842(o) of the Act. In the August 16, 2004 proposed rule, we proposed to pay for drugs and biologicals with pass-through status in CY 2005 consistent with the provisions of section 1842(o) of the Act as amended by Pub. L. 108–173, at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting and set in accordance with the methodology described in the Medicare Physician Fee Schedule Proposed Rule for CY 2005 (69 FR 47488, 47520 through 47524).

We issued an interim final rule with comment period entitled ''Medicare Program: Manufacturer Submission of Manufacturer's Average Sales Price (ASP) Data for Medicare Part B Drugs and Biologicals'' in the April 6, 2004 **Federal Register**, related to the calculation and submission of manufacturer's ASP data (69 FR 17935). We need these data in order to determine payment for drugs and biologicals furnished in a physician office setting in accordance with the methodology described in the Medicare Physician Fee Schedule Proposed Rule (69 FR 47488, 47520 through 47524). However, the April 6, 2004 interim final rule with comment period excludes radiopharmaceuticals from the data reporting requirements that apply to Medicare Part B covered drugs and biologicals paid under sections 1842(o)(1)(D), 1847A, or 1881(b)(13)(A)(ii) of the Act (69 FR 17935). As a consequence, we would not have the same type of data available to determine payment for a new radiopharmaceutical approved for pass-through status after January 1, 2005 that would be available to determine payment for a new drug or biological with pass-through status in CY 2005.

Therefore, in order to set payment for a new radiopharmaceutical approved for pass-through status in accordance with 1842(o) of the Act and in a manner that is consistent with how we proposed to set payment for a pass-through drug or biological, we proposed a methodology that would apply solely to new radiopharmaceuticals for which payment would be made under the OPPS and for which an application for pass-through status is submitted after January 1, 2005. That is, in order to receive pass-through payment for a new radiopharmaceutical under the OPPS, a manufacturer would be required to submit data and certification for the radiopharmaceutical in accordance with the requirements that apply to drugs and biologicals under section 303 of Pub. L. 108–173 as set forth in the interim final rule with comment period issued in the April 6, 2004 **Federal Register** (66 FR 17935) and described on the CMS Web site at *http://cms.hhs.gov.* We proposed that payment would be determined in accordance with the methodology applicable to drugs and biologicals that is discussed in the CY 2005 Medicare Physician Fee Schedule proposed rule (69 FR 47488, 47520–47524). In the event the manufacturer seeking pass-through status for a radiopharmaceutical does not submit data in accordance with the requirements specified for new drugs and biologicals, we proposed to set payment for the new radiopharmaceutical as a specified covered outpatient drug, under section 1833(t)(14)(A) as added by section 621(a)(1) of Pub. L. 108–173.

We received many public comments on our proposals.

Comment: Many commenters applauded CMS for proposing to treat radiopharmaceuticals as drugs and encouraged CMS to continue to pay for these products as ''specified covered outpatient drugs'' under the OPPS, consistent with section 621(a) of the MMA. They indicated that this policy ensures consistent treatment of drugs and radiopharmaceuticals, eliminates confusion related to the prior differences in their treatment under the OPPS, and facilitates patient access to these important therapies in clinically appropriate settings. One of the commenters also supported the proposal to exclude radiopharmaceuticals from receiving outlier payments in CY 2005.

Response: We appreciate the commenters' support of our policy to treat radiopharmaceuticals as drugs and will finalize this policy for CY 2005.

Comment: Several commenters opposed our proposal to require manufacturers to submit ASP data for radiopharmaceutical agents with pass-through status. One manufacturer of radiopharmaceuticals stated that there are significant practical problems and legal barriers to reporting ASP for radiopharmaceuticals. The commenter indicated that manufacturers often sell the components of a radiopharmaceutical to independent radiopharmacies. These radiopharmacies then sell unit doses to many hospitals; however, some hospitals also purchase the components

of the radiopharmaceutical and prepare the radiopharmaceutical through in-house radiopharmacies. This commenter asserted that the end result is that there is very often no ASP for the finished radiopharmaceutical product. For example, there may only be manufacturer pricing for the components; however, the price set by the manufacturer for one component of a radiopharmaceutical does not directly translate into the acquisition cost of the ''complete'' radiopharmaceutical, which may result from the combination of several components. This commenter recommended that CMS be consistent and not require ASP in the OPPS, as CMS does not require ASP for radiopharmaceuticals in the Medicare Physician Fee Schedule. The commenter thus urged CMS to determine payment for pass-through radiopharmaceuticals as specified covered outpatient drugs, based on AWP or acquisition costs. Another commenter recommended that CMS set payment for all pass-through radiopharmaceuticals in CY 2005 using the AWP-based ''specified covered outpatient drugs'' payment methodology, regardless of whether ASP data are available for the drug and stated that this methodology is more appropriate for these products, because it will be more likely to ensure adequate payment as use of the product is adopted, and thus will provide for robust cost data for future rate-setting purposes.

Response: We appreciate these comments and understand the concerns commenters stated regarding our proposal to require manufacturers of radiopharmaceutical agents with pass-through status to submit ASP data. We recognize the complexities of determining ASP for radiopharmaceuticals because of their unique preparation processes; therefore, we agree with the commenters' concerns about finalizing the proposed policy. Because radiopharmaceuticals are not paid on ASP in the physician office setting, manufacturers of these agents will not be required to report ASPs for payment purposes under the OPPS. Therefore, payment for radiopharmaceuticals with pass-through status will be made in accordance with their status as sole source ''specified covered outpatient drugs.'' That is, in the absence of both ASP data and hospital claims data, we will set payment for new radiopharmaceuticals approved for pass-through status beginning in CY 2005 at the floor for sole source ''specified coveraged outpatient drugs,'' which is 83 percent of the AWP.

Comment: A few commenters urged CMS to revise the HCPCS code descriptors for radiopharmaceutical products that do not currently have ''per dose'' or ''per study'' descriptors and indicated that ''per dose'' or ''per study'' code descriptors will facilitate the collection of more accurate charge and cost data which are necessary to establish equitable payment for radiopharmaceutical agents.

Response: We recognize the concerns expressed by these commenters. As we have stated in the November 7, 2003 OPPS final rule with comment period (68 FR 63451), we continue to believe that in changing descriptors to ''per dose'' or ''per study'', 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'' or that claims data based on the current code descriptors 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 obtain accurate data for future rate setting.

Comment: A commenter strongly supported CMS requiring that hospitals report all HCPCS codes for drugs including those that are packaged and indicated that this will enable CMS to track costs and help to ensure that only correctly coded claims (those with radiopharmaceuticals) are used in setting payment rates for nuclear medicine procedures. Therefore, the commenter recommended that CMS require continued reporting of HCPCS codes for all radiopharmaceuticals (packaged and non-packaged products).

Response: We will continue to strongly encourage hospitals to report charges for all drugs using the correct HCPCS codes for the items used, including the drugs that have packaged status in CY 2005. We agree with the commenter that it is most useful to us when we have a robust set of claims for each item paid for under the OPPS. We would note, however, that with just a very few exceptions, hospitals do appear to be reporting charges for drugs, biologicals and radiopharmaceuticals using the existing HCPCS codes, even when such items have packaged status. At this time, we do not believe it is necessary to institute a requirement for drugs as we are doing for the device category codes. However, we will continue to monitor this through our annual analysis of claims data and will reconsider this in the future, if we determine that it is necessary.

H. Coding and Payment for Drug Administration

Since implementation of the OPPS, Medicare OPPS payment for administration of cancer chemotherapy drugs and infusion of other drugs has been made using the following HCPCS codes:

- Q0081, Infusion therapy other than chemotherapy, per visit
- Q0083, Administration of chemotherapy by any route other than infusion, per visit
- Q0084, Administration of chemotherapy by infusion only, per visit
- Q0085, Administration of chemotherapy by both infusion and another route, per visit

In the CY 2004 proposed rule, we proposed to change coding and payment for these services to enable us to pay more accurately for the wide range of services and the drugs that we package into these per visit codes. (Background discussion on these codes is included in the August 12, 2003 OPPS proposed rule (68 FR 47998). Commenters on the CY 2004 proposed rule recommended that we use the CPT codes for drug administration. One commenter provided a crosswalk from the CPT codes for drug administration to the Q codes that we could use in a transition. We did not implement this in the final rule for CY 2004 OPPS but indicated that we would consider it for CY 2005 and would discuss it with the APC Panel at its February 2004 meeting.

Commenters and the APC Panel recommended that we discontinue use of code Q0085 for CY 2004 because codes Q0083 and Q0084 could be used together to report the services described by code Q0085. We did implement this change for CY 2004 and made code Q0085 nonpayable for CY 2004 OPPS.

At the February 2004 APC Panel meeting, we presented a proposal from an outside organization that matched CPT codes for chemotherapy and nonchemotherapy infusions to the Q codes currently used to pay for these services under the OPPS. We asked the APC Panel for their perspective on the potential benefit of using the proposed coding approach as the basis for billing and determining the OPPS payment for administering these drugs. The APC Panel recommended that CMS continue to review the organization's proposed coding crosswalk with the goal of using it to transition from the use of Q-codes

to that of CPT codes to bill for administration of these drugs.

In the August 16, 2004 proposed rule, for CY 2005, we proposed to use the CPT codes for drug administration but to crosswalk the CPT codes into APCs that reflect how the services would have been paid under the Q codes. Although hospitals would bill the CPT codes and include the charges for each CPT code on the claim, payment would be made on a per visit basis, using the cost data from the per visit Q codes (Q0081, Q0083 and Q0084) to set the payment rate for CY 2005. See Table 29 of the proposed rule for the proposed crosswalk of CPT codes into APCs based on the Q codes (69 FR 50521). The only change from the crosswalk that was submitted by the outside organization is that we proposed a Q code and APC crosswalk for CPT code 96549 (Unlisted chemotherapy procedure), rather than bundling that service. We believe that Q0083 is the code that would have previously been reported by hospitals to describe the unlisted service. In addition, this would place the unlisted service in our lowest resource utilization APC for chemotherapy, consistent with our policy for other unlisted services.

We proposed to establish the Q code and APC crosswalk for CPT code 96549 because there is no CPT specific charge or frequency data on which to set payments. The CY 2005 OPPS is based on CY 2003 claims data which used the Q codes. Therefore, the only cost data available to us for establishment of median costs is the data based on the Q codes for drug administration. Moreover, the only frequency data that are available for use in calculating the scalar for budget neutrality of payment weights are the frequency data for the Q codes. Therefore, the payments set for the CPT codes must use the cost data for the Q codes and must result in the same payments that would have been made had the Q codes been continued.

Under this proposed methodology, hospitals would report the services they furnish with the CPT codes and would show the charges that they assign to the CPT codes on the claim. The Medicare OCE would assign the code to an APC whose payment is based on the per visit Q code that would have been used absent coding under CPT. In most cases, the OCE would collapse multiple codes or multiple units of the same CPT code into a single unit to be paid a single APC amount. This approach is needed because the data for the Q codes is reported on a per visit basis and more than one unit of a CPT code can be provided in a visit.

For example, CPT code 96410 (Chemotherapy administration infusion technique, up to 1 hour) is for infusion of chemotherapy drugs for the first hour, and CPT code 96412 is for chemotherapy infusion up to 8 hours, each additional hour. The claims data used to set the APC payment rate for these codes is for a per visit amount (taken from CY 2003 data for Q0084 a per visit code). The frequency data on the claim are also on a per visit basis. For CY 2005, we proposed that CPT code 96410 would be paid one unit of APC 0117 (to which CPT code 96410 would be crosswalked) and no separate payment would be made for CPT code 96412, regardless of whether one unit or more than one unit is billed. CPT code 96412 would be a packaged code for CY 2005. Under the Q code data on which the payment weight for APC 0117 is based, the per visit amount would represent a payment that is appropriate for all drug administration services in a visit (that is, one unit of CPT code 96410 and as many units of CPT code 96412 as were furnished in the same visit).

Similarly, we proposed that when a hospital bills 3 units of CPT code 96400 (Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia), the OCE would assign one unit of APC 0116 for that code. (APC 0116 is the APC to which CPT code 96400 would be crosswalked.) The payment would be based on Q0083, a per visit code, because, absent the ability to be paid based on CPT codes, the hospital would have billed one unit of Q0083 (for the 3 injections) had we not discontinued the Q codes for CY 2005. The OCE would assume that there was one and only one visit in which there were 3 injections and would pay accordingly (that is, one unit of APC 0116).

We noted that if we adopt the CPT codes for drug administration to ensure accurate payment in the future, it would be critical for hospitals to bill the charges for the packaged CPT codes for drug administration for CY 2005 (that is, the CPT codes with SI=N), even though there would be no separate payment for them in CY 2005. For CY 2007 OPPS, CY 2005 claims data would be used as the basis for setting median costs for each CPT code, based on the reported charges reduced to cost, and would determine what APC configuration ensures most appropriate payment for the CPT drug administration codes. If hospitals do not bill charges in CY 2005 for the packaged drug administration CPT codes such as CPT codes 96412, 96423, 96545, or 90781, they would jeopardize our ability to make accurate payments for services billed and paid under these codes in CY 2007 when we use the CY 2005 data to set the payment weights.

Comment: Most commenters supported our proposal to code drug administration using CPT codes instead of the HCPCS codes. They indicated that it would be less burdensome for hospitals to code services using just one method for Medicare and all other payers. Some commenters opposed the use of CPT codes unless CMS pays an amount for each use of the CPT code, as CMS does under the Medicare Physician Fee Schedule.

Response: We cannot pay an amount for each use of each CPT code because all of our drug administration cost data are on a per visit (not a per code) basis as charges for each of the following three HCPCPS codes, Q0081, Q0083, and Q0084, are reported for a visit and not a service.

We agree that billing for drug administration using the CPT codes will be less burdensome to hospitals and will also facilitate development of more accurate payment rates for drug administration services in future years. For CY 2005 OPPS, we will collapse the CPT codes billed for drug administration into a single unit of the applicable APC for payment as we do not have the CPT code specific claims data for use in establishing a CPT code specific payment. However, we anticipate that we would have the necessary claims for CY 2007 OPPS to set an appropriate APC payment rate for the services described by the CPT codes.

Comment: Several commenters asked that we affirm that hospitals may report CPT codes 90780 (intravenous infusion for therapy/diagnosis administered by physician or under direct supervision of physician; up to one hour) and 90781 (each additional hour up to (8) hours), notwithstanding that the administration is not done by a physician or under the direct supervision of a physician. The commenters stated that such services are typically administered in hospitals by nurses without direct physician supervision and that if hospitals report these codes only when the full definition of the code is met, they would not be able to report the infusion services they furnish.

Response: We do not view the language of these CPT codes' definitions as being an obstacle to or inconsistent with the use of the codes by hospitals for billing Medicare. We view our general requirements regarding physician supervision (with respect to payment for services that are incident to a physician's service in the outpatient hospital setting) as meeting the

physician supervision aspect of the codes and thus, do not believe that use of the codes in the hospital outpatient setting would be prevented by the inclusion of the language in the code definition.

Comment: A commenter asked that we change the status indicator for CPT code 90780 and 90781 to ''X'' from ''T'' thereby eliminating the multiple procedure reduction for these codes, which in CY 2005 will replace HCPCS code Q0081 in billing for the administration of infusion therapy. The commenter stated that there is no situation in which the time and resources involved in infusion care should be reduced in the case of an observation patient.

Response: We disagree. The costs of space, utilities and staff attendance are duplicated when the beneficiary is receiving another service at the same time as infusion therapy, in particular when the patient is in observation. Hence it is appropriate to apply a multiple procedure reduction to infusion therapy particularly when the patient is in observation status. We believe it is necessary to understand how the OCE multiple procedure discounting logic functions. Line-items with a service indicator of ''T'' are subject to multiple procedure discounting unless modifiers 76, 77, 78, and/or 79 are present on the claim. The ''T'' line-item with the highest payment amount will not be discounted but all other ''T'' line items will be discounted as multiple procedures. All line-items that do not have a service indicator of ''T'' will be ignored in determining the discount. Therefore, if the only other services reported with infusion therapy are an emergency department or other visit code, or diagnostic tests and services assigned status indicator ''S,'' the infusion therapy code would not be subject to the multiple procedure discounting.

Comment: Several commenters stated that multiple visits per day for antibiotic infusion are common and the drug administration policies should permit such visits to be paid separately. The commenters stated that multiple visits for chemotherapy are possible and that provisions should be made for billing and paying them when they occur.

Response: We agree with the commenters on this issue. The reporting and payment for these multiple visits and services will not be an issue once payment for drug administration under the OPPS is made based on CPT code-specific data. However, until such time, hospitals will need to use modifier 59 (distinct procedure) when billing charges for services furnished during multiple visits that follow the initial visit. For CPT codes 90780 and 90781, where there are multiple visits for infusion on the same day, the hospital should report CPT code 90780 with modifier 59 and CPT code 90781, if appropriate, with modifier 59 for each separate visit for infusion. With modifier 59 appended to CPT codes 90780 and 90781, the OCE will allow up to 4 units of APC 0120 (Infusion of nonchemotherapy drugs) to be paid. Similarly, for the chemotherapy administration codes, where there is no modifier 59 reported, the OCE will collapse all codes that map to a particular APC into one unit of that APC and will pay one unit of each applicable APC. The system will assume that all services were furnished in one single encounter. Where the chemotherapy services are provided in multiple encounters, the hospital will need to show modifier 59 on the service furnished in the second encounter. The OCE will map those services into an additional unit of each applicable APC and will pay for each visit. The OCE will not, for a single date of service, pay more than 4 units of APC 120, nor more than 2 units of APCs 116 and 117 (chemotherapy by route other than infusion and infusion of chemotherapy drugs). We intend to reassess these limits based on provider feedback and our review of later claims data.

Comment: One commenter asked that CMS ensure that the costs for CPT code 90780 (Infusion therapy one hour) are included in payment for CPT codes 67221 (Ocular photodynamic therapy) and 67225 (Eye photodynamic therapy add-on) because CPT code 90780 is bundled into both of these procedure codes.

Response: The procedure code definition for CPT code 67221 specifies that intravenous infusion is included, and CPT code 67225 is to be listed separately in addition to CPT code 67221, if a second eye is treated. Therefore, the National Correct Coding Initiative (NCCI) edits preclude payment for CPT code 90780 with CPT codes 67221 and 67225 because the charges for the procedure CPT codes 67221 and 67225 are presumed to include all costs of administering the drug. Correct coding would not include reporting CPT code 90780 for the same visits when photodynamic therapy was provided. We expect that hospitals will include their charges for the necessary infusion in their charges for the procedure codes when they bill CPT codes 67221 or 67225, so that our claims data reflect the costs of all resources necessary to perform the services.

Comment: Several commenters urged CMS to adopt the new and revised AMA definitions for drug administration, which will be HCPCS G-codes in the CY 2005 Medicare Physician Fee Schedule, because the existing CPT codes do not adequately capture the costs of the range of drug administrations. They also urged CMS to educate providers on the correct use of the new CPT codes. The commenters indicated that implementing the new CPT codes for drug administration will be more difficult in hospitals than in physicians' offices because the services are typically provided in more places in hospitals than in physicians' offices.

Response: For CY 2005 OPPS, we are implementing the existing CPT codes for drug administration rather than the new G-codes that will be used for the Medicare Physician Fee Schedule payments. We do not intend to use the new HCPCS G-codes for the OPPS drug administration services until such time as the new CPT codes for those services are issued in CY 2006. We believe that it would be disruptive to hospitals if we required them to implement the HCPCS alphanumeric codes for drug administration in CY 2005 and then switch to the new CPT codes in CY 2006. While only a subset of the physician community administers anti-neoplastic drugs in their offices, we believe that most hospitals do so on an outpatient basis and hence most hospitals would have to change to the new HCPCS codes for CY 2005, only to change again to new CPT codes for CY 2006. However, we are told that all hospitals use the current CPT codes to bill other payers and crosswalk from the current CPT codes to the Q codes to bill Medicare. Thus, using the current CPT codes should be easier for hospitals than their current method for billing Medicare. This would not be the case if we were to require that they use the new HCPCS codes for drug administration.

Comment: One commenter indicated that CMS should revise the OPPS to mirror the policy under the Medicare Physician Fee Schedule that pays separately for each drug administered to permit the payment of one unit of each APC for each and every drug administered. The commenter stated that since CMS acknowledged that there are additional resources used with each administration of a drug, it should apply the same policy to hospitals since all of these services are furnished by nurses, whether in a physician's office setting or a hospital setting.

Response: We are moving to the use of CPT codes for CY 2005 OPPS. However, we will not be paying an APC amount for each unit of each CPT code.

The APC rate is, by necessity, based on historic data for a code that was billed and reported on a per visit basis. Therefore, to pay each unit of a CPT code an APC amount would not accurately reflect the resources used and would result in an overpayment of the costs of the services provided.

Comment: A commenter asked CMS to permit hospitals to continue billing HCPCS codes Q0081, Q0083 and Q0084 for drug administration until April 1, 2005 so that hospitals that do not currently bill the CPT codes for drug administration may have a transition period to convert to CPT code billing.

Response: The three cited Q-codes will be deactivated for the OPPS effective January 1, 2005 and therefore cannot be used up to April 1, 2005. As discussed in our proposed rule, we are eliminating the 90-day grace period for deleted codes effective January 1, 2005. We are adopting this policy because the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules require usage of the medical code that is valid at the time that the service is provided. Details regarding elimination of the 90-day grace period for billing deleted codes were issued to our contractors on February 4, 2004, in Transmittal 89, Change Request 3093. Moreover, we are not aware that there are any hospitals that do not bill the CPT codes for drug administration, as hospitals have told us that all payers other than Medicare require that they use the CPT codes and will not accept the Q-codes.

Comment: A commenter asked that CMS use the first two quarters of the CY 2005 claims to set the median costs for drug administration in CY 2006 OPPS so that the transition to the more accurate payments under the CPT codes could begin earlier than CY 2007.

Response: As the CY 2005 claims data will be the basis for the CY 2007 payment weights, we regret that we are unable to transition to the new payments earlier than CY 2007 because of the time required to access the CY 2005 claims data and to process and construct our database for ratesetting and impact analyses. The second quarter of CY 2005 data will not be available to us until at least August 15, 2005, which is far too late for us to have developed and published any CY 2006 proposed rule.

After carefully reviewing all comments received, we are adopting as final our proposal to use the CPT codes for drug administration, effective January 1, 2005. We will collapse the CPT codes billed into a single unit of the applicable APC for payment. In addition, we are establishing the Q-code and APC crosswalk for CPT code 96549 and will be paying 1 unit of APC 0117 for CPT code 96410 (to which CPT code 96410 will be crosswalked). We will not make a separate payment for CPT code 96412 regardless of whether 1 unit or more units are billed. For CY 2005, CPT code 96412 will be a packaged and not paid separately. Further, when a hospital bills 3 units of CPT code 96400 (Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia), the OCE will assign 1 unit of APC 0116 for that code and the payment will be based on HCPCS code Q0083, a per visit code. Modifier 59 may be used with codes in APCs 0116, 0117, and 0120 to signify additional encounters on the same date of service for which additional APC payments may be made.

Table 33 below contains the crosswalk of CPT codes for drug administration to drug administration APCs for CY 2005. The last two columns of this table indicate the maximum number of units of the APC that the OCE will assign without or with modifier 59, respectively.

BILLING CODE 4120–01–P

Table 33.--Crosswalk from CPT Codes for Drug Administration to Drug Administration APCs

CPT Code	Description	SI	APC	Corresponding HCPCS Code	OCE Maximum APC Units without Modifier 59	OCE Maximum APC Units with Modifier 59
96400	Chemotherapy, sc/im	S	116	Q0083	1	2
96405	Intralesional chemo admin	S	116	Q0083	1	2
96406	Intralesional chemo admin	S	116	Q0083	1	2
96408	Chemotherapy, push technique	S	116	Q0083	1	2
96410	Chemotherapy,infusion method	S	117	Q0084	1	2
96412	Chemo, infuse method add-on	N	--	--	0	0
96414	Chemo, infuse method add-on	S	117	Q0084	1	2
96420	Chemotherapy, push technique	S	116	Q0083	1	2
96422	Chemotherapy,infusion method	S	117	Q0084	1	2
96423	Chemo, infuse method add-on	N	--	--	0	0
96425	Chemotherapy,infusion method	S	117	Q0084	1	2
96440	Chemotherapy, intracavitary	S	116	Q0083	1	2
96445	Chemotherapy, intracavitary	S	116	Q0083	1	2
96450	Chemotherapy, into CNS	S	116	Q0083	1	2
96542	Chemotherapy injection	S	116	Q0083	1	2
96545	Provide chemotherapy agent	N	--	--	0	0
96549	Chemotherapy, unspecified	S	116	Q0083	1	2
90780	IV infusion therapy, 1 hour	T	120	Q0081	1	4
90781	IV infusion, additional hour	N	--	--	0	0

BILLING CODE 4120–01–C

I. Payment for Blood and Blood Products

Since the OPPS was first implemented in August 2000, separate payments have been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. Administrative costs for processing and storage specific to the transfused blood product are included in the blood product APC payment, which is based on hospitals' charges. Payment for the collection, processing, and storage of autologous blood, as described by CPT code 86890, is made

through APC 0347 (Level III Transfusion Laboratory Procedures).

In CY 2000, payments for bloods were established based on external data provided by commenters due to limited Medicare claims data. From CY 2000 to CY 2002, blood and blood product payment rates were updated for inflation. For CY 2003, as described in the November 1, 2002 final rule (67 FR 66773), we applied a special dampening methodology to blood and blood products that had significant reductions in payment rates from CY 2002 to CY 2003, when median costs were first calculated from hospital claims. Using the dampening methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For CY 2004, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels. This allowed us to undertake further study of the issues raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

In the August 16, 2004 proposed rule for CY 2005 OPPS, we proposed to continue to pay separately for blood and blood products. We also proposed to establish new APCs that would allow each blood product to be in its own separate APC, as several of the blood product APCs currently contained multiple blood products with no clinical homogeneity or whose product-specific median costs may not have been similar. Thus, we also proposed to reassign some of these HCPCS codes already contained in certain APCs to new APCs. (*See* Table 30 of the proposed rule (69 FR 50523.)

Other than for autologous blood products, hospital reimbursement for the costs of collection, processing, and storage of blood and blood products are made through the OPPS payments for specific blood product APCs. Wastage and other administrative costs for blood are attributable to overhead and distributed across all hospital services linked to cost centers in the Medicare cost report, through the standard process of converting charges to costs using hospitals' CCRs for each cost center on the cost report.

In the August 16, 2004 proposed rule, we noted that comments to previous OPPS rules had stated that the CCRs that we used to adjust claim charges to costs for blood in past years were too low, resulting in underestimation of the true hospital costs for blood and blood products. In response, we conducted a thorough analysis of the OPPS claims to compare CCRs between hospitals with a blood-specific cost center and hospitals defaulting to the overall hospital CCR. Our past methodology for determining CCRs for blood products included a default to the overall CCR when any given provider had chosen not to report costs and charges in a blood-specific cost center on the cost report. After matching the two blood-specific cost centers to the 38X and 39X revenue codes, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median CCR for those hospitals with a blood-specific cost center was 0.66 for revenue code 38X and 0.64 for revenue code 39X, and for those defaulting to the overall hospital CCR, the result was a CCR of 0.34 for revenue code 38X and 0.33 for revenue code 39X. The median overall CCR for all hospitals in the CY 2005 analysis was 0.33.

In light of this information, we applied the methodology described in our August 16, 2004 proposed rule to calculate simulated medians for each blood and blood product based on our CY 2003 claims data. We assumed that those hospitals not reporting costs and charges in a blood-specific cost center on their annual cost report, in general, face similar costs and engage in comparable charging practices for blood as those reporting a blood-specific cost center. For those hospitals not reporting a blood-specific cost center, we simulated a blood-specific CCR, which we then applied to convert charges to costs for blood products. Overall, this methodology increased the estimated median costs of blood and blood products by 25 percent for CY 2005 relative to the median costs used to set CY 2004 APC rates. For example, the estimated median for HCPCS code P9016 (Red blood cells, leukocyte reduced), the most frequently billed blood product, increased by 32 percent relative to the CY 2004 median.

As discussed in the proposed rule, in reviewing the simulated medians calculated using the methodology described above relative to those medians used to set CY 2004 payment rates, we noticed that some low-volume blood products (< 1,000 units) demonstrated significant decreases in median costs utilizing our general methodology. Overall, the simulated median costs for low-volume blood products declined by 14 percent for CY 2005. Because a small sample size can lead to great variability in point estimates, we sought to increase the number of units of low-volume blood products by combining CY 2002 and CY 2003 claims data for the low-volume products. We used the simulated CCRs to calculate costs from charges from CY 2002 and CY 2003 claims data. To ensure that we combined comparable costs, we updated the simulated costs on the CY 2002 claims to the base year of CY 2003 using the Producer Price Index (PPI) for blood and derivatives for human use (Commodity Code #063711). This is the PPI used to update blood and blood product prices in the market basket (67 FR 50039, August 1, 2002). We recognize that not all of the low-volume blood products had claims in CY 2002.

After combining the 2 years of claims data, we were able to raise the volume of blood units billed for several of these products above 1,000 units. Since the publication of the proposed rule, additional claims data from the last quarter of CY 2003 have become available to us. The data showed that a few of the blood products had utilization in CY 2003 that exceeded the 1,000 unit low-volume threshold and will not be subject to the low-volume blood product payment adjustment described below, that we are adopting for CY 2005. The low-volume blood products that we are adopting as final are listed below in Table 31 of this final rule with comment period.

The DHHS Advisory Committee on Blood Safety and Availability has recommended that CMS establish payment rates for blood and blood products based on current year acquisition costs and actual total costs of providing such blood products. At the February 2004 APC Panel meeting, the APC Panel recommended that CMS use external data to derive costs of blood and blood products in order to establish payment rates. At the September 2004 APC Panel meeting, the APC Panel recommended that CMS freeze payment rates for low-volume blood products for CY 2005 at CY 2004 levels. The Panel also recommended that CMS consider using external data for setting payment rates for blood and blood products in the future.

We received the following comments on our August 16, 2004 proposed rule regarding payment for blood and blood products.

Comment: A few commenters expressed strong support for payment rates developed using hospital data rather than blood industry data. The commenters urged CMS to exercise caution in using blood industry data and to consider evaluating the data for their validity, reliability and consistency with geographic variations in costs, in addition to being publicly available and subject to audit.

Response: We agree with the commenters that the OPPS payment rates should be based on the most

recently available and accurate hospital claims data. However, in rare circumstances when accurate hospital claims data capturing the full costs of services may not be available, we evaluate all external data very carefully to make sure that they meet our external data criteria. As discussed above, in setting all blood and blood product payment rates for CY 2005, we have relied upon data from hospital claims submitted to CMS.

Comment: Several commenters expressed concern about the proposed payment rates for blood and blood products. The commenters indicated that despite increases in the CY 2005 proposed payment rates for blood and blood products, the proposed payment rates still do not meet the actual costs to hospitals of acquiring these products. Some commenters stated that, in addition to hospital coding and billing problems, only a small number of hospitals were actually reporting blood costs, and that lack of reporting explains why the payment rates are still significantly below hospital acquisition costs. The commenters expressed concerns that this would create barriers to access to a safe blood supply for Medicare beneficiaries.

The commenters also expressed concerns about reductions in payment rates for low-volume blood products. They recommended that CMS either freeze payment rates at the CY 2004 OPPS levels for low-volume blood products that experienced a decrease in their proposed rates or use external data in setting payment rates for these products.

Response: We appreciate the commenters' concerns and share the same concern for protecting beneficiaries' access to a safe blood supply. As with all of the OPPS services, we prefer to rely on our claims data whenever possible. Comments received for previous rules also suggested that current hospital blood costs are not captured because hospitals underreport blood on their claims because it is too costly to bill for blood. However, our thorough analysis of billing for blood from CY 2003 claims data indicated that 81 percent of all hospitals included in our ratesetting and modeling for CY 2005 billed at least one unit of blood or blood product in CY 2003. Of these hospitals however, only 47 percent reported separate costs and charges in the two cost centers specific to blood on their most recent annual cost reports. It may be that those hospitals billing for blood but not reporting costs and charges on their cost reports for either of the two blood-specific cost centers reported their blood costs and charges under other cost centers, such as operating room. As discussed in the proposed rule, we simulated blood-specific hospital CCRs to account for these reporting differences and used these simulated CCRs to develop proposed median costs for blood products for CY 2005. Our claims data clearly show that the vast majority of hospitals do bill the OPPS for blood and blood products. In addition, the distribution of costs for individual products provides no evidence of significant coding problems.

As explained in the preamble of this section, we estimate that by using our new methodology of simulating medians and implementing the proposed payment rates for blood and blood products, excluding low-volume blood products, there would be a 25 percent increase in payment for blood and blood products overall. This includes a 32 percent increase in payment from CY 2004 for leukocyte reduced red blood cells (HCPCS code P9016), the highest volume blood product in the hospital OPD, and a 25 percent increase in payment for each unit of red blood cells (HCPCS code P9021), the second highest volume blood product.

After carefully reviewing all of the public comments received timely regarding low-volume blood products, we are convinced that due to the low utilization of these products, in addition to possible hospital coding and billing problems for these low-volume products, the claims data may not have captured the complete costs of these products to hospitals as fully as possible. We believe it is imperative that Medicare beneficiaries have full access to all medically necessary blood and blood products, including products that are infrequently utilized. Therefore, for blood products that would have experienced a decrease in median cost from CY 2004 to CY 2005 based on our proposed methodology, we are establishing CY 2005 payment rates that are adjusted to a 50/50 blend of CY 2004 product-specific OPPS median costs and our proposed CY 2005 simulated medians. This adjustment methodology will allow us to undertake further study of the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low-volume blood products at risk.

Comment: One commenter suggested that CMS survey all hospitals across the country to investigate direct and indirect costs for blood. The commenter expressed concern that our proposed rates were insufficient to cover the costs of blood and its testing and storage. The commenter also expressed the need for continued increases in payments for blood products.

Response: We appreciate the commenter's recommendation and will take it into consideration as needed, when we reassess the payment rates for blood and blood products. While we believe our payment rates are appropriate and adequate for the provision of blood and blood product services, we are aware of the increasing number of tests required to ensure the safety of the nation's blood supply, which could possibly add to the costs of processing blood and blood products. The APC payment rates for blood and blood products are intended to cover the costs of medically necessary testing by community blood banks or blood banks operated by hospitals. However, the APC payment rates are not meant to include costs of tests requiring a specific patient's blood, such as cross-matching in preparation for transfusion, because these tests are separately payable under the OPPS.

Comment: Several commenters, including a hospital association, recommended that CMS issue more specific guidance to hospitals for billing of blood-related services in order to improve hospital claims data. Specifically, commenters requested that CMS address issues related to application of the Medicare blood deductible, differences between donor and nondonor states, hospital markups for blood costs, the appropriate use of HCPCS code P9011 (Split blood unit) in billing, blood processing and preparation costs and autologous blood collection. In addition, the same commenter recommended that CMS share its draft guidance for review with the Outpatient Medicare Technical Advisory Group (MTAG) or the National Uniform Billing Committee (NUBC), or both, to ensure it is correct, comprehensive, and reflective of the billing provider's perspective.

Response: We recognize the need for comprehensive billing guidelines for hospitals and other providers to address a variety of blood-related services under the OPPS. In the near future, we intend to provide further billing guidelines to clarify our original Program Transmittal A–01–50 issued on April 12, 2001 (CR Request 1585) regarding correct billing for blood-related services. We agree with the commenters and intend to gather information from all relevant and available resources.

Comment: One commenter, a hospital association, indicated that the revenue code 390 (Blood Storage and Processing) should not have been included in Table 18 (Proposed Packaged Services by

Revenue Codes) of the August 16, 2004 proposed rule. The commenter expressed concern that by including revenue code 390 in this table, hospitals would not be paid for the services because of a line-item claim rejection.

Response: We are clarifying that a HCPCS code billed with revenue codes listed in Table 18 of the proposed rule could be paid separately as long as the HCPCS code is not assigned a status indicator of ''N.'' When a revenue code charge is billed without a HCPCS code, the charge is reduced to cost using the appropriate CCR for the revenue code. This cost is then added to a line item charge (reduced to cost) for a separately payable HCPCS code. This allows costs associated with uncoded revenue code charges to be captured so we can make a more accurate payment for the claim. If we did not add the costs of the line item revenue code charges without HCPCS codes, the full cost data for all resources necessary to deliver a separately payable service might not be captured, possibly resulting in a lesser payment for the claim.

In summary, after carefully reviewing all public comments received timely, we are adopting as final for CY 2005 OPPS the following proposals:

- To continue to pay separately for blood and blood products, to establish new APCs that would place each blood product in its own separate APC, and to implement proposed APC reassignments for such blood and blood products.
- Effective for services furnished on or after January 1, 2005, in this final rule with comment period, we are providing that the payment rates for blood and blood products, excluding low-volume blood products whose CY 2005 simulated medians decreased from the CY 2004 medians, will be determined according to the methodology we described in the August 16, 2004 proposed rule.
- Effective for services furnished on or after January 1, 2005, in this final rule with comment period, we are providing that the CY 2005 payment rates for low-volume blood products that would have experienced a decrease in median costs from CY 2004 to CY 2005 based on our proposed methodology are adjusted to a 50/50 blend of CY 2004 product-specific median costs and our proposed CY 2005 simulated medians.

BILLING CODE 4120–01–P

Table 34.—CY 2005 APC Assignment of Blood and Blood Product Codes

HCPCS	Expired HCPCS	Status Indicator	Description	APC
P9010		K	Whole blood for transfusion	0950
P9011		K	Split unit of blood	0967
P9012		K	Cryoprecipitate each unit	0952
P9016		K	RBC leukocytes reduced	0954
P9017		K	Plasma 1 donor frz w/in 8 hr	9508
P9019		K	Platelets, each unit	0957
P9020		K	Plaelet rich plasma unit	0958
P9021		K	Red blood cells unit	0959
P9022		K	Washed red blood cells unit	0960
P9023		K	Frozen plasma, pooled, sd	0949
P9031		K	Platelets leukocytes reduced	1013
P9032		K	Platelets, irradiated	9500
P9033		K	Platelets leukoreduced irradiated	0968
P9034		K	Platelets, pheresis	9507
P9035		K	Platelet pheres leukoreduced	9501
P9036		K	Platelet pheresis irradiated	9502
P9037		K	Plate pheres leukoredu irradiated	1019
P9038		K	RBC irradiated	9505
P9039		K	RBC deglycerolized	9504
P9040		K	RBC leukoreduced irradiated	0969
P9043		K	Plasma protein fract,5%,50ml	0956
P9044		K	Cryoprecipitate reduced plasma	1009
P9048		K	Plasmaprotein fract,5%,250ml	0966
P9050		K	Granulocytes, pheresis unit	9506
P9051	C1010	K	Blood, L/R, CMV-NEG	1010
P9052	C1011	K	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	K	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	K	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	K	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	K	Blood, L/R, Irradiated	1018
P9057	C1020	K	RBC, frz/deg/wsh, L/R, irradiated	1021
P9058	C1021	K	RBC, L/R, CMV neg, irradiated	1022
P9059	C1022	K	Plasma, frz within 24 hour	0955
P9060	C9503	K	Fresh frozen plasma, ea unit	9503

Table 35.—Low Volume Blood and Blood Product Codes for CY 2005 Payments

HCPCS	Description
P9039	Red blood cells deglycerolized
P9043	Plasma protein fractionated, 5 percent, 50 ml
P9048	Plasmaprotein fractionated, 5 percent, 250 ml
P9050	Granulocytes, pheresis unit
P9053	Platelet, pher, L/R, CMV, irradiated
P9054	Blood, leukocyte reduced, frozen, deglycerolized, washed
P9055	Platelet, APH/PHER, leukocyte reduced, CMV, irradiated
P9057	RBC, frozen/deg/washed, L/R, irradiated
P9058	RBC, L/R CMV-neg, irradiated
P9059	Plasma, frozen within 24 hour
P9060	Fresh frozen plasma, each unit

BILLING CODE 4120–01–C

VI. Estimated Transitional Pass-Through Spending in CY 2005 for Drugs, Biologicals, and Devices

A. Basis for 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 CY 2004, the applicable percentage is 2.5 percent; for CY 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a 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 payments exceed the applicable percentage but also to determine the appropriate reduction to the conversion factor.

For devices, making an estimate of pass-through spending in CY 2005 entails estimating spending for two groups of items. The first group consists of those items for which we have claims data for procedures that we believe used devices that were eligible for pass-through status in CY 2003 and CY 2004 and that would continue to be eligible for pass-through payment in CY 2005. The second group consists of those items for which we have no direct claims data, that is, items that became, or would become, eligible in CY 2004 and would retain pass-through status in CY 2005, as well as items that would be newly eligible for pass-through payment beginning in CY 2005.

B. Estimate of Pass-Through Spending for CY 2005

In the August 16, 2004 proposed rule, we proposed to set the applicable percentage cap at 2.0 percent of the total OPPS projected payments for CY 2005. In this final rule with comment period, we are setting the applicable percentage cap at the same 2.0 percent.

We are using the same methodology described in the proposed rule to estimate the pass-through spending for CY 2005. To estimate CY 2005 pass-through spending for device categories in the first group described above, we used volume information from CY 2003 claims data for procedures associated with a pass-through device and manufacturer's price information from applications for pass-through status. This information was projected forward to CY 2005 levels, using inflation and utilization factors based on total growth in Medicare Part B as projected by the CMS Office of the Actuary (OACT).

To estimate CY 2005 pass-through spending for device categories included in the second group, that is, items for which we have no direct claims data, we used the following approach: For categories with no claims data in CY 2003 that would be active in CY 2005, we followed the methodology described in the November 2, 2001 final rule (66 FR 55857). That is, we used price information from manufacturers and volume estimates based on claims for procedures that would most likely use the devices in question. This information was projected forward to CY 2005 using the inflation and utilization factors supplied by the CMS OACT to estimate CY 2005 pass-through spending for this group of device categories. For categories that become eligible in CY 2005, we will use the same methodology. No new device categories for January 1, 2005, were announced after the publication of the proposed rule. Therefore, the estimate of pass-through spending does not incorporate any pass-through spending for categories made effective January 1, 2005.

With respect to CY 2005 pass-through spending for drugs and biologicals, as we explain in section V.A.3. of this final rule with comment period, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status equals zero. Therefore, our estimate of total pass-through spending for drugs and biologicals with pass-through status in CY 2005 equals zero.

Table 36.--Estimates for CY 2005 Transitional Pass-Through Spending for Current Pass-Through Device Categories Continuing Into CY 2005

New HCPCS	APC	Existing Pass-Through Devices	CY 2005 Estimated Utilization	CY 2005 Anticipated Pass-through Payments
C1814	1814	Retinal tamponade device, silicone oil	33,865	$13,166,712
C1818	1818	Integrated keratoprosthesis device	5	$34,750
C1819	1819	Tissue localization excision device	10,979	$2,031,115

In accordance with the methodology described above, we estimate that total pass-through spending for devices in CY 2005 would equal approximately $23.4 million, which represents 0.10 percent of total OPPS projected payments for CY 2005. This figure includes estimates for the current device categories continuing into CY 2005, in addition to projections for categories that first become eligible during CY 2005. This estimate is significantly lower than previous year's estimates because of the method we discuss in section V.A.3. of this preamble for determining the amount of pass-through payment for drugs and biologicals with pass-through status in CY 2005.

Therefore, we will institute no pro rata reduction for CY 2005.

In section V.G. of this final rule with comment period, we indicate that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. The pass-through amount for new radiopharmaceuticals approved for pass-through status in CY 2005 would be the difference between the OPPS payment for the radiopharmaceutical, that is, the payment amount determined for the radiopharmaceutical as a sole source specified covered drug, and the payment amount for the radiopharmaceutical under section 1842(o) of the Act. However, we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned after January 1, 2005 for which pass-through status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specify in section V.G. However, we do not believe that pass-through spending for new radiopharmaceuticals in CY 2005 will be significant enough to materially affect our estimate of total pass-through spending in CY 2005. Therefore, we are not including radiopharmaceuticals in our estimate of pass-through spending in CY 2005.

Because we estimate pass-through spending in CY 2005 will amount to 0.10 percent of total projected OPPS CY 2005 spending, we are returning 1.90 percent of the pass-through pool to adjust the conversion factor, as we discuss in section VIII. of this preamble.

We received a few public comments on our estimate of CY 2005 pass-through spending for drugs, biologicals, and devices.

Comment: One commenter, a hospital organization, commended CMS for returning a portion of the pass-through pool that exceeds its estimate for pass-through payments for CY 2005, by increasing the conversion factor.

Response: We appreciate the commenter's support.

Comment: One commenter was concerned that CMS did not provide information on the extent to which amounts that are actually spent on pass-through payments and outlier payments compared to the amounts that are carved out of the total amount allowed OPPS payments for these projected payments. The commenter was concerned that the amounts carved out for these purposes may not actually be spent and thus would be lost to hospitals.

Response: We are required by law to estimate the amounts that we expect to spend on pass-through payments and outliers each year before the start of the calendar year. We share the commenter's interest in making those estimates as accurately as possible to ensure that hospitals receive the amount to which they are entitled. We make our final estimate for each calendar year to the best of our ability based on all of the most recently available data when we prepare our final rule, including comments we receive concerning those issues in response to the proposed rule. With respect to the availability of data, we have established limited data sets that include the set of claims we use for, first, the proposed rule and, ultimately, the final rule estimates. For example, the claims for CY 2003 used for the final rule for CY 2005 will be available to the public in a limited data set format. We will continue to assess the means by which we provide such information to determine if there are alternate ways to ensure that our stakeholders obtain the information that is important to them on a timely basis.

VII. Other Policy Decisions and Policy Changes

A. Statewide Average Default Cost-to-Charge Ratios

CMS uses cost-to-charge ratios (CCRs) to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. When OPPS was first implemented in CY 2000, we used CY 1996 and CY 1997 cost reports to calculate default urban and rural CCRs for each State to use in determining the reasonable cost-based payments for those hospitals without a valid CCR (Program Memorandum A–00–63, CR 1310, issued on September 8, 2000). In the August 16, 2004 OPPS proposed rule, we proposed to update the default ratios for CY 2005.

As we proposed, in this final rule, we calculated the statewide default CCRs using the same CCRs that we use to adjust charges to costs on claims data. Table 31 lists the final CY 2005 default urban and rural CCRs by State. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

The majority of submitted cost reports, 87 percent, were for CY 2002. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam and the U.S. Virgin Islands because these entities are not paid under the OPPS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPPS during CY 2003.

Finally, we calculated an overall average CCR, weighted by a measure of volume, for each State except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. Calculating a rate for Maryland presented a unique challenge. There are only a few providers in Maryland that are eligible to receive payment under the OPPS. However, we had no usable in-house cost report data for these Maryland hospitals, which is why we remove Maryland providers from our claims data for modeling OPPS. Therefore, we obtained data from the fiscal intermediary for Maryland, which we attempted to use in calculating the CCRs for Maryland, but which we ultimately determined could not be used to calculate representative CCRs. The cost data for three Maryland hospitals with very low volumes of services and cost data were so irregular that we lacked confidence that it would result in a valid statewide CCR. Thus, for Maryland, we used an overall weighted average CCR for all hospitals in the nation to calculate the weighted average CCRs appearing in Table 37. The overall decrease in default statewide CCRs can be attributed to the general decline in the ratio between costs and charges widely observed in the cost report data.

BILLING CODE 4120–01–P

Table 37.--Statewide Average Cost-to-Charge Ratios

State	Urban/Rural	Previous Default CCR	Default CCR
Alabama	RURAL	0.31552	0.26715
Alabama	URBAN	0.29860	0.24577
Alaska	RURAL	0.59388	0.61859
Alaska	URBAN	0.38555	0.42717
Arizona	RURAL	0.39748	0.32769
Arizona	URBAN	0.30922	0.26980
Arkansas	RURAL	0.35936	0.31754
Arkansas	URBAN	0.38278	0.30471
California	RURAL	0.40335	0.29314
California	URBAN	0.32427	0.24213
Colorado	RURAL	0.51041	0.43069
Colorado	URBAN	0.41863	0.32179
Connecticut	RURAL	0.42702	0.47250
Connecticut	URBAN	0.46592	0.44626
Delaware	RURAL	0.36289	0.36304
Delaware	URBAN	0.45061	0.45948
District of Columbia	URBAN	0.38690	0.37513
Florida	RURAL	0.31782	0.24304
Florida	URBAN	0.28363	0.22401
Georgia	RURAL	0.39829	0.33823
Georgia	URBAN	0.40262	0.32105
Hawaii	RURAL	0.44420	0.41027
Hawaii	URBAN	0.34815	0.34474
Idaho	RURAL	0.49682	0.46454
Idaho	URBAN	0.51942	0.49178
Illinois	RURAL	0.41825	0.34063
Illinois	URBAN	0.36825	0.29964
Indiana	RURAL	0.44596	0.36862
Indiana	URBAN	0.44205	0.37237
Iowa	RURAL	0.50166	0.41996
Iowa	URBAN	0.46963	0.38788
Kansas	RURAL	0.48065	0.38973
Kansas	URBAN	0.34698	0.29271

State	Urban/Rural	Previous Default CCR	Default CCR
Kentucky	RURAL	0.36987	0.31089
Kentucky	URBAN	0.37381	0.32476
Louisiana	RURAL	0.34317	0.29912
Louisiana	URBAN	0.34357	0.27736
Maine	RURAL	0.47857	0.38801
Maine	URBAN	0.54084	0.44897
Massachusetts	URBAN	0.44439	0.38812
Michigan	RURAL	0.44890	0.39418
Michigan	URBAN	0.41143	0.37428
Minnesota	RURAL	0.48514	0.47136
Minnesota	URBAN	0.45259	0.37416
Mississippi	RURAL	0.34264	0.30290
Mississippi	URBAN	0.37097	0.29322
Missouri	RURAL	0.42187	0.34160
Missouri	URBAN	0.38128	0.31081
Montana	RURAL	0.51173	0.47891
Montana	URBAN	0.49396	0.44817
Nebraska	RURAL	0.49386	0.42378
Nebraska	URBAN	0.42043	0.33875
Nevada	RURAL	0.42878	0.50623
Nevada	URBAN	0.22854	0.22333
New Hampshire	RURAL	0.50083	0.43585
New Hampshire	URBAN	0.39954	0.33224
New Jersey	URBAN	0.49024	0.34038
New Mexico	RURAL	0.44932	0.33899
New Mexico	URBAN	0.50857	0.43311
New York	RURAL	0.52062	0.43944
New York	URBAN	0.54625	0.42556
North Carolina	RURAL	0.37776	0.35416
North Carolina	URBAN	0.42726	0.38114
North Dakota	RURAL	0.52829	0.41175
North Dakota	URBAN	0.47341	0.36740
Ohio	RURAL	0.42562	0.41161
Ohio	URBAN	0.42718	0.32814
Oklahoma	RURAL	0.40628	0.32908
Oklahoma	URBAN	0.36264	0.29193
Oregon	RURAL	0.47915	0.42468
Oregon	URBAN	0.49958	0.43762
Pennsylvania	RURAL	0.40582	0.36015
Pennsylvania	URBAN	0.33807	0.28011
Puerto Rico	URBAN	0.42208	0.41376

State	Urban/Rural	Previous Default CCR	Default CCR
Rhode Island	URBAN	0.43930	0.35106
South Carolina	RURAL	0.35996	0.29377
South Carolina	URBAN	0.36961	0.29167
South Dakota	RURAL	0.49599	0.39218
South Dakota	URBAN	0.44259	0.33947
Tennessee	RURAL	0.36663	0.30294
Tennessee	URBAN	0.36464	0.28313
Texas	RURAL	0.41763	0.33642
Texas	URBAN	0.33611	0.30306
Utah	RURAL	0.49748	0.47097
Utah	URBAN	0.46733	0.45230
Vermont	RURAL	0.47278	0.46757
Vermont	URBAN	0.54533	0.44259
Virginia	RURAL	0.39408	0.33502
Virginia	URBAN	0.38604	0.32559
Washington	RURAL	0.54246	0.43429
Washington	URBAN	0.54658	0.41362
West Virginia	RURAL	0.42671	0.35073
West Virginia	URBAN	0.45616	0.40700
Wisconsin	RURAL	0.50126	0.42304
Wisconsin	URBAN	0.46268	0.38487
Wyoming	RURAL	0.54596	0.51581
Wyoming	URBAN	0.41265	0.41087

BILLING CODE 4120–01–C

Comment: Several commenters recommended that CMS instruct fiscal intermediaries to work with those facilities that have given up their all-inclusive rate status to quickly determine an appropriate CCR that will provide an accurate estimate of costs for each facility.

Response: We have already instructed intermediaries to update CCRs in a timely manner. In Program Memorandum A–03–004 dated January 17, 2003, we instructed fiscal intermediaries to recalculate each provider's CCR on an ongoing basis whenever a more recent full year cost report becomes available, which includes tentatively settled cost reports. Fiscal intermediaries will calculate a hospital-specific CCR for all-inclusive rate hospitals, as with all hospitals relying on default CCRs, when their first tentatively settled cost report becomes available after no longer being considered as all-inclusive rate hospitals.

Comment: A few commenters asserted that the decrease in CCRs between 1996 and 2002 was caused by the fact that charges were increasing faster than costs and that the increase in charges has been much lower since 2003. They requested that CMS take this fact into account in developing default CCRs.

Response: We did not inflate charges when calculating the default CCRs, and therefore, we do not believe that there is a need to adjust for charge inflation since CY 2002.

B. Transitional Corridor Payments: Technical Change

1. Provisions of the August 16, 2004 Proposed Rule

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (or transitional corridor payment) if the payments it received under the OPPS were less than the payment it would have received for the same services under the prior reasonable cost-based system (section 1833(t)(7) of the Act). Transitional corridor payments were intended to be temporary payments for most providers but permanent payments for cancer and children's hospitals to ease their transition from the prior reasonable cost-based payment system to the prospective payment system. Section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend such payments through December 31, 2005, for rural hospitals with 100 or fewer beds and extended such payments for services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004 and ends on December 31, 2005, for sole community hospitals located in rural areas. Accordingly, transitional corridor payments are only available to children's hospitals, cancer hospitals, rural hospitals having 100 or fewer beds, and sole community hospitals located in rural areas.

At the time the OPPS was implemented, section 1833(t)(7)(F)(ii) of the Act defined the payment-to-cost ratio (PCR) used to calculate the ''pre-BBA amount'' [2] for purposes of calculating the transitional corridor

[2] Section 1833(t)(7) of the Act defined the ''pre-BBA'' amount for a period as the amount equal to the product of (1) the payment-to-cost ratio for the hospital based on its *cost reporting period ending in 1996,* and (2) the reasonable cost of the services for the period. (Emphasis added.) In this context, BBA refers to the Balanced Budget Act of 1997, Pub. L. 105–33, enacted on August 5, 1997.

payments to be determined using the payments and reasonable costs of services furnished during the provider's cost reporting period ending in calendar year 1996. The BIPA, Pub. L. 106–554, enacted on December 21, 2000, revised that requirement. Section 403 of BIPA amended section 1833(t)(7)(F)(ii)(I) of the Act to allow transitional corridor payments to hospitals subject to the OPPS that did not have a 1996 cost report by authorizing use of the first available cost reporting period ending after 1996 and before 2001 in calculating a provider's PCR.

Although we discussed the BIPA amendment in the CY 2002 OPPS proposed rule published on August 24, 2001 (66 FR 44674), and implemented the amendment through Program Memorandum No. A–01–51, issued on April 13, 2001, we failed to revise the regulations at § 419.70(f)(2) to reflect the change. In the August 16, 2004 OPPS proposed rule, we proposed a technical correction to § 419.70(f)(2) to conform it to the provision of section 1833(t)(7)(F)(ii)(I) of the Act.

We did not receive any comments on this proposed technical change. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal and correcting § 419.70(f)(2) to conform it to the provision of section 1833(t)(7)(F)(ii)(I) of the Act.

However, we did receive several comments on the proposed rule related to the transitional corridor payments.

Comment: A few commenters expressed appreciation for the extension of transitional corridor payments for children's hospitals, cancer hospitals, rural hospitals having 100 or fewer beds, and sole community hospitals located in rural areas, but requested that CMS consider extending payment protections to rural hospitals that are not eligible for transitional corridor payments. The commenters noted that rural hospitals that have converted to critical access hospitals are paid at cost and, therefore, have a competitive advantage over rural hospitals that are not eligible for transitional corridor payments and cannot convert to critical access hospital status. One commenter requested protection for rural hospitals that provide emergency services.

A few commenters noted that the transitional corridor payment provision for rural hospitals having 100 or fewer beds and sole community hospitals located in rural areas expires on December 31, 2005, and requested that CMS further extend this payment protection.

Response: We share the concerns of rural hospitals and do not intend to limit access to health care to beneficiaries in rural areas. However, we note that the statute is very specific and does not provide transitional corridor payments for entities other than those listed in the statute, nor extend transitional corridor payments past December 31, 2005, for rural or sole community hospitals.

2. Comments on the Provisions of the January 6, 2004 Interim Final Rule With Comment Period

As discussed in the January 6, 2004 interim final rule with comment period (69 FR 828), section 411(a)(1)(B) of Pub. L. 108–173 provided that hold harmless transitional corridor provisions shall apply to sole community hospitals located in rural areas. Section 411(a)(2) states that the effective date for section 411(a)(1)(B) ''shall apply with respect to cost reporting periods beginning on or after January 1, 2004'' for sole community hospitals located in rural areas. The Conference Agreement for Pub. L. 108–173 states, ''The hold harmless provisions are extended to sole community hospitals located in a rural area starting for services furnished on or after January 1, 2004 * * *''

Comment: Commenters noted that there appears to be a discrepancy between the effective date in section 411 of Pub. L. 108–173 and the Conference Agreement. The commenters noted that, in accordance with section 411, a sole community hospital with a cost reporting period beginning on a date other than January 1 will not receive transitional corridor payments and ''interim'' transitional corridor payments for services furnished after December 31, 2003, and before the beginning of the provider's next cost reporting period.

Response: Section 411(a)(2) of Pub. L. 108–173 provides the effective date with respect to the transitional corridor payments applied to sole community hospitals. Specifically, a sole community hospital with a cost reporting period beginning on or after April 1, 2004, is subject to the hold harmless provisions. We note that if a hospital qualifies as both a rural hospital having 100 or fewer beds and as a sole community hospital located in a rural area, for purposes of receiving transitional corridor payments and interim transitional corridor payments, the hospital will be treated as a rural hospital having 100 or fewer beds. In this case, transitional corridor payments would begin on January 1, 2004, and there would be no gap in transitional corridor payments.

C. Status Indicators and Comment Indicators Assigned in the Outpatient Code Editor (OCE)

1. Payment Status Indicators

The payment status indicators (SIs) that we assign to HCPCS codes and APCs under the OPPS play an important role in determining payment for services under the OPPS because they indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. As we proposed, for CY 2005, we are providing our status indicator assignments for APCs in Addendum A, for the HCPCS codes in Addendum B, and the definitions of the status indicators in Addendum D1 to this final rule with comment period.

Payment under 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 through the Outpatient Code Editor (OCE) software, as to HCPCS codes that are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through the establishment of a system of status indicators with specific meanings. Addendum D1 contains the definitions of each status indicator for purposes of the OPPS for CY 2005.

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.

In the August 16, 2004 OPPS proposed rule, for CY 2005, we proposed to use the following status indicators in the specified manner:

- ''A'' to indicate services that are paid under some payment method other than OPPS, such as under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the Medicare Physician Fee Schedule. Some, but not all, of these other payment systems are identified in Addendum D1 to this final rule with comment period.
- ''B'' to indicate the services that are not payable under the OPPS when submitted on an outpatient hospital Part B bill type, but that may be payable by

fiscal intermediaries to other provider types when submitted on an appropriate bill type.

- ''C'' to indicate inpatient services that are not payable under the OPPS.
- ''D'' to indicate a code that is discontinued, effective January 1, 2005.
- ''E'' to indicate items or services that are not covered by Medicare or codes that are not recognized by Medicare.
- ''F'' to indicate acquisition of corneal tissue, which is paid on a reasonable cost basis and certain CRNA services that are paid on a reasonable cost basis.
- ''G'' to indicate drugs, biologicals, and radiopharmaceutical agents that are paid under the OPPS transitional pass-through rules.
- ''H'' to indicate devices that are paid under the OPPS transitional pass-through rules and brachytherapy sources that are paid on a cost basis.
- ''K'' to indicate drugs, biologicals (including blood and blood products), and radiopharmaceutical agents that are paid in separate APCs under the OPPS, but that are not paid under the OPPS transitional pass-through rules.
- ''L'' to indicate flu and pneumococcal immunizations that are paid at reasonable cost but to which no coinsurance or copayment apply.
- ''N'' to indicate services that are paid under the OPPS, but for which payment is packaged into another service or APC group.
- ''P'' to indicate services that are paid under the OPPS, but only in partial hospitalization programs.
- ''S'' to indicate significant procedures that are paid under the OPPS, but to which the multiple procedure reduction does not apply.
- ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under the OPPS applies.
- ''V'' to indicate medical visits (including emergency department or clinic visits) that are paid under the OPPS.
- ''X'' to indicate ancillary services that are paid under the OPPS.
- ''Y'' to indicate nonimplantable durable medical equipment that must be billed directly to the durable medical equipment regional carrier rather than to the fiscal intermediary.

We proposed the payment status indicators identified above for each HCPCS code and each APC in Addenda A and B and requested comments on the appropriateness of the indicators we have assigned.

We received several public comments on our proposal relating to status indicators.

Comment: Two commenters, representing radionuclide, radiopharmaceutical, and nuclear medicine interests, expressed concern about assignment of status indicator ''N'' in Transmittal 290, issued August 27, 2004, to the new revenue codes for diagnostic and therapeutic radiopharmaceuticals, revenue codes 0343 and 0344, that were effective October 1, 2004. The commenters recommended changing the status indicators for both 0343 and 0344 to ''K'' for nonpass-through drugs, biologicals, and radiopharmaceutical agents, and asked that CMS clarify and notify hospitals to use these revenue codes when billing and reporting costs for radiopharmaceuticals that can be paid separately. The commenters also stated that clarifying that these are nonpass-through and not packaged will assist CMS in tracking and analyzing costs for the radiopharmaceuticals and contribute to more accurate payment determinations. They recommended that CMS require hospitals to use the new revenue codes to report charges for radiopharmaceuticals.

Response: The assignment of status indicator ''N'' to revenue codes 0343 and 0344 in Transmittal 290 relates to OCE treatment of lines on a claim that report a charge with a revenue code but with no HCPCS code. The assignment of certain status indicators to revenue codes reported in the attachment to quarterly OPPS updates entitled ''Summary of Data Modifications'' is an OCE specification only, and should not be confused with how we use the status indicators listed in Addendum D1 that we assign to HCPCS codes and to APCs.

Additional information related to how revenue codes are used can be found in Pub. 100–04, Medicare Claims Processing, Chapter 4, Section 20, Subsection 5.1.1, entitled ''Packaged Revenue Codes.'' As indicated in that section, certain revenue codes when reported on an OPPS bill *without* a HCPCS code, including revenue codes 0343 and 0344, are considered packaged services that are to be factored into the transitional outpatient payment and outlier calculations.

Although we strongly encourage hospitals to report charges and HCPCS codes for diagnostic and therapeutic radiopharmaceuticals using revenue codes 0343 and 0344, respectively, we generally try to not to impose requirements on the assignment of HCPCS codes to revenue codes for OPPS services because the way hospitals assign costs varies so widely. Nevertheless, we agree with the commenters that, to the extent hospitals report charges for radiopharmaceuticals, both packaged and separately payable, using the new revenue codes 0343 and 0344, our cost data related to radiopharmaceuticals should be more precise.

We will review our manual instructions and previous issuances related to the reporting of revenue codes and make any revisions needed to clarify and update those instructions.

Comment: One commenter asked that CMS change the status indicator for code 90780 and 90781 to ''X'' from ''T'' and thereby cease the application of the multiple procedure reduction to these services, which will be billed for administration of infusion therapy in place of Q0081 for CY 2005. The commenter indicated that there is no situation in which the time and resources involved in infusion care should be reduced in the case of an observation patient.

Response: We disagree. The costs of space, utilities and staff attendance are duplicated when the beneficiary is receiving another service at the same time as infusion therapy, in particular when the patient is in observation. Hence, a multiple procedure reduction to infusion therapy is appropriate, particularly when the patient is in observation status. However, we are noting how the multiple procedure discounting logic in the OCE functions. Line items with a service indicator of ''T'' are subject to multiple procedure discounting unless modifiers 76, 77, 78, or 79, or all, are present. The ''T'' line item with the highest payment amount will not be multiple procedure discounted, and all other ''T'' line items will be multiple procedure discounted. All line items that do not have a service indicator of ''T'' will be ignored in determining the discount. Therefore, if the only other services reported with infusion therapy are an emergency department or other visit code, or diagnostic tests and services assigned status indicator ''S,'' the infusion therapy code would not be subject to the multiple procedure discounting.

2. Comment Indicators

In the November 1, 2002 and the November 7, 2003 final rules with comment period, which implemented changes in the OPPS for CYs 2003 and 2004, respectively, we provided code condition indicators in Addendum B. The code condition indicators and their meaning are as follows:

- ''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.

• ''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.

Medicare had permitted a 90-day grace period after implementation of an updated medical code set, such as the HCPCS, to give providers time to incorporate new codes in their coding and billing systems and to remove the discontinued codes. HCPCS codes are updated annually every January 1, so the grace period for billing discontinued HCPCS was implemented every January 1 through March 31.

The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules require usage of the medical code set that is valid at the time that the service is provided. Therefore, effective January 1, 2005, CMS is eliminating the 90-day grace period for billing discontinued HCPCS codes. Details about elimination of the 90-day grace period for billing discontinued HCPCS codes were issued to our contractors on February 6, 2004, in Transmittal 89, Change Request 3093.

In order to be consistent with the HIPPA rule that results in the elimination of the 90-day grace period for billing discontinued HCPCS codes, in the August 16, 2004 OPPS proposed rule, we proposed, effective January 1, 2005, to delete code condition indicators ''DNG'' and ''DG''. We proposed to designate codes that are discontinued effective January 1, 2005 with status indicator ''D,'' as described in section VII.C.1. of this preamble.

Further, we proposed to rename ''code condition'' indicators as ''comment indicators.'' In Addendum D2 to this final rule with comment period, we list the following two comment indicators that we had proposed to use to identify HCPCS codes assigned to APCs that are or are not subject to comment:

• ''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.

We did not receive any public comments on our proposal relating to comment indicators. We are implementing the comment indicators and discontinuing the use of code condition indicators as we proposed, without modification.

D. Observation Services

Frequently, beneficiaries are placed in ''observation status'' in order to receive treatment or to be monitored before making a decision concerning their next placement (that is, admit to the hospital or discharge). This status assignment occurs most frequently after surgery or a visit to the emergency department. For a detailed discussion of the clinical and payment history of observation services, see the November 1, 2002 final rule with comment period (67 FR 66794).

Before the implementation of the OPPS in CY 2000, payment for observation care was made on a reasonable cost basis, which gave hospitals a financial incentive to keep beneficiaries in ''observation status'' even though clinically they were being treated as inpatients. With the initiation of the OPPS, observation services were no longer paid separately; that is, they were not assigned to a separate APC. Instead, costs for observation services were packaged into payments for the services with which the observation care was associated.

Beginning in early 2001, the APC Panel began discussing the topic of separate payment for observation services. In its deliberations, the APC Panel asserted that observation services following clinical and emergency room visits should be paid separately, and that observation following surgery should be packaged into the payment for the surgical procedure. For CY 2002, we implemented separate payment for observation services (APC 0339) under the OPPS for three medical conditions: chest pain, congestive heart failure, and asthma. A number of accompanying requirements were established, including the billing of an evaluation and management visit in conjunction with the presence of certain specified diagnosis codes on the claim, hourly billing of observation care for a minimum of 8 hours up to a maximum of 48 hours, timing of observation beginning with the clock time on the nurse's admission note and ending at the clock time on the physician's discharge orders, a medical record documenting that the beneficiary was under the care of a physician who specifically assessed patient risk to determine that the beneficiary would benefit from observation care, and provision of specific diagnostic tests to beneficiaries based on their diagnoses. In developing this policy for separately payable observation services, we balanced issues of access, medical necessity, potential for abuse, and the need to ensure appropriate payment. We selected the three medical conditions, noted previously, and the accompanying diagnosis codes and diagnostic tests to avoid significant morbidity and mortality from inappropriate discharge while, at the same time, avoiding unnecessary inpatient admissions.

Over the past 2 years, we have continued to review observation care claims data for information on utilization and costs, along with additional information provided to us by physicians and hospitals concerning our current policies regarding separately payable observation services. Our primary goal is to ensure that Medicare beneficiaries have access to medically necessary observation care. We also want to ensure that separate payment is made only for beneficiaries actually receiving clinically appropriate observation care.

In January 2003, the APC Panel established an Observation Subcommittee. Over the last year, this subcommittee has held discussions concerning observation care and reviewed data extracted from claims that reported observation services. The subcommittee presented the results of its deliberations to the full APC Panel at the February 2004 meeting. The APC Panel recommendations regarding observation care provided under the OPPS were broad in scope and included elimination of the diagnosis requirement for separate payment for observation services, elimination of the requirement for the concomitant diagnostic tests for patients receiving observation care, unpackaging of observation services beyond the typical expected recovery time from surgical and interventional procedures, and modification of the method for measuring beneficiaries' time in observation to make it more compatible with routine hospital practices and their associated electronic systems.

In response to the APC Panel recommendations, we undertook a number of studies regarding observation services, while acknowledging data limitations from the brief 2-year experience the OPPS has had with separately payable observation services.

To assess the appropriateness of the APC Panel's recommendation not to pay separately for observation services following surgical or interventional procedures, we analyzed the claims for these procedures to determine the extent to which the claims reported packaged observation services codes. This analysis revealed that while

observation services are being reported on some claims for surgical and interventional procedures, the great majority of claims for these procedures reported no observation services. The packaged status of these observation services codes may result in underreporting their frequency, but the proportion of surgical and interventional procedures reported with the packaged observation services codes was so small that any increase would not change our substantive conclusion. This confirmed our belief that, although an occasional surgical case may require a longer recovery period than expected for the procedure, as a rule, surgical outpatients do not require observation care. Given the rapidly changing nature of outpatient surgical and interventional services, it would be difficult to determine an expected typical recovery time for each procedure. We have concerns about overutilization of observation services in the post-procedural setting as partial replacement for recovery room time. However, we noted that, to the extent observation care or extended recovery services are provided to surgical or interventional patients, the cost of that care is packaged into the payment for the procedural APC which may result in higher median costs for those procedures.

We also analyzed the possibility of expanding the list of medical conditions for separately payable visit-related observation services, altering the requirements for diagnostic tests while in observation, and modifying the rules for counting time in observation care.

We looked at CY 2003 OPPS claims data for all packaged visit-related observation care for all medical conditions in order to determine whether or not there were other diagnoses that would be candidates for separately payable observation services. Our analysis confirmed that the three diagnoses that are currently eligible for separate payment for observation services are appropriate, as those diagnoses are frequently reported in our visit-related claims with packaged observation services. In fact, diagnoses related to chest pain were, by far, the diagnosis most frequently reported for observation care, either separately payable or packaged. Other diagnoses that appeared in the claims data with packaged observation services included syncope and collapse, transient cerebral ischemia, and hypovolemia.

The packaged status of those observation stays means that the data are often incomplete and the frequency of services may be underreported. Generally, information about packaged services is not as reliably reported as is that for separately paid services. However, we are not convinced that, for those other conditions (such as hypovolemia, syncope and collapse, among others), there is a well-defined set of hospital services that are distinct from the services provided during a clinic or emergency room visit. Separately payable observation care must include specific, clinically appropriate services, and we are still accumulating data and experience for the three medical conditions for which we are currently making separate payment. Therefore, we believed it was premature to expand the conditions for which we would separately pay for visit-related observation services.

Hospitals have indicated that, even in the cases where the diagnostic tests have been performed, to assure that billing requirements for separately payable observation services under APC 0339 are met, they must manually review the medical records to prepare the claims. If they do not conduct this manual review, they may not be coding appropriately for separately payable observation services.

As noted in our August 16, 2004 proposed rule, we have also received comments from the community and the APC Panel asserting that the requirements for diagnostic testing are overly prescriptive and administratively burdensome, and that hospitals may perform tests to comply with the CMS requirements, rather than based on clinical need. For example, a patient admitted directly to observation care with a diagnosis of chest pain may have had an electrocardiogram in a physician's office just prior to admission to observation and may only need one additional electrocardiogram while receiving observation care. Thus, two more electrocardiograms performed in the hospital as required under the current OPPS observation policy might not be medically necessary.

We continue to believe that the diagnostic testing criteria we established for the three medical conditions are the minimally appropriate tests for patients receiving a well-defined set of hospital observation services for those conditions. The previous example, notwithstanding, we also continue to believe that the majority of these tests would be performed in the hospital outpatient setting. We define observation care as an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if the condition resolves itself and the patient is discharged. The currently required diagnostic tests reflect that an active assessment of the patient was being undertaken, and we believe they are generally medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and aid in determining the appropriate disposition of the patient following observation care.

After careful consideration, we agree that specifying which diagnostic tests must be performed as a prerequisite for payment of APC 0339 may be imposing an unreasonable reporting burden on hospitals and may, in some cases, result in unnecessary tests being performed. Therefore, in the August 16, 2004 proposed rule, we proposed, beginning in CY 2005, to remove the current requirements for specific diagnostic testing, and to rely on clinical judgment in combination with internal and external quality review processes to ensure that appropriate diagnostic testing (which we expect would include some of the currently required diagnostic tests) is provided for patients receiving high quality, medically necessary observation care.

Accordingly, we proposed that, beginning in CY 2005, the following tests would no longer be required to receive payment for APC 0339 (Observation):

- For congestive heart failure, a chest x-ray (71010, 71020, 71030), and electrocardiogram (93005) and pulse oximetry (94760, 94761, 94762)
- For asthma, a breathing capacity test (94010) or pulse oximetry (94760, 94761, 94762)
- For chest pain, two sets of cardiac enzyme tests; either two CPK (82550, 82552, 82553) or two troponins (84484, 84512) and two sequential electrocardiograms (93005)

We believe that this proposed policy change would benefit hospitals because it would reduce administrative burden, allow more flexibility in management of beneficiaries in observation care, provide payment for clinically appropriate care, and remove a requirement that may have resulted in duplicative diagnostic testing.

We received numerous public comments supporting our proposed policy. We did not receive any comments that opposed the proposed policy. Therefore, we are adopting, without modification, our proposal to no longer require specified diagnostic tests to receive payment for APC 0339, beginning in CY 2005.

Hospitals and the APC Panel further suggested that we modify the method for accounting for the beneficiary's time in observation care. Currently, hospitals report the time in observation beginning with the admission of the beneficiary to

observation and ending with the physician's order to discharge the patient from observation. There are two problems related to using the time of the physician discharge order to determine the ending time of observation care. First, providers assert that it is not possible to electronically capture the time of the physician's orders for discharge. As a result, manual medical record review is required in order to bill accurately. Second, the hospital may continue to provide specific discharge-related observation care for a short time after the discharge orders are written and, therefore, may not be allowed to account for the full length of the observation care episode. In an effort to reduce hospitals' administrative burden related to accurate billing, in the proposed rule, we proposed to modify our instructions for counting time in observation care to end at the time the outpatient is actually discharged from the hospital or admitted as an inpatient. Our expectation was that specific, medically necessary observation services were being provided to the patient up until the time of discharge. However, we did not expect reported observation time to include the time patients remain in the observation area after treatment is finished for reasons that include waiting for transportation home.

Although beneficiaries may be in observation care up to 48 hours or longer, we believed that, in general, 24 hours was adequate for the clinical staff to determine what further care the patient needs. In CY 2005, we proposed to continue to make separate payment for observation care based on claims meeting the requirement for payment of HCPCS code G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum 8 hours, maximum 48 hours). However, we proposed not to include claims reporting more than 48 hours of observation care in calculating the final payment rate for APC 0339.

We received several public comments on our proposal.

Comment: A number of commenters urged that CMS include claims for stays greater than 48 hours in the data used to calculate the payment rate for observation because any such claims in our dataset would have withstood local fiscal intermediary scrutiny for reasonableness and medical necessity and should therefore be regarded as legitimate for pricing calculations. One commenter requested that CMS provide clarification to fiscal intermediaries regarding billing for stays that exceed 48 hours because code G0244 (Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours, maximum 48 hours) would seem to preclude billing G0244 for stays that exceed 48 hours but that otherwise meet all the criteria for payment.

Response: In an effort to clarify the apparent confusion cited by commenters with regard to billing for stays that exceed 48 hours, beginning in CY 2005, we are changing the descriptor for HCPCS code G0244 to read as follows:

G0244, Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours.

We expect that hospitals will report one unit of G0244 for each hour of observation care provided to patients for congestive heart failure, chest pain, or asthma, with a minimum 8 units billed to be eligible for separate observation payment.

We carefully considered the comments that urged us to include reporting more than 48 hours to calculate the median cost of G0244. The final payment rate for APC 0339 listed in Addendum A is based on all CY 2003 claims for G0244 taken from the National Claims History file, without regard to units of service. Prior to implementation of the OPPS, when hospital outpatient services were paid on a reasonable cost basis, Medicare did allow payment for observation services that exceeded 48 hours when medical review determined that a more extended period of observation care was reasonable and necessary. Since implementation of the OPPS, Medicare has ceased paying separately for observation care, with the exception of services reported with G0244, because payment for observation services was packaged into payment for services with which observation services were reported. We believe that, in the overwhelming majority of cases, decisions can be and are routinely made in less than 48 hours whether to release a beneficiary from the hospital following resolution of the reason for the outpatient visit or whether to admit the beneficiary as an inpatient. Therefore, we intend to revisit this issue in future updates.

For the reasons stated above, we are not adopting as final for CY 2005, our proposal to exclude claims for G0244 that reported more than 48 hours of observation from calculation of the median cost for APC 0339.

We also proposed the following requirements to receive separate payment for HCPCS code G0244 in APC 0339 for medically necessary observation services involving specific goals and a plan of care that are distinct from the goals and plan of care for an emergency department, physician office, or clinic visit:

- The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma. The hospital bill must report as the admitting or principal diagnosis an appropriate ICD–9–CM code to reflect the condition. The eligible ICD–9–CM diagnosis codes for CY 2005 are shown in Table 38 below.
- The hospital must provide and report on the bill an emergency department visit (APC 0610, 0611, or 0612), clinic visit (APC 0600, 0601, or 0602), or critical care (APC 0620) on the same day or the day before the separately payable observation care (G0244) is provided. For direct admissions to observation, in lieu of an emergency department visit, clinic visit, or critical care, G0263 (Adm with CHF, CP, asthma) must be billed on the same day as G0244.
- HCPCS code G0244 must be billed for a minimum of 8 hours.
- No procedures with a 'T' status indicator, except the code for infusion therapy of other than a chemotherapy drug (CPT code 90780) can be reported on the same day or day before observation care is provided.
- Observation time must be documented in the medical record and begins with the beneficiary's admission to an observation bed and ends when he or she is discharged from the hospital.
- The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
- The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

We received numerous public comments on our proposal.

Comment: Most commenters applauded our proposal to eliminate the requirement that specified diagnostic tests be reported in order to receive payment for HCPCS code G0244. However, many commenters expressed disappointment that CMS did not propose to expand the conditions for which separate payment would be provided for observation care. One commenter, representing cancer centers, requested that CMS study febrile neutropenia, chemotherapy hypersensitivity reaction, hypovolemia, and electrolyte imbalance as conditions that would warrant separate payment for observation. A few commenters

supported the APC Panel recommendation that we eliminate altogether the diagnosis coding requirement for APC 0339. One commenter stated that medical care included in hourly observation charges billed under revenue code 762 for syncope and collapse, transient cerebral ischemia, and hypovolemia is medically necessary and distinct from services rendered in the emergency department or a clinic, is similar to that furnished to patients with congestive heart failure, asthma, and chest pain, and should therefore be paid for separately.

Response: We appreciate the support expressed by numerous commenters for the changes in requirements that we proposed for CY 2005 in order for hospitals to receive separate payment for observation services. As we indicate below, we are making final most of the changes that we proposed, with some modifications based on comments that we received. Although we are not going to implement in the CY 2005 OPPS the recommendations made by commenters and the APC Panel to expand separate payment for observation to include conditions in addition to congestive heart failure, asthma, and chest pain, we will continue to analyze our data and study the impact of such a change for reconsideration in future updates of the OPPS.

Comment: Several commenters supported our proposal to change how we define ending time or ''discharge'' from observation care. However, those commenters also requested further clarification of what we mean by ''discharge.''

Response: We carefully considered the thoughtful comments related to our proposal to modify the current policy regarding the time that should be recorded to designate when observation care ends. Based on suggestions from commenters, we are elaborating upon our proposal to define as the end of observation, the time the outpatient is either discharged from the hospital or admitted as an inpatient. Specifically, we consider the time when a patient is ''discharged'' from observation status to be the clock time when all clinical or medical interventions have been completed, including any necessary followup care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient. However, observation care does not include time spent by the patient in the hospital subsequent to the conclusion of therapeutic, clinical, or medical interventions, such as time spent waiting for transportation to go home.

Comment: A few commenters requested clarification of the starting time for observation. One commenter recommended that CMS make it clear that observation time begins with the patient's placement in the bed and initiation of observation care, regardless of whether the bed is in a holding area or is in an actual observation bed or unit, as long as appropriate observation care is being provided. Another commenter asked if CMS will allow providers to document observation start time on any applicable document in the medical record and not limit the start time documentation to the nurse's observation admission note.

Response: We have stated in past issuances and rules that observation time begins at the clock time appearing on the nurse's observation admission note, which coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit (66 FR 59879, November 30, 2001; Transmittal A–02–026 issued on March 28, 2002; and Transmittal A–02–129 issued on January 3, 2003.) In the August 16, 2004 proposed rule, we stated that observation time must be documented in the medical record and begins with the beneficiary's admission to an observation bed (69 FR 50534). We agree with the commenter on the need for clarification, and we will reiterate in provider education materials developed for the CY 2005 OPPS update that observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order.

Comment: One commenter, a hospital trade association, recommended that CMS reconsider requiring hospitals to report one of the ICD–9–CM diagnosis codes designated for payment of APC 0339 as the admitting or principal diagnosis on the hospital claim. The commenter was concerned that, if we restrict the position of the diagnosis code to the admitting or principal field, many claims that otherwise meet the criteria for separate payment of observation will not be payable because coding rules and the frequency by which Medicare beneficiaries with asthma, congestive heart failure or chest pains have other presenting signs, symptoms, and clinical conditions will result in inappropriate placement of the requisite diagnosis code. Therefore, the commenter recommended that CMS accept the required diagnosis code in any diagnosis code field.

Response: Our proposal to require hospitals to report one of the specified ICD–9–CM codes in the admitting or principal diagnosis field is a modification of policy that we implemented in the November 30, 2001 final rule (66 FR 59880). We disagree with the commenter that this requirement will result in many claims for APC 0339 not being paid. Rather, we believe that requiring hospitals to report the signs, symptoms, and conditions that are the reason for the patient's visit will enhance coding accuracy and ensure that we are paying appropriately for APC 0339 by limiting separate payment to those observation services furnished to monitor asthma, chest pain, or congestive heart failure. If we continued to accept the required ICD–9–CM diagnosis code as a secondary diagnosis, we would remain concerned that we may be making separate payment for observation for conditions other than asthma, congestive heart failure or chest pain because these conditions are reported in the secondary diagnosis field even though they are not the clinical reason that the patient is receiving observation services.

Because we want to give hospitals ample time to incorporate this requirement into their billing systems, we will not implement this requirement before April 1, 2005. However, we are making final in this final rule with comment period the requirement that, beginning April 1, 2005, hospitals must report a qualifying ICD–9 CM diagnosis code in Form Locator (FL) 76, Patient Reason for Visit, and/or FL 67, principal diagnosis, in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9 diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL 76) or the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

Comment: One commenter requested that CMS modify the requirement that there be documentation that the physician has explicitly assessed the beneficiary risk to determine that he would benefit from observation care.

Response: We expect that, prior to issuing an order to place a patient in observation status, it is standard procedure for the physician to assess the patient's condition to determine the clinically appropriate intervention that is most likely to result in maximum benefit for the patient given his or her condition at that time. To expect documentation of that assessment in the medical record of a patient for whom an order to receive observation care has been issued is not new, excessive, or

unduly burdensome, but rather is an essential part of the patient's medical record to support the medically reasonable and necessary nature of the services ordered and furnished.

Comment: One commenter requested that CMS allow observation care following surgery if recovery time is longer than expected.

Response: As stated in the proposed rule, this situation is precisely contrary to the purpose of the observation care benefit. We again note that recovery time has been factored into the payment for the surgery. Although there is variation among patients' recovery times, that variation is part of the averaging that is inherent in a prospective payment system. Those costs are not considered as part of the payment for observation care, which serves an entirely different purpose for beneficiaries in the outpatient setting.

Comment: One commenter recommended adding ICD–9–CM diagnosis code 427.31 (Atrial fibrillation) to the list of specified diagnosis codes that could be included on claims for separately payable observation services furnished to patients with congestive heart failure or chest pain, or both.

Response: While many patients may have chronic atrial fibrillation that is asymptomatic, we agree that some patients may present chest pain as a significant symptom associated with atrial fibrillation. Atrial fibrillation may also complicate acute myocardial infarction. Patients who are being evaluated and managed with observation care for chest pain in a hospital may be found to have symptomatic atrial fibrillation as the likely etiology of their chest discomfort following comprehensive assessment. However, we would generally expect that patients with chest pain and atrial fibrillation receiving observation services in the hospital would be receiving these services specifically for their chest pain and that one of the chest pain diagnoses already on our list of diagnosis codes would be present on the claim as the reason for the visit or the principal diagnosis. Similarly, with respect to atrial fibrillation and congestive heart failure, congestive heart failure is an independent predictor of atrial fibrillation. However, as with chest pain and atrial fibrillation, we would generally expect that patients with congestive heart failure and atrial fibrillation receiving observation services in the hospital to be receiving these services specifically for their congestive heart failure and that one of the congestive heart failure diagnoses already on our list of diagnosis codes would be present on the claim as the reason for the visit or the principal diagnosis.

Therefore, while we agree with the commenter's suggestion that code 427.31 could be viewed as a reasonable diagnosis code for chest pain for which separate payment for observation services might be made under the OPPS, we believe it is unnecessary and redundant to add it to the list for chest pain because any of the existing ICD–9–CM diagnosis codes listed in Table 32 for chest pain suffices for purposes of the OPPS observation payment policy. Likewise, we are not adding code 427.31 to the list of acceptable congestive heart failure diagnoses for which separate payment for observation services is made by the OPPS.

Comment: One commenter recommended that diagnostic heart catheterization procedures, CPT codes 93510 through 92529, performed within 24 hours of an observation stay not disqualify separate payment for the observation even though these codes are assigned status indicator ''T,'' because it is not uncommon for patients admitted through the emergency department to observation for chest pain to be followed up with a diagnostic heart catheterization within 24 hours.

Response: This scenario was discussed during the February 2004 APC Panel meeting, although it was not advanced as a formal recommendation. While we are not adopting the commenter's recommendation at this time, we are making final in this final rule with comment period several changes in the requirements for separate payment for observation care, for implementation in CY 2005. We believe further analysis of any impact of such a change, in addition to analysis of the other changes being implemented in CY 2005, is necessary. We note that by the APC Panel may wish to consider this in future meetings.

Comment: One commenter, representing a health system, suggested extensive billing and coding changes to further simplify claims submission for observation services. These suggestions included revision of the definition of HCPCS code G0263 and elimination of HCPCS code G0264 for direct admissions; replacing use of HCPCS code G0244 with a revenue code and CPT codes and letting the OCE determine if the criteria for payment of APC 0339 are met; clarification of billing for postanesthesia care unit (PACU) services; and use of revenue codes to distinguish between observation in a clinic and observation in an emergency department.

Response: We welcome the commenter's suggestions and will endeavor during the next year to evaluate their feasibility and impact of any such changes. However, we recognize that extensive systems changes would be required to implement many of these suggestions, but will consider them for possible implementation in future updates of the OPPS.

After carefully considering the public comments received related to our proposed requirements to receive separate payment for observation services in CY 2005, we are adopting our proposal as final without modification.

BILLING CODE 4120–01–P

Table 38.--CY 2005 Eligible Diagnosis Codes for Billing Observation Services

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
Chest Pain	411.0	Postmyocardial infarction syndrome
	411.1	Intermediate coronary syndrome
	411.81	Coronary occlusion without myocardial infarction
	411.89	Other acute ischemic heart disease
	413.0	Angina decubitus
	413.1	Prinzmetal angina
	413.9	Other and unspecified angina pectoris
	786.05	Shortness of breath
	786.50	Chest pain, unspecified
	786.51	Precordial pain
	786.52	Painful respiration
	786.59	Other chest pain
Asthma	493.01	Extrinsic asthma with status asthmaticus
	493.02	Extrinsic asthma with acute exacerbation
	493.11	Intrinsic asthma with status asthmaticus
	493.12	Intrinsic asthma with acute exacerbation
	493.21	Chronic obstructive asthma with status asthmaticus
	493.22	Chronic obstructive asthma with acute exacerbation
	493.91	Asthma, unspecified with status asthmaticus
	493.92	Asthma, unspecified with acute exacerbation
Heart Failure	391.8	Other acute rheumatic heart disease
	398.91	Rheumatic heart failure (congestive)
	402.01	Malignant hypertensive heart disease with congestive heart failure
	402.11	Benign hypertensive heart disease with congestive heart failure
	402.91	Unspecified hypertensive heart disease with congestive heart failure

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
	404.01	Malignant hypertensive heart and renal disease with congestive heart failure
	404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
	404.11	Benign hypertensive heart and renal disease with congestive heart failure
	404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
	404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
	404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure
	428.0	Congestive heart failure
	428.1	Left heart failure
	428.20	Unspecified systolic heart failure
	428.21	Acute systolic heart failure
	428.22	Chronic systolic heart failure
	428.23	Acute on chronic systolic heart failure
	428.30	Unspecified diastolic heart failure
	428.31	Acute diastolic heart failure
	428.32	Chronic diastolic heart failure
	428.33	Acute on chronic diastolic heart failure
	428.40	Unspecified combined systolic and diastolic heart failure
	428.41	Acute combined systolic and diastolic heart failure
	428.42	Chronic combined systolic and diastolic heart failure
	428.43	Acute on chronic combined systolic and diastolic heart failure
	428.9	Heart failure, unspecified

BILLING CODE 4120–01–C

E. 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 provide 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 with comment period, 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 postoperative 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 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), 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 (67 FR 66792), 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 ASC procedures or proposed by us for addition to the ASC list.

In the November 7, 2003 final rule with comment period, we did not implement any changes in our payment policies for the OPPS inpatient list. However, we addressed issues and concerns raised by commenters in response to the August 12, 2003 proposed rule and further clarified payment policies related to the OPPS inpatient list.

At the February 2004 meeting, the APC Panel made the recommendation to remove the following four abscess drainage CPT codes from the inpatient list: 44901, 49021, 49041, and 49061. As discussed in the proposed rule, we agreed with the APC Panel's recommendation and we proposed to remove these four abscess codes from the inpatient list and to assign them to APC 0037 for OPPS payment in CY 2005.

The APC Panel also made a recommendation to either eliminate the inpatient list from the OPPS or to evaluate the current list of procedures for any other appropriate changes. As recommended by the APC Panel, we sought to identify additional procedure codes to propose for removal from the inpatient list, consistent with the criteria listed above. To assist us in identifying procedures that were being widely performed on an outpatient basis for clinical review, we looked for services on the inpatient list that were performed on Medicare beneficiaries in all sites of service other than the hospital inpatient setting approximately 60 percent or more of the time. We relied on CY2003 Medicare Part B Extract and Summary System (BESS) data for this information. We chose 60 percent as a threshold because, in general, we believe that a procedure should be specifically considered for removal from the inpatient list if there is evidence that it is being performed less than one half of the time in the hospital inpatient setting. For procedures where data demonstrate that they are being delivered to Medicare beneficiaries in a safe and appropriate manner on an outpatient basis in a variety of different hospitals, we believe that it is reasonable to consider the removal of these procedures from the inpatient list. After further clinical evaluation of codes that met our 60-percent threshold to ensure that these procedures met our other criteria for removal from the inpatient list and were truly appropriate for consideration, we proposed to place 20 procedures that are on the inpatient list for the CY 2004 OPPS into clinical APCs for payment under the OPPS for CY 2005. We proposed to assign all of these codes the status indicator ''T.'' Two additional services, CPT codes 00174 and 00928, were proposed to be removed and assigned a status indicator ''N'' because, under the OPPS, anesthesia codes are packaged into the procedures with which they are billed.

We proposed not to accept the APC Panel's recommendation to completely eliminate the inpatient list for CY 2005. We solicited comments, especially from professional societies and hospitals, on whether any procedures on the CY 2005 proposed inpatient list were appropriate for removal and whether any other such procedures should be separately paid under the OPPS. We also asked commenters who recommend that a procedure that is currently on the inpatient list be reclassified 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 requested that commenters suggest an appropriate APC assignment for the procedure and furnish supporting data to assist us in determining, based on comments, if the procedure could be payable under the OPPS in CY 2005.

We received a number of public comments on our proposal to retain the inpatient list and to delete 22 procedure codes from the inpatient list and our solicitation of additional procedures currently on the inpatient list that should be reclassified to an APC, with supporting evidence.

Comment: One commenter recommended that CMS remove the following CPT codes for spinal procedures currently on the inpatient list: CPT codes 22554, 22585, 22840, 22842, 22845, 22846, 22855, 63043, 63044, 63075, and 63076. The commenter submitted several published articles related to the performance of these procedures in the hospital outpatient setting.

Response: After careful review of the list of procedures and the accompanying articles submitted by the commenter, we believe these procedures should remain on the inpatient list for CY 2005. All of the procedures recommended by the commenter for removal were performed more than 90 percent of the time in the hospital inpatient setting on Medicare beneficiaries according to our BESS data. There was no evidence submitted to demonstrate that the procedures were being provided safely and effectively to patients demographically similar to Medicare beneficiaries in multiple hospitals in the outpatient hospital setting. We are concerned that none of the published studies, with the exception of one, included patients in the general Medicare-eligible age range of 65 years or older. We do not believe that experience in providing these major spinal procedures to young and middle-aged adults in the outpatient setting can necessarily be generalized as safe and appropriate for typical Medicare beneficiaries.

Comment: One commenter requested that CPT code 58260 (Vaginal hysterectomy) be removed from the inpatient list. The commenter stated that surgeons at the hospital believed that performing this procedure in an outpatient setting has been a standard of practice for a long time.

Response: According to our BESS data, the procedure described by CPT 58260 was performed more than 90 percent of the time in the hospital inpatient setting on Medicare beneficiaries. There was no evidence submitted by the commenter to demonstrate that this procedure was being provided safely and effectively to patients demographically similar to Medicare beneficiaries in multiple hospitals in the outpatient hospital setting. Thus, we believe this procedure should remain on the inpatient list.

Comment: Several commenters, including a hospital association, recommended the elimination of the inpatient list, echoing the APC Panel's recommendation from February 2004. The commenters stated that, while it is appropriate to leave the decision of site of service to the physicians, hospitals are unable to receive payment for services on this list that are performed in the hospital outpatient setting. One commenter argued that the current policy penalizes beneficiaries because they must be admitted as inpatients to receive these procedures, rather than receiving these services in an outpatient setting and being allowed to return home.

Response: In the November 7, 2003 final rule (67 FR 66797), we specified the inpatient list to include services that are payable by Medicare only when provided in an inpatient setting. These are services that generally require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the Medicare beneficiary. We also listed in the November 7, 2003 final rule (68 FR 63466) the criteria that we use to evaluate whether a procedure should be

removed from the inpatient list. We do not believe that all services can be safely and effectively delivered to Medicare beneficiaries in the outpatient setting. We are concerned that elimination of the inpatient list could result in unsafe or uncomfortable care for Medicare beneficiaries. Among the potential results are long observation stays after some procedures and imposition of OPPS copayments, which could differ significantly from a patient's inpatient cost-sharing responsibilities.

We believe that it is important for hospitals to educate physicians on Medicare services provided under the OPPS to avoid inadvertently providing services in an outpatient setting that are more appropriate to an inpatient setting.

Comment: A few commenters recommended that CMS consider developing an appeals process to address circumstances in which payment for a procedure provided on an outpatient basis is denied because it is on the inpatient list.

Response: We would like to emphasize that procedures on the inpatient list that are performed on a patient whose status is that of an outpatient are not payable under Medicare. CPT codes assigned a status indicator of ''C,'' such as those listed in Addendum E, are not payable under the OPPS, except under conditions described in the November 1, 2002 final rule (67 FR 66799).

Comment: A few commenters requested that CMS clarify the criteria and the sources of data used to determine whether a procedure is appropriate for removal from the list. Other commenters expressed concern with the 60-percent threshold criterion used to evaluate codes for removal from the inpatient list. One commenter recommended that CMS revise its criteria because major teaching hospital outpatient departments often are the first places to perform services that had previously been performed only in the inpatient setting. This commenter argued that there would most likely be a time gap between when these services could be performed safely in teaching hospital outpatient departments and their dissemination to most hospitals' outpatient departments. The commenter recommended that the determining factor regarding whether a procedure should be removed from the inpatient list should be whether the procedure can be performed safely in an outpatient department and not the number of outpatient departments in which the procedure is performed.

Response: We recognize that teaching hospitals may have more technologically advanced equipment, more experienced staff, and greater resources than nonteaching hospitals. These characteristics may lead teaching hospitals to be the first places to perform on an outpatient basis some procedures on the inpatient list. On the other hand, community, nonteaching hospitals have pioneered the movement of some procedures to the outpatient setting, in part because of their responsiveness to identified local needs or their development of specific pathways for care. We cannot expect that all hospitals will have the necessary staff experience, resources, equipment, and interest to move many procedures to the outpatient setting. For these reasons, we do not believe that procedures that have been demonstrated to be performed safely and effectively on an outpatient basis in any single hospital or small group of hospitals alone are routinely appropriate for removal from the inpatient list.

In addition, we want to clarify that the 60-percent threshold discussed in our proposed rule is not an established criterion that we use to determine whether a procedure is appropriate for removal from the inpatient list. The 60-percent threshold was used as an operational tool to identify from the entire inpatient list those procedures that we believe are currently already being performed in the outpatient setting a majority of the time based on our CY 2003 BESS data, so that these services could then undergo clinical review against the criteria for removal from the inpatient list. The BESS database aggregates all physician billing throughout the year for each service provided to Medicare beneficiaries and billed under the Medicare Physician Fee Schedule. Summary data include information regarding the site of service (hospital inpatient, hospital outpatient, physician's office, among others) and specialty of the physician performing the service. We emphasize that our review of the codes recommended by the commenters for removal from the list was not based on this threshold. Rather, our determination was based on the set of criteria described in the November 7, 2003 final rule (68 FR 63466).

We encourage hospitals and physicians to submit recommendations regarding procedures they believe meet our criteria for removal from the inpatient list at any time. We ask that evidence be submitted 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: Numerous commenters supported the proposed removal of the 22 CPT codes from the inpatient list. In addition, a few commenters expressed support for retaining the list of inpatient procedures. One commenter stated that eliminating the list could create an increase in inappropriate observation stays by assigning observation status to patients whose status should have been inpatient.

Response: We appreciate the commenters' support.

In this final rule, we are finalizing our proposed retention of the inpatient list for the OPPS. We also are finalizing our proposal to remove 22 procedures from the CY 2004 list. Table 39 below lists the procedure codes that are being removed from the inpatient list and their APC assignments, effective January 1, 2005.

BILLING CODE 4120–01–P

Table 39.--Procedure Codes Removed From Inpatient List and APC Assignment, Effective January 1, 2005

HCPCS	Description	APC Assignment	SI
00174	Anesth, pharyngeal surgery	n/a	N
00928	Anesth, removal of testis	n/a	N
21356	Treat cheek bone fracture	0254	T
21557	Remove tumor, neck/chest	0022	T
22222	Revision of thorax spine	0208	T
24149	Radical resection of elbow	0050	T
31292	Nasal/sinus endoscopy, surg	0075	T
43510	Surgical opening of stomach	0141	T
45541	Correct rectal prolapse	0150	T
50020	Renal abscess, open drain	0162	T
50570	Kidney endoscopy	0160	T
50572	Kidney endoscopy	0160	T
50574	Kidney endoscopy & biopsy	0160	T
50575	Kidney endoscopy	0163	T
50576	Kidney endoscopy & treatment	0161	T
53085	Drainage of urinary leakage	0166	T
58770	Create new tubal opening	0195	T
50578	Renal endoscopy/radiotracer	0161	T
44901	Drain app abscess, precut	0037	T
49021	Drain abdominal abscess	0037	T
49041	Drain, percut, abdom abscess	0037	T
49061	Drain, percut, retroper absc	0037	T

BILLING CODE 4120–01–C

F. Hospital Coding for Evaluation and Management Services

1. Background

Currently, for claims processing purposes, we direct hospitals to use the CPT codes used by physicians to report clinic and emergency department visits on claims paid under the OPPS. However, as discussed in the proposed rule, we have received comments suggesting that the CPT codes are insufficient to describe the range and mix of services provided to patients in the clinic and emergency department setting because they are defined to reflect only the activities of physicians (for example, ongoing nursing care, and patient preparation for diagnostic tests). For both clinic and emergency department visits, there are currently five levels of care. To facilitate proper coding, we require each hospital to create an internal set of guidelines to determine what level of visit to report for each patient (April 7, 2000, final rule with comment period (65 FR 18434)).

We have continued our efforts to address the situation of proper coding of clinic and emergency department visits to ensure proper Medicare payments to hospitals. Commenters who responded to the August 24, 2001 OPPS proposed rule (66 FR 44672) recommended that we retain the existing evaluation and management coding system until facility-specific evaluation and management 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 and to implement, and that are compliant with the HIPAA requirements. We agreed with these commenters, and in our November 1, 2002 OPPS final rule (67 FR 66792), we stated that we believed the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that could provide information and data to us. We believed that, in light of the expertise of organizations such as the AHA and the AHIMA, these organizations were particularly well equipped to do so and to provide ongoing education to providers.

The AHA and the AHIMA, on their own initiative, convened an independent expert panel comprised of members of the AHA and AHIMA, as well as representatives of the American College of Emergency Physicians, the Emergency Nurses Association, and the American Organization of Nurse Executives, to develop code descriptions and guidelines for hospital emergency department and clinic visits and to provide us with the information and data. In June 2003, we received the panel's input concerning a set of national coding guidelines for emergency and clinic visits.

As we noted in the proposed rule, we are still considering the panel's set of coding guidelines. Although we did not propose the panel's set of coding guidelines, we received several comments on the Panel's coding guidelines and are continuing to review these public comments. In the November 7, 2003 OPPS final rule with comment period (68 FR 63463), we also indicated that we would implement new evaluation and management codes only when we are also ready to implement guidelines for their use. As we have not yet proposed new evaluation and management codes, we again note that we will allow ample opportunity for public comment, systems changes, and provider education before implementing such new coding requirements.

2. Proposal for Evaluation and Management Guidelines

In the November 7, 2003 OPPS final rule with comment period (68 FR 63463), we discussed our primary concerns and direction for developing the proposed coding guidelines for emergency department and clinic visits and indicated our plans to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them.

We received a number of comments on our proposal.

Comment: Many commenters supported the development of evaluation and management codes and guidelines in the hospital outpatient setting and urged CMS to move forward as quickly as possible with reviewing the guidelines presented by the AHA and AHIMA Evaluation and Management Panel. Several commenters expressed concern that the current lack of uniformity impairs CMS' ability to gather consistent, meaningful data on services provided in the emergency department and hospital clinics. Commenters reminded CMS of its commitment to make the evaluation and management codes and guidelines available for public comment and to provide at least 6 to 12 months notice prior to implementation of the new evaluation and management codes and guidelines.

Response: As stated in the August 16, 2004 OPPS proposed rule, we intend to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them. As stated in the August 16, 2004 OPPS proposed rule, we will notify the public through our ''listserve'' when the proposed guidelines will become available. To subscribe to this listserve, individuals should access the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. When we post the proposed guidelines on the Web site, we will provide ample opportunity for the public to comment.

In addition, we will provide ample time to train clinicians and coders on the use of new codes and guidelines and for hospitals to modify their systems. We anticipate providing at least 6 to 12 months notice prior to implementation of the new evaluation and management codes and guidelines. We will continue working to develop and test the new codes even though we have not yet made plans for their implementation.

G. Brachytherapy Payment Issues Related to Pub. L. 108–173

1. Payment for Brachytherapy Sources (Section 621(b) of Pub. L. 108–173)

Sections 621(b)(1) and (b)(2) of Pub. L. 108–173 amended the Act by adding section 1833(t)(16)(C) and section 1833(t)(2)(H), respectively, to establish separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. Charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS. In addition, consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items must be excluded from budget neutrality as well. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004 through December 31, 2006.

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and 621(b)(2)(C) of Pub. L. 108–173. We stated that we will pay for the brachytherapy sources listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. The status indicator for brachytherapy sources was changed to ''H.'' The definition of status indicator ''H'' was for pass-through payment only for devices, but the brachytherapy sources affected by new sections 1833(t)(16)(C) and 1833(t)(2)(H) of the Act are not pass-through device categories. Therefore, we also changed, for CY 2004, the definition of payment status indicator ''H'' to include nonpass-through brachytherapy sources paid on a cost basis. This use of status indicator ''H'' was a pragmatic decision that allowed us to pay for brachytherapy sources in accordance with new section 1833(t)(16)(C) of the Act, effective January 1, 2004, without having to modify our claims processing systems. We stated in the January 6, 2004 interim final rule with comment period that we would revisit the use and definition of status indicator ''H'' for this purpose in the OPPS update for CY 2005. Therefore, in the August 16, 2004 proposed rule, we solicited further comments on this policy.

We received several public comments on our August 16, 2004 proposal and on the January 6, 2004 interim final rule with comment period.

Comment: One commenter, a hospital association, recommended that CMS establish a new status indicator for brachytherapy sources paid on a cost basis other than the status indicator ''H'', which is also used for device categories paid on a transitional pass-through basis. The commenter noted that, because brachytherapy sources are subject to coinsurance and devices paid on a pass-through basis are not, a separate status indicator is needed for consistency in the classification of status indicators.

Response: The commenter is correct that beneficiaries are not subject to copayment for the cost of device categories with pass-through payment, while beneficiaries are subject to copayment for other separately paid brachytherapy sources. However, our systems' logic incorporates this difference in copayment for pass-through device categories versus nonpass-through brachytherapy sources, even though the status indicator for each is ''H''. Therefore, we are not establishing a separate status indicator at this time. However, we will consider making a change if the need arises.

Comment: A number of commenters on the January 6, 2004 interim final rule with comment period urged us to continue to use, for CY 2005, the C-codes and descriptors that we published in that interim final rule with comment period (69 FR 828) for both prostate and nonprostate brachytherapy that we implemented for CY 2004. Several commenters also suggested that we add the phrase ''per source'' to each of the brachytherapy source descriptors to reinforce that each source equals one unit of payment.

Response: We agree and are retaining the current brachytherapy source C-codes and descriptors with which hospitals are familiar. We have been using these codes and descriptors since we unpackaged brachytherapy sources when the pass-through payment for

these sources ended on December 31, 2002, in addition to other C-codes that we established either for pass-through payment (for example, C2632) or nonpass-through payment (for example, C2633). We also note that, in the August 16, 2004 proposed rule, we proposed adding ''per source'' to each of the applicable brachytherapy descriptors, similar to the APC Panel's recommendation (and the commenter's suggestion) to do so for two new high-activity source categories, discussed below. We are adopting this clarification as final policy in this final rule with comment period and adding ''per source'' to the brachytherapy source descriptors that are paid on a per unit basis for each source.

2. HCPCS Codes and APC Assignments for Brachytherapy Sources

As we indicated in the January 6, 2004 interim final rule with comment period, we began payment for the brachytherapy source in HCPCS code C1717 (Brachytx source, HCR lr-192) based on the hospital's charge adjusted to cost beginning January 1, 2004. Prior to enactment of Pub. L. 108–173, these sources were paid as packaged services in APC 0313. As a result of the requirement under Pub. L. 108–173 to pay for C1717 separately, we adjusted the payment rate for APC 0313, Brachytherapy, to reflect the unpackaging of the brachytherapy source. We received no public comments on this methodology, and we are finalizing the payment methodology in this final rule with comment period.

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must be created in a manner that reflects the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for Palladium-103 and Iodine-125 devices.

We invited the public to submit recommendations for new codes to describe brachytherapy sources in a manner that reflects the number, radioisotope, and radioactive intensity of the sources. We requested commenting parties to provide a detailed rationale to support recommended new codes. We stated that we would propose appropriate changes in codes for brachytherapy sources in the CY 2005 OPPS update.

At its meetings of February 18 through 20, 2004, the APC Panel heard from parties that recommended the addition of two new brachytherapy codes and HCPCS codes for high activity Iodine-125 and high activity Paladium-103. The APC Panel, in turn, recommended that CMS establish new HCPCS codes and new APCs, on a per source basis, for these two brachytherapy sources.

We considered this recommendation and agreed with the APC Panel. Therefore, in the August 16, 2004 proposed rule, we proposed to establish the following two new brachytherapy source codes for CY 2005:

- Cxxx1 Brachytherapy source, high activity, Iodine-125, per source.
- Cxxx2 Brachytherapy source, high activity, Paladium-103, per source.

In addition, we believe the APC Panel's recommendation to establish new HCPCS codes that would distinguish high activity Iodine-125 from high activity Paladium-103 on a per source basis should be implemented for other brachytherapy code descriptors, as well. Therefore, as stated previously, we proposed to include ''per source'' in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment are not already delineated.

Further, a new linear source Paladium-103 came to our attention in CY 2003 by means of an application for a new device category for pass-through payment. While we declined to create a new category for pass-through payment, we believe that this source falls under the provisions of Pub. L. 108–173 for separate cost-based payment as a brachytherapy source. Accordingly, we proposed to add, for separate payment, the following code of linear source Paladium-103: Cxxx3 Brachytherapy linear source, Paladium-103, per 1 mm.

We received a number of public comments on our August 16, 2004 proposed rule and on the January 6, 2004 interim final rule with comment period, which deal with these issues.

Comment: In response to the January 6, 2004 interim final rule with comment period, several commenters recommended adding two new brachytherapy source codes and descriptors, to reflect the ranges in radioactive intensities that are frequently required in clinical practice for Iodine-125 and Palladium-103. The recommendations are for high activity payment codes for these two isotopes. The commenters recommended the following specific descriptors:

Cxxx1 Brachytherapy source, Low Dose Rate, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source.

Cxxx2 Brachytherapy source, Low Dose Rate, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source.

The commenters suggested that CMS include in the two proposed APCs and HCPCS codes an appropriate measurement of minimum radioactivity in mCi, based on calibrations establish by the National Institute of Standards and Technology (NIST).

In response to the August 16, 2004 OPPS proposed rule, one commenter agreed with our proposal to create two new brachytherapy codes for high activity Iodine-125 and Palladium-103 sources, but recommended that we change the proposed descriptors. The commenter again recommended that we add the mCi (NIST) descriptions for the high activity ranges to these new high activity Iodine-125 and Palladium-103 sources we proposed.

Response: During its meetings of February 18 through 20, 2004, the APC Panel recommended that CMS establish two new HCPCS codes and APCs for High Activity Iodine-125 and High Activity Palladium-103 on a per source basis, but did not recommend adoption of other specific language regarding mCi in the descriptions above. As previously mentioned, in the August 16, 2004 proposed rule, we noted the APC Panel's recommendation to establish two new HCPCS codes and APCs for these high activity sources, as noted above.

We agree that, with the establishment of these new codes, which are the first to specify high activity, we should provide an appropriate quantitative measurement of minimum source activity to specifically differentiate the high activity sources from other sources with differences in radioactive intensity for the two isotopes.

Accordingly, we are accepting the commenter's suggestion to utilize the calibrations established by the NIST to specify the high activity ranges.

The final code descriptors are:

C2634 Brachytherapy source, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source.

C2635 Brachytherapy source, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source.

Comment: One commenter objected to our proposal to create the two high activity brachytherapy codes based on radioactive intensity and claimed that there is uncertainty regarding availability of radioactive substance and that providers will need to distinguish between low and high activity without a definition of high activity.

Response: We have now defined high activity level in our code descriptors for C2634 and C2635, using calibrations

established by the NIST. We will implement these codes with the definitions described herein.

Comment: One commenter on the January 6, 2004 interim final rule with comment period suggested that we include ''low dose rate'' into the descriptors for each of the existing APCS for which the low dose rate may be applicable, to clarify that those descriptors refer to ''low dose rate'' brachytherapy.

Response: We do not believe that changes in the descriptors of all APCs and HCPCS codes are warranted without evidence that there are alternative low and high dose rate sources requiring a high or low dose rate indicator in the C-code descriptor to distinguish among the sources. In this manner, if there are both low and high dose rate forms, they may be paid on a cost basis for brachytherapy sources described by the same C-code until a new code is indicated for a high dose rate source. If we receive evidence that high dose rate sources are used in clinical practice, we will determine at that time whether to establish new codes and APCs and whether the existing codes need to be modified in some way.

Comment: One commenter on the January 6, 2004 interim final rule with comment period recommended that we establish a new source category for Brachytherapy linear source, Palladium-103, per 10 millimeter length. The commenter claimed that this linear source is provided in 10-millimeter lengths from 10 to 60 millimeters, and not on a ''per seed'' basis. Although the commenter indicated there were dosimetry studies comparing the Palladium-103 linear source to the per seed form, the commenter recommended against using the same Palladium-103 code for both sources, claiming it would cause confusion in billing and cost reporting.

Response: We agree that a separate code for Palladium-103 linear source should be established for payment under Pub. L. 108–173. In our proposed rule, we indicated that we were aware of a new linear source Palladium-103, which came to our attention by means of an application for a new device category for pass-through payment. We stated that, while we decided not to create a new category for pass-through payment, we believed that the new linear source falls under the provisions of Pub. L. 108–173 for separate cost-based payment as a brachytherapy source. Therefore, we proposed to add the following code for linear source Palladium-103: Cxxx3 Brachytherapy linear source, Palladium-103, per 1 mm. We believe that the 1 millimeter increments of payment affords greater flexibility for describing other linear source Palladium-103 sources that may enter the market and be sold in other than 10 mm increments.

We received several public comments in support of our proposed addition and descriptor of Brachytherapy linear source, Palladium-103, per 1 mm. Therefore, in this final rule with comment period, we are establishing the new code and descriptor for this new brachytherapy source, to be paid at cost:

C2636 Brachytherapy linear source, Palladium-103, per 1 mm.

Comment: One commenter on the January 6, 2004 interim final rule with comment period stated that CMS should pay for codes C1715 (Brachytherapy needle) and C1728 (Catheter, brachytherapy seed administration) on a cost basis as well as brachytherapy sources, asserting that these are brachytherapy devices.

Response: Brachytherapy needles and catheters for administration of sources are not brachytherapy devices under section 621(b) of Pub. L. 108–173. Section 1833(t)(16)(C) of the Act specifies that, to qualify for payment at charges reduced to cost, a device of brachytherapy must consist of ''a seed or seeds (or radioactive sources).'' The special payment provision does not include needles or catheters in the definition of devices of brachytherapy. Therefore, in this final rule with comment period, we are not establishing new payment categories for these devices that were formerly paid as transitional pass-through devices.

Comment: One commenter, a developer of a brachytherapy radiation system, recommended that CMS create a C-code and APC for miscellaneous brachytherapy sources for payment of new brachytherapy sources at cost in accordance with Pub. L. 108–173. This commenter contended that such a miscellaneous source code would allow CMS to pay hospitals for new brachytherapy sources in the interval between FDA approval of the source and the development of specific coding for new sources.

Response: Section 621(b) of Pub. L. 108–173 requires us to establish new codes and separate payment for specific seed or seeds or other radioactive sources of brachytherapy. We do not believe that the statute contemplates a separate payment for an over-inclusive (''catch-all'') category such as a miscellaneous brachytherapy source code. Such a category would inappropriately include all new brachytherapy sources until separate payment is established. Moreover, we note that hospitals and brachytherapy source manufacturers might be able to use a miscellaneous category to bill Medicare for brachytherapy systems that do not meet our standard of a separately payable radioactive source of brachytherapy. In addition, new brachytherapy sources may be added more frequently than annually, when we are able to add new codes and payment instructions to our electronic claims processing systems. Therefore, in this final rule with comment period, we are not creating a new code of miscellaneous brachytherapy sources.

Table 40 provides a complete listing of the HCPCS codes, long descriptors, APC assignments and status indicators that we will use for brachytherapy sources paid under the OPPS in CY 2005.

TABLE 40.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES

HCPCS	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198	H
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytherapy source, Iodine 125, per source	1718	Brachytx source, Iodine 125	H
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytherapy source, Palladium 103, per source	1720	Brachytx source, Palladium 103	H
C2616	Brachytherapy source, Yttrium-90, per source	2616	Brachytx source, Yttrium-90	H
C2632*	Brachytherapy solution, Iodine125, per mCi	2632	Brachytx sol, I–125, per mCi	H
C2633	Brachytherapy source, Cesium-131, per source	2633	Brachytx source, Cesium-131	H

TABLE 40.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES—Continued

HCPCS	Long descriptor	APC	APC title	New status indicator
C2634**	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I–125	H
C2635**	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P–103	H
C2636**	Brachytherapy linear source, Palladium-103, per 1MM	2636	Brachytx linear source, P–103	H

* Currently paid as a pass-through device category, scheduled to expire from pass-through payment as of January 1, 2005.
** Newly created brachytherapy payment codes beginning January 1, 2005.

Comment: A few commenters requested that CMS discuss in the OPPS final rule the process for adding other new brachytherapy devices for qualification under the separate cost-based payment methodology under Pub. L. 108–173. The commenters urged CMS to add new brachytherapy devices for separate cost-based payment on a quarterly basis, rather than annually.

Response: In the OPPS interim final rule published on January 6, 2004 that implemented the brachytherapy provisions of Pub. L. 108–173 for CY 2004, we invited the public to submit recommendations for new codes to describe brachytherapy sources in a manner reflecting the number, radioisotope, and radioactivity intensity of the sources (69 FR 828). We requested that commenters provide a detailed rationale to support recommended new codes. The public may send such recommendations to the Division of Outpatient Care, Mailstop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Blvd., 21244. We will endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly rather than an annual basis.

H. Payment for APC 0375, Ancillary Outpatient Services When Patient Expires

In CY 2003, we implemented a new modifier –CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. The purpose of this modifier is to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as a HCPCS code with status indicator ''C'' that is billed with modifier –CA. When a procedure with status indicator ''C'' (inpatient services not payable under the OPPS) was billed with modifier –CA, we made payment of a fixed amount, under New Technology APC 0977.

In the November 7, 2003 final rule with comment period, we implemented APC 0375 to pay for services furnished in CY 2004 on the same date billed for a procedure code with modifier –CA (68 FR 63467). We were concerned that our policy of paying a fixed amount under a new technology APC for otherwise payable outpatient services furnished on the same date of service that a procedure with status indicator ''C'' is performed emergently on an outpatient would not result in appropriate payment for these services. That is, continuing to make payment under a new technology APC would not allow us to establish a relative payment weight for the services, subject to recalibration based on actual hospital costs.

We implemented a payment rate of $1,150 for APC 0375, which is the payment amount for the restructured New Technology—Level XIII, APC 1513, that replaced APC 0977, in CY 2004. We also stated that for the CY 2005 update of the OPPS, we would calculate a median cost and relative payment weight for APC 0375 using charge data from CY 2003 claims for line items with a HCPC code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code, that have the same date of service reported for a procedure billed with modifier –CA. We would then determine whether to set payment for APC 0375 based on our claims data or continue a fixed payment rate for these special services.

In accordance with this methodology, for CY 2005 we reviewed the services on the 18 claims that reported modifier –CA in CY 2003. We calculated a median cost for the aggregated payable services on the 18 claims reporting modifier –CA in the amount of $2,804.18. The mix of outpatient services that were reported appeared reasonable for a patient with an emergent condition requiring immediate medical intervention, and revealed a wide range of costs, which would also be expected. As we indicated in the August 16, 2004 proposed rule, we proposed to set the payment rate for APC 0375 in accordance with the same methodology we have followed to set payment rates for the other procedural APCS in CY 2005, based on the relative payment weight calculated for APC 0375.

Comment: A few commenters were concerned whether the proposed rate of $2,757.68 for CY 2005 appropriately reflects the costs incurred by hospitals in cases where the –CA modifier is reported and requested that CMS review the rate and adjust it accordingly for CY 2006.

Response: We appreciate the commenters' concerns. Services with a –CA modifier appended are paid under APC 0375. As we explained in our August 16, 2004 proposed rule, the proposed rate of $2,757.68 for CY 2005 was calculated using actual claims billed in CY 2003. The final payment rate for CY 2005, using the updated data file, is calculated as $3,214.22. As we stated previously, review of the claims data revealed a reasonable mix of outpatient services that a hospital could be expected to furnish during an encounter with a patient with an emergent condition requiring immediate medical intervention, as well as cases with a wide range of costs. We will continue to monitor the appropriateness of this payment rate as we develop future rules.

VIII. Conversion Factor Update for CY 2005

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2005, 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 2005 published in the IPPS final rule on August 11, 2004 is 3.3 percent (69 FR 49272), the same as the forecast published in the IPPS proposed rule on May 18, 2004 (69 FR 28374) and referenced in the CY 2005 OPPS August 16, 2004 proposed rule. To set the OPPS conversion factor

for CY 2005, we increased the CY 2004 conversion factor of $54.561, as specified in the November 7, 2003 final rule with comment period (68 FR 63459), by 3.3 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2004 to ensure that the revisions we are making to our updates by means of the wage index are made on a budget-neutral basis. For the OPPS proposed rule, we calculated a budget neutrality factor of 1.001 for wage index changes by comparing total payments from our simulation model using the FY 2005 IPPS wage index values to those payments using the FY 2004 IPPS wage index values. For this final rule with comment period, we calculated a budget neutrality factor of 0.9986 for wage index changes by comparing total payments from our simulation model using the revised final FY 2005 IPPS wage index values to those payments using the current (FY 2004) IPPS wage index values. In addition, for CY 2005, allowed pass-through payments have decreased to 0.10 percent of total OPPS payments, down from 1.3 percent in CY 2004. The conversion factor is also adjusted by the difference in estimated pass-through payments of 1.20 percent.

The market basket increase update factor of 3.3 percent for CY 2005, the required wage index budget neutrality adjustment of approximately 0.9986, and the 1.20 percent adjustment to the pass-through estimate result in a conversion factor for CY 2005 of $56.983.

We did not receive any public comments on the proposed conversion factor update for CY 2005.

IX. Wage Index Changes for CY 2005

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we proposed to adopt the IPPS wage indices and extend these wage indices to TEFRA hospitals that participate in the OPPS but not the IPPS.

As discussed in the proposed rule and finalized in section III.B. of this preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as a source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. We also continue to believe that individual hospitals do not distinguish in hiring practices between their inpatient and outpatient departments and that hospitals face one labor market for both inpatient and outpatient services. Further, because hospital staff frequently provide services in both the inpatient and outpatient departments, labor costs associated with the hospital outpatient services are generally reflected in the hospital wage and salary data that are the basis of the IPPS wage index. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In the August 16, 2004 proposed rule, we proposed to use the corrected proposed FY 2005 hospital IPPS wage index for urban areas published in the **Federal Register** on June 25, 2004 (69 FR 35919) and the proposed FY 2005 hospital IPPS wage index for rural areas published in the **Federal Register** on May 18, 2004 (69 FR 28580) to determine the wage adjustments for the OPPS payment rate and the copayment standardized amount for CY 2005.

We customarily publish the wage index tables in the final rule for the OPPS update. We are not including the tables in this final rule with comment period as CMS is in the process of reviewing the wage indices for IPPS. This review may impact the wage index values. We emphasize that our methodology for calculating the wage index for the OPPS has not changed. As noted above, our policy has consistently been to adopt the IPPS wage index for purposes of payment under the OPPS. We will publish finalized tables in a later **Federal Register** document.

We note that the FY 2005 IPPS wage indices reflect a number of changes as a result of the new OMB standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index, and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the changes in the FY 2005 IPPS wage indices and any adjustments that we are applying to the OPPS for CY 2005. (We refer the reader to the August 11, 2004 IPPS final rule (69 FR 49026–49070) and the October 7, 2004 IPPS correction notice (69 FR 60242) for a fuller discussion of the changes to the wage indices.)

A. The use of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index. The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 hospital IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. We treated, as urban, hospitals located in MSAs and treated, as rural, hospitals that are located in Micropolitan Areas or Outside CBSAs. To help alleviate the decreased payments for previously urban hospitals that became rural under the new MSA definitions, we allowed these hospitals to maintain their assignment to the MSA where they previously had been located for the 3-year period from FY 2005 through FY 2007. To be consistent, we are applying the same criterion to TEFRA hospitals paid under the OPPS but not under the IPPS and to maintain that MSA designation for determining a wage index for the next 3 years. This policy will impact four TEFRA providers for purposes of OPPS payment. In addition to this ''hold harmless'' provision, the IPPS final rule implemented a one-year transition for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. These hospitals received 50 percent of their wage indices based on the new MSA configurations and 50 percent based on the FY 2004 labor market areas. For purposes of the OPPS, we also are applying this 50-percent transition blend to TEFRA hospitals.

B. The incorporation of a blend of an occupational mix adjusted wage index into the unadjusted wage index to reflect the effect of hospitals' employment choices of occupational categories to provide specific patient care. Specifically, OPPS will adopt the 10-percent blend of an average hourly wage, adjusted for occupational mix, and 90 percent of an average hourly wage, unadjusted for occupational mix, as finalized in the IPPS final rule. As discussed in the IPPS final rule, this

blend is appropriate because this was the first time that the occupational mix survey was administered and optimum data could not be collected in the limited timeframe available. In addition, CMS had no baseline data to use in developing a desk review program that could ensure the accuracy of the occupational mix survey data. Moving slowly to implement the occupational mix adjustment is also appropriate because of changing trends in the hiring nurses due changes in State law governing staffing levels and physician shortages. Finally, the blend minimizes the impact of the occupational mix adjustment on hospitals' wage index values without nullifying the value and intent of the adjustment.

C. The reclassifications of hospitals to geographic areas for purposes of the wage index. For purposes of the OPPS wage index, we are adopting all of the IPPS reclassifications in effect for FY 2005, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173.

D. The implementation of an adjustment to the wage index to reflect the ''out-migration'' of hospital employees who reside in one county but commute to work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173 (August 11, 2004 IPPS final rule (69 FR 49061 through 49067), as revised and corrected on October 7, 2004 (69 FR 60242)). Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties received a wage index increase. We are applying the same criterion to TEFRA hospitals paid under the OPPS but not paid under the IPPS. Therefore, TEFRA hospitals located in a qualifying section 505 county will also receive an increase to their wage index under OPPS.

We will use final revised IPPS indices to adjust the payment rates and coinsurance amounts that we are publishing in this OPPS final rule with comment period for CY 2005.

In general, geographic labor market area reclassifications must be done in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2005, we have included the wage index changes that result from MGCRB reclassifications, implementation of section 505 of Pub. L. 108–173, and other refinements made in the IPPS final rule, such as the 50-percent transition blend for hospitals with FY 2005 wage indices that decreased solely as a result of the new MSA definitions. However, we did not take into account the reclassifications that resulted from implementation of the one-time appeal process under section 508 of Pub. L. 108–173. Section 508 set aside $900 million to implement the section 508 reclassifications. We considered the increased Medicare payments that the section 508 reclassifications would create in both the IPPS and OPPS when we determined the impact of the one-time appeal process. Because the increased OPPS payments already counted against the $900 million limit, we did not consider these reclassifications when we calculated the OPPS budget neutrality adjustment.

We received a number of public comments on the application of the FY 2005 IPPS wage indices under the OPPS.

Comment: In general, commenters approved of CMS' adoption of the FY 2005 final rule wage indices for IPPS. Several commenters requested clarification that CMS would adopt the temporary, 1-year relief for hospitals with wage areas changing due to the revised labor market definitions provided in the FY 2005 IPPS final rule.

Response: We are adopting the IPPS temporary, 1-year relief provision of a 50/50 blend of old and new wage indices in this OPPS final rule with comment period. Hospitals billing Medicare under IPPS in FY 2005 will receive the same wage index for OPPS.

Comment: One commenter requested clarification that CMS would adopt the technical correction to the IPPS wage index to include counties incorrectly excluded from the out-migration adjustment under section 505 of Pub. L. 108–173.

Response: In this OPPS final rule with comment period, we are adopting all technical corrections to the FY 2005 IPPS final rule wage indices, including the referenced correction to the out-migration counties.

Comment: Several commenters requested clarification that CMS would adopt the wage index provisions for ''Special Circumstances of Hospitals in All-Urban States.''

Response: We are adopting all of the changes to the IPPS wage indices discussed in the FY 2005 IPPS final rule and any subsequent corrections to that final rule, including calculation of a wage index floor for hospitals in all-urban States.

Comment: One commenter noted that the wage index listed in the impact file that we made available on the CMS Web site for the August 16, 2004 proposed rule listed a different wage index from the wage index adopted in the FY 2005 IPPS final rule and requested clarification that the hospital would receive the IPPS final rule wage index.

Response: We note that the proposed wage indices have to be assembled before the IPPS wage indices are finalized in order to model impact tables for the OPPS proposed rule. The final wage indices used for payment in CY 2005 for OPPS will reflect the wage indices in the FY 2005 IPPS final rule and any subsequent corrections to that final rule.

Comment: Several commenters, specifically individual hospitals adversely impacted by the final FY 2005 IPPS wage index, requested that CMS address several issues beyond the scope of the OPPS proposed rule, such as exempting hospitals from the new wage indices and employing former wage indices, calculating new wage indices or recalculating the current wage indices with additional provider or providers removed, calculating new ''in-migration'' adjustments, and, where permanent wage indices changes are not possible, providing a transition period beyond the 1-year 50/50 blend discussed above or extending ''hold harmless'' provisions. One commenter also requested that adversely impacted hospitals be able to bill under the provider numbers of affiliated institutions.

Response: As noted earlier in this section of the preamble, we believe, and other commenters concurred, that hospitals face the same labor costs for their inpatient and outpatient departments and that separate wage indices are not appropriate for different integrated components of the same institution. It is for this reason that we have always adopted the same wage index for both the IPPS and the OPPS payment systems. Moreover, our policy has consistently been to use the IPPS wage indices and, to the extent these wage indices are used, the IPPS process provides an opportunity for hospitals to comment specifically on the construction of the IPPS wage indices.

Comment: Several commenters requested that CMS reduce the labor-related share from the current 60 percent to some smaller percentage, frequently 52 percent or less, for outpatient payment purposes for hospitals in areas with a Medicare wage index of 1.0 or lower to maintain consistency with the inpatient hospital policy.

Response: Section 403 of Pub. L. 108–173 mandated that the IPPS make a change to the labor-related share of the wage index, reducing the percentage from 71 to 62 for hospitals in areas with a wage index of 1.0 or lower. However, as discussed in the IPPS final rule (69

FR 49069, August 11, 2004), prior to this mandate, we had determined that the labor-related share was increasing for inpatient services, not declining. Unlike IPPS, OPPS has no mandate to reduce the labor-related share, and we believe the current 60 percent labor-related share remains appropriate for OPPS payment purposes. We recognize that the IPPS final rule discusses CMS' current analyses of the labor-related share, and we will carefully consider any research findings in light of their appropriateness for OPPS.

Comment: Several commenters expressed concern that CMS proposed to adopt the IPPS proposed wage index rather than the IPPS final wage index.

Response: As we have stated previously in this section of the preamble, we note that we are adopting the final IPPS wage indices and any subsequent corrections for the OPPS.

X. Determination of Payment Rates and Outlier Payments for CY 2005

A. Calculation of the National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at §§ 419.31 and 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section VIII. of this final rule with comment period, and the relative weight determined under section III. of this final rule with comment period. Therefore, the national unadjusted payment rate for APCs contained in Addendum A to this final rule with comment period and for payable HCPCS codes in Addendum B to this final rule with comment period (Addendum B is provided as a convenience for readers) was calculated by multiplying the CY 2005 scaled weight for the APC by the CY 2005 conversion factor.

To determine the payment that will be made in a calendar year under the OPPS to a specific hospital for an APC for a service other than a drug, in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (See the April 7, 2000 final rule with comment period (65 FR 18496 through 18497), for a detailed discussion of how we derived this percentage.)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals would be assigned for FY 2005 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, LUGAR, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. Assess whether the previous MSA-based wage index is higher than the CBSA-based wage index, and, if higher, apply a 50/50 blend. The wage index values include the occupational mix adjustment described in section IX. of this final rule with comment period that was developed for the IPPS.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. This step is to be followed only if the hospital has chosen not to accept reclassification under step 2 above.

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

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

B. Hospital Outpatient Outlier Payments

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 through 59888), we specified that, beginning with CY 2002, we 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 outlier payments on a service-by-service basis.

As explained in the April 7, 2000 final rule with comment period (65 FR 18498), we set a projected target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we set the projected target for outlier payments at 2.0 percent for CYs 2001, 2002, 2003, and 2004. For reasons discussed in the November 7, 2003 final rule with comment period (68 FR 63469), for CY 2004, we established a separate outlier threshold for CMHCs. For CY 2004, the outlier threshold is met when costs of furnishing a service or procedure by a hospital exceed 2.6 times the APC payment amount or when the cost of furnishing services by a CMHC exceeds 3.65 times the APC payment amount. The current outlier payment is calculated to equal 50 percent of the amount of costs in excess of the threshold.

As we proposed, for CY 2005, we are continuing to set the projected target for outlier payments at 2.0 percent of total OPPS payments (a portion of that 2.0 percent, 0.6 percent, will be allocated to CMHCs for partial hospitalization program (PHP) services).

Outlier payments are intended to ensure beneficiary access to services by having the Medicare program share in the financial loss incurred by a provider associated with individual, extraordinarily expensive cases. They are not intended to pay hospitals additional amounts for specific services on a routine basis. In its March 2004 Report, MedPAC found that 50 percent of OPPS outlier payments in CY 2004 were for 21 fairly common services that had relatively low APC payment rates, such as plain film x-rays and pathology services. We remain concerned by the MedPAC findings which indicate that a significant portion of outlier payments are being made for high volume, lower cost services rather than for unusually high cost services, contrary to the intent of an outlier policy. (A full discussion of the 2004 MedPAC recommendations related to the OPPS and the CMS response to those recommendations can be found in section XII. of this preamble.)

In light of the MedPAC findings, in the August 16, 2004 proposed rule, we proposed to change the standard we have used to qualify a service for outlier payments since the OPPS was originally implemented. That is, in addition to the outlier threshold we have applied since the beginning of the OPPS, which requires that a hospital's cost for a service exceed the APC payment rate for that service by a specified multiple of the APC payment rate, we proposed to add a fixed dollar threshold that would have to be met in order for a service to qualify for an outlier payment. Section 1833(t)(5)(A) of the Act gives the

Secretary the authority to impose a fixed dollar threshold in addition to an APC multiplier threshold. By imposing a dollar threshold, we expect to redirect outlier payments from lower cost, relatively simple procedures to more complex, expensive procedures for which the costs associated with individual cases could be exceptionally high and for which hospitals would be at greater risk financially.

In the proposed rule, we proposed to require that, in order to qualify for an outlier payment, the cost of a service must exceed 1.5 times the APC payment rate and the cost must also exceed the sum of the APC rate plus a $625 fixed dollar threshold. Based upon our review of the data, a proposed threshold of $625 best met our 2.0 percent projected target. When the cost of a hospital outpatient service exceeds these thresholds, we proposed to pay 50 percent of the amount by which the cost of furnishing the service exceeds 1.5 times the APC payment rate (the APC multiple) as an outlier payment.

However, in this final rule, we are increasing the proposed APC multiplier of 1.5 to 1.75 and the fixed-dollar threshold from $625 to $1,175. This revision to the proposed rule estimates results from the inclusion of a charge inflation factor of 18.76 percent to account for charge inflation between the CY 2003 claims data that we used to model the outlier thresholds and their application in CY 2005. As we note below, many hospital associations expressed concern that the proposed $625 threshold for outlier payments was too high and suggested that OPPS consider the decision in the IPPS final rule to lower the charge inflation assumption from 31.1 percent to 18.76 percent. These same commenters suggested that we provide the details of the assumptions used to set outlier thresholds and asked that we ensure that the charges used to set outlier thresholds were not inappropriately inflated.

Previously, OPPS has not used a charge inflation factor to adjust charges on the claims used to model the payment system to reflect current dollars. We have historically set the projected target for outlier payments at 2 percent of the estimated spending under the proposed payment system, but have modeled that projected target without inflating charges on the claims, which usually lag behind the proposed system by 2 years. This year, we used CY 2003 claims to model the CY 2005 payment system. When we modeled the thresholds discussed in the August 16, 2004 proposed rule, we did not include a charge inflation factor. By not adjusting for charge inflation between CY 2003 and CY 2005, the estimated service costs will be lower than those that will be billed under OPPS next year. Underestimated service costs also led us to underestimate our outlier thresholds. As reflected in the comments, we should have included a charge inflation factor similar to that used in the IPPS outlier calculation when we developed the proposed outlier payments. In this final rule with comment period, we have done so as explained below, which results in an APC multiplier of 1.75 and a fixed-dollar threshold of $1,175.

To calculate the 1.75 multiple and $1,175 fixed-dollar thresholds, we first estimated the 2-percent projected target for outlier payments by estimating 2 percent of total spending in CY 2005 using the CY 2005 APC payment rates in this final rule with comment period and services in the CY 2003 claims. We then inflated the charges on these claims by 18.76 percent, which is the estimated increase in charges between CY 2003 and CY 2005 used in the outlier policy for the IPPS final rule. We believe the use of this estimate is appropriate for OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services. As also noted in the IPPS final rule, we believe that this inflation factor is more appropriate than an adjustment to costs because charges increase at a faster rate than costs. We then used the same CCRs that we used to adjust charges to costs in our ratesetting process to estimate a cost for each service from the inflated charges on the CY 2003 claims. Although these CCRs are based largely on CY 2002 cost report data, we did not adjust them for probable increases in charges relative to costs between CY 2002 and CY 2005. Finally, we estimated a multiple threshold and fixed-dollar threshold that would produce outlier payments that met our 2-percent projected target amount.

The large increase in the fixed-dollar threshold is largely a function of the additive impact of increasing all estimated outlier payments by 18.76 percent and restricting increased estimates of outlier payments to a fixed, projected target of 2 percent, as well as the addition of a fixed-dollar threshold to determine outlier eligibility instead of using only a multiple threshold to determine outlier payment. As charges are inflated, each estimated outlier payment is higher by some proportional amount, but the total dollar increase varies with the magnitude of the difference in the cost of the service and APC payment rate. The addition of the fixed-dollar threshold policy ensures that outlier payments are made for high-cost services, thereby increasing the dollar amount of outlier payments and the total dollar impact of 18.76 percent that must be contained within the projected outlier target. Further, the actual based on outlier payment for a service is not affected by the fixed-dollar threshold but, rather, is the difference between the hospital's cost and the product of the multiple threshold and the APC payment rate. Changing the fixed-dollar threshold does not impact the amount of outlier payment. Adding the inflation adjustment to charges also increases the number of services eligible for an outlier payment under the proposed 1.5 multiple and $625 fixed-dollar thresholds. The combined impact of more services and higher payments greatly increases estimated outlier payments. Therefore, in order to reduce the number of services eligible for higher payments and the payments themselves to stay within our projected target of 2 percent of total OPPS payments, we had to raise both the fixed-dollar and multiple thresholds.

We are setting the dollar threshold at a level that will, for all intents and purposes, exclude outliers for a number of lower cost services. For example, under the CY 2004 methodology, a service mapped to an APC with a payment rate of $20 would only have to exceed $52 (2.6 × APC payment amount) in order to qualify for an outlier payment. Our final policy for CY 2005 with the additional fixed dollar threshold will require that the service in this example exceed $1,195 in order to qualify for an outlier payment. That is, the cost of the service will have to exceed both 1.75 times the APC payment rate, or $35, and $1,195 ($20 + $1,175).

The dollar threshold will also enable us to lower the APC multiplier portion of the total outlier threshold from 2.6 to 1.75. We have chosen a multiple of 1.75 because this continues to recognize some variability relative to APC payment implicit in the current statute, but limits its impact in determining outlier payments. Under the changes to the outlier methodology, it will also be easier for the higher cost cases of a complex, expensive procedure or service to qualify for outlier payments because the $1,175 threshold is a small portion of the total payment rate for high cost services. For example, under the CY 2004 methodology, a service mapped to an APC with a payment rate of $20,000 would have to exceed $52,000 in order to qualify for an outlier

payment but, as proposed for CY 2005, will have to exceed only $35,000. That is, the cost of the service will have to exceed both 1.75 times the APC payment rate, or $35,000, and $21,175 ($20,000 + $1,175). Further, outlier payments for unusually expensive cases would be higher because the APC multiplier for outlier payment would decrease from 2.6 to 1.75 times the APC payment rate.

Comment: Many commenters, including MedPAC, favored our proposed outlier policy that redirects outlier payments to expensive procedures for which hospitals' financial risk is potentially greater. (Under the proposed rule, outlier payments would be made when the cost of a separately payable service exceeds both 1.5 times the APC payment and a fixed dollar amount.) Several commenters agreed with this revision in policy, but requested that CMS monitor the impact of the new policy on hospitals with a relatively high volume of low cost cases and find some way to ensure that providers of less-intensive services be afforded outlier ''protection.''

Response: As noted above, outlier payments are intended to ensure beneficiary access to services by having the Medicare program share in the financial loss incurred by a provider associated with individual, extraordinarily expensive cases. They are not intended to pay hospitals additional amounts for specific services on a routine basis, and we demonstrated in Table 39 of the proposed rule that this policy moderately redistributes outlier dollars to providers of high-cost, complex services, such as teaching hospitals. We will continue to model the distribution of outlier payments among hospitals. However, the purpose of the new policy is to limit financial risk attributable to patients whose costs are extraordinarily high. Therefore, our goal is to redirect outlier payments to those services that better meet our goal of providing outlier payments to those costly services with high financial risk. The intent is not to continue to provide a significant portion of outlier payments to high volume, low cost services.

Using the final rule data and updated charge inflation estimates, we have modeled a fixed-dollar threshold of $1,175 for CY 2005.

Comment: Several commenters requested data that support the presumption that the revised outlier methodology will definitely result in payment of 2 percent of total OPPS payments. The commenters also urged CMS to release data on actual outlier payments made in CY 2004 and in prior years, and to continue to report this data in the future.

Response: The outlier thresholds and payment percentages are determined each year based on our best estimate of the thresholds and payment percentages needed to achieve the projected target of outlier payment. As discussed above, in order to estimate the outlier multiple and fixed-dollar thresholds, we first estimated 2 percent of the total spending using the APC payment rates in this final rule with comment period and the services in the CY 2003 claims. Using this estimate, we inflated the charges on the CY 2003 claims to reflect CY 2005 dollars using the 1.1876 inflation adjustment used in the IPPS final rule. We then applied the overall CCR for each hospital based on their most recently submitted cost report, whether tentatively settled or final, and if tentatively settled, adjusted by a submitted-to-settled ratio taken from the previous year's cost report. These are the same CCRs that we use in our ratesetting process. We then estimated outlier payments for various combinations of multiple and fixed-dollar thresholds until we reached the targeted outlier expenditures.

Interested parties may calculate the amount of outlier spending from previous years. Such information is available in the claims data, not the limited data set, available from CMS for this final rule with comment period.

Comment: Several commenters were concerned that the proposed fixed-dollar threshold of $625 was too high. Specifically, the commenters were concerned that CMS had overstated its charge inflation estimates in calculating the fixed dollar threshold, as had been done in the FY 2005 IPPS proposed rule. The commenters requested that CMS review its estimates and make comparable adjustments to these in the FY 2005 IPPS final rule.

Response: As noted previously, the OPPS had not used a charge inflation factor. In this final rule with comment period, we realized that we should have adopted a charge inflation estimate. We used the charge inflation estimate used in the IPPS final rule of 18.76 percent to update charges on the CY 2003 claims that we used to model the fixed-dollar threshold in order to reflect CY 2005 dollars. Comparable to IPPS, we did not update the CCRs that we employed to estimate costs from these inflated charges. The CCRs are based on hospitals' most recently submitted cost report, frequently CY 2002, adjusted by the most recent settled-to-submitted ratio, and were not updated for changes in relative costs and charges since the cost report year.

Comment: One commenter supported the proposed change, but urged CMS to adopt MedPAC's recommendation to fully eliminate outpatient outlier payments and to increase the base APC rates by a commensurate amount. The commenter asserted that the separate payment of services under OPPS eliminates the need for an outlier policy.

Response: We believe that an outlier policy is necessary and appropriate under the OPPS. Outlier payments dampen the financial risk of and improve beneficiary access to expensive, complex outpatient services. The range of services provided in the outpatient setting continues to expand, continually including more services previously performed in the inpatient setting. Many of these procedures are high-cost, extensive, and as complex as inpatient procedures. The device-dependent APCs provide a good example. We agree that separate payment for many individual services under OPPS reduces the need for an extensive outlier policy, but do not believe it eliminates the need entirely. We believe that the lower outlier payment percentage under the OPPS of 50 percent relative to 80 percent under the IPPS and the smaller OPPS projected outlier target of 2 percent relative to the IPPS projected target of between 5 and 6 percent reflect the more limited outlier liability associated with the outpatient payment system.

Comment: One commenter disagreed with our proposed policy and noted that it will substantially restrict outlier payments for a lot of outpatient services and recommended that CMS remove the fixed-dollar threshold and apply outlier payments only when the cost of a service exceeds 1.5 times the APC payment.

Response: We disagree with the commenter as removing the fixed-dollar threshold and relying only on a multiple of 1.5 or 1.75 would result in outlier payments well in excess of the proposed 2-percent projected target. To meet the projected target, we would have to raise the multiple threshold to 2.95 if we eliminated the fixed dollar threshold.

Comment: Several commenters requested that CMS release limited data set data files in a more timely manner.

Response: We have always attempted to, and will continue to, provide data necessary for evaluation of the OPPS in a timely manner. For example, this year, several data files were available through CMS' Web site before the publication of the proposed rule.

Comment: Several commenters recommended that CMS consider reinstating outlier payments at the claim

level, rather than at the individual service level, resulting in easier administration of outliers and payments that are more equitable for high cost patients.

Response: We believe that calculating outliers on a service-by-service basis is the most appropriate way to calculate outliers for outpatient services. Outliers on a claim or bill basis requires both the aggregation of costs and the aggregation of OPPS payments thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in the claim or bill not meeting the outlier criterion. While the implementation of service-based outliers is somewhat more complex because it involves allocating the costs of packaged services across multiple payable codes, we believe that under this approach, outlier payments are more appropriately directed to those specific services for which a hospital incurs significantly increased costs. We also believe that the introduction of the fixed dollar threshold improves payment for expensive patients by targeting outlier payments to the more high-cost, complex services.

Comment: One commenter requested that CMS demonstrate the accuracy of its assumption that providers are receiving inappropriate outlier payments and suggest that the distribution of packaged costs on a claim could be affecting the outlier determination and payment. The commenter specifically requested that CMS exempt all drug administration APCs from the new fixed-dollar threshold methodology.

Response: We agree that the allocation of packaged costs could modestly under or overestimate the cost of a single procedure for purposes of determining outlier payments. However, this observation cannot explain the huge concentration of services in low-cost, simple procedures receiving outlier payments observed by MedPAC in its March 2004 report referenced above. This concentration is clearly a function of the multiple threshold policy.

In accordance with section 1833(t)(5) of the Act, we have set a uniform fixed-dollar outlier threshold that applies to all OPPS services in a given calendar year. We cannot exempt specific services from the outlier methodology because the statute does not provide for different thresholds for different types of OPPS services. Further, the magnitude of the multiple and fixed dollar thresholds is determined prospectively before the beginning of each year based on all OPPS services qualifying for outlier payments in that year.

Comment: One commenter was concerned that CMS does not provide information to determine how the amounts that are actually spent on pass-through and outlier payments compare to the amount that is carved out of the total amount allowed OPPS payment for these projected payments. The commenter was concerned that the amounts carved out for these purposes may not actually be spent and thus, would be lost to hospitals.

Response: We are required by law to estimate the amounts that we expect to spend on pass-through and outlier payments each year before the start of the calendar year. We share the commenter's interest in assuring that those estimates are made as accurately as possible to ensure that hospitals receive the amount to which they are entitled by law. We make our final estimate for each calendar year to the best of our ability based on all of the best data available at the time we prepare our final rule, including comments we receive in response to our proposed rule. With respect to the availability of data for modeling our outlier estimates, we have established limited data sets which include the set of claims we used first for the proposed rule estimates and, ultimately, for those for our final rule with comment period. For example, the CY 2003 claims used in ratesetting and modeling for this final rule with comment period for CY 2005 OPPS will be available to the public in a limited data set format. However, estimates of total outlier payments made in previous years are not available in the limited data set, in no small part because outlier payments on these claims would underestimate total outlier payments. Interested parties can estimate total outlier expenditures from a full year of OPPS claims data. We will continue to assess the means by which we provide data.

Comment: One commenter who did not support the proposed outlier policy suggested that the payment for outliers in low-cost services could be an indication that the APC payment rate is too low for these services. The commenter also wondered if the concentration of outlier payments in low-cost services was the result of high packaged costs appearing with these separately payable services, and indicated that one example might include packaged observation services. Ultimately, this commenter suggested that a better understanding of why outlier payments are directed to common services is necessary before a change in policy can be supported.

Response: As MedPAC discussed in its March 2004 report, the main reason to include outlier policies with prospective payment systems is to limit providers' financial risk attributable to patients whose costs are extraordinarily high relative to the median cost of providing the service. We believe that such risk is more substantial in high cost procedures. When the financial risk of providing a service becomes too high, providers may choose not to provide the service, an outcome that can harm beneficiary access.

The CY 2004 outlier policy does not distinguish between high cost services and low cost services. In fact, MedPAC found that 50 percent of OPPS outlier payments in CY 2004 were for services in low-paying APCs. These observations suggested the need to modify the outlier policy to provide better protection against financial risk. The fixed-dollar threshold limits financial risk to providers who provide high-cost services.

Although it is possible that extensive packaged costs have created the current concentration of outliers in low cost services, it is unlikely in most circumstances. Separately payable services consistently billed with extensive packaged costs would ultimately increase payment rates as packaged costs were incorporated in the cost of the payable service. Although packaged observation services can be extensive, the review of OPPS claims data indicates that there are too many outlier payments to be associated with the limited number of claims with packaged observation services. We believe the current policy creates an easy threshold for low-cost services to qualify for outlier payments and does little to protect hospitals against the financial risk associated with complex and high-cost services.

C. Payment for Partial Hospitalization

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified CMHC. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPPS. Section 419.21(c) of the Medicare regulations that implement this provision specifies that payments under the OPPS will be made for partial hospitalization services

furnished by CMHCs. Section 1883(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. 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. For a detailed discussion, see the April 7, 2000 OPPS final rule (65 FR 18452).

2. PHP APC Update for CY 2005

As proposed, for calculation of the CY 2005 per diem payment in this final rule, we used the same methodology that was used to compute the CY 2004 per diem payment. For CY 2004, the per diem amount was based on three quarters of hospital and CMHC PHP claims data (for services furnished from April 1, 2002, through December 31, 2002). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line item charges as reported on bills, to estimate the provider's cost for a day of PHP services. Per diem costs are then computed by summing the line item costs on each bill and dividing by the number of days on the bill.

Unlike hospitals, CMHCs do not file cost reports electronically and the cost report information is not included in the Healthcare Cost Report Information System (HCRIS). The CMHC cost reports are held by the Medicare fiscal intermediaries. In a Program Memorandum issued on January 17, 2003 (Transmittal A–03–004), we directed fiscal intermediaries to recalculate hospital and CMHC CCRs using the most recently settled cost reports by April 30, 2003. Following the initial update of CCRs, fiscal intermediaries were further instructed to continue to update a provider's CCR and enter revised CCRs into the outpatient provider specific file. Therefore, for CMHCs, we use CCRs from the outpatient provider specific file. For CY 2005, we analyzed 12 months of data for hospital and CMHC PHP claims for services furnished between January 1, 2003, and December 31, 2003. Updated CCRs reduced the median cost per day for CMHCs. The revised medians are $310 for CMHCs and $215 for hospitals. Combining these files results in a median per diem PHP cost of $289. 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 PHP is $281.33 for CY 2005, of which $56.33 is the beneficiary's coinsurance.

Comment: One commenter summed payments for three Group Therapy Sessions (APC 0325) and one Extended Individual Therapy Session (APC 0323) and requested that amount as the minimum for a day of PHP.

Response: We do not believe this is an appropriate comparison. It is important to note that the APC services cited by the commenter (APC 0325 and APC 0323) 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. In addition, a minimal day of PHP treatment does encompass three services.

Comment: One commenter requested that the same provisions given to rural hospital outpatient departments also be given to rural CMHCs.

Response: We believe the commenter may be referring to the statutory hold harmless provisions. Section 1833(t)(7)(D) of the Act authorizes such payments, on a permanent basis, for children's hospitals and cancer hospitals and, through CY 2005, for rural hospitals having 100 or fewer beds and sole community hospitals in rural areas. Section 1866(t)(7)(D) of the Act does not authorize hold harmless payments to CMHC providers.

3. Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. Further analysis indicated the use of outlier payments was contrary to the intent of the outlier policy as discussed previously in section X.B. above. Therefore, for CY 2004, we established a separate outlier threshold for CMHCs. We designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2004, excluding outlier payments.

As stated in the November 7, 2003 final rule with comment period, CMHCs were projected to receive 0.5 percent of the estimated total OPPS payments in CY 2004. The CY 2004 outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.65 times the APC payment amount. The current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

CMS and the Office of the Inspector General are continuing to monitor the excessive outlier payments to CMHCs. However, we do not yet have CY 2004 claims data that will show the effect of the separate outlier threshold for CMHCs that was effective January 1, 2004. Therefore, for CY 2005, as discussed in section X.B. of this preamble, we are continuing to set the target for hospital outpatient outlier payments at 2.0 percent of total OPPS payments. We are also allocating a portion of that 2.0 percent, 0.6 percent, to CMHCs for PHP services. We are adopting as final 0.6 percent for CMHCs because the percentage of CMHC's payment to total OPPS payment rose slightly in the CY 2003 claims data. In the absence of CY 2004 claims data, we developed simulations for CY 2005. As discussed in section X.B. of this final rule, we are establishing a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not establishing a dollar threshold for CMHC outliers. In this final rule, we are setting the outlier threshold for CMHCs for CY 2005 at 3.5 percent times the APC payment amount and the CY 2005 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

Comment: One commenter expressed concern about a separate outlier threshold for partial hospitalization services because many partial hospitalization programs are hospital based. The commenter recommended that CMS use the same threshold for all hospital services.

Response: We agree that the same outlier policy should apply to all

hospital services. Under OPPS, we establish two sets of outlier thresholds, one for hospitals and one for CMHCs. The higher multiple threshold of 3.5 is reserved for services provided by CMHCs only. Hospitals billing for partial hospitalization will be subject to the outlier thresholds and payment percentages identified for all hospital services.

XI. Beneficiary Copayments for CY 2005

A. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2005, the specified percentage is 45 percent of the APC payment rate. The statute provides a further reduction in CY 2006 so that the national unadjusted coinsurance for an APC cannot exceed 40 percent in CY 2006 and in calendar years thereafter. Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount.

Comment: One commenter expressed concern that the law does not further reduce the maximum coinsurance rate for CY 2007. The commenter believed that this may cause coinsurance rates to stagnate at 40 percent for a few years. The commenter indicated that its organization will continue to advocate for a legislative change that would accelerate the copayment buy-down.

Response: We understand the concerns of this organization. In CY 2004, we determined that 63 percent of APCs had a national unadjusted coinsurance rate of 20 percent. Therefore, we will continue to apply our current methodology for calculating national unadjusted coinsurance rates, as explained in earlier **Federal Register** notices, which ensures that the copayments of the remaining 37 percent of APCs will continue to decrease relative to increases in payment rates.

B. Copayment for CY 2005

For CY 2005, we determined copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004 (see the November 7, 2003 OPPS final rule with comment period, 68 FR 63458). The unadjusted copayment amounts for services payable under the OPPS effective January 1, 2005 are shown in Addendum A and Addendum B of this final rule with comment period.

XII. Addendum Files Available to the Public Via Internet

The data referenced for Addendum C to this final rule with comment period are available on the following CMS Web site via Internet only: *http://www.cms.hhs.gov/providers/hopps/*. We are not republishing the data represented in this Addendum to this final rule with comment period because of its volume. For additional assistance, contact Chris Smith Ritter at (410) 786–0378. Addendum C—Healthcare Common Procedure Coding System (HCPCS) Codes by Ambulatory Payment Classification (APC).

This file contains the HCPCS codes sorted by the APCs into which they are assigned for payment under the OPPS. The file also includes the APC status indicators, relative weights, and OPPS payment amounts.

XIII. Collection of Information Requirements

This document does 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.

XIV. Regulatory Impact Analysis

A. OPPS: General

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

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 with comment period will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2005 compared to CY 2004 to be approximately $1.5 billion. Therefore, this final rule with comment period is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would 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 (65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals would 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 would 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.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a

significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we are adopting in this final rule with comment period (consistent with the FY 2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. 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 with comment period 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 with comment period will have a significant impact on a substantial number of small entities.

4. 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 with comment period does not mandate any requirements for State, local, or tribal governments. This final rule with comment period also does not impose unfunded mandates on the private sector of more than $110 million dollars.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or 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 with comment period in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (see Table 41) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 3.7 percent under this final rule with comment period.

Comment: One commenter expressed concern that CMS had removed the eye and ear specialty hospital category from our regulatory impact analysis and requested that we reinstate this line-item. They further requested information on why specific analyses were retained for cancer and children's hospitals.

Response: We removed the specific regulatory impact analysis of eye and ear hospitals because, unlike cancer and children's hospitals, they are not specifically protected by statute. Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with less than 100 beds, and sole community hospitals in rural areas. These hospitals cannot receive less payment in CY 2005 than they did in the CY 2004. However, because hold harmless provisions for cancer and children's hospitals are permanent, we will not specifically identify these hospital classes in future impact analyses.

Comment: One commenter expressed concern about the observed impact on teaching hospitals, specifically the observed increase of 2.9 percent under the proposed system, which is less than the overall increase modeled for all hospitals of 4.6 percent in the proposed rule. This commenter requested that CMS conduct analyses assessing the need for an adjustment for specific classes of hospitals, which is within CMS' regulatory authority. The commenter further suggested that these analyses assess whether teaching hospitals rely more on pass-through, outlier, transitional corridor, and device-dependent APC payments, and suggested that an adjustment is necessary if this is the outcome.

Response: We agree that it is important to monitor ongoing trends for specific classes of hospitals, and we are especially concerned when hospitals experience a negative increase. In this specific instance, major teaching hospitals are experiencing a positive increase in payments. We also agree that major teaching hospitals may be more dependent on costs estimated outside of the primary impact tables provided in the regulation. However, we are not convinced that a reliance on pass-through, outlier, or transitional corridor payments is a reason to propose an adjustment. This is especially true in light of the outlier policy as proposed, which redirects money to complex and costly procedures that are more likely to be performed at academic medical institutions.

B. Impact of Changes in This Final Rule With Comment Period

We are adopting as final the proposed 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 with comment period, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2005, as we discuss in sections VIII. and IX., respectively, of this final rule with comment period. We also have revised the relative APC payment weights using claims data from January 1, 2003, through December 31, 2003. Finally, we are removing 6 device categories and 13 drugs and biological agents from pass-through payment status. In particular, see section V.A.2 with regard to the expiration of pass-through status for devices and see section IV.A.2 with regard to the expiration of pass-through status for drugs and biological agents.

Under this final rule with comment period, the update change to the conversion factor as provided by statute as well as the additional money for the OPPS payments in CY 2005 as authorized by Pub. L. 108–173, including money for drugs and increases in the wage indices, will increase total OPPS payments by 4.0 percent in CY 2005. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for several drugs and devices) would not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes would change the distribution of payments within the budget neutral system as shown in Table 41 and described in more detail in this section.

C. 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 with comment period. Some of the

major issues discussed in this final rule with comment period and the options considered are discussed below.

1. Payment for Device-Dependent APCs

We package payment for an implantable device into the APC payment for the procedure performed to insert the device. Because almost all devices lost pass-through status at the end of CY 2002, we discontinued use of separate codes to report devices in CY 2003. We have found that claims that we use to set payment rates for device-dependent APCs frequently have packaged costs that are much lower than the cost of the device. This is attributed, in part, to variations in hospital billing practices. In response, we reestablished device codes for reporting on a voluntary basis in CY 2004.

The APC Panel recommended that we use CY 2004 device-dependent APC rates updated for inflation as the CY 2005 payments. We considered this option but did not adopt it because it would not recognize changes in relative cost for these APCs and would not advance us towards our goal of using unadjusted claims data as the basis for payment weights for all OPPS services.

In addition to consideration of the APC Panel's recommendation, we considered using CY 2002 claims to calculate a ratio between the median calculated using all single bills and the median calculated using only claims with HCPCS codes for devices on them, and applying that ratio to the median calculated using CY 2003 claims data. We rejected this option because it assumes that the relationship between the costs of the claims with and without codes for devices is a valid relationship not only for CY 2002 but CY 2003 as well. It also assumes no changes in billing behavior. We have no reason to believe either of these assumptions is true and, therefore, we did not choose this option. We also considered using external data provided by manufacturers and other stakeholders as the estimated device cost. We did not choose this alternative because we believe that, in a relative weight system, there should be a single stable and objective source of data for setting relative weights for all items and services for which payment is made in the system.

We do not believe that any of the above options would help us progress toward reliance on our data. Rather than adopt any of those approaches, we developed an option to adjust the payment for only those device-dependent APCs that have the most dramatic decreases for CY 2005. We believe that the better payment approach for determining median costs for device-dependent APCs in CY 2005 is to base these medians on the greater of: (1) Median costs calculated using CY 2003 claims data; or (2) 95 percent of the APC payment median used in CY 2004 for these services. We believe that this adjustment methodology provides an appropriate transition to eventual use of all single bill claims data without adjustment.

We are also requiring hospitals to report C-codes for device categories used in conjunction with procedures billed and paid for under the OPPS. We have decided to implement edits, starting April 1, to enforce the reporting of C-codes to bill for most of the device-dependent procedures for which we adjusted the medians for CY 2005, as well as for a few APCs that require devices that are coming off pass-through payment in CY 2005 (a continuation of current billing practice). We believe that adoption of our proposal will mitigate barriers to beneficiary access to care while encouraging hospitals to bill correctly for the services they furnish. For a more detailed discussion of this issue, see section III.C. of this final rule with comment period.

2. Hospital Outpatient Outlier Payments

In its March 2004 Report, MedPAC made a recommendation to the Congress to eliminate the outlier provision under the OPPS. MedPAC made its recommendation after studying outlier payments on claims for services furnished during CY 2002 and concluding that in 2002, 50 percent of outlier payments were paid for 21 fairly common services that had relatively low APC payment rates, while high cost services accounted for only a small share of outlier payments. However, outlier payments are required under the statute. Therefore, we cannot discontinue outlier payments absent a legislative change by the Congress.

In light of the MedPAC findings, we are adopting a fixed-dollar threshold in addition to the threshold based on a multiple of the APC amount that we have applied since the beginning of the OPPS. A fixed-dollar threshold will redirect OPPS outlier payments toward the complex and expensive services that can create high financial risk for a hospital. In its comments on the proposed rule, MedPAC recognized that elimination of the outlier policy for OPPS requires a legislative change and approved of the proposed policy to adopt a fixed-dollar threshold. For a more detailed discussion of this issue, see section X. of this final rule with comment period.

D. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes, as well as the statutory changes that would be effective for CY 2005, 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. We also do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

E. Estimated Impacts of This Final Rule With Comment Period on Hospitals

The estimated increase in the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. However, total payments actually made under the system also may be influenced by changes in volume and service-mix, which CMS cannot forecast. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the payment of additional dollars in 2004 and 2005 to providers of OPPS services outside of the budget neutrality requirements for both specified covered outpatient drugs (see section V.A.3.a. of this final rule with comment period) and the wage indexes for specific hospitals through reclassification reform in section 508 of Pub. L. 108–173 (see section IX. of this final rule with comment period). Table 41 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure and wage indices, which are budget neutral; the estimated distribution of increased payments in CY 2005 resulting from the combined impact of APC recalibration and wage effects, and market basket update to the conversion factor; and estimated payments considering all payments for CY 2005 relative to all payments for CY 2004. In some cases, specific hospitals may receive more total payment in CY 2005 than in CY 2004, while, in other cases, they may receive less total payment than they received in CY 2004. However, our impact analysis suggests that no class of hospitals would receive less total payments in CY 2005 than in CY 2004. Because updates to the conversion factor, including the market basket and any reintroduction of pass-through dollars, are applied uniformly, observed redistributions of payments in the impact table largely depends on the

mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change) and the impact of the wage index changes on the hospital. However, the extent to which this final rule redistributes money during implementation will also depend on changes in volume, practice patterns, and case-mix of services billed between CY 2003 and CY 2005.

Overall, the final OPPS rates for CY 2005 will have a positive effect for all hospitals paid under OPPS. Adopted changes will result in a 4.0 percent increase in Medicare payments to all hospitals, exclusive of outlier and transitional pass-through payments. 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 indices, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and APC recalibration changes are fairly moderate across most classes of hospitals.

To illustrate the impact of the CY 2005 changes adopted in this final rule with comment period, our analysis begins with a baseline simulation model that uses the final CY 2004 weights, the FY 2004 final post-reclassification IPPS wage indices, as subsequently corrected, without changes in wage indices resulting from section 508 reclassifications, and the final CY 2004 conversion factor. Columns 2 and 3 in Table 41 reflect the independent effects of the changes in the APC reclassification and recalibration changes and the wage indices, respectively. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on a complete year of CY 2003 hospital OPPS claims data. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2004 weights versus the final CY 2005 weights, in our baseline model, and calculating the percent difference in payments. Column 3 shows the impact of updating the wage indices used to calculate payment by applying the final FY 2005 IPPS wage indices, as subsequently corrected. In addition to new wage data, the new IPPS wage indices use the CBSA system as the basis for geographic adjustment for wages, rather than the MSA designations used previously. The FY 2005 IPPS wage indices also include the new adjustment for occupational mix, the reclassifications of hospitals to geographic areas by the MGCRB, the increased payment authorized by section 505 of Pub. L. 108–173 for out-migration, hold-harmless provisions for hospitals redesignated from urban to rural by the new labor market definitions, and the one-year transition, 50/50 blend for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. The OPPS wage indices used in Column 3 do not include wage increases due to reclassification of hospitals through section 508 of Pub. L. 108–173. We modeled the independent effect of introducing the new wage indices by varying only the wage index between years, using CY 2004 weights, and a CY 2004 conversion factor that included a budget neutrality adjustment for changes in wage effects between 2004 and 2005.

Column 4 demonstrates the combined ''budget neutral'' impact of APC recalibration and wage index updates on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket. We modeled the independent effect of budget neutrality adjustments and the market basket update by using the weights and wage indices for each year, and using a CY 2004 conversion factor that included a budget neutrality adjustment for differences in wages and the market basket increase. Finally, column 5 depicts the full impact of final CY 2005 policy on each hospital group by including the effect of all the changes for CY 2005 and comparing them to the full effect of all payments in CY 2004, including those authorized by Pub. L. 108–173. Column 5 shows not only the combined budget neutral effects of APC and wage updates, and the market basket update, but it also shows the effects of additional monies added to the OPPS as a result of Pub. L. 108–173 and pass-through money returned to the conversion factor from CY 2004. We modeled the independent effect of all changes using the final weights for CY 2004 and CY 2005 with additional money for drugs authorized by section 621 of Pub. L. 108–173, final wage indices including wage index increases for hospitals eligible for reclassification under section 508 of Pub. L. 108–173, and the CY 2005 conversion factor of $56.983.

Column 1: Total Number of Hospitals

Column 1 in Table 41 shows the total number of hospital providers (4,296) for which we were able to use CY 2003 hospital outpatient claims to model CY 2004 and CY 2005 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2004 or CY 2005 payment and entities that are not paid under the OPPS. The latter include critical access hospitals, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, and the State of Maryland. This process is discussed in greater detail in section III.B of this final rule with comment period. In prior years, we displayed non-TEFRA hospitals paid under PPS separately from TEFRA hospitals in our impact and outlier tables. The distinction between TEFRA and non-TEFRA holds little value for OPPS as all hospitals are treated equally under the OPPS payment system. For this reason, we did not include TEFRA hospitals as a distinct hospital category in Table 41. The impact on this specific class of hospitals is captured in the rows addressing disproportionate share (DSH) as we only calculate a DSH variable for hospitals participating in the IPPS. Finally, of the hospitals displayed in Table 41 and Table 42, it is important to note that section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with less than 100 beds, and sole community hospitals in rural areas. The hold harmless provisions for cancer and children's hospitals are permanent; these hospitals cannot receive less payment in CY 2005 than they did in the CY 2004. For this reason, we will not specifically identify these classes of hospitals in future impact analyses.

Column 2: APC Recalibration

The APC reclassification and recalibration changes tend to favor rural hospitals especially those characterized as small, although the overall redistribution impact is modest. Rural hospitals show a 0.6 percent increase, which is somewhat less than that observed in the proposed rule of 0.9. Specifically, rural hospitals with 50 to 100 beds show a 0.8 percent increase and rural hospitals with 101 to 149 beds show a 0.7 percent increase attributable to the APC recalibration. Mid-volume hospitals performing between 11,000 and 20,999 services experience an increase of 1.0 percent. Rural hospitals also show overall increases by region, with the East North Central and East South Central regions benefiting by at least 0.9 percent and the South Atlantic and West North Central regions benefiting by 0.7 percent.

Urban hospitals show, on an average, a 0.2 percent decrease, which is comparable to that observed in the

proposed rule. This decrease is spread among all urban hospitals. Large urban hospitals experience a decline of 0.1 percent and ''other'' urban hospitals experience a decline of 0.2 percent. Urban hospitals with greater than 200 beds show decreases, and the largest urban hospitals with bed size greater than 500 report a decrease of 0.9 percent. The smallest urban hospitals report a positive percent increases. Urban hospitals providing the lowest volume of services and those providing the highest also demonstrate negative impacts from APC recalibration. Decreases for urban hospitals are also concentrated in some regions, specifically, the South Atlantic, West South Central, Mountain, and Pacific experience decreases of at least 0.1 percent. West South Central loses the most, 0.9 percent.

The largest observed impacts among other hospital classes resulting from APC recalibration include declines of 1 percent for major teaching hospitals and 2.3 percent for hospitals without a valid DSH variable, most of which are TEFRA hospitals. Hospitals treating more low-income patients (high DSH percentage) also demonstrate declines of 0.8 percent. However, hospitals treating fewer low-income patients experience positive impacts from APC recalibration. Government hospitals demonstrate a decline of 0.8 percent. The specialty hospitals, cancer and children's hospitals, also would experience declines of 2.4 and 1.5 percent due to APC recalibration, respectively, if they were not held harmless under section 1833(t)(7)(D) of the Act.

In general, APC changes effect the distribution of hospital payments by increasing payments to small rural hospitals while decreasing payments made to large urban hospitals, including major teaching hospitals and those serving a high percentage of low-income patients.

Column 3: Wage Effect

Changes introduced by the new IPPS wage indices had a modest impact, but the distributions have changed since the proposed rule with the changes and additional provisions included in the final IPPS wage indices. Decreases in OPPS payment due to the new wage indices are generally located in rural hospitals, although specific classes of other hospitals also experience declines. Overall, urban hospitals experience no change in payments as a result of the new wage indices. However, large urban hospitals experience an increase of 0.1 percent. We estimate that rural hospitals will experience a decrease in payments of 0.2 percent. This pattern of urban gain and rural loss is evident in all of the urban and rural comparisons. Low-volume urban hospitals with fewer than 5,000 services and urban hospitals in the West South Central region show the largest percentage increase of 0.5.

Rural hospitals show modest decreases for most bed sizes but show the largest losses for hospitals with more than 200 beds. The new wage indices result in a 0.5 percent decrease for the largest rural hospitals. Similarly, high volume rural hospitals demonstrate an anticipated decline of 0.4 percent. Hospitals located in the New England and Middle Atlantic regions show a negative impact due to wage index changes regardless of urban or rural designation. However, rural hospitals in New England and the Middle Atlantic experience the largest decreases among regions of 0.7 and 0.6 percent, respectively. Rural hospitals in the South Atlantic, East North Central, East South Central, and Mountain regions also experience decreased payments. Rural sole community hospitals show the same impact as other rural hospitals; they experience a decline of 0.2 percent.

Looking across other categories of hospitals, major teaching hospitals are estimated to lose 0.3 percent. Almost all hospitals serving low-income patients lose 0.1 percent. Hospitals for which DSH is not available, mostly TEFRA hospitals, lose 0.3 percent.

Column 4: Budget Neutrality and Market Basket Update

In general, the market basket update alleviates any negative impacts on payments created by the budget neutrality adjustments made in columns 2 and 3. As column 4 demonstrates, with the addition of the market basket update, we do not expect any class of hospital providers to experience an overall negative impact as a result of the proposed changes to OPPS for CY 2005. Further, the redistributions created by APC recalibration tend to offset those created by the new wage indices. For example, rural hospitals gain 0.6 percent from the APC changes but lose 0.2 percent as a result of changes to the wage indices, leading to an overall adjustment of 3.7 percent with the addition of the market basket. Urban hospitals show a decrease of 0.2 percent resulting from APC recalibration and no change as a result of the new wage index, leading to an update in column 4 of 3.2 percent.

For several classes of hospitals, positive or neutral wage effects do not offset the larger impacts of APC recalibration leading to lower update amounts. For example, low volume urban hospitals experience a negative APC recalibration effect of 1.1, but a positive wage effect of 0.5. The result is an overall update of 2.6, which is less than the market basket. A few hospital providers may experience much lower and much higher update amounts than the market basket because the combined impact of the budget neutrality adjustments for the APC recalibration and the new wage index are reinforcing. Urban hospitals with more than 500 beds show a gain of 2.2 percent because the impact of APC recalibration was −0.9 percent and the new wage indices added −0.1 percent. Major teaching hospitals experience a decline in payment due to APC recalibration of −1.0 and a decline due to wage indices of −0.3 resulting in an overall, budget neutral update of 2.0. Hospitals for which we have no DSH variable, mostly TEFRA hospitals, will experience a decrease in payments due to both APC recalibration and the new wage indices, leading to a budget neutral increase of 0.7 percent. Hospitals serving a high number of low-income patients experience an overall update of 2.4 percent. Finally, cancer hospitals show an update of only 0.2 percent, and children's hospitals, of only 2.0 percent, but statutory provisions ensure that each of these hospitals is ''held harmless'' relative to last year's payments.

A few hospitals may also gain from the combined positive effect of the APC recalibration and the wage effect. Overall, mid-volume urban hospitals and urban hospitals with a small number of beds, rural hospitals in the East South and North Central, West North and South Central, and nonteaching hospitals experience positive impacts from both APC recalibration and the new wage indices.

Column 5: All Changes for CY 2005

Column 5 compares all changes for CY 2005 to a final simulated payment for CY 2004 and includes all additional dollars resulting from provisions in Pub. L. 108–173 in both years and the difference in pass-through estimates. Overall, we estimate that hospitals will gain 4.0 percent under this final rule with comment period relative to total spending with Pub. L. 108–173 dollars for drugs and wage indices in CY 2004. Hospitals do receive a 4.5-percent increase in dollars (3.3 percent for the market basket and 1.2 percent for pass-through dollars returned to the conversion factor), which is reflected in the conversion factor. However, hospitals received more additional money from provisions in Pub. L. 108–173 for spending on drugs and wage

indices in CY 2004 than in CY 2005. This is largely a result of the decline in the statutory minimum payment for sole source specified covered outpatient drugs from 88 percent to 83 percent of AWP. The observed 4.0 percent reflects this difference in spending.

Some hospitals experience large increases in addition to those already garnered under budget neutrality. In rural areas, hospitals providing between 11,000 and 20,999 services are projected to experience an increase of 5.1 percent. Rural hospitals in the East South Central, West North Central, and West South Central are all projected to experience an increase of at least 5 percent. Very small urban hospitals, less than 99 beds, will experience an increase of 4.9 percent. On the other hand, a handful of types of hospitals will experience much smaller updates. Large urban hospitals will receive an update of 3.9 percent. Urban hospitals in the Middle Atlantic and Mountain regions will experience updates less than or equal to 3.5 percent. Rural hospitals in New England and the Middle Atlantic also have updates less than or equal to 3.5 percent.

Major teaching hospitals are projected to experience a smaller increase in payments, 2.6 percent, than the 4.0 percent aggregate for all hospitals due to negative impacts from both the APC recalibration, the new wage indices, and most probably the decline in spending for drugs under Pub. L. 108–73. Hospitals serving a disproportionate share of low-income patients also experience a lower increase, 3.4 percent. Hospitals for which there is no DSH information, mostly TEFRA hospitals, are estimated to receive an update of 0.3 percent. This low-observed increase appears to be largely due to APC recalibration issues and declines in the payment for drugs. The impact of final payment on the specialty hospitals, cancer and children's hospitals, is not shown. If these hospitals were paid under OPPS, the cancer hospitals would experience a negative impact. However, these hospitals are held harmless and, therefore, will not experience any decline in payment. As noted above, we do not intend to specifically identify these hospitals in our future impact analyses.

F. Projected Distribution of Outlier Payments

As stated in section X.B. of this preamble, we have a projected target of 2 percent of the estimated CY 2005 expenditures to outlier payments. For CY 2005, we are adopting a fixed-dollar threshold. As discussed in section X.B. of the preamble, we are changing our current policy, which sets the outlier threshold using only a multiple of the APC payment rate, to a policy that includes both a multiple of the APC payment rate and a new fixed dollar threshold. This policy will better target outlier payments to higher cost, complex cases that create greater financial risk for hospitals.

For CY 2005, we are specifically proposing to require that, in order to qualify for an outlier payment, the cost of a service must exceed 1.75 times the APC payment rate and the cost must also exceed the sum of the APC rate plus a $1,175 fixed-dollar threshold. The outlier payment under this policy remains at 50 percent of the cost minus the multiple of the APC payment rate.

Table 42 below compares the percentage of outlier payments relative to total projected payments for the simulated CY 2004 and CY 2005 outlier policies. As discussed in section X.B. of this preamble, we included a charge inflation factor in our modeling for this final rule with comment period that was not included in our modeling for the proposed rule. This resulted in increased thresholds for both the simulated CY 2004 and final CY 2005 outlier policies. To provide an accurate comparison for the new policy, we estimated the CY 2004, multiple-only policy, using the CY 2003 claims with inflated charges to pay total outlier payments that are 2 percent of total estimated spending. This resulted in a multiple threshold of 2.95.

Overall, Table 42 demonstrates that the outlier policy accomplishes the goal of redistributing outlier payments to hospitals performing more expensive procedures and incurring greater financial risk. Notwithstanding the inclusion of a charge inflation factor, the observed distributions for both policies differ very little from those provided in the proposed rule. First, based on the mix of services for the hospitals that would be paid under the OPPS in CY 2005, fewer hospitals would receive outlier payments. This is appropriate as more outlier money is targeted to specific services. We estimate that approximately 85 percent of all hospitals will receive outlier payments under the new policy, whereas 95 percent of all hospitals were estimated to get outlier payments under the CY 2004 policy.

We estimate that the redistribution of outlier payments is modest, rarely shifting total payments by more than 1 percent. In light of this, many hospitals receiving outlier payments under the previous policy will continue to receive outlier payments but for a different set of services. Nonetheless, this final outlier policy appears to accomplish the goal of redirecting payments to high-cost, expensive services. The adopted outlier policy tends to benefit large urban hospitals, teaching hospitals, proprietary hospitals, and hospitals serving a moderate share of low-income patients. The distribution observed here may offset the less than average increases in payment observed for these same classes of hospitals in the overall impact Table 41. Selected hospitals are predicted to lose outlier payments. Rural hospitals, specifically those that show a small number of beds and provide a low volume of services, are eligible for fewer outlier payments when compared to other types of hospital categories, but, in general, these hospitals experience greater OPPS payment increases. Government hospitals experience a decrease in outlier payments of 0.3 percent, and TEFRA hospitals are projected to lose 1.2 percent in outlier payments.

G. Estimated Impacts of This Final Rule With Comment Period 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 copayment in CY 2004 was $10.71. In this final rule with comment period, the minimum unadjusted copayment for APC 601 is $11.22 because the OPPS payment for the service will increase under this final rule with comment period. In another example, for a Level III Pathology Procedure (APC 0344), the minimum unadjusted copayment in CY 2004 was $17.16. In this final rule with comment period, the minimum unadjusted copayment for APC 0344 is $15.66 because the minimum unadjusted copayment is limited to 45 percent of the APC payment rate for CY 2005, as discussed in section XI. of this final rule with comment period.

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 $912 for CY 2005.

BILLING CODE 4102–01–P

Table 41.—Impact Changes for CY 2005 Hospital Outpatient Prospective Payment System

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
ALL HOSPITALS	4,296	0.0	0.0	3.3	4.0
Urban Hospitals	2,981	-0.2	0.0	3.2	3.9
Large Urban (greater than 1 million)	1,613	-0.1	0.1	3.3	3.9
Other Urban (less than or equal to 1 million)	1,368	-0.2	0.0	3.1	3.9
Rural Hospitals	1,315	0.6	-0.2	3.7	4.5
BEDS (URBAN)					
0 - 99 Beds	929	0.6	0.3	4.3	4.9
100-199 Beds	990	0.3	0.0	3.6	4.3
200-299 Beds	508	-0.1	0.2	3.4	4.2
300-499 Beds	397	-0.2	0.0	3.0	3.7
500 + Beds	157	-0.9	-0.1	2.2	3.2
BEDS (RURAL)					
0 - 49 Beds[2]	584	0.4	0.1	3.9	4.6
50- 100 Beds[2]	437	0.8	-0.1	4.1	4.7
101- 149 Beds	183	0.7	-0.2	3.8	4.4
150- 199 Beds	62	0.1	-0.2	3.1	4.3
200 + Beds	49	0.4	-0.5	3.1	4.4
VOLUME (URBAN)					

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
Less than 5,000 Lines	636	-1.1	0.5	2.6	3.8
5,000 - 10,999 Lines	291	0.0	0.4	3.7	4.8
11,000 - 20,999 Lines	410	0.6	0.3	4.3	5.2
21,000 - 42,999 Lines	665	0.2	0.1	3.5	4.5
Greater than 42,999 Lines	979	-0.3	0.0	3.0	3.7
VOLUME (RURAL)					
Less than 5,000 Lines	186	0.0	0.0	3.3	4.9
5,000 - 10,999 Lines	312	-0.2	-0.1	2.9	3.8
11,000 - 20,999 Lines	387	1.0	0.1	4.4	5.1
21,000 - 42,999 Lines	301	0.7	-0.1	4.0	4.7
Greater than 42,999 Lines	129	0.3	-0.4	3.2	4.1
REGION (URBAN)					
New England	169	0.1	-0.2	3.2	3.7
Middle Atlantic	396	0.0	-0.2	3.1	3.5
South Atlantic	458	-0.5	0.1	2.9	4.1
East North Central	478	0.2	0.0	3.5	4.2
East South Central	196	0.0	-0.3	3.0	3.9
West North Central	192	0.0	0.0	3.4	4.3
West South Central	432	-0.9	0.5	2.9	3.9
Mountain	168	-0.4	-0.2	2.7	3.3
Pacific	440	-0.1	0.1	3.4	4.2
Puerto Rico	52	0.8	-0.1	4.0	5.0
REGION (RURAL)					
New England	38	0.2	-0.7	2.7	3.0
Middle Atlantic	79	0.1	-0.6	2.7	3.5
South Atlantic	191	0.7	-0.1	3.9	4.6
East North Central	189	1.0	-0.3	4.0	4.9
East South Central	205	0.9	-0.2	4.0	5.0

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
West North Central	205	0.7	0.1	4.2	5.1
West South Central	247	0.3	0.3	4.0	5.0
Mountain	99	-0.1	-0.3	2.9	3.7
Pacific	62	-0.8	0.3	2.8	3.6
TEACHING STATUS					
Nonteaching	3,171	0.4	0.1	3.8	4.6
Minor	807	-0.1	0.0	3.3	4.1
Major	318	-1.0	-0.3	2.0	2.6
DSH PATIENT PERCENTAGE					
0	5	2.3	0.6	6.3	7.6
Greater than 0 - 0.10	502	0.3	-0.1	3.5	4.4
0.10 - 0.16	633	0.2	-0.1	3.4	4.2
0.16 - 0.23	856	0.3	-0.1	3.5	4.3
0.23 - 0.35	910	-0.1	0.2	3.5	4.2
Greater than or equal to 0.35	770	-0.8	-0.1	2.4	3.4
DSH Not Available[1]	620	-2.3	-0.3	0.7	0.3
URBAN TEACHING/DSH					
Teaching & DSH	962	-0.4	-0.1	2.8	3.6
No Teaching/DSH	1466	0.3	0.2	3.8	4.7
No Teaching/No DSH	4	1.8	0.7	5.9	7.3
DSH Not Available[1]	549	-2.6	-0.1	0.6	0.2
RURAL HOSPITAL TYPES					
No Special Status	815	0.7	-0.1	3.9	4.6
SCH[2]	500	0.3	-0.2	3.4	4.5
TYPE OF OWNERSHIP					

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
Voluntary	2,498	0.1	0.0	3.4	4.1
Proprietary	1,031	-0.1	0.0	3.3	4.3
Government	767	-0.8	0.1	2.6	3.6
SPECIALTY HOSPITALS[2]					
Cancer	11	-2.4	-0.6	0.2	
Children's	46	-1.5	0.3	2.0	

(1) Total hospitals in CY 2005.

(2) 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 CY 2003 hospital claims data.

(3) This column shows the impact of updating the wage index used to calculate payment by applying the final FY 2005 IPPS wage indices, as corrected including the impact of new wage data, occupational mix, CBSA system, geographic reclassification by the MGCRB, and any technical corrections or updates made in the IPPS final rule and subsequent correction notices.

(4) This column shows the combined impact of budget neutrality (columns 2 and 3) with the market basket update.

(5) This column shows changes in total payment from CY 2004 to CY 2005, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2, 3, and 4. In addition, it shows the impact of payment for drugs under MMA, 508 additions to the wage index, and any additional pass through money included in the conversion factor.

1 Complete DSH numbers are not available for some hospitals, including TEFRA hospitals.

2 Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with 100 or fewer beds beds, and sole community hospitals located in rural areas.

Table 42.--Distribution of Outlier Payments for 2005 Hospital Outpatient Prospective Payment System

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
ALL HOSPITALS	4,296	4,075	2.0	3,671	2.0	0.0
Urban Hospitals	2,981	2,774	2.0	2,496	2.1	0.1
Large Urban (greater than 1 million)	1,613	1,499	2.3	1,364	2.2	0.0
Other Urban (less than or equal to I million	1,368	1,275	1.8	1,132	2.0	0.2
Rural Hospitals	1,315	1,301	1.6	1,175	1.2	-0.4
BEDS (URBAN)						
0 – 99 Beds	929	770	2.0	564	1.7	-0.3
100-199 Beds	990	948	1.8	887	1.7	-0.1
200-299 Beds	508	503	1.8	493	1.9	0.1
300-499 Beds	397	396	2.0	395	2.1	0.1
500 + Beds	157	157	2.7	157	2.9	0.3
BEDS (RURAL)						
0 – 49 Beds	584	576	2.2	472	1.2	-1.0
50- 100 Beds	437	431	1.5	410	1.1	-0.4
101- 149 Beds	183	183	1.4	182	1.1	-0.3
150- 199 Beds	62	62	1.4	62	1.2	-0.2
200 + Beds	49	49	1.3	49	1.3	0.0
VOLUME (URBAN)						
Less than 5,000 Lines	636	435	3.3	207	2.5	-0.8
5,000 - 10,999 Lines	291	287	2.1	249	1.9	-0.2
11,000 – 20,999 Lines	410	408	2.0	397	2.1	0.0

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
21,000 – 42,999 Lines	665	665	1.9	664	1.9	0.0
Greater than 42,999 Lines	979	979	2.1	979	2.2	0.1
VOLUME (RURAL)						
Less than 5,000 Lines	186	172	3.2	98	1.7	-1.5
5,000 - 10,999 Lines	312	312	2.3	268	1.3	-1.1
11,000 - 20,999 Lines	387	387	1.9	380	1.2	-0.7
21,000 - 42,999 Lines	301	301	1.4	300	1.1	-0.3
Greater than 42,999 Lines	129	129	1.3	129	1.1	-0.2
REGION (URBAN)						
New England	169	156	2.0	139	1.6	-0.4
Middle Atlantic	396	378	2.5	349	2.3	-0.2
South Atlantic	458	425	1.9	393	2.2	0.3
East North Central	478	446	1.9	412	2.0	0.1
East South Central	196	182	1.6	161	1.8	0.2
West North Central	192	186	1.5	167	1.6	0.1
West South Central	432	381	2.5	319	2.4	-0.2
Mountain	168	155	2.1	134	2.3	0.1
Pacific	440	417	2.1	387	2.5	0.4
Puerto Rico	52	48	1.2	35	1.8	0.6
REGION (RURAL)						
New England	38	36	1.7	37	1.4	-0.2
Middle Atlantic	79	79	1.4	76	0.7	-0.8
South Atlantic	191	189	1.4	185	1.1	-0.3
East North Central	189	188	1.4	186	1.2	-0.2

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
East South Central	205	203	1.2	163	0.8	-0.4
West North Central	205	203	1.6	184	1.3	-0.3
West South Central	247	243	1.7	192	1.1	-0.6
Mountain	99	99	2.6	92	2.1	-0.6
Pacific	62	61	2.2	60	1.6	-0.6
TEACHING STATUS						
Nonteaching	3,171	2,964	1.6	2,581	1.5	-0.1
Minor	807	793	1.7	776	1.8	0.1
Major	318	318	3.1	314	3.2	0.1
DSH PATIENT PERCENTAGE						
0	5	5	2.5	3	4.2	1.8
Greater than 0 - 0.10	502	502	1.8	477	1.8	0.0
0.10 - 0.16	633	633	1.6	614	1.5	-0.1
0.16 - 0.23	856	855	1.7	818	1.7	0.1
0.23 - 0.35	910	906	1.8	872	1.9	0.1
Greater than or equal to 0.35	770	769	3.0	721	2.9	-0.1
DSH Not Aavilable[1]	620	405	3.0	166	1.8	-1.2
URBAN TEACHING/DSH						
Teaching & DSH	962	962	2.3	959	2.4	0.2
No Teaching/DSH	1,466	1,462	1.7	1,408	1.7	0.0
No Teaching/NO DSH	4	4	3.4	3	5.7	2.4
DSH Not Available[1]	549	346	3.1	126	1.8	-1.2
RURAL HOSPITAL TYPES						

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
No special Status	815	801	1.5	716	1.1	-0.4
SCH[3]	500	500	1.7	459	1.2	-0.4
TYPE OF OWNERSHIP						
Voluntary	2,498	2,442	1.9	2,305	1.9	0.0
Proprietary	1,031	877	1.6	715	1.8	0.2
Government	767	756	2.7	651	2.4	-0.3
SPECIALTY HOSPITALS						
Cancer[3]	11	11	3.5	11	2.2	
Children's[3]	46	44	9.2	38	9.0	

(1) The column shows the impact of the CY 2004 policy, after adjusting the multiple to pay the 2 percent of estimated CY 2005 total payments.

FY 2005 costs were estimated from 2003 claims using a charge inflation factor of 1.1876.

The outlier threshold is 2.95 times the APC payment, and the outlier payment is 50 percent of the observed cost less 2.95 times APC payment

(2) This column shows the impact of the CY 2005 policy.

CY 2005 costs were estimated from CY 2003 claims using a charge inflation factor of 1.1876.

The outlier thesholds are 1.75 times the APC payment and $1,175 plus the APC payment.

The outlier payment is 50 percent of the observed cost less 1.75 times the APC payment

1 DSH is not available for some hospitals, including TEFRA.

2 Calculated differences may not be exact due to rounding.

3 Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with 100 or fewer beds and sole community hospitals located in rural areas.

BILLING CODE 4120–01–C

Conclusion

The changes in this final rule with comment period affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but all hospitals will experience positive updates in OPPS payments in CY 2005. Table 41 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 4.0 percent increase in payments for CY 2005, exclusive of outlier and transitional pass-through payments, across various classes of hospitals. Table 42 demonstrates the distributional impact of outlier payments under the new policy of a multiple and fixed-dollar threshold. These two tables and the accompanying discussion, in combination with the rest of this final rule with comment period, constitute a regulatory impact analysis.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

XV. Regulation Text

List of Subjects in 42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Chapter IV, Part 419, as set forth below:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

■ 1. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

■ 2. Section 419.21 is amended by adding a new paragraph (e) to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(e) Effective January 1, 2005, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

■ 3. Section 419.22 is amended by adding a new paragraph (s) to read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

* * * * *

(s) Effective December 8, 2003, screening mammography services and effective January 1, 2005, diagnostic mammography services.

■ 4. Section 419.64 is amended by revising paragraph (d) to read as follows:

§ 419.64 Transitional pass-through payments: Drugs and biologicals.

* * * * *

(d) *Amount of pass-through payment.* Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological equals the amount determined under section 1842(o) of the Social Security Act, minus the portion of the APC payment amount that CMS determines is associated with the drug or biological.

■ 5. Section 419.70 is amended by revising the section heading and paragraphs (f)(2)(i) and (f)(2)(ii) to read as follows:

§ 419.70 Transitional adjustment to limit decline in payments.

* * * * *

(f) *Pre-BBA amount defined.* * * *

(2) *Base payment-to-cost ratio defined.* * * *

(i) The provider's payment under this part for covered outpatient services furnished during one of the following periods, including any payment for these services through cost-sharing described in paragraph (e) of this section:

(A) The cost reporting period ending in 1996; or

(B) If the provider does not have a cost reporting period ending in 1996, the first cost reporting period ending on or after January 1, 1997, and before January 1, 2001; and

(ii) The reasonable costs of these services for the same cost reporting period.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 28, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 28, 2004.

Tommy G. Thompson,

Secretary.

Addendum A.--List of Ambulatory Payment Classifications (APCs) With Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2005

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.4007	22.83	7.00	4.57
0002	Level I Fine Needle Biopsy/Aspiration	T	0.9553	54.44		10.89
0003	Bone Marrow Biopsy/Aspiration	T	2.4779	141.20		28.24
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.7081	97.33	22.36	19.47
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.7391	213.07	71.59	42.61
0006	Level I Incision & Drainage	T	1.6854	96.04	23.26	19.21
0007	Level II Incision & Drainage	T	12.4496	709.42		141.88
0008	Level III Incision and Drainage	T	19.3572	1103.03		220.61
0009	Nail Procedures	T	0.6817	38.85	8.34	7.77
0010	Level I Destruction of Lesion	T	0.5940	33.85	9.65	6.77
0011	Level II Destruction of Lesion	T	2.4040	136.99	27.88	27.40
0012	Level I Debridement & Destruction	T	0.7477	42.61	11.18	8.52
0013	Level II Debridement & Destruction	T	1.1380	64.85	14.20	12.97
0015	Level III Debridement & Destruction	T	1.7248	98.28	20.35	19.66
0016	Level IV Debridement & Destruction	T	2.8321	161.38	57.31	32.28
0017	Level VI Debridement & Destruction	T	17.3894	990.90	227.84	198.18
0018	Biopsy of Skin/Puncture of Lesion	T	0.9669	55.10	16.04	11.02
0019	Level I Excision/ Biopsy	T	4.1677	237.49	71.87	47.50
0020	Level II Excision/ Biopsy	T	7.6248	434.48	113.25	86.90
0021	Level III Excision/ Biopsy	T	14.8872	848.32	219.48	169.66
0022	Level IV Excision/ Biopsy	T	19.3700	1103.76	354.45	220.75
0023	Exploration Penetrating Wound	T	3.2236	183.69	40.37	36.74
0024	Level I Skin Repair	T	1.7742	101.10	33.10	20.22
0025	Level II Skin Repair	T	4.7315	269.62	101.85	53.92
0027	Level IV Skin Repair	T	16.8355	959.34	329.72	191.87
0028	Level I Breast Surgery	T	18.7869	1070.53	303.74	214.11
0029	Level II Breast Surgery	T	31.3655	1787.30	632.64	357.46
0030	Level III Breast Surgery	T	39.2810	2238.35	763.55	447.67
0032	Insertion of Central Venous/Arterial Catheter	T	10.7448	612.27		122.45
0033	Partial Hospitalization	P	4.9370	281.33		56.27
0035	Placement of Arterial or Central Venous Catheter	T	0.2889	16.46		3.29
0036	Level II Fine Needle Biopsy/Aspiration	T	2.2377	127.51		25.50
0037	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.3421	532.34	234.20	106.47
0039	Level I Implantation of Neurostimulator	S	219.9203	12531.72		2506.34

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0040	Level II Implantation of Neurostimulator Electrodes	S	49.2740	2807.78		561.56
0041	Level I Arthroscopy	T	28.0254	1596.97		319.39
0042	Level II Arthroscopy	T	43.5802	2483.33	804.74	496.67
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.8527	105.57		21.11
0045	Bone/Joint Manipulation Under Anesthesia	T	14.2091	809.68	268.47	161.94
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	35.1105	2000.70	535.76	400.14
0047	Arthroplasty without Prosthesis	T	31.0492	1769.28	537.03	353.86
0048	Level I Arthroplasty with Prosthesis	T	40.3978	2301.99	570.30	460.40
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	20.2046	1151.32		230.26
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	24.6002	1401.79		280.36
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	35.8607	2043.45		408.69
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	43.5754	2483.06		496.61
0053	Level I Hand Musculoskeletal Procedures	T	15.5097	883.79	253.49	176.76
0054	Level II Hand Musculoskeletal Procedures	T	24.8731	1417.34		283.47
0055	Level I Foot Musculoskeletal Procedures	T	19.3444	1102.30	355.34	220.46
0056	Level II Foot Musculoskeletal Procedures	T	26.5813	1514.68	405.81	302.94
0057	Bunion Procedures	T	27.0029	1538.71	475.91	307.74
0058	Level I Strapping and Cast Application	S	1.1091	63.20		12.64
0060	Manipulation Therapy	S	0.4737	26.99		5.40
0068	CPAP Initiation	S	1.1546	65.79	29.48	13.16
0069	Thoracoscopy	T	29.9158	1704.69	591.64	340.94
0070	Thoracentesis/Lavage Procedures	T	3.3166	188.99		37.80
0071	Level I Endoscopy Upper Airway	T	0.7396	42.14	11.31	8.43
0072	Level II Endoscopy Upper Airway	T	1.3903	79.22	21.27	15.84
0073	Level III Endoscopy Upper Airway	T	4.1373	235.76	73.38	47.15
0074	Level IV Endoscopy Upper Airway	T	16.1205	918.59	295.70	183.72
0075	Level V Endoscopy Upper Airway	T	20.9362	1193.01	445.92	238.60
0076	Level I Endoscopy Lower Airway	T	9.4372	537.76	189.82	107.55
0077	Level I Pulmonary Treatment	S	0.3228	18.39	7.74	3.68
0078	Level II Pulmonary Treatment	S	0.8315	47.38	14.55	9.48
0079	Ventilation Initiation and Management	S	2.4268	138.29		27.66
0080	Diagnostic Cardiac Catheterization	T	36.2660	2066.55	838.92	413.31
0081	Non-Coronary Angioplasty or Atherectomy	T	32.7548	1866.47		373.29
0082	Coronary Atherectomy	T	103.0652	5872.96	1263.32	1174.59

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	55.3618	3154.68		630.94
0084	Level I Electrophysiologic Evaluation	S	10.6370	606.13		121.23
0085	Level II Electrophysiologic Evaluation	T	34.7491	1980.11	426.25	396.02
0086	Ablate Heart Dysrhythm Focus	T	45.0490	2567.03	833.33	513.41
0087	Cardiac Electrophysiologic Recording/Mapping	T	37.2315	2121.56		424.31
0088	Thrombectomy	T	36.0282	2052.99	655.22	410.60
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	109.5827	6244.35	1682.28	1248.87
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	90.5432	5159.42	1612.80	1031.88
0091	Level II Vascular Ligation	T	29.6620	1690.23	348.23	338.05
0092	Level I Vascular Ligation	T	26.9952	1538.27	505.37	307.65
0093	Vascular Reconstruction/Fistula Repair without Device	T	24.0351	1369.59	277.34	273.92
0094	Level I Resuscitation and Cardioversion	S	2.6945	153.54	48.58	30.71
0095	Cardiac Rehabilitation	S	0.6044	34.44	15.49	6.89
0096	Non-Invasive Vascular Studies	S	1.7035	97.07	43.68	19.41
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0180	58.01	23.79	11.60
0098	Injection of Sclerosing Solution	T	1.3424	76.49		15.30
0099	Electrocardiograms	S	0.3812	21.72		4.34
0100	Cardiac Stress Tests	X	2.4975	142.32	41.44	28.46
0101	Tilt Table Evaluation	S	4.3954	250.46	105.27	50.09
0103	Miscellaneous Vascular Procedures	T	13.1337	748.40	223.63	149.68
0104	Transcatheter Placement of Intracoronary Stents	T	81.1177	4622.33		924.47
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	21.5449	1227.69	370.40	245.54
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	55.1440	3142.27		628.45
0107	Insertion of Cardioverter-Defibrillator	T	315.2469	17963.71	3612.57	3592.74
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	423.3141	24121.71		4824.34
0109	Removal of Implanted Devices	T	7.5181	428.40	131.49	85.68
0110	Transfusion	S	3.7809	215.45		43.09
0111	Blood Product Exchange	S	12.7259	725.16	200.18	145.03
0112	Apheresis, Photopheresis, and Plasmapheresis	S	37.3315	2127.26	612.47	425.45
0113	Excision Lymphatic System	T	21.0044	1196.89		239.38
0114	Thyroid/Lymphadenectomy Procedures	T	39.6713	2260.59	485.91	452.12
0115	Cannula/Access Device Procedures	T	25.6621	1462.30	459.35	292.46

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0116	Chemotherapy Administration by Other Technique Except Infusion	S	1.1117	63.35	.	12.67
0117	Chemotherapy Administration by Infusion Only	S	2.9533	168.29	42.54	33.66
0119	Implantation of Infusion Pump	T	125.9746	7178.41	.	1435.68
0120	Infusion Therapy Except Chemotherapy	T	1.9620	111.80	28.21	22.36
0121	Level I Tube changes and Repositioning	T	2.2909	130.54	43.80	26.11
0122	Level II Tube changes and Repositioning	T	8.2869	472.21	96.84	94.44
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	10.6755	608.32	.	121.66
0124	Revision of Implanted Infusion Pump	T	19.9665	1137.75	.	227.55
0125	Refilling of Infusion Pump	T	2.1652	123.38	.	24.68
0130	Level I Laparoscopy	T	31.6832	1805.40	659.53	361.08
0131	Level II Laparoscopy	T	42.7526	2436.17	1001.89	487.23
0132	Level III Laparoscopy	T	61.3208	3494.24	1239.22	698.85
0140	Esophageal Dilation without Endoscopy	T	6.4907	369.86	107.24	73.97
0141	Level I Upper GI Procedures	T	8.0725	460.00	143.38	92.00
0142	Small Intestine Endoscopy	T	8.7069	496.15	152.78	99.23
0143	Lower GI Endoscopy	T	8.5992	490.01	186.06	98.00
0146	Level I Sigmoidoscopy	T	4.3484	247.78	64.40	49.56
0147	Level II Sigmoidoscopy	T	8.0251	457.29	.	91.46
0148	Level I Anal/Rectal Procedure	T	4.3129	245.76	63.38	49.15
0149	Level III Anal/Rectal Procedure	T	17.7572	1011.86	293.06	202.37
0150	Level IV Anal/Rectal Procedure	T	23.1856	1321.19	437.12	264.24
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	18.7294	1067.26	245.46	213.45
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	12.4585	709.92	.	141.98
0153	Peritoneal and Abdominal Procedures	T	24.2544	1382.09	410.87	276.42
0154	Hernia/Hydrocele Procedures	T	28.0759	1599.85	464.85	319.97
0155	Level II Anal/Rectal Procedure	T	13.1091	747.00	188.89	149.40
0156	Level II Urinary and Anal Procedures	T	2.4782	141.22	40.52	28.24
0157	Colorectal Cancer Screening: Barium Enema	S	2.5110	143.08	.	28.62
0158	Colorectal Cancer Screening: Colonoscopy	T	7.7409	441.10	.	110.28
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.8464	162.20	.	40.55
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.7674	385.63	105.06	77.13
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.8851	1019.15	249.36	203.83
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	23.0182	1311.65	.	262.33

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.0744	2055.63	.	411.13
0164	Level I Urinary and Anal Procedures	T	1.2563	71.59	17.59	14.32
0165	Level III Urinary and Anal Procedures	T	16.0415	914.09	.	182.82
0166	Level I Urethral Procedures	T	17.7694	1012.55	218.73	202.51
0167	Level III Urethral Procedures	T	28.4301	1620.03	549.80	324.01
0168	Level II Urethral Procedures	T	30.7725	1753.51	405.60	350.70
0169	Lithotripsy	T	44.6235	2542.78	1115.69	508.56
0170	Dialysis	S	6.2255	354.75	.	70.95
0180	Circumcision	T	19.7320	1124.39	304.87	224.88
0181	Penile Procedures	T	31.6828	1805.38	621.82	361.08
0183	Testes/Epididymis Procedures	T	23.0563	1313.82	.	262.76
0184	Prostate Biopsy	T	4.1543	236.72	96.27	47.34
0187	Miscellaneous Placement/Repositioning	T	3.8526	219.53	.	43.91
0188	Level II Female Reproductive Proc	T	1.1045	62.94	.	12.59
0189	Level III Female Reproductive Proc	T	2.1451	122.23	.	24.45
0190	Level I Hysteroscopy	T	20.5171	1169.13	424.28	233.83
0191	Level I Female Reproductive Proc	T	0.1831	10.43	2.93	2.09
0192	Level IV Female Reproductive Proc	T	3.8280	218.13	.	43.63
0193	Level V Female Reproductive Proc	T	13.3052	758.17	158.05	151.63
0194	Level VIII Female Reproductive Proc	T	19.1146	1089.21	397.84	217.84
0195	Level IX Female Reproductive Proc	T	26.4573	1507.62	483.80	301.52
0196	Dilation and Curettage	T	16.9266	964.53	338.23	192.91
0197	Infertility Procedures	T	2.2368	127.46	.	25.49
0198	Pregnancy and Neonatal Care Procedures	T	1.3503	76.94	32.19	15.39
0200	Level VII Female Reproductive Proc	T	14.7568	840.89	263.69	168.18
0201	Level VI Female Reproductive Proc	T	18.0011	1025.76	329.65	205.15
0202	Level X Female Reproductive Proc	T	39.6674	2260.37	1017.16	452.07
0203	Level IV Nerve Injections	T	10.9230	622.43	272.25	124.49
0204	Level I Nerve Injections	T	2.1801	124.23	40.13	24.85
0206	Level II Nerve Injections	T	5.4311	309.48	75.55	61.90
0207	Level III Nerve Injections	T	5.8248	331.91	86.92	66.38
0208	Laminotomies and Laminectomies	T	42.5700	2425.77	.	485.15
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.6170	661.97	280.58	132.39
0212	Nervous System Injections	T	2.9465	167.90	74.67	33.58
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.7461	156.48	64.89	31.30
0214	Electroencephalogram	S	2.2788	129.85	58.12	25.97
0215	Level I Nerve and Muscle Tests	S	0.6600	37.61	15.76	7.52
0216	Level III Nerve and Muscle Tests	S	2.6359	150.20	.	30.04
0218	Level II Nerve and Muscle Tests	S	1.1442	65.20	.	13.04
0220	Level I Nerve Procedures	T	17.2963	985.60	.	197.12

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0221	Level II Nerve Procedures	T	28.7081	1635.87	463.62	327.17
0222	Implantation of Neurological Device	T	217.1298	12372.71		2474.54
0223	Implantation or Revision of Pain Management Catheter	T	26.2731	1497.12		299.42
0224	Implantation of Reservoir/Pump/Shunt	T	38.8952	2216.37	453.41	443.27
0225	Level I Implantation of Neurostimulator Electrodes	S	210.5195	11996.03		2399.21
0226	Implantation of Drug Infusion Reservoir	T	43.4005	2473.09		494.62
0227	Implantation of Drug Infusion Device	T	150.3961	8570.02		1714.00
0228	Creation of Lumbar Subarachnoid Shunt	T	42.1332	2400.88	537.78	480.18
0229	Transcatherter Placement of Intravascular Shunts	T	62.1357	3540.68	771.23	708.14
0230	Level I Eye Tests & Treatments	S	0.8019	45.69	14.97	9.14
0231	Level III Eye Tests & Treatments	S	2.0073	114.38	44.61	22.88
0232	Level I Anterior Segment Eye Procedures	T	6.9120	393.87	103.17	78.77
0233	Level II Anterior Segment Eye Procedures	T	14.6847	836.78	266.33	167.36
0234	Level III Anterior Segment Eye Procedures	T	22.1360	1261.38	511.31	252.28
0235	Level I Posterior Segment Eye Procedures	T	5.1864	295.54	72.04	59.11
0236	Level II Posterior Segment Eye Procedures	T	21.3506	1216.62		243.32
0237	Level III Posterior Segment Eye Procedures	T	34.5277	1967.49	818.54	393.50
0238	Level I Repair and Plastic Eye Procedures	T	2.9594	168.64		33.73
0239	Level II Repair and Plastic Eye Procedures	T	6.7015	381.87		76.37
0240	Level III Repair and Plastic Eye Procedures	T	18.0715	1029.77	315.31	205.95
0241	Level IV Repair and Plastic Eye Procedures	T	23.5349	1341.09	384.47	268.22
0242	Level V Repair and Plastic Eye Procedures	T	30.2444	1723.42	597.36	344.68
0243	Strabismus/Muscle Procedures	T	22.4844	1281.23	431.39	256.25
0244	Corneal Transplant	T	39.6990	2262.17	803.26	452.43
0245	Level I Cataract Procedures without IOL Insert	T	13.9367	794.15	222.22	158.83
0246	Cataract Procedures with IOL Insert	T	23.3312	1329.48	495.96	265.90
0247	Laser Eye Procedures Except Retinal	T	5.0892	290.00	104.31	58.00
0248	Laser Retinal Procedures	T	4.9276	280.79	95.08	56.16
0249	Level II Cataract Procedures without IOL Insert	T	28.4617	1621.83	524.67	324.37
0250	Nasal Cauterization/Packing	T	1.3781	78.53	27.49	15.71
0251	Level I ENT Procedures	T	1.9352	110.27		22.05
0252	Level II ENT Procedures	T	6.5183	371.43	113.41	74.29

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0253	Level III ENT Procedures	T	15.9877	911.03	282.29	182.21
0254	Level IV ENT Procedures	T	23.3442	1330.22	321.35	266.04
0256	Level V ENT Procedures	T	36.9298	2104.37		420.87
0258	Tonsil and Adenoid Procedures	T	21.7774	1240.94	437.25	248.19
0259	Level VI ENT Procedures	T	444.1223	25307.42	9394.83	5061.48
0260	Level I Plain Film Except Teeth	X	0.7698	43.87	19.74	8.77
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.3351	76.08		15.22
0262	Plain Film of Teeth	X	1.4556	82.94		16.59
0263	Level I Miscellaneous Radiology Procedures	X	1.8514	105.50	38.51	21.10
0264	Level II Miscellaneous Radiology Procedures	X	3.4194	194.85	79.41	38.97
0265	Level I Diagnostic Ultrasound	S	1.0473	59.68	26.85	11.94
0266	Level II Diagnostic Ultrasound	S	1.6275	92.74	41.73	18.55
0267	Level III Diagnostic Ultrasound	S	2.4250	138.18	62.18	27.64
0268	Ultrasound Guidance Procedures	S	1.1835	67.44		13.49
0269	Level III Echocardiogram Except Transesophageal	S	3.2554	185.50	83.47	37.10
0270	Transesophageal Echocardiogram	S	6.1046	347.86	146.79	69.57
0272	Level I Fluoroscopy	X	1.3880	79.09	35.59	15.82
0274	Myelography	S	3.2901	187.48	84.36	37.50
0275	Arthrography	S	3.5084	199.92	69.09	39.98
0276	Level I Digestive Radiology	S	1.5808	90.08	40.53	18.02
0277	Level II Digestive Radiology	S	2.4364	138.83	60.47	27.77
0278	Diagnostic Urography	S	2.8522	162.53	66.07	32.51
0279	Level II Angiography and Venography except Extremity	S	8.8113	502.09	150.03	100.42
0280	Level III Angiography and Venography except Extremity	S	20.1741	1149.58	353.85	229.92
0281	Venography of Extremity	S	7.2117	410.94	115.16	82.19
0282	Miscellaneous Computerized Axial Tomography	S	1.7145	97.70	43.96	19.54
0283	Computerized Axial Tomography with Contrast Material	S	4.7485	270.58	121.76	54.12
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras	S	6.7851	386.64	173.98	77.33
0285	Myocardial Positron Emission Tomography (PET)	S	12.9121	735.77	318.72	147.15
0287	Complex Venography	S	8.3130	473.70	111.33	94.74
0288	Bone Density:Axial Skeleton	S	1.2735	72.57		14.51
0289	Needle Localization for Breast Biopsy	X	1.5701	89.47	21.05	17.89
0296	Level I Therapeutic Radiologic Procedures	S	2.4185	137.81	61.04	27.56

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0297	Level II Therapeutic Radiologic Procedures	S	5.2294	297.99	122.13	59.60
0299	Miscellaneous Radiation Treatment	S	5.8368	332.60	.	66.52
0300	Level I Radiation Therapy	S	1.5279	87.06	.	17.41
0301	Level II Radiation Therapy	S	2.1782	124.12	.	24.82
0302	Level III Radiation Therapy	S	5.4315	309.50	117.25	61.90
0303	Treatment Device Construction	X	2.8722	163.67	66.95	32.73
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.7107	97.48	41.52	19.50
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9322	224.07	91.38	44.81
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.2774	813.57	325.27	162.71
0312	Radioelement Applications	S	5.5783	317.87	.	63.57
0313	Brachytherapy	S	13.8770	790.75	.	158.15
0314	Hyperthermic Therapies	S	4.2608	242.79	98.36	48.56
0315	Level II Implantation of Neurostimulator	T	352.3658	20078.86	.	4015.77
0320	Electroconvulsive Therapy	S	5.3260	303.49	80.06	60.70
0321	Biofeedback and Other Training	S	1.4150	80.63	21.72	16.13
0322	Brief Individual Psychotherapy	S	1.2917	73.60	.	14.72
0323	Extended Individual Psychotherapy	S	1.7589	100.23	20.90	20.05
0324	Family Psychotherapy	S	2.8357	161.59	.	32.32
0325	Group Psychotherapy	S	1.4675	83.62	18.27	16.72
0330	Dental Procedures	S	14.0629	801.35	.	160.27
0332	Computerized Axial Tomography and Computerized Angiography without Contras	S	3.3910	193.23	86.95	38.65
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material	S	5.6225	320.39	144.17	64.08
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.0472	344.59	150.64	68.92
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont	S	6.3150	359.85	161.93	71.97
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed	S	9.1701	522.54	235.14	104.51
0339	Observation	S	7.1646	408.26	.	81.65
0340	Minor Ancillary Procedures	X	0.6328	36.06	.	7.21
0341	Skin Tests	X	0.1132	6.45	2.62	1.29
0342	Level I Pathology	X	0.2068	11.78	5.30	2.36
0343	Level II Pathology	X	0.4329	24.67	11.10	4.93
0344	Level III Pathology	X	0.6110	34.82	15.66	6.96
0345	Level I Transfusion Laboratory Procedures	X	0.2413	13.75	3.06	2.75

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0346	Level II Transfusion Laboratory Procedures	X	0.3586	20.43	5.15	4.09
0347	Level III Transfusion Laboratory Procedures	X	0.9386	53.48	13.20	10.70
0348	Fertility Laboratory Procedures	X	0.7675	43.73		8.75
0352	Level I Injections	X	0.1197	6.82		1.36
0353	Level II Allergy Injections	X	0.3981	22.68		4.54
0355	Level I Immunizations	K	0.3596	20.49		4.10
0356	Level II Immunizations	K	1.5752	89.76		17.95
0359	Level II Injections	X	0.8693	49.54		9.91
0360	Level I Alimentary Tests	X	1.6719	95.27	42.45	19.05
0361	Level II Alimentary Tests	X	3.6408	207.46	83.23	41.49
0362	Contact Lens and Spectacle Services	X	1.0861	61.89		12.38
0363	Level I Otorhinolaryngologic Function Tests	X	0.8653	49.31	17.44	9.86
0364	Level I Audiometry	X	0.4766	27.16	9.06	5.43
0365	Level II Audiometry	X	1.2743	72.61	18.95	14.52
0366	Level III Audiometry	X	1.8412	104.92	30.04	20.98
0367	Level I Pulmonary Test	X	0.5775	32.91	14.80	6.58
0368	Level II Pulmonary Tests	X	0.9465	53.93	24.26	10.79
0369	Level III Pulmonary Tests	X	2.7431	156.31	44.18	31.26
0370	Allergy Tests	X	0.9661	55.05	11.58	11.01
0371	Level I Allergy Injections	X	0.4310	24.56		4.91
0372	Therapeutic Phlebotomy	X	0.5656	32.23	10.09	6.45
0373	Neuropsychological Testing	X	2.3347	133.04		26.61
0374	Monitoring Psychiatric Drugs	X	1.0880	62.00		12.40
0375	Ancillary Outpatient Services When Patient Expires	T		3217.47		643.49
0376	Level II Cardiac Imaging	S	4.9171	280.19	121.42	56.04
0377	Level III Cardiac Imaging	S	7.0532	401.91	180.85	80.38
0378	Level II Pulmonary Imaging	S	5.5820	318.08	143.13	63.62
0379	Injection adenosine 6 MG	K	0.2163	12.33		2.47
0380	Dipyridamole injection	K	0.2053	11.70		2.34
0384	GI Procedures with Stents	T	27.0831	1543.28	335.19	308.66
0385	Level I Prosthetic Urological Procedures	S	69.6845	3970.83		794.17
0386	Level II Prosthetic Urological Procedures	S	113.9823	6495.05		1299.01
0387	Level II Hysteroscopy	T	30.3356	1728.61	655.55	345.72
0388	Discography	S	11.7568	669.94	301.47	133.99
0389	Non-imaging Nuclear Medicine	S	1.7805	101.46	44.54	20.29
0390	Level I Endocrine Imaging	S	2.8999	165.25	74.36	33.05
0391	Level II Endocrine Imaging	S	3.3043	188.29	84.73	37.66
0393	Red Cell/Plasma Studies	S	4.6873	267.10	120.19	53.42
0394	Hepatobiliary Imaging	S	4.5876	261.42	117.63	52.28
0395	GI Tract Imaging	S	3.9819	226.90	102.10	45.38

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0396	Bone Imaging	S	4.2024	239.47	107.76	47.89
0397	Vascular Imaging	S	2.5517	145.40	60.51	29.08
0398	Level I Cardiac Imaging	S	4.6280	263.72	118.67	52.74
0399	Nuclear Medicine Add-on Imaging	S	1.5961	90.95	40.92	18.19
0400	Hematopoietic Imaging	S	4.1858	238.52	104.32	47.70
0401	Level I Pulmonary Imaging	S	3.3594	191.43	86.14	38.29
0402	Brain Imaging	S	5.2120	297.00	133.65	59.40
0403	CSF Imaging	S	3.6801	209.70	94.36	41.94
0404	Renal and Genitourinary Studies Level I	S	3.9496	225.06	101.27	45.01
0405	Renal and Genitourinary Studies Level II	S	4.4571	253.98	114.29	50.80
0406	Tumor/Infection Imaging	S	4.5311	258.20	116.19	51.64
0407	Radionuclide Therapy	S	4.0836	232.70	97.77	46.54
0409	Red Blood Cell Tests	X	0.1272	7.25	2.22	1.45
0411	Respiratory Procedures	S	0.4194	23.90		4.78
0412	IMRT Treatment Delivery	S	5.4261	309.20		61.84
0415	Level II Endoscopy Lower Airway	T	21.9912	1253.12	459.92	250.62
0416	Level I Intravascular and Intracardiac Ultrasound and Flow Reserve	S	4.8182	274.56	99.43	54.91
0417	Computerized Reconstruction	S	4.6807	266.72		53.34
0418	Insertion of Left Ventricular Pacing Elect.	T	74.5141	4246.04		849.21
0421	Prolonged Physiologic Monitoring	X	1.8691	106.51		21.30
0422	Level II Upper GI Procedures	T	22.1959	1264.79	425.00	252.96
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	30.7704	1753.39		350.68
0425	Level II Arthroplasty with Prosthesis	T	97.6127	5562.26	1378.01	1112.45
0426	Level II Strapping and Cast Application	S	1.9972	113.81		22.76
0600	Low Level Clinic Visits	V	0.9033	51.47		10.29
0601	Mid Level Clinic Visits	V	0.9847	56.11		11.22
0602	High Level Clinic Visits	V	1.3977	79.65		15.93
0610	Low Level Emergency Visits	V	1.3544	77.18	19.57	15.44
0611	Mid Level Emergency Visits	V	2.3926	136.34	36.16	27.27
0612	High Level Emergency Visits	V	4.1139	234.42	54.12	46.88
0620	Critical Care	S	9.0648	516.54	142.30	103.31
0648	Breast Reconstruction with Prosthesis	T	50.5103	2878.23		575.65
0651	Complex Interstitial Radiation Source Application	S	21.9176	1248.93		249.79
0652	Insertion of Intraperitoneal Catheters	T	27.7725	1582.56		316.51
0653	Vascular Reconstruction/Fistula Repair with Device	T	28.0840	1600.31		320.06
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	105.3805	6004.90		1200.98
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	135.1464	7701.05		1540.21

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	105.1296	5990.60	.	1198.12
0657	Placement of Tissue Clips	S	1.8392	104.80	.	20.96
0658	Percutaneous Breast Biopsies	T	6.6823	380.78	.	76.16
0659	Hyperbaric Oxygen	S	1.5926	90.75	.	18.15
0660	Level II Otorhinolaryngologic Function Tests	X	1.7060	97.21	30.66	19.44
0661	Level IV Pathology	X	3.5068	199.83	88.87	39.97
0662	CT Angiography	S	5.6204	320.27	144.12	64.05
0664	Level I Proton Beam Radiation Therapy	S	9.8560	561.62	.	112.32
0665	Bone Density:AppendicularSkeleton	S	0.7707	43.92	.	8.78
0668	Level I Angiography and Venography except Extremity	S	6.7346	383.76	114.67	76.75
0670	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve	S	30.3817	1731.24	542.37	346.25
0671	Level II Echocardiogram Except Transesophageal	S	1.7087	97.37	43.81	19.47
0672	Level IV Posterior Segment Procedures	T	39.9292	2275.29	988.43	455.06
0673	Level IV Anterior Segment Eye Procedures	T	29.0816	1657.16	649.56	331.43
0674	Prostate Cryoablation	T	112.1858	6392.68	.	1278.54
0675	Prostatic Thermotherapy	T	46.1821	2631.59	.	526.32
0676	Level II Thrombolysis and Thrombectomy	T	4.2729	243.48	.	48.70
0677	Level I Thrombolysis and Thrombectomy	T	2.5535	145.51	.	29.10
0678	External Counterpulsation	T	1.7931	102.18	.	20.44
0679	Level II Resuscitation and Cardioversion	S	5.5971	318.94	95.30	63.79
0680	Insertion of Patient Activated Event Recorders	S	63.9488	3643.99	.	728.80
0681	Knee Arthroplasty	T	91.7896	5230.45	2081.48	1046.09
0682	Level V Debridement & Destruction	T	7.6149	433.92	171.85	86.78
0683	Level II Photochemotherapy	S	2.3761	135.40	30.42	27.08
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	5.8806	335.09	115.47	67.02
0686	Level III Skin Repair	T	5.6176	320.11	144.04	64.02
0687	Revision/Removal of Neurostimulator Electrodes	T	20.0762	1144.00	513.05	228.80
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	41.7281	2377.79	1070.00	475.56
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5852	33.35	.	6.67
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3963	22.58	10.16	4.52
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.5289	144.10	64.84	28.82

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	2.0584	117.29	30.16	23.46
0693	Level II Breast Reconstruction	T	41.2736	2351.89	798.17	470.38
0694	Mohs Surgery	T	4.2031	239.51	64.93	47.90
0695	Level VII Debridement & Destruction	T	20.5193	1169.25	266.59	233.85
0697	Level I Echocardiogram Except Transesophageal	S	1.5184	86.52	38.93	17.30
0698	Level II Eye Tests & Treatments	S	1.4649	83.47	18.72	16.69
0699	Level IV Eye Tests & Treatments	T	9.7041	552.97	.	110.59
0700	Antepartum Manipulation	T	3.6661	208.91	.	41.78
0701	SR 89 chloride, per mCi	K	7.1278	406.16	.	81.23
0702	SM 153 lexidronam	K	15.9228	907.33	.	181.47
0703	Butorphanol tartrate	K	.	5.00	.	1.00
0704	IN 111 Satumomab pendetide per dose	K	.	1390.25	.	278.05
0705	Technetium TC99M tetrofosmin	K	.	104.58	.	20.92
0726	Dexrazoxane hcl injection	K	.	113.28	.	22.66
0728	Filgrastim injection	K	.	162.41	.	32.48
0729	Injection, Meropenem	K	.	36.26	.	7.25
0730	Pamidronate disodium	K	.	128.74	.	25.75
0731	Sargramostim injection	K	.	25.39	.	5.08
0732	Mesna injection	K	.	17.66	.	3.53
0733	Non esrd epoetin alpha inj	K	.	11.09	.	2.22
0734	Injection, darbepoetin alfa (for non-ESRD), per 1 mcg	K	.	3.66	.	0.73
0735	Ampho b cholesteryl sulfate	K	.	15.20	.	3.04
0736	Amphotericin b liposome inj	K	.	31.27	.	6.25
0737	Ammonia N-13, per dose	K	1.9280	109.86	.	21.97
0738	Rasburicase	G	.	106.04	.	21.21
0750	Dolasetron mesylate	K	.	14.38	.	2.88
0763	Dolasetron mesylate oral	K	.	63.28	.	12.66
0764	Granisetron HCl injection	K	.	16.20	.	3.24
0765	Granisetron HCl oral	K	.	39.04	.	7.81
0768	Ondansetron hcl injection	K	.	5.54	.	1.11
0769	Ondansetron hcl oral	K	.	26.12	.	5.22
0800	Leuprolide acetate	K	.	451.98	.	90.40
0802	Etoposide oral	K	.	21.91	.	4.38
0807	Aldesleukin/single use vial	K	.	680.35	.	136.07
0809	Bcg live intravesical vac	K	.	139.90	.	27.98
0810	Goserelin acetate implant	K	.	390.09	.	78.02
0811	Carboplatin injection	K	.	129.96	.	25.99
0812	Carmus bischl nitro inj	K	.	65.94	.	13.19
0813	Cisplatin injection	K	.	7.73	.	1.55
0814	Asparaginase injection	K	.	54.71	.	10.94

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0815	Cyclophosphamide inj	K	.	2.77	.	0.55
0816	Cyclophosphamide lyophilized	K	.	2.36	.	0.47
0817	Cytarabine hcl inj	K	.	1.55	.	0.31
0819	Dacarbazine inj	K	.	6.14	.	1.23
0820	Daunorubicin	K	.	35.94	.	7.19
0821	Daunorubicin citrate liposom	K	.	56.44	.	11.29
0822	Diethylstilbestrol injection	K	.	6.98	.	1.40
0823	Docetaxel	K	.	312.69	.	62.54
0824	Etoposide inj	K	.	0.83	.	0.17
0827	Floxuridine injection	K	.	66.24	.	13.25
0828	Gemcitabine HCL	K	.	105.73	.	21.15
0830	Irinotecan injection	K	.	127.33	.	25.47
0831	Ifosfomide injection	K	.	72.81	.	14.56
0832	Idarubicin hcl injection	K	1.1684	66.58	.	13.32
0834	Interferon alfa-2a inj	K	.	30.48	.	6.10
0836	Interferon alfa-2b inj recombinant, 1 million	K	.	13.00	.	2.60
0838	Interferon gamma 1-b inj	K	.	209.22	.	41.84
0840	Melphalan hydrochl	K	.	367.03	.	73.41
0842	Fludarabine phosphate inj	K	.	311.09	.	62.22
0843	Pegaspargase	K	.	1247.08	.	249.42
0844	Pentostatin injection	K	.	1683.24	.	336.65
0845	Phentolaine mesylate inj	K	0.3651	20.82	.	4.16
0846	Cilastatin sodium injection	K	0.1994	11.37	.	2.27
0847	Doxorubic hcl chemo	K	.	4.69	.	0.94
0848	Testosterone enanthate inj	K	0.6713	38.27	.	7.65
0849	Rituximab	K	.	437.83	.	87.57
0851	Thiotepa injection	K	.	45.31	.	9.06
0852	Topotecan	K	.	697.76	.	139.55
0855	Vinorelbine tartrate	K	.	95.23	.	19.05
0856	Porfimer sodium	K	.	2274.78	.	454.96
0857	Bleomycin sulfate injection	K	.	88.32	.	17.66
0858	Cladribine	K	.	24.84	.	4.97
0860	Plicamycin (mithramycin) inj	K	.	93.80	.	18.76
0861	Leuprolide acetate injection	K	.	14.48	.	2.90
0862	Mitomycin	K	.	30.91	.	6.18
0863	Paclitaxel injection	K	.	79.04	.	15.81
0864	Mitoxantrone hcl	K	.	313.96	.	62.79
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K	.	8.17	.	1.63
0866	Foscarnet sodium injection	K	0.2069	11.80	.	2.36
0867	Methacholine chloride, neb	K		0.47		0.09
0887	Azathioprine parenteral	K	.	30.18	.	6.04
0888	Cyclosporine oral	K	0.0312	1.78	.	0.36

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0890	Lymphocyte immune globulin	K	.	243.50	.	48.70
0891	Tacrolimus oral	K	.	3.05	.	0.61
0900	Alglucerase injection	K	.	37.53	.	7.51
0901	Alpha 1 proteinase inhibitor	K	.	3.43	.	0.69
0902	Botulinum toxin a, per unit	K	.	4.32	.	0.86
0903	Cytomegalovirus imm IV/vial	K	.	622.13	.	124.43
0905	Immune globulin	K	.	80.68	.	16.14
0906	RSV-ivig	K	.	16.55	.	3.31
0910	Interferon beta-1b	K	.	58.73	.	11.75
0911	Streptokinase	K	0.7618	43.41	.	8.68
0916	Injection imiglucerase /unit	K	.	3.75	.	0.75
0917	Adenosine injection	K	0.1528	8.71	.	1.74
0925	Factor viii	K	.	0.76	.	0.15
0926	Factor VIII (porcine)	K	.	1.78	.	0.36
0927	Factor viii recombinant	K	.	1.10	.	0.22
0928	Factor ix complex	K	.	0.32	.	0.06
0929	Anti-inhibitor per iu	K	.	1.29	.	0.26
0931	Factor IX non-recombinant	K	.	0.98	.	0.20
0932	Factor IX recombinant	K	.	0.98	.	0.20
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	1.3689	78.00	.	15.60
0950	Blood (Whole) For Transfusion	K	1.9805	112.85	.	22.57
0952	Cryoprecipitate	K	0.8467	48.25	.	9.65
0954	RBC leukocytes reduced	K	2.9079	165.70	.	33.14
0955	Plasma, Fresh Frozen	K	1.3026	74.23	.	14.85
0956	Plasma Protein Fraction	K	1.1719	66.78	.	13.36
0957	Platelet Concentrate	K	0.8453	48.17	.	9.63
0958	Platelet Rich Plasma	K	2.6561	151.35	.	30.27
0959	Red Blood Cells	K	1.9881	113.29	.	22.66
0960	Washed Red Blood Cells	K	3.4014	193.82	.	38.76
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.3303	18.82	.	3.76
0963	Albumin (human), 5%	K	1.0624	60.54	.	12.11
0964	Albumin (human), 25%	K	0.2284	13.01	.	2.60
0965	Albumin (human), 25%	K	0.9181	52.32	.	10.46
0966	Plasmaprotein fract,5%	K	5.6751	323.38	.	64.68
0967	Split unit of blood	K	1.4533	82.81	.	16.56
0968	Platelets leukocyte reduced irradiated	K	2.7068	154.24	.	30.85
0969	Red blood cell leukocyte reduced irradiated	K	3.6080	205.59	.	41.12
1009	Cryoprecip reduced plasma	K	1.0793	61.50	.	12.30
1010	Blood, L/R, CMV-neg	K	2.9433	167.72	.	33.54
1011	Platelets, HLA-m, L/R, unit	K	9.9709	568.17	.	113.63
1013	Platelet concentrate, L/R, unit	K	1.5161	86.39	.	17.28
1016	Blood, L/R, froz/deglycerol/washed	K	4.7085	268.30	.	53.66

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.3586	476.30	.	95.26
1018	Blood, L/R, irradiated	K	3.2064	182.71	.	36.54
1019	Platelets, aph/pher, L/R, irradiated, unit	K	10.3081	587.39	.	117.48
1020	Pit, pher,L/R,CMV,irrad	K	9.7863	557.65	.	111.53
1021	RBC, frz/deg/wsh, L/R, irrad	K	5.5861	318.31	.	63.66
1022	RBC, L/R, CMV neg, irrad	K	4.7977	273.39	.	54.68
1045	Iobenguane sulfate I-131	K	.	996.00	.	199.20
1046	Inj, moxifloxacin	K	.	8.75	.	1.75
1049	Thiamine hcl	K	.	0.95	.	0.19
1050	Pyridoxine hcl	K	.	2.64	.	0.53
1052	Injection, Voriconazole	K	.	4.54	.	0.91
1062	Acyclovir	K	.	0.03	.	0.01
1064	I-131 sodium iodide capsule	K	0.1153	6.57	.	1.31
1065	I-131 sodium iodide solution	K	0.1707	9.73	.	1.95
1070	Dopamine hcl	K	.	0.81	.	0.16
1079	CO 57/58	K	.	221.78	.	44.36
1080	I-131 tositumomab, dx	K	.	2241.00	.	448.20
1081	I-131 tositumomab, tx	K	.	19422.00	.	3884.40
1082	Treprostinil	K	.	54.02	.	10.80
1083	Injection, Adalimumab	K	.	620.64	.	124.13
1084	Denileukin diftitox	K	.	1232.88	.	246.58
1085	Injection, Gallium Nitrate	K	.	0.23	.	0.05
1086	Temozolomide,oral	K	.	6.42	.	1.28
1089	Cyanocobalamin cobalt co57	K	.	85.49	.	17.10
1091	IN 111 Oxyquinoline	K	.	373.50	.	74.70
1092	IN 111 Pentetate	K	.	224.10	.	44.82
1093	TC99M fanolesomab	K	.	1045.80	.	209.16
1095	Technetium TC 99M Depreotide	K	0.6631	37.79	.	7.56
1096	TC 99M Exametazime, per dose	K	.	778.13	.	155.63
1122	TC 99M arcitumomab, per vial	K	.	1079.00	.	215.80
1167	Epirubicin hcl	K	.	24.14	.	4.83
1178	Busulfan IV	K	.	24.35	.	4.87
1201	TC 99M SUCCIMER, PER Vial	K	.	118.52	.	23.70
1203	Verteporfin for injection	K	.	8.49	.	1.70
1207	Octreotide injection, depot	K	.	69.44	.	13.89
1305	Apligraf	K	.	1130.88	.	226.18
1409	Factor viia recombinant	K	.	1410.34	.	282.07
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

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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
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	.	1050.00	.	210.00
1513	New Technology - Level XIII ($1100 - $1200)	S	.	1150.00	.	230.00
1514	New Technology-Level XIV ($1200- $1300)	S	.	1250.00	.	250.00
1515	New Technology - Level XV ($1300 - $1400)	S	.	1350.00	.	270.00
1516	New Technology - Level XVI ($1400 - $1500)	S	.	1450.00	.	290.00
1517	New Technology - Level XVII ($1500- $1600)	S	.	1550.00	.	310.00
1518	New Technology - Level XVIII ($1600- $1700)	S	.	1650.00	.	330.00
1519	New Technology - Level IXX ($1700- $1800)	S	.	1750.00	.	350.00
1520	New Technology - Level XX ($1800- $1900)	S	.	1850.00	.	370.00
1521	New Technology - Level XXI ($1900- $2000)	S	.	1950.00	.	390.00
1522	New Technology - Level XXII ($2000- $2500)	S	.	2250.00	.	450.00
1523	New Technology - Level XXIII ($2500- $3000)	S	.	2750.00	.	550.00
1524	New Technology - Level XIV ($3000- $3500)	S	.	3250.00	.	650.00
1525	New Technology - Level XXV ($3500- $4000)	S	.	3750.00	.	750.00
1526	New Technology - Level XXVI ($4000- $4500)	S	.	4250.00	.	850.00
1527	New Technology - Level XXVII ($4500- $5000)	S	.	4750.00	.	950.00
1528	New Technology - Level XXVIII ($5000- $5500)	S	.	5250.00	.	1050.00
1529	New Technology - Level XXIX ($5500- $6000)	S	.	5750.00	.	1150.00
1530	New Technology - Level XXX ($6000- $6500)	S	.	6250.00	.	1250.00
1531	New Technology - Level XXXI ($6500-	S	.	6750.00	.	1350.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	$7000)					
1532	New Technology - Level XXXII ($7000-$7500)	S	.	7250.00	.	1450.00
1533	New Technology - Level XXXIII ($7500-$8000)	S	.	7750.00	.	1550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S	.	8250.00	.	1650.00
1535	New Technology - Level XXXV ($8500-$9000)	S	.	8750.00	.	1750.00
1536	New Technology - Level XXXVI ($9000-$9500)	S	.	9250.00	.	1850.00
1537	New Technology - Level XXXVII ($9500-$10000)	S	.	9750.00	.	1950.00
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	.	1050.00	.	210.00
1550	New Technology - Level XIII ($1100 - $1200)	T	.	1150.00	.	230.00
1551	New Technology-Level XIV ($1200-$1300)	T	.	1250.00	.	250.00
1552	New Technology - Level XV ($1300 - $1400)	T	.	1350.00	.	270.00
1553	New Technology - Level XVI ($1400 - $1500)	T	.	1450.00	.	290.00
1554	New Technology - Level XVII ($1500-$1600)	T	.	1550.00	.	310.00
1555	New Technology - Level XVIII ($1600-$1700)	T	.	1650.00	.	330.00
1556	New Technology - Level XIX ($1700-$1800)	T	.	1750.00	.	350.00
1557	New Technology - Level XX ($1800-$1900)	T	.	1850.00	.	370.00
1558	New Technology - Level XXI ($1900-	T	.	1950.00	.	390.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	$2000)					
1559	New Technology - Level XXII ($2000-$2500)	T	.	2250.00	.	450.00
1560	New Technology - Level XXIII ($2500-$3000)	T	.	2750.00	.	550.00
1561	New Technology - Level XXIV ($3000-$3500)	T	.	3250.00	.	650.00
1562	New Technology - Level XXV ($3500-$4000)	T	.	3750.00	.	750.00
1563	New Technology - Level XXVI ($4000-$4500)	T	.	4250.00	.	850.00
1564	New Technology - Level XXVII ($4500-$5000)	T	.	4750.00	.	950.00
1565	New Technology - Level XXVIII ($5000-$5500)	T	.	5250.00	.	1050.00
1566	New Technology - Level XXIX ($5500-$6000)	T	.	5750.00	.	1150.00
1567	New Technology - Level XXX ($6000-$6500)	T	.	6250.00	.	1250.00
1568	New Technology - Level XXXI ($6500-$7000)	T	.	6750.00	.	1350.00
1569	New Technology - Level XXXII ($7000-$7500)	T	.	7250.00	.	1450.00
1570	New Technology - Level XXXIII ($7500-$8000)	T	.	7750.00	.	1550.00
1571	New Technology - Level XXXIV ($8000-$8500)	T	.	8250.00	.	1650.00
1572	New Technology - Level XXXV ($8500-$9000)	T	.	8750.00	.	1750.00
1573	New Technology - Level XXXVI ($9000-$9500)	T	.	9250.00	.	1850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T	.	9750.00	.	1950.00
1600	Technetium TC 99m sestamibi	K	.	106.32	.	21.26
1602	Technetium tc 99m apcitide	K	.	415.00	.	83.00
1603	Thallous chloride TL 201	K	.	18.29	.	3.66
1604	IN 111 capromab pendetide, per dose	K	.	1915.23	.	383.05
1605	Abciximab injection	K	.	448.22	.	89.64
1606	Anistreplase	K	.	2353.53	.	470.71
1607	Eptifibatide injection	K	.	11.21	.	2.24
1608	Etanercept injection	K	.	135.56	.	27.11
1609	Rho(D) immune globulin h, sd	K	.	17.95	.	3.59
1611	Hylan G-F 20 injection	K	.	203.70	.	40.74
1612	Daclizumab, parenteral	K	.	393.78	.	78.76
1613	Trastuzumab	K	.	50.79	.	10.16
1615	Basiliximab	K	.	1461.34	.	292.27
1618	Vonwillebrandfactrcmplx, per iu	K	.	0.83	.	0.17

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1619	Gallium ga 67	K	.	27.10	.	5.42
1620	Technetium tc99m bicisate	K	.	370.60	.	74.12
1622	Technetium tc99m mertiatide	K	.	31.13	.	6.23
1624	Sodium phosphate p32	K	.	94.98	.	19.00
1625	Indium 111-in pentetreotide	K	.	1079.00	.	215.80
1628	Chromic phosphate p32	K	2.5841	147.25	.	29.45
1716	Brachytx source, Gold 198	H	.	.	.	.
1717	Brachytx source, HDR Ir-192	H	.	.	.	.
1718	Brachytx source, Iodine 125	H	.	.	.	.
1719	Brachytx sour,Non-HDR Ir-192	H	.	.	.	.
1720	Brachytx sour, Palladium 103	H	.	.	.	.
1775	FDG, per dose (4-40 mCi/ml)	K	3.8803	221.11	.	44.22
1814	Retinal tamp, silicone oil	H	.	.	.	.
1818	Integrated keratoprosthesis	H	.	.	.	.
1819	Tissue localization-excision dev	H	.	.	.	.
2616	Brachytx source, Yttrium-90	H	.	.	.	.
2632	Brachytx sol, I-125, per mCi	H	.	.	.	.
2633	Brachytx source, Cesium-131	H	.	.	.	.
2634	Brachytx source, HA, I-125	H	.	.	.	.
2635	Brachytx source, HA, P-103	H	.	.	.	.
2636	Brachytx linear source, P-103	H	.	.	.	.
7000	Amifostine	K	.	395.75	.	79.15
7003	Epoprostenol injection	K	.	15.78	.	3.16
7005	Gonadorelin hydroch	K	0.2998	17.08	.	3.42
7007	Inj milrinone lactate	K	0.1442	8.22	.	1.64
7011	Oprelvekin injection	K	.	248.16	.	49.63
7015	Busulfan, oral	K	.	2.08	.	0.42
7019	Aprotinin	K	.	12.51	.	2.50
7022	Elliotts b solution per ml	K	.	1.50	.	0.30
7024	Corticorelin ovine triflutat	K	.	353.70	.	70.74
7025	Digoxin immune FAB (ovine)	K	.	332.00	.	66.40
7026	Ethanolamine oleate	K	.	63.29	.	12.66
7027	Fomepizole	K	.	10.04	.	2.01
7028	Fosphenytoin	K	.	5.31	.	1.06
7030	Hemin	K	.	6.47	.	1.29
7031	Octreotide acetate injection	K	.	3.72	.	0.74
7034	Somatropin injection	K	.	280.87	.	56.17
7035	Teniposide	K	.	224.94	.	44.99
7036	Urokinase inj	K	2.1873	124.64	.	24.93
7037	Urofollitropin	K	.	56.59	.	11.32
7038	Monoclonal antibodies	K	.	747.31	.	149.46
7040	Pentastarch 10% solution	K	.	131.99	.	26.40
7041	Tirofiban hcl	K	.	8.24	.	1.65

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
7042	Capecitabine, oral	K	.	2.96	.	0.59
7043	Infliximab injection	K	.	57.40	.	11.48
7045	Trimetrexate glucoronate	K	.	142.50	.	28.50
7046	Doxorubicin hcl liposome inj	K	.	343.78	.	68.76
7048	Alteplase recombinant	K	0.3165	18.04	.	3.61
7049	Filgrastim injection	K	.	274.40	.	54.88
7051	Leuprolide acetate implant	K	.	4717.72	.	943.54
7308	Aminolevulinic acid hcl top	K	.	88.76	.	17.75
7316	Sodium hyaluronate injection	K	0.9466	53.94	.	10.79
9001	Linezolid injection	K	.	32.15	.	6.43
9002	Tenecteplase	K	.	2350.98	.	470.20
9003	Palivizumab	K	.	576.51	.	115.30
9004	Gemtuzumab ozogamicin	K	.	2183.81	.	436.76
9005	Reteplase injection	K	.	1192.09	.	238.42
9008	Baclofen Refill Kit-500mcg	K	.	10.21	.	2.04
9009	Baclofen refill kit - per 2000 mcg	K	.	37.64	.	7.53
9012	Arsenic Trioxide	K	.	34.10	.	6.82
9013	Co 57 cobaltous chloride	K	2.4999	142.45	.	28.49
9015	Mycophenolate mofetil oral	K	.	2.46	.	0.49
9018	Botulinum toxin B	K	.	7.68	.	1.54
9019	Caspofungin acetate	K	.	28.78	.	5.76
9020	Sirolimus tablet	K	.	6.23	.	1.25
9021	Immune globulin	K	.	0.75	.	0.15
9022	IM inj interferon beta 1-a	K	.	74.44	.	14.89
9023	Rho d immune globulin	K	.	30.38	.	6.08
9024	Amphotericin b lipid complex	K	.	19.09	.	3.82
9025	Rubidium-Rb-82	K	.	153.39	.	30.68
9026	High dose contrast MRI	K	0.4605	26.24	.	5.25
9027	Supp-paramagnetic contrast material	K	0.6245	35.59	.	7.12
9028	Tetracyclin injection	K	1.7547	99.99	.	20.00
9029	Amiodarone HCl	K	0.1931	11.00	.	2.20
9030	Amphotericin B	K	0.3622	20.64	.	4.13
9031	Arbutamine HCl injection	K	1.1947	68.08	.	13.62
9032	Baclofen 10 MG injection	K	0.1874	10.68	.	2.14
9033	Cidofovir injection	K	7.1527	407.58	.	81.52
9034	Brompheniramine maleate inj	K	1.0356	59.01	.	11.80
9035	Medroxyprogesterone injection	K	0.3082	17.56	.	3.51
9036	Dimethyl sulfoxide 50%	K	0.9360	53.34	.	10.67
9037	Methadone injection	K	0.2337	13.32	.	2.66
9038	Inj estrogen conjugate	K	0.7986	45.51	.	9.10
9040	Intraocular Fomivirsen na	K	16.4925	939.79	.	187.96
9041	Gamma globulin inj	K	0.5550	31.63	.	6.33
9042	Glucagon hydrochloride	K	0.8100	46.16	.	9.23

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9044	Ibutilide fumarate injection	K	2.1724	123.79	.	24.76
9045	Iron dextran	K	0.2593	14.78	.	2.96
9046	Iron sucrose injection	K	0.0093	0.53	.	0.11
9047	Itraconazole injection	K	0.7389	42.10	.	8.42
9048	Inj desmopressin acetate	K	0.0794	4.52	.	0.90
9049	Inj protirelin	K	0.7161	40.81	.	8.16
9050	Na ferric gluconate complex	K	0.1058	6.03	.	1.21
9051	Urea injection	K	1.2239	69.74	.	13.95
9053	Nasal vaccine inhalation	K	1.6217	92.41	.	18.48
9054	Metabolically active tissue	K	0.1255	7.15	.	1.43
9055	Injectable human tissue	K	0.1412	8.05	.	1.61
9057	Lepirudin	K	.	130.30	.	26.06
9104	Anti-thymocycte globulin rabbit	K	.	312.41	.	62.48
9105	Hep B imm glob	K	.	118.32	.	23.66
9108	Thyrotropin alfa	K	.	617.50	.	123.50
9110	Alemtuzumab injection	K	.	541.45	.	108.29
9111	Inj, bivalirudin	K	.	1.52	.	0.30
9112	Perflutren lipid micro	K	.	129.69	.	25.94
9114	Nesiritide	K	.	132.47	.	26.49
9115	Inj, zoledronic acid	K	.	197.87	.	39.57
9117	Yttrium 90 ibritumomab tiuxetan	K	.	20948.25	.	4189.65
9118	In-111 ibritumomab tiuxetan	K	.	2419.78	.	483.96
9119	Pegfilgrastim	K	.	2448.50	.	489.70
9120	Inj, Fulvestrant	K	.	79.65	.	15.93
9121	Inj, Argatroban	K	.	12.45	.	2.49
9122	Triptorelin pamoate	K	.	362.78	.	72.56
9123	Transcyte	G	.	707.97	.	141.59
9124	Injection, daptomycin	G	.	0.28	.	0.06
9125	Risperidone, long acting	G	.	4.58	.	0.92
9200	Orcel	K	.	991.85	.	198.37
9201	Dermagraft	K	.	529.54	.	105.91
9202	Octafluoropropane	K	.	129.48	.	25.90
9203	Perflexane lipid micro	G	.	142.50	.	28.50
9204	Ziprasidone mesylate	G	.	18.22	.	3.64
9205	Oxaliplatin	G	.	81.61	.	16.32
9206	Integra	K	.	6.60	.	1.321
9207	Injection, bortezomib	G	.	27.53	.	5.51
9208	Injection, agalsidase beta	G	.	121.14	.	24.23
9209	Injection, laronidase	G	.	22.74	.	4.55
9210	Injection, palonosetron HCL	G	.	18.25	.	3.65
9211	Inj, alefacept, IV	G	.	560.00	.	112.00
9212	Inj, alefacept, IM	G	.	398.49	.	79.70
9213	Injection, Pemetrexed	G	.	40.54	.	8.11

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9214	Injection, Bevacizumab	G	.	57.13	.	11.43
9215	Injection, Cetuximab	G	.	49.87	.	9.97
9216	Abarelix Injection	G	.	67.62	.	13.52
9217	Leuprolide acetate suspnsion	K	.	543.72	.	108.74
9218	Injection, Azacitidine	G	.	3.81	.	0.76
9219	Mycophenolic Acid	G	.	2.43	.	0.49
9220	Sodium hyaluronate	G	.	238.36	.	47.67
9221	Graftjacket Reg Matrix	G	.	1068.75	.	213.75
9222	Graftjacket SftTis	G	.	743.38	.	148.68
9300	Injection, Omalizumab	G	.	15.24	.	3.05
9400	Thallous chloride, brand	K	.	21.19	.	4.24
9401	Strontium-89 chloride, brand	K	.	406.16	.	81.23
9402	Th I131 so iodide cap, brand	K	.	6.57	.	1.31
9403	Dx I131 so iodide cap, brand	K	.	6.57	.	1.31
9404	Dx I131 so iodide sol, brand	K	.	9.73	.	1.95
9405	Th I131 so iodide sol, brand	K	.	9.73	.	1.95
9410	Dexrazoxane HCl inj, brand	K	.	123.93	.	24.79
9411	Pamidronate disodium, brand	K	.	160.65	.	32.13
9413	Sodium hyaluronate inj, brand	K	.	53.94	.	10.79
9414	Etoposide oral, brand	K	.	25.71	.	5.14
9415	Doxorubic hcl chemo, brand	K	.	6.94	.	1.39
9417	Bleomycin sulfate inj, brand	K	.	130.56	.	26.11
9418	Cisplatin inj, brand	K	.	11.42	.	2.28
9419	Inj cladribine, brand	K	.	36.72	.	7.34
9420	Cyclophosphamide inj, brand	K	.	4.10	.	0.82
9421	Cyclophosphamide lyo, brand	K	.	3.50	.	0.70
9422	Cytarabine hcl inj, brand	K	.	2.28	.	0.46
9423	Dacarbazine inj, brand	K	.	8.15	.	1.63
9424	Daunorubicin, brand	K	.	53.14	.	10.63
9425	Etoposide inj, brand	K	.	1.22	.	0.24
9426	Floxuridine inj, brand	K	.	97.92	.	19.58
9427	Ifosfomide inj, brand	K	.	90.80	.	18.16
9428	Mesna injection, brand	K	.	23.79	.	4.76
9429	Idarubicin hcl inj, brand	K	.	66.58	.	13.32
9430	Leuprolide acetate inj, bran	K	.	21.41	.	4.28
9431	Paclitaxel inj, brand	K	.	93.50	.	18.70
9432	Mitomycin inj, brand	K	.	45.70	.	9.14
9433	Thiotepa inj, brand	K	.	66.98	.	13.40
9435	Gonadorelin hydroch, brand	K	.	17.08	.	3.42
9436	Azathioprine parenteral,brand	K	.	44.61	.	8.92
9437	Carmus bischl nitro inj	K	.	79.42	.	15.88
9438	Cyclosporine oral, brand	K	.	1.78	.	0.36
9439	Diethylstilbestrol injection	K	.	10.32	.	2.06

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9500	Platelets, irradiated	K	1.5559	88.66	.	17.73
9501	Platelets, pheresis, leukocytes reduced	K	8.3026	473.11	.	94.62
9502	Platelet pheresis irradiated	K	5.8578	333.80	.	66.76
9503	Fresh frozen plasma, ea unit	K	1.3397	76.34	.	15.27
9504	RBC deglycerolized	K	5.2108	296.93	.	59.39
9505	RBC irradiated	K	2.0849	118.80	.	23.76
9506	Granulocytes, pheresis	K	17.8797	1018.84	.	203.77
9507	Platelets, pheresis	K	7.6823	437.76	.	87.55
9508	Plasma, frozen w/in 8 hours	K	1.1117	63.35	.	12.67

Addendum B.--Payment Status by HCPCS Code and Related Information
Calendar Year 2005

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001F	D		Blood pressure, measured		.	.	.	.
0001T	D		Endovas repr abdo ao aneurys		.	.	.	.
0002F	D		Tobacco use, smoking, assess		.	.	.	.
0003F	D		Tobacco use, non-smoking		.	.	.	.
0003T	S		Cervicography	1501	.	25.00	.	5.00
0004F	D		Tobacco use txmnt counseling		.	.	.	.
0005F	D		Tobacco use txmnt, pharmacol		.	.	.	.
0005T	D		Perc cath stent/brain cv art		.	.	.	.
0006F	D		Statin therapy, prescribed		.	.	.	.
0006T	D		Perc cath stent/brain cv art		.	.	.	.
0007F	D		Beta-blocker thx prescribed		.	.	.	.
0007T	D		Perc cath stent/brain cv art		.	.	.	.
0008F	D		Ace inhibitor thx prescribed		.	.	.	.
0008T	T	NI	Upper gi endoscopy w/suture	0422	22.1959	1264.79	425.00	252.96
0009F	D		Assess anginal symptom/level		.	.	.	.
0009T	D		Endometrial cryoablation		.	.	.	.
00100	N		Anesth, salivary gland		.	.	.	.
00102	N		Anesth, repair of cleft lip		.	.	.	.
00103	N		Anesth, blepharoplasty		.	.	.	.
00104	N		Anesth, electroshock		.	.	.	.
0010F	D		Assess anginal symptom/level		.	.	.	.
0010T	A		Tb test, gamma interferon		.	.	.	.
0011F	D		Oral antiplat thx prescribed		.	.	.	.
00120	N		Anesth, ear surgery		.	.	.	.
00124	N		Anesth, ear exam		.	.	.	.
00126	N		Anesth, tympanotomy		.	.	.	.
0012T	D		Osteochondral knee autograft		.	.	.	.
0013T	D		Osteochondral knee allograft		.	.	.	.
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	D		Meniscal transplant, knee		.	.	.	.
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	5.1864	295.54	72.04	59.11
00170	N		Anesth, procedure on mouth		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00172	N		Anesth, cleft palate repair		.	.	.	.
00174	N		Anesth, pharyngeal surgery		.	.	.	.
00176	C		Anesth, pharyngeal surgery		.	.	.	.
0017T	E		Photocoagulat macular drusen		.	.	.	.
0018T	S		Transcranial magnetic stimul	0215	0.6600	37.61	15.76	7.52
00190	N		Anesth, face/skull bone surg		.	.	.	.
00192	C		Anesth, facial bone surgery		.	.	.	.
0019T	E		Extracorp shock wave tx, ms		.	.	.	.
0020T	B		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		.	.	.	.
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		.	.	.	.
00404	C		Anesth, surgery of breast		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		Whole body photography		.	.	.	.
0046T	T		Cath lavage, mammary duct(s	0021	14.8872	848.32	219.48	169.66
00470	N		Anesth, removal of rib		.	.	.	.
00472	N		Anesth, chest wall repair		.	.	.	.
00474	C		Anesth, surgery of rib(s)		.	.	.	.
0047T	T		Cath lavage, mammary duct(s)	0021	14.8872	848.32	219.48	169.66
0048T	C		Implant ventricular device		.	.	.	.
0049T	C		External circulation assist		.	.	.	.
00500	N		Anesth, esophageal surgery		.	.	.	.
0050T	C		Removal circulation assist		.	.	.	.
0051T	C		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		Anesth, chest partition view		.	.	.	.
0052T	C		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		Replace component heart syst		.	.	.	.
00540	C		Anesth, chest surgery		.	.	.	.
00541	N		Anesth, one lung ventilation		.	.	.	.
00542	C		Anesth, release of lung		.	.	.	.
00546	C		Anesth, lung,chest wall surg		.	.	.	.
00548	N		Anesth, trachea,bronchi surg		.	.	.	.
0054T	B		Bone surgery using computer		.	.	.	.
00550	N		Anesth, sternal debridement		.	.	.	.
0055T	B		Bone surgery using computer		.	.	.	.
00560	C		Anesth, heart surg w/o pump		.	.	.	.
00561	C		Anesth, heart surg < age 1		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00562	C		Anesth, heart surg w/pump		.	.	.	.
00563	N		Anesth, heart surg w/arrest		.	.	.	.
00566	N		Anesth, cabg w/o pump		.	.	.	.
0056T	B		Bone surgery using computer		.	.	.	.
0057T	D		Uppr gi scope w/ thrml txmnt		.	.	.	.
00580	C		Anesth, heart/lung transplnt		.	.	.	.
0058T	X		Cryopreservation, ovary tiss	0348	0.7675	43.73	.	8.75
0059T	X		Cryopreservation, oocyte	0348	0.7675	43.73	.	8.75
00600	N		Anesth, spine, cord surgery		.	.	.	.
00604	C		Anesth, sitting procedure		.	.	.	.
0060T	B		Electrical impedance scan		.	.	.	.
0061T	B		Destruction of tumor, breast		.	.	.	.
00620	N		Anesth, spine, cord surgery		.	.	.	.
00622	C		Anesth, removal of nerves		.	.	.	.
0062T	T	NI	Rep intradisc annulus;1 lev	0203	10.9230	622.43	272.25	124.49
00630	N		Anesth, spine, cord surgery		.	.	.	.
00632	C		Anesth, removal of nerves		.	.	.	.
00634	C		Anesth for chemonucleolysis		.	.	.	.
00635	N		Anesth, lumbar puncture		.	.	.	.
0063T	T	NI	Rep intradisc annulus;>1lev	0203	10.9230	622.43	272.25	124.49
00640	N		Anesth, spine manipulation		.	.	.	.
0064T	A		Spectroscop eval expired gas		.	.	.	.
0065T	A		Ocular photoscreen bilat		.	.	.	.
0066T	E		Ct colonography;screen		.	.	.	.
00670	C		Anesth, spine, cord surgery		.	.	.	.
0067T	S	NI	Ct colonography;dx	0332				
0068T	B	NI	Interp/rept heart sound		.	.	.	.
0069T	N	NI	Analysis only heart sound		.	.	.	.
00700	N		Anesth, abdominal wall surg		.	.	.	.
00702	N		Anesth, for liver biopsy		.	.	.	.
0070T	N	NI	Interp only heart sound		.	.	.	.
0071T	T	NI	U/s leiomyomata ablate <200	0193	13.3052	758.17	158.05	151.63
0072T	T	NI	U/s leiomyomata ablate >200	0193	13.3052	758.17	158.05	151.63
00730	N		Anesth, abdominal wall surg		.	.	.	.
0073T	S	NI	Delivery, comp imrt	0412	5.4261	309.20	.	61.84
00740	N		Anesth, upper gi visualize		.	.	.	.
0074T	E	NI	Online physician e/m		.	.	.	.
00750	N		Anesth, repair of hernia		.	.	.	.
00752	N		Anesth, repair of hernia		.	.	.	.
00754	N		Anesth, repair of hernia		.	.	.	.
00756	N		Anesth, repair of hernia		.	.	.	.
0075T	C	NI	Perq stent/chest vert art		.	.	.	.
0076T	C	NI	S&i stent/chest vert art		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00770	N		Anesth, blood vessel repair		.	.	.	.
0077T	C	NI	Cereb therm perfusion probe		.	.	.	.
0078T	C	NI	Endovasc aort repr w/device		.	.	.	.
00790	N		Anesth, surg upper abdomen		.	.	.	.
00792	C		Anesth, hemorr/excise liver		.	.	.	.
00794	C		Anesth, pancreas removal		.	.	.	.
00796	C		Anesth, for liver transplant		.	.	.	.
00797	N		Anesth, surgery for obesity		.	.	.	.
0079T	C	NI	Endovasc visc extnsn repr		.	.	.	.
00800	N		Anesth, abdominal wall surg		.	.	.	.
00802	C		Anesth, fat layer removal		.	.	.	.
0080T	C	NI	Endovasc aort repr rad s&i		.	.	.	.
00810	N		Anesth, low intestine scope		.	.	.	.
0081T	C	NI	Endovasc visc extnsn s&i		.	.	.	.
00820	N		Anesth, abdominal wall surg		.	.	.	.
0082T	B	NI	Stereotactic rad delivery		.	.	.	.
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		.	.	.	.
0083T	N	NI	Stereotactic rad tx mngmt		.	.	.	.
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		.	.	.	.
0084T	T	NI	Temp prostate urethral stent	0164	1.2563	71.59	17.59	14.32
00851	N		Anesth, tubal ligation		.	.	.	.
0085T	X	NI	Breath test heart reject	0340	0.6328	36.06	.	7.21
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		.	.	.	.
0086T	N	NI	L ventricle fill pressure		.	.	.	.
00870	N		Anesth, bladder stone surg		.	.	.	.
00872	N		Anesth kidney stone destruct		.	.	.	.
00873	N		Anesth kidney stone destruct		.	.	.	.
0087T	X	NI	Sperm eval hyaluronan	0348	0.7675	43.73	.	8.75
00880	N		Anesth, abdomen vessel surg		.	.	.	.
00882	C		Anesth, major vein ligation		.	.	.	.
0088T	T	NI	Rf tongue base vol reduxn	0253	15.9877	911.03	282.29	182.21

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	N		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		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01230	N		Anesth, surgery of femur		.	.	.	.
01232	C		Anesth, amputation of femur		.	.	.	.
01234	C		Anesth, radical femur surg		.	.	.	.
01250	N		Anesth, upper leg surgery		.	.	.	.
01260	N		Anesth, upper leg veins surg		.	.	.	.
01270	N		Anesth, thigh arteries surg		.	.	.	.
01272	C		Anesth, femoral artery surg		.	.	.	.
01274	C		Anesth, femoral embolectomy		.	.	.	.
01320	N		Anesth, knee area surgery		.	.	.	.
01340	N		Anesth, knee area procedure		.	.	.	.
01360	N		Anesth, knee area surgery		.	.	.	.
01380	N		Anesth, knee joint procedure		.	.	.	.
01382	N		Anesth, 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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		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		.	.	.	.
0500F	E	NI	Initial prenatal care visit		.	.	.	.
0501F	E	NI	Prenatal flow sheet		.	.	.	.
0502F	E	NI	Subsequent prenatal care		.	.	.	.
0503F	E	NI	Postpartum care visit		.	.	.	.
1000F	E	NI	Tobacco use, smoking, assess		.	.	.	.
1001F	E	NI	Tobacco use, non-smoking		.	.	.	.
10021	T		Fna w/o image	0002	0.9553	54.44	.	10.89
10022	T		Fna w/image	0036	2.2377	127.51	.	25.50
1002F	E	NI	Assess anginal symptom/level		.	.	.	.
10040	T		Acne surgery	0010	0.5940	33.85	9.65	6.77
10060	T		Drainage of skin abscess	0006	1.6854	96.04	23.26	19.21
10061	T		Drainage of skin abscess	0006	1.6854	96.04	23.26	19.21
10080	T		Drainage of pilonidal cyst	0006	1.6854	96.04	23.26	19.21
10081	T		Drainage of pilonidal cyst	0007	12.4496	709.42	.	141.88
10120	T		Remove foreign body	0006	1.6854	96.04	23.26	19.21
10121	T		Remove foreign body	0021	14.8872	848.32	219.48	169.66
10140	T		Drainage of hematoma/fluid	0007	12.4496	709.42	.	141.88
10160	T		Puncture drainage of lesion	0018	0.9669	55.10	16.04	11.02
10180	T		Complex drainage, wound	0007	12.4496	709.42	.	141.88
11000	T		Debride infected skin	0015	1.7248	98.28	20.35	19.66

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11001	T		Debride infected skin add-on	0012	0.7477	42.61	11.18	8.52
11004	C	NI	Debride genitalia & perineum		.	.	.	.
11005	C	NI	Debride abdom wall		.	.	.	.
11006	C	NI	Debride genit/per/abdom wall		.	.	.	.
11008	C	NI	Remove mesh from abd wall		.	.	.	.
11010	T		Debride skin, fx	0019	4.1677	237.49	71.87	47.50
11011	T		Debride skin/muscle, fx	0019	4.1677	237.49	71.87	47.50
11012	T		Debride skin/muscle/bone, fx	0019	4.1677	237.49	71.87	47.50
11040	T		Debride skin, partial	0015	1.7248	98.28	20.35	19.66
11041	T		Debride skin, full	0015	1.7248	98.28	20.35	19.66
11042	T		Debride skin/tissue	0016	2.8321	161.38	57.31	32.28
11043	T		Debride tissue/muscle	0016	2.8321	161.38	57.31	32.28
11044	T		Debride tissue/muscle/bone	0682	7.6149	433.92	171.85	86.78
11055	T		Trim skin lesion	0012	0.7477	42.61	11.18	8.52
11056	T		Trim skin lesions, 2 to 4	0012	0.7477	42.61	11.18	8.52
11057	T		Trim skin lesions, over 4	0013	1.1380	64.85	14.20	12.97
11100	T		Biopsy, skin lesion	0018	0.9669	55.10	16.04	11.02
11101	T		Biopsy, skin add-on	0018	0.9669	55.10	16.04	11.02
11200	T		Removal of skin tags	0013	1.1380	64.85	14.20	12.97
11201	T		Remove skin tags add-on	0015	1.7248	98.28	20.35	19.66
11300	T		Shave skin lesion	0012	0.7477	42.61	11.18	8.52
11301	T		Shave skin lesion	0012	0.7477	42.61	11.18	8.52
11302	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11303	T		Shave skin lesion	0015	1.7248	98.28	20.35	19.66
11305	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11306	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11307	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11308	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11310	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11311	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11312	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11313	T		Shave skin lesion	0016	2.8321	161.38	57.31	32.28
11400	T		Exc tr-ext b9+marg 0.5 < cm	0019	4.1677	237.49	71.87	47.50
11401	T		Exc tr-ext b9+marg 0.6-1 cm	0019	4.1677	237.49	71.87	47.50
11402	T		Exc tr-ext b9+marg 1.1-2 cm	0019	4.1677	237.49	71.87	47.50
11403	T		Exc tr-ext b9+marg 2.1-3 cm	0020	7.6248	434.48	113.25	86.90
11404	T		Exc tr-ext b9+marg 3.1-4 cm	0021	14.8872	848.32	219.48	169.66
11406	T		Exc tr-ext b9+marg > 4.0 cm	0021	14.8872	848.32	219.48	169.66
11420	T		Exc h-f-nk-sp b9+marg 0.5 <	0020	7.6248	434.48	113.25	86.90
11421	T		Exc h-f-nk-sp b9+marg 0.6-1	0020	7.6248	434.48	113.25	86.90
11422	T		Exc h-f-nk-sp b9+marg 1.1-2	0020	7.6248	434.48	113.25	86.90
11423	T		Exc h-f-nk-sp b9+marg 2.1-3	0020	7.6248	434.48	113.25	86.90
11424	T		Exc h-f-nk-sp b9+marg 3.1-4	0021	14.8872	848.32	219.48	169.66

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11426	T		Exc h-f-nk-sp b9+marg > 4 cm	0022	19.3700	1103.76	354.45	220.75
11440	T		Exc face-mm b9+marg 0.5 < cm	0019	4.1677	237.49	71.87	47.50
11441	T		Exc face-mm b9+marg 0.6-1 cm	0019	4.1677	237.49	71.87	47.50
11442	T		Exc face-mm b9+marg 1.1-2 cm	0020	7.6248	434.48	113.25	86.90
11443	T		Exc face-mm b9+marg 2.1-3 cm	0020	7.6248	434.48	113.25	86.90
11444	T		Exc face-mm b9+marg 3.1-4 cm	0020	7.6248	434.48	113.25	86.90
11446	T		Exc face-mm b9+marg > 4 cm	0022	19.3700	1103.76	354.45	220.75
11450	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11451	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11462	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11463	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11470	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11471	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11600	T		Exc tr-ext mlg+marg 0.5 < cm	0019	4.1677	237.49	71.87	47.50
11601	T		Exc tr-ext mlg+marg 0.6-1 cm	0019	4.1677	237.49	71.87	47.50
11602	T		Exc tr-ext mlg+marg 1.1-2 cm	0019	4.1677	237.49	71.87	47.50
11603	T		Exc tr-ext mlg+marg 2.1-3 cm	0020	7.6248	434.48	113.25	86.90
11604	T		Exc tr-ext mlg+marg 3.1-4 cm	0020	7.6248	434.48	113.25	86.90
11606	T		Exc tr-ext mlg+marg > 4 cm	0021	14.8872	848.32	219.48	169.66
11620	T		Exc h-f-nk-sp mlg+marg 0.5 <	0020	7.6248	434.48	113.25	86.90
11621	T		Exc h-f-nk-sp mlg+marg 0.6-1	0019	4.1677	237.49	71.87	47.50
11622	T		Exc h-f-nk-sp mlg+marg 1.1-2	0020	7.6248	434.48	113.25	86.90
11623	T		Exc h-f-nk-sp mlg+marg 2.1-3	0021	14.8872	848.32	219.48	169.66
11624	T		Exc h-f-nk-sp mlg+marg 3.1-4	0021	14.8872	848.32	219.48	169.66
11626	T		Exc h-f-nk-sp mlg+mar > 4 cm	0022	19.3700	1103.76	354.45	220.75
11640	T		Exc face-mm malig+marg 0.5 <	0019	4.1677	237.49	71.87	47.50
11641	T		Exc face-mm malig+marg 0.6-1	0019	4.1677	237.49	71.87	47.50
11642	T		Exc face-mm malig+marg 1.1-2	0020	7.6248	434.48	113.25	86.90
11643	T		Exc face-mm malig+marg 2.1-3	0020	7.6248	434.48	113.25	86.90
11644	T		Exc face-mm malig+marg 3.1-4	0021	14.8872	848.32	219.48	169.66
11646	T		Exc face-mm mlg+marg > 4 cm	0022	19.3700	1103.76	354.45	220.75
11719	T		Trim nail(s)	0009	0.6817	38.85	8.34	7.77
11720	T		Debride nail, 1-5	0009	0.6817	38.85	8.34	7.77
11721	T		Debride nail, 6 or more	0009	0.6817	38.85	8.34	7.77
11730	T		Removal of nail plate	0013	1.1380	64.85	14.20	12.97
11732	T		Remove nail plate, add-on	0012	0.7477	42.61	11.18	8.52
11740	T		Drain blood from under nail	0009	0.6817	38.85	8.34	7.77
11750	T		Removal of nail bed	0019	4.1677	237.49	71.87	47.50
11752	T		Remove nail bed/finger tip	0022	19.3700	1103.76	354.45	220.75
11755	T		Biopsy, nail unit	0019	4.1677	237.49	71.87	47.50
11760	T		Repair of nail bed	0024	1.7742	101.10	33.10	20.22
11762	T		Reconstruction of nail bed	0024	1.7742	101.10	33.10	20.22
11765	T		Excision of nail fold, toe	0015	1.7248	98.28	20.35	19.66

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11770	T		Removal of pilonidal lesion	0022	19.3700	1103.76	354.45	220.75
11771	T		Removal of pilonidal lesion	0022	19.3700	1103.76	354.45	220.75
11772	T		Removal of pilonidal lesion	0022	19.3700	1103.76	354.45	220.75
11900	T		Injection into skin lesions	0012	0.7477	42.61	11.18	8.52
11901	T		Added skin lesions injection	0012	0.7477	42.61	11.18	8.52
11920	T		Correct skin color defects	0024	1.7742	101.10	33.10	20.22
11921	T		Correct skin color defects	0024	1.7742	101.10	33.10	20.22
11922	T		Correct skin color defects	0024	1.7742	101.10	33.10	20.22
11950	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11951	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11952	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11954	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11960	T		Insert tissue expander(s)	0027	16.8355	959.34	329.72	191.87
11970	T		Replace tissue expander	0027	16.8355	959.34	329.72	191.87
11971	T		Remove tissue expander(s)	0022	19.3700	1103.76	354.45	220.75
11975	E		Insert contraceptive cap		.	.	.	.
11976	T		Removal of contraceptive cap	0019	4.1677	237.49	71.87	47.50
11977	E		Removal/reinsert contra cap		.	.	.	.
11980	X		Implant hormone pellet(s)	0340	0.6328	36.06	.	7.21
11981	X		Insert drug implant device	0340	0.6328	36.06	.	7.21
11982	X		Remove drug implant device	0340	0.6328	36.06	.	7.21
11983	X		Remove/insert drug implant	0340	0.6328	36.06	.	7.21
12001	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12002	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12004	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12005	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12006	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12007	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12011	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12013	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12014	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12015	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12016	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12017	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12018	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12020	T		Closure of split wound	0024	1.7742	101.10	33.10	20.22
12021	T		Closure of split wound	0024	1.7742	101.10	33.10	20.22
12031	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12032	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12034	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12035	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12036	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12037	T		Layer closure of wound(s)	0025	4.7315	269.62	101.85	53.92

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
12041	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12042	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12044	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12045	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12046	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12047	T		Layer closure of wound(s)	0025	4.7315	269.62	101.85	53.92
12051	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12052	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12053	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12054	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12055	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12056	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12057	T		Layer closure of wound(s)	0025	4.7315	269.62	101.85	53.92
13100	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13101	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13102	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13120	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13121	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13122	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13131	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13132	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13133	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13150	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13151	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13152	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13153	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13160	T		Late closure of wound	0027	16.8355	959.34	329.72	191.87
14000	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14001	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14020	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14021	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14040	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14041	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14060	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14061	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14300	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14350	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
15000	T		Skin graft	0025	4.7315	269.62	101.85	53.92
15001	T		Skin graft add-on	0025	4.7315	269.62	101.85	53.92
15050	T		Skin pinch graft	0025	4.7315	269.62	101.85	53.92
15100	T		Skin split graft	0027	16.8355	959.34	329.72	191.87
15101	T		Skin split graft add-on	0027	16.8355	959.34	329.72	191.87
15120	T		Skin split graft	0027	16.8355	959.34	329.72	191.87

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15121	T		Skin split graft add-on	0027	16.8355	959.34	329.72	191.87
15200	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15201	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15220	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15221	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15240	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15241	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15260	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15261	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15342	T		Cultured skin graft, 25 cm	0024	1.7742	101.10	33.10	20.22
15343	T		Culture skn graft addl 25 cm	0024	1.7742	101.10	33.10	20.22
15350	T		Skin homograft	0686	5.6176	320.11	144.04	64.02
15351	T		Skin homograft add-on	0027	16.8355	959.34	329.72	191.87
15400	T		Skin heterograft	0025	4.7315	269.62	101.85	53.92
15401	T		Skin heterograft add-on	0025	4.7315	269.62	101.85	53.92
15570	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15572	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15574	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15576	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15600	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15610	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15620	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15630	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15650	T		Transfer skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15732	T		Muscle-skin graft, head/neck	0027	16.8355	959.34	329.72	191.87
15734	T		Muscle-skin graft, trunk	0027	16.8355	959.34	329.72	191.87
15736	T		Muscle-skin graft, arm	0027	16.8355	959.34	329.72	191.87
15738	T		Muscle-skin graft, leg	0027	16.8355	959.34	329.72	191.87
15740	T		Island pedicle flap graft	0027	16.8355	959.34	329.72	191.87
15750	T		Neurovascular pedicle graft	0027	16.8355	959.34	329.72	191.87
15756	C		Free myo/skin flap microvasc		.	.	.	.
15757	C		Free skin flap, microvasc		.	.	.	.
15758	C		Free fascial flap, microvasc		.	.	.	.
15760	T		Composite skin graft	0027	16.8355	959.34	329.72	191.87
15770	T		Derma-fat-fascia graft	0027	16.8355	959.34	329.72	191.87
15775	T		Hair transplant punch grafts	0025	4.7315	269.62	101.85	53.92
15776	T		Hair transplant punch grafts	0025	4.7315	269.62	101.85	53.92
15780	T		Abrasion treatment of skin	0022	19.3700	1103.76	354.45	220.75
15781	T		Abrasion treatment of skin	0019	4.1677	237.49	71.87	47.50
15782	T		Abrasion treatment of skin	0019	4.1677	237.49	71.87	47.50
15783	T		Abrasion treatment of skin	0016	2.8321	161.38	57.31	32.28
15786	T		Abrasion, lesion, single	0013	1.1380	64.85	14.20	12.97
15787	T		Abrasion, lesions, add-on	0013	1.1380	64.85	14.20	12.97

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15788	T		Chemical peel, face, epiderm	0012	0.7477	42.61	11.18	8.52
15789	T		Chemical peel, face, dermal	0015	1.7248	98.28	20.35	19.66
15792	T		Chemical peel, nonfacial	0013	1.1380	64.85	14.20	12.97
15793	T		Chemical peel, nonfacial	0012	0.7477	42.61	11.18	8.52
15810	T		Salabrasion	0016	2.8321	161.38	57.31	32.28
15811	T		Salabrasion	0016	2.8321	161.38	57.31	32.28
15819	T		Plastic surgery, neck	0025	4.7315	269.62	101.85	53.92
15820	T		Revision of lower eyelid	0027	16.8355	959.34	329.72	191.87
15821	T		Revision of lower eyelid	0027	16.8355	959.34	329.72	191.87
15822	T		Revision of upper eyelid	0027	16.8355	959.34	329.72	191.87
15823	T		Revision of upper eyelid	0027	16.8355	959.34	329.72	191.87
15824	T		Removal of forehead wrinkles	0027	16.8355	959.34	329.72	191.87
15825	T		Removal of neck wrinkles	0027	16.8355	959.34	329.72	191.87
15826	T		Removal of brow wrinkles	0027	16.8355	959.34	329.72	191.87
15828	T		Removal of face wrinkles	0027	16.8355	959.34	329.72	191.87
15829	T		Removal of skin wrinkles	0027	16.8355	959.34	329.72	191.87
15831	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15832	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15833	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15834	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15835	T		Excise excessive skin tissue	0025	4.7315	269.62	101.85	53.92
15836	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15837	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15838	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15839	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15840	T		Graft for face nerve palsy	0027	16.8355	959.34	329.72	191.87
15841	T		Graft for face nerve palsy	0027	16.8355	959.34	329.72	191.87
15842	T		Flap for face nerve palsy	0027	16.8355	959.34	329.72	191.87
15845	T		Skin and muscle repair, face	0027	16.8355	959.34	329.72	191.87
15850	T		Removal of sutures	0016	2.8321	161.38	57.31	32.28
15851	T		Removal of sutures	0016	2.8321	161.38	57.31	32.28
15852	X		Dressing change not for burn	0340	0.6328	36.06		7.21
15860	X		Test for blood flow in graft	0359	0.8693	49.54		9.91
15876	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15877	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15878	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15879	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15920	T		Removal of tail bone ulcer	0019	4.1677	237.49	71.87	47.50
15922	T		Removal of tail bone ulcer	0027	16.8355	959.34	329.72	191.87
15931	T		Remove sacrum pressure sore	0022	19.3700	1103.76	354.45	220.75
15933	T		Remove sacrum pressure sore	0022	19.3700	1103.76	354.45	220.75
15934	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87
15935	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15936	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87
15937	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87
15940	T		Remove hip pressure sore	0022	19.3700	1103.76	354.45	220.75
15941	T		Remove hip pressure sore	0022	19.3700	1103.76	354.45	220.75
15944	T		Remove hip pressure sore	0027	16.8355	959.34	329.72	191.87
15945	T		Remove hip pressure sore	0027	16.8355	959.34	329.72	191.87
15946	T		Remove hip pressure sore	0027	16.8355	959.34	329.72	191.87
15950	T		Remove thigh pressure sore	0022	19.3700	1103.76	354.45	220.75
15951	T		Remove thigh pressure sore	0022	19.3700	1103.76	354.45	220.75
15952	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15953	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15956	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15958	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15999	T		Removal of pressure sore	0019	4.1677	237.49	71.87	47.50
16000	T		Initial treatment of burn(s)	0012	0.7477	42.61	11.18	8.52
16010	T		Treatment of burn(s)	0016	2.8321	161.38	57.31	32.28
16015	T		Treatment of burn(s)	0017	17.3894	990.90	227.84	198.18
16020	T		Treatment of burn(s)	0013	1.1380	64.85	14.20	12.97
16025	T		Treatment of burn(s)	0013	1.1380	64.85	14.20	12.97
16030	T		Treatment of burn(s)	0015	1.7248	98.28	20.35	19.66
16035	C		Incision of burn scab, initi		.	.	.	.
16036	C		Escharotomy; add'l incision		.	.	.	.
17000	T		Destroy benign/premlg lesion	0010	0.5940	33.85	9.65	6.77
17003	T		Destroy lesions, 2-14	0010	0.5940	33.85	9.65	6.77
17004	T		Destroy lesions, 15 or more	0011	2.4040	136.99	27.88	27.40
17106	T		Destruction of skin lesions	0011	2.4040	136.99	27.88	27.40
17107	T		Destruction of skin lesions	0011	2.4040	136.99	27.88	27.40
17108	T		Destruction of skin lesions	0011	2.4040	136.99	27.88	27.40
17110	T		Destruct lesion, 1-14	0010	0.5940	33.85	9.65	6.77
17111	T		Destruct lesion, 15 or more	0010	0.5940	33.85	9.65	6.77
17250	T		Chemical cautery, tissue	0013	1.1380	64.85	14.20	12.97
17260	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17261	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17262	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17263	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17264	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17266	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28
17270	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17271	T		Destruction of skin lesions	0013	1.1380	64.85	14.20	12.97
17272	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17273	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17274	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28
17276	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17280	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17281	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17282	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17283	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17284	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28
17286	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17304	T		1 stage mohs, up to 5 spec	0694	4.2031	239.51	64.93	47.90
17305	T		2 stage mohs, up to 5 spec	0694	4.2031	239.51	64.93	47.90
17306	T		3 stage mohs, up to 5 spec	0694	4.2031	239.51	64.93	47.90
17307	T		Mohs addl stage up to 5 spec	0694	4.2031	239.51	64.93	47.90
17310	T		Mohs any stage > 5 spec each	0694	4.2031	239.51	64.93	47.90
17340	T		Cryotherapy of skin	0012	0.7477	42.61	11.18	8.52
17360	T		Skin peel therapy	0013	1.1380	64.85	14.20	12.97
17380	T		Hair removal by electrolysis	0013	1.1380	64.85	14.20	12.97
17999	T		Skin tissue procedure	0006	1.6854	96.04	23.26	19.21
19000	T		Drainage of breast lesion	0004	1.7081	97.33	22.36	19.47
19001	T		Drain breast lesion add-on	0004	1.7081	97.33	22.36	19.47
19020	T		Incision of breast lesion	0007	12.4496	709.42	.	141.88
19030	N		Injection for breast x-ray		.	.	.	.
19100	T		Bx breast percut w/o image	0005	3.7391	213.07	71.59	42.61
19101	T		Biopsy of breast, open	0028	18.7869	1070.53	303.74	214.11
19102	T		Bx breast percut w/image	0005	3.7391	213.07	71.59	42.61
19103	T		Bx breast percut w/device	0658	6.6823	380.78	.	76.16
19110	T		Nipple exploration	0028	18.7869	1070.53	303.74	214.11
19112	T		Excise breast duct fistula	0028	18.7869	1070.53	303.74	214.11
19120	T		Removal of breast lesion	0028	18.7869	1070.53	303.74	214.11
19125	T		Excision, breast lesion	0028	18.7869	1070.53	303.74	214.11
19126	T		Excision, addl breast lesion	0028	18.7869	1070.53	303.74	214.11
19140	T		Removal of breast tissue	0028	18.7869	1070.53	303.74	214.11
19160	T		Partial mastectomy	0028	18.7869	1070.53	303.74	214.11
19162	T		P-mastectomy w/ln removal	0693	41.2736	2351.89	798.17	470.38
19180	T		Removal of breast	0029	31.3655	1787.30	632.64	357.46
19182	T		Removal of breast	0029	31.3655	1787.30	632.64	357.46
19200	C		Removal of breast		.	.	.	.
19220	C		Removal of breast		.	.	.	.
19240	T		Removal of breast	0030	39.2810	2238.35	763.55	447.67
19260	T		Removal of chest wall lesion	0021	14.8872	848.32	219.48	169.66
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	1.8392	104.80	.	20.96
19296	S	NI	Place po breast cath for rad	1524	.	3250.00	.	650.00

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
19297	S	NI	Place breast cath for rad	1523	.	2750.00	.	550.00
19298	S	NI	Place breast rad tube/caths	1524	.	3250.00	.	650.00
19316	T		Suspension of breast	0029	31.3655	1787.30	632.64	357.46
19318	T		Reduction of large breast	0693	41.2736	2351.89	798.17	470.38
19324	T		Enlarge breast	0693	41.2736	2351.89	798.17	470.38
19325	T		Enlarge breast with implant	0648	50.5103	2878.23	.	575.65
19328	T		Removal of breast implant	0029	31.3655	1787.30	632.64	357.46
19330	T		Removal of implant material	0029	31.3655	1787.30	632.64	357.46
19340	T		Immediate breast prosthesis	0030	39.2810	2238.35	763.55	447.67
19342	T		Delayed breast prosthesis	0648	50.5103	2878.23	.	575.65
19350	T		Breast reconstruction	0028	18.7869	1070.53	303.74	214.11
19355	T		Correct inverted nipple(s)	0029	31.3655	1787.30	632.64	357.46
19357	T		Breast reconstruction	0648	50.5103	2878.23	.	575.65
19361	C		Breast reconstruction		.	.	.	.
19364	C		Breast reconstruction		.	.	.	.
19366	T		Breast reconstruction	0029	31.3655	1787.30	632.64	357.46
19367	C		Breast reconstruction		.	.	.	.
19368	C		Breast reconstruction		.	.	.	.
19369	C		Breast reconstruction		.	.	.	.
19370	T		Surgery of breast capsule	0029	31.3655	1787.30	632.64	357.46
19371	T		Removal of breast capsule	0029	31.3655	1787.30	632.64	357.46
19380	T		Revise breast reconstruction	0030	39.2810	2238.35	763.55	447.67
19396	T		Design custom breast implant	0029	31.3655	1787.30	632.64	357.46
19499	T		Breast surgery procedure	0028	18.7869	1070.53	303.74	214.11
20000	T		Incision of abscess	0006	1.6854	96.04	23.26	19.21
20005	T		Incision of deep abscess	0049	20.2046	1151.32	.	230.26
2000F	E	NI	Blood pressure, measured		.	.	.	.
20100	T		Explore wound, neck	0023	3.2236	183.69	40.37	36.74
20101	T		Explore wound, chest	0027	16.8355	959.34	329.72	191.87
20102	T		Explore wound, abdomen	0027	16.8355	959.34	329.72	191.87
20103	T		Explore wound, extremity	0023	3.2236	183.69	40.37	36.74
20150	T		Excise epiphyseal bar	0051	35.8607	2043.45	.	408.69
20200	T		Muscle biopsy	0021	14.8872	848.32	219.48	169.66
20205	T		Deep muscle biopsy	0021	14.8872	848.32	219.48	169.66
20206	T		Needle biopsy, muscle	0005	3.7391	213.07	71.59	42.61
20220	T		Bone biopsy, trocar/needle	0019	4.1677	237.49	71.87	47.50
20225	T		Bone biopsy, trocar/needle	0020	7.6248	434.48	113.25	86.90
20240	T		Bone biopsy, excisional	0022	19.3700	1103.76	354.45	220.75
20245	T		Bone biopsy, excisional	0022	19.3700	1103.76	354.45	220.75
20250	T		Open bone biopsy	0049	20.2046	1151.32	.	230.26
20251	T		Open bone biopsy	0049	20.2046	1151.32	.	230.26
20500	T		Injection of sinus tract	0251	1.9352	110.27	.	22.05
20501	N		Inject sinus tract for x-ray		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20520	T		Removal of foreign body	0019	4.1677	237.49	71.87	47.50
20525	T		Removal of foreign body	0022	19.3700	1103.76	354.45	220.75
20526	T		Ther injection, carp tunnel	0204	2.1801	124.23	40.13	24.85
20550	T		Inj tendon sheath/ligament	0204	2.1801	124.23	40.13	24.85
20551	T		Inj tendon origin/insertion	0204	2.1801	124.23	40.13	24.85
20552	T		Inj trigger point, 1/2 muscl	0204	2.1801	124.23	40.13	24.85
20553	T		Inject trigger points, =/> 3	0204	2.1801	124.23	40.13	24.85
20600	T		Drain/inject, joint/bursa	0204	2.1801	124.23	40.13	24.85
20605	T		Drain/inject, joint/bursa	0204	2.1801	124.23	40.13	24.85
20610	T		Drain/inject, joint/bursa	0204	2.1801	124.23	40.13	24.85
20612	T		Aspirate/inj ganglion cyst	0204	2.1801	124.23	40.13	24.85
20615	T		Treatment of bone cyst	0004	1.7081	97.33	22.36	19.47
20650	T		Insert and remove bone pin	0049	20.2046	1151.32	.	230.26
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	0.6328	36.06	.	7.21
20670	T		Removal of support implant	0021	14.8872	848.32	219.48	169.66
20680	T		Removal of support implant	0022	19.3700	1103.76	354.45	220.75
20690	T		Apply bone fixation device	0050	24.6002	1401.79	.	280.36
20692	T		Apply bone fixation device	0050	24.6002	1401.79	.	280.36
20693	T		Adjust bone fixation device	0049	20.2046	1151.32	.	230.26
20694	T		Remove bone fixation device	0049	20.2046	1151.32	.	230.26
20802	C		Replantation, arm, complete		.	.	.	.
20805	C		Replant forearm, complete		.	.	.	.
20808	C		Replantation hand, complete		.	.	.	.
20816	C		Replantation digit, complete		.	.	.	.
20822	C		Replantation digit, complete		.	.	.	.
20824	C		Replantation thumb, complete		.	.	.	.
20827	C		Replantation thumb, complete		.	.	.	.
20838	C		Replantation foot, complete		.	.	.	.
20900	T		Removal of bone for graft	0050	24.6002	1401.79	.	280.36
20902	T		Removal of bone for graft	0050	24.6002	1401.79	.	280.36
20910	T		Remove cartilage for graft	0027	16.8355	959.34	329.72	191.87
20912	T		Remove cartilage for graft	0027	16.8355	959.34	329.72	191.87
20920	T		Removal of fascia for graft	0027	16.8355	959.34	329.72	191.87
20922	T		Removal of fascia for graft	0027	16.8355	959.34	329.72	191.87
20924	T		Removal of tendon for graft	0050	24.6002	1401.79	.	280.36
20926	T		Removal of tissue for graft	0027	16.8355	959.34	329.72	191.87
20930	C		Spinal bone allograft		.	.	.	.
20931	C		Spinal bone allograft		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20936	C		Spinal bone autograft		.	.	.	.
20937	C		Spinal bone autograft		.	.	.	.
20938	C		Spinal bone autograft		.	.	.	.
20950	T		Fluid pressure, muscle	0006	1.6854	96.04	23.26	19.21
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	X		Electrical bone stimulation	0340	0.6328	36.06	.	7.21
20979	A		Us bone stimulation		.	.	.	.
20982	T		Ablate, bone tumor(s) perq	1557	.	1850.00	.	370.00
20999	T		Musculoskeletal surgery	0049	20.2046	1151.32	.	230.26
21010	T		Incision of jaw joint	0254	23.3442	1330.22	321.35	266.04
21015	T		Resection of facial tumor	0253	15.9877	911.03	282.29	182.21
21025	T		Excision of bone, lower jaw	0256	36.9298	2104.37	.	420.87
21026	T		Excision of facial bone(s)	0256	36.9298	2104.37	.	420.87
21029	T		Contour of face bone lesion	0256	36.9298	2104.37	.	420.87
21030	T		Excise max/zygoma b9 tumor	0254	23.3442	1330.22	321.35	266.04
21031	T		Remove exostosis, mandible	0254	23.3442	1330.22	321.35	266.04
21032	T		Remove exostosis, maxilla	0254	23.3442	1330.22	321.35	266.04
21034	T		Excise max/zygoma mlg tumor	0256	36.9298	2104.37	.	420.87
21040	T		Excise mandible lesion	0254	23.3442	1330.22	321.35	266.04
21044	T		Removal of jaw bone lesion	0256	36.9298	2104.37	.	420.87
21045	C		Extensive jaw surgery		.	.	.	.
21046	T		Remove mandible cyst complex	0256	36.9298	2104.37	.	420.87
21047	T		Excise lwr jaw cyst w/repair	0256	36.9298	2104.37	.	420.87
21048	T		Remove maxilla cyst complex	0256	36.9298	2104.37	.	420.87
21049	T		Excis uppr jaw cyst w/repair	0256	36.9298	2104.37	.	420.87
21050	T		Removal of jaw joint	0256	36.9298	2104.37	.	420.87
21060	T		Remove jaw joint cartilage	0256	36.9298	2104.37	.	420.87
21070	T		Remove coronoid process	0256	36.9298	2104.37	.	420.87
21076	T		Prepare face/oral prosthesis	0254	23.3442	1330.22	321.35	266.04
21077	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21079	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21080	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21081	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21082	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21083	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21084	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21085	T		Prepare face/oral prosthesis	0253	15.9877	911.03	282.29	182.21
21086	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21087	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21088	T		Prepare face/oral prosthesis	0256	36.9298	2104.37	.	420.87
21089	T		Prepare face/oral prosthesis	0251	1.9352	110.27	.	22.05
21100	T		Maxillofacial fixation	0256	36.9298	2104.37	.	420.87
21110	T		Interdental fixation	0252	6.5183	371.43	113.41	74.29
21116	N		Injection, jaw joint x-ray		.	.	.	.
21120	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21121	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21122	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21123	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21125	T		Augmentation, lower jaw bone	0254	23.3442	1330.22	321.35	266.04
21127	T		Augmentation, lower jaw bone	0256	36.9298	2104.37	.	420.87
21137	T		Reduction of forehead	0254	23.3442	1330.22	321.35	266.04
21138	T		Reduction of forehead	0256	36.9298	2104.37	.	420.87
21139	T		Reduction of forehead	0256	36.9298	2104.37	.	420.87
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	23.3442	1330.22	321.35	266.04
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21198	T		Reconstr lwr jaw segment	0256	36.9298	2104.37		420.87
21199	T		Reconstr lwr jaw w/advance	0256	36.9298	2104.37		420.87
21206	T		Reconstruct upper jaw bone	0256	36.9298	2104.37		420.87
21208	T		Augmentation of facial bones	0256	36.9298	2104.37		420.87
21209	T		Reduction of facial bones	0256	36.9298	2104.37		420.87
21210	T		Face bone graft	0256	36.9298	2104.37		420.87
21215	T		Lower jaw bone graft	0256	36.9298	2104.37		420.87
21230	T		Rib cartilage graft	0256	36.9298	2104.37		420.87
21235	T		Ear cartilage graft	0254	23.3442	1330.22	321.35	266.04
21240	T		Reconstruction of jaw joint	0256	36.9298	2104.37		420.87
21242	T		Reconstruction of jaw joint	0256	36.9298	2104.37		420.87
21243	T		Reconstruction of jaw joint	0256	36.9298	2104.37		420.87
21244	T		Reconstruction of lower jaw	0256	36.9298	2104.37		420.87
21245	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21246	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21249	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21261	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21263	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21267	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	36.9298	2104.37		420.87
21275	T		Revision, orbitofacial bones	0256	36.9298	2104.37		420.87
21280	T		Revision of eyelid	0256	36.9298	2104.37		420.87
21282	T		Revision of eyelid	0253	15.9877	911.03	282.29	182.21
21295	T		Revision of jaw muscle/bone	0252	6.5183	371.43	113.41	74.29
21296	T		Revision of jaw muscle/bone	0254	23.3442	1330.22	321.35	266.04
21299	T		Cranio/maxillofacial surgery	0251	1.9352	110.27		22.05
21300	T		Treatment of skull fracture	0253	15.9877	911.03	282.29	182.21
21310	T		Treatment of nose fracture	0251	1.9352	110.27		22.05
21315	T		Treatment of nose fracture	0251	1.9352	110.27		22.05
21320	T		Treatment of nose fracture	0252	6.5183	371.43	113.41	74.29
21325	T		Treatment of nose fracture	0254	23.3442	1330.22	321.35	266.04
21330	T		Treatment of nose fracture	0254	23.3442	1330.22	321.35	266.04
21335	T		Treatment of nose fracture	0254	23.3442	1330.22	321.35	266.04
21336	T		Treat nasal septal fracture	0046	35.1105	2000.70	535.76	400.14
21337	T		Treat nasal septal fracture	0253	15.9877	911.03	282.29	182.21
21338	T		Treat nasoethmoid fracture	0254	23.3442	1330.22	321.35	266.04
21339	T		Treat nasoethmoid fracture	0254	23.3442	1330.22	321.35	266.04

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21340	T		Treatment of nose fracture	0256	36.9298	2104.37	.	420.87
21343	C		Treatment of sinus fracture		.	.	.	.
21344	C		Treatment of sinus fracture		.	.	.	.
21345	T		Treat nose/jaw fracture	0254	23.3442	1330.22	321.35	266.04
21346	C		Treat nose/jaw fracture		.	.	.	.
21347	C		Treat nose/jaw fracture		.	.	.	.
21348	C		Treat nose/jaw fracture		.	.	.	.
21355	T		Treat cheek bone fracture	0256	36.9298	2104.37	.	420.87
21356	T		Treat cheek bone fracture	0254	23.3442	1330.22	321.35	266.04
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	36.9298	2104.37	.	420.87
21395	C		Treat eye socket fracture		.	.	.	.
21400	T		Treat eye socket fracture	0252	6.5183	371.43	113.41	74.29
21401	T		Treat eye socket fracture	0253	15.9877	911.03	282.29	182.21
21406	T		Treat eye socket fracture	0256	36.9298	2104.37	.	420.87
21407	T		Treat eye socket fracture	0256	36.9298	2104.37	.	420.87
21408	C		Treat eye socket fracture		.	.	.	.
21421	T		Treat mouth roof fracture	0254	23.3442	1330.22	321.35	266.04
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	23.3442	1330.22	321.35	266.04
21445	T		Treat dental ridge fracture	0254	23.3442	1330.22	321.35	266.04
21450	T		Treat lower jaw fracture	0251	1.9352	110.27	.	22.05
21451	T		Treat lower jaw fracture	0252	6.5183	371.43	113.41	74.29
21452	T		Treat lower jaw fracture	0253	15.9877	911.03	282.29	182.21
21453	T		Treat lower jaw fracture	0256	36.9298	2104.37	.	420.87
21454	T		Treat lower jaw fracture	0254	23.3442	1330.22	321.35	266.04
21461	T		Treat lower jaw fracture	0256	36.9298	2104.37	.	420.87
21462	T		Treat lower jaw fracture	0256	36.9298	2104.37	.	420.87
21465	T		Treat lower jaw fracture	0256	36.9298	2104.37	.	420.87
21470	T		Treat lower jaw fracture	0256	36.9298	2104.37	.	420.87
21480	T		Reset dislocated jaw	0251	1.9352	110.27	.	22.05
21485	T		Reset dislocated jaw	0253	15.9877	911.03	282.29	182.21

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21490	T		Repair dislocated jaw	0256	36.9298	2104.37	.	420.87
21493	T		Treat hyoid bone fracture	0252	6.5183	371.43	113.41	74.29
21494	T		Treat hyoid bone fracture	0252	6.5183	371.43	113.41	74.29
21495	C		Treat hyoid bone fracture		.	.	.	.
21497	T		Interdental wiring	0253	15.9877	911.03	282.29	182.21
21499	T		Head surgery procedure	0251	1.9352	110.27	.	22.05
21501	T		Drain neck/chest lesion	0008	19.3572	1103.03	.	220.61
21502	T		Drain chest lesion	0049	20.2046	1151.32	.	230.26
21510	C		Drainage of bone lesion		.	.	.	.
21550	T		Biopsy of neck/chest	0021	14.8872	848.32	219.48	169.66
21555	T		Remove lesion, neck/chest	0022	19.3700	1103.76	354.45	220.75
21556	T		Remove lesion, neck/chest	0022	19.3700	1103.76	354.45	220.75
21557	T		Remove tumor, neck/chest	0022	19.3700	1103.76	354.45	220.75
21600	T		Partial removal of rib	0050	24.6002	1401.79	.	280.36
21610	T		Partial removal of rib	0050	24.6002	1401.79	.	280.36
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		Hyoid myotomy & suspension	0252	6.5183	371.43	113.41	74.29
21700	T		Revision of neck muscle	0049	20.2046	1151.32	.	230.26
21705	C		Revision of neck muscle/rib		.	.	.	.
21720	T		Revision of neck muscle	0049	20.2046	1151.32	.	230.26
21725	T		Revision of neck muscle	0006	1.6854	96.04	23.26	19.21
21740	C		Reconstruction of sternum		.	.	.	.
21742	T		Repair stern/nuss w/o scope	0051	35.8607	2043.45	.	408.69
21743	T		Repair sternum/nuss w/scope	0051	35.8607	2043.45	.	408.69
21750	C		Repair of sternum separation		.	.	.	.
21800	T		Treatment of rib fracture	0043	1.8527	105.57	.	21.11
21805	T		Treatment of rib fracture	0046	35.1105	2000.70	535.76	400.14
21810	C		Treatment of rib fracture(s)		.	.	.	.
21820	T		Treat sternum fracture	0043	1.8527	105.57	.	21.11
21825	C		Treat sternum fracture		.	.	.	.
21899	T		Neck/chest surgery procedure	0251	1.9352	110.27	.	22.05
21920	T		Biopsy soft tissue of back	0020	7.6248	434.48	113.25	86.90
21925	T		Biopsy soft tissue of back	0022	19.3700	1103.76	354.45	220.75
21930	T		Remove lesion, back or flank	0022	19.3700	1103.76	354.45	220.75
21935	T		Remove tumor, back	0022	19.3700	1103.76	354.45	220.75
22100	T		Remove part of neck vertebra	0208	42.5700	2425.77	.	485.15
22101	T		Remove part, thorax vertebra	0208	42.5700	2425.77	.	485.15
22102	T		Remove part, lumbar vertebra	0208	42.5700	2425.77	.	485.15

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22103	T		Remove extra spine segment	0208	42.5700	2425.77	.	485.15
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	T		Revision of thorax spine	0208	42.5700	2425.77	.	485.15
22224	C		Revision of lumbar spine		.	.	.	.
22226	C		Revise, extra spine segment		.	.	.	.
22305	T		Treat spine process fracture	0043	1.8527	105.57	.	21.11
22310	T		Treat spine fracture	0043	1.8527	105.57	.	21.11
22315	T		Treat spine fracture	0043	1.8527	105.57	.	21.11
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	14.2091	809.68	268.47	161.94
22520	T		Percut vertebroplasty thor	0050	24.6002	1401.79	.	280.36
22521	T		Percut vertebroplasty lumb	0050	24.6002	1401.79	.	280.36
22522	T		Percut vertebroplasty add'l	0050	24.6002	1401.79	.	280.36
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		.	.	.	.
22612	T		Lumbar spine fusion	0208	42.5700	2425.77	.	485.15
22614	T		Spine fusion, extra segment	0208	42.5700	2425.77	.	485.15
22630	C		Lumbar spine fusion		.	.	.	.
22632	C		Spine fusion, extra segment		.	.	.	.
22800	C		Fusion of spine		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	1.8527	105.57	.	21.11
22900	T		Remove abdominal wall lesion	0022	19.3700	1103.76	354.45	220.75
22999	T		Abdomen surgery procedure	0019	4.1677	237.49	71.87	47.50
23000	T		Removal of calcium deposits	0021	14.8872	848.32	219.48	169.66
23020	T		Release shoulder joint	0051	35.8607	2043.45	.	408.69
23030	T		Drain shoulder lesion	0008	19.3572	1103.03	.	220.61
23031	T		Drain shoulder bursa	0008	19.3572	1103.03	.	220.61
23035	T		Drain shoulder bone lesion	0049	20.2046	1151.32	.	230.26
23040	T		Exploratory shoulder surgery	0050	24.6002	1401.79	.	280.36
23044	T		Exploratory shoulder surgery	0050	24.6002	1401.79	.	280.36
23065	T		Biopsy shoulder tissues	0021	14.8872	848.32	219.48	169.66
23066	T		Biopsy shoulder tissues	0022	19.3700	1103.76	354.45	220.75
23075	T		Removal of shoulder lesion	0021	14.8872	848.32	219.48	169.66
23076	T		Removal of shoulder lesion	0022	19.3700	1103.76	354.45	220.75
23077	T		Remove tumor of shoulder	0022	19.3700	1103.76	354.45	220.75
23100	T		Biopsy of shoulder joint	0049	20.2046	1151.32	.	230.26
23101	T		Shoulder joint surgery	0050	24.6002	1401.79	.	280.36
23105	T		Remove shoulder joint lining	0050	24.6002	1401.79	.	280.36
23106	T		Incision of collarbone joint	0050	24.6002	1401.79	.	280.36
23107	T		Explore treat shoulder joint	0050	24.6002	1401.79	.	280.36
23120	T		Partial removal, collar bone	0051	35.8607	2043.45	.	408.69

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23125	T		Removal of collar bone	0051	35.8607	2043.45	.	408.69
23130	T		Remove shoulder bone, part	0051	35.8607	2043.45	.	408.69
23140	T		Removal of bone lesion	0049	20.2046	1151.32	.	230.26
23145	T		Removal of bone lesion	0050	24.6002	1401.79	.	280.36
23146	T		Removal of bone lesion	0050	24.6002	1401.79	.	280.36
23150	T		Removal of humerus lesion	0050	24.6002	1401.79	.	280.36
23155	T		Removal of humerus lesion	0050	24.6002	1401.79	.	280.36
23156	T		Removal of humerus lesion	0050	24.6002	1401.79	.	280.36
23170	T		Remove collar bone lesion	0050	24.6002	1401.79	.	280.36
23172	T		Remove shoulder blade lesion	0050	24.6002	1401.79	.	280.36
23174	T		Remove humerus lesion	0050	24.6002	1401.79	.	280.36
23180	T		Remove collar bone lesion	0050	24.6002	1401.79	.	280.36
23182	T		Remove shoulder blade lesion	0050	24.6002	1401.79	.	280.36
23184	T		Remove humerus lesion	0050	24.6002	1401.79	.	280.36
23190	T		Partial removal of scapula	0050	24.6002	1401.79	.	280.36
23195	T		Removal of head of humerus	0050	24.6002	1401.79	.	280.36
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	7.6248	434.48	113.25	86.90
23331	T		Remove shoulder foreign body	0022	19.3700	1103.76	354.45	220.75
23332	C		Remove shoulder foreign body		.	.	.	.
23350	N		Injection for shoulder x-ray		.	.	.	.
23395	T		Muscle transfer,shoulder/arm	0051	35.8607	2043.45	.	408.69
23397	T		Muscle transfers	0052	43.5754	2483.06	.	496.61
23400	T		Fixation of shoulder blade	0050	24.6002	1401.79	.	280.36
23405	T		Incision of tendon & muscle	0050	24.6002	1401.79	.	280.36
23406	T		Incise tendon(s) & muscle(s)	0050	24.6002	1401.79	.	280.36
23410	T		Repair rotator cuff, acute	0052	43.5754	2483.06	.	496.61
23412	T		Repair rotator cuff, chronic	0052	43.5754	2483.06	.	496.61
23415	T		Release of shoulder ligament	0051	35.8607	2043.45	.	408.69
23420	T		Repair of shoulder	0052	43.5754	2483.06	.	496.61
23430	T		Repair biceps tendon	0052	43.5754	2483.06	.	496.61
23440	T		Remove/transplant tendon	0052	43.5754	2483.06	.	496.61
23450	T		Repair shoulder capsule	0052	43.5754	2483.06	.	496.61
23455	T		Repair shoulder capsule	0052	43.5754	2483.06	.	496.61
23460	T		Repair shoulder capsule	0052	43.5754	2483.06	.	496.61
23462	T		Repair shoulder capsule	0052	43.5754	2483.06	.	496.61
23465	T		Repair shoulder capsule	0052	43.5754	2483.06	.	496.61
23466	T		Repair shoulder capsule	0052	43.5754	2483.06	.	496.61
23470	T		Reconstruct shoulder joint	0425	97.6127	5562.26	1378.01	1112.45

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23472	C		Reconstruct shoulder joint		.	.	.	.
23480	T		Revision of collar bone	0051	35.8607	2043.45	.	408.69
23485	T		Revision of collar bone	0051	35.8607	2043.45	.	408.69
23490	T		Reinforce clavicle	0051	35.8607	2043.45	.	408.69
23491	T		Reinforce shoulder bones	0051	35.8607	2043.45	.	408.69
23500	T		Treat clavicle fracture	0043	1.8527	105.57	.	21.11
23505	T		Treat clavicle fracture	0043	1.8527	105.57	.	21.11
23515	T		Treat clavicle fracture	0046	35.1105	2000.70	535.76	400.14
23520	T		Treat clavicle dislocation	0043	1.8527	105.57	.	21.11
23525	T		Treat clavicle dislocation	0043	1.8527	105.57	.	21.11
23530	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23532	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23540	T		Treat clavicle dislocation	0043	1.8527	105.57	.	21.11
23545	T		Treat clavicle dislocation	0043	1.8527	105.57	.	21.11
23550	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23552	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23570	T		Treat shoulder blade fx	0043	1.8527	105.57	.	21.11
23575	T		Treat shoulder blade fx	0043	1.8527	105.57	.	21.11
23585	T		Treat scapula fracture	0046	35.1105	2000.70	535.76	400.14
23600	T		Treat humerus fracture	0043	1.8527	105.57	.	21.11
23605	T		Treat humerus fracture	0043	1.8527	105.57	.	21.11
23615	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
23616	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
23620	T		Treat humerus fracture	0043	1.8527	105.57	.	21.11
23625	T		Treat humerus fracture	0043	1.8527	105.57	.	21.11
23630	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
23650	T		Treat shoulder dislocation	0043	1.8527	105.57	.	21.11
23655	T		Treat shoulder dislocation	0045	14.2091	809.68	268.47	161.94
23660	T		Treat shoulder dislocation	0046	35.1105	2000.70	535.76	400.14
23665	T		Treat dislocation/fracture	0043	1.8527	105.57	.	21.11
23670	T		Treat dislocation/fracture	0046	35.1105	2000.70	535.76	400.14
23675	T		Treat dislocation/fracture	0043	1.8527	105.57	.	21.11
23680	T		Treat dislocation/fracture	0046	35.1105	2000.70	535.76	400.14
23700	T		Fixation of shoulder	0045	14.2091	809.68	268.47	161.94
23800	T		Fusion of shoulder joint	0051	35.8607	2043.45	.	408.69
23802	T		Fusion of shoulder joint	0051	35.8607	2043.45	.	408.69
23900	C		Amputation of arm & girdle		.	.	.	.
23920	C		Amputation at shoulder joint		.	.	.	.
23921	T		Amputation follow-up surgery	0025	4.7315	269.62	101.85	53.92
23929	T		Shoulder surgery procedure	0043	1.8527	105.57	.	21.11
23930	T		Drainage of arm lesion	0008	19.3572	1103.03	.	220.61
23931	T		Drainage of arm bursa	0007	12.4496	709.42	.	141.88
23935	T		Drain arm/elbow bone lesion	0049	20.2046	1151.32	.	230.26

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24000	T		Exploratory elbow surgery	0050	24.6002	1401.79	.	280.36
24006	T		Release elbow joint	0050	24.6002	1401.79	.	280.36
24065	T		Biopsy arm/elbow soft tissue	0021	14.8872	848.32	219.48	169.66
24066	T		Biopsy arm/elbow soft tissue	0021	14.8872	848.32	219.48	169.66
24075	T		Remove arm/elbow lesion	0021	14.8872	848.32	219.48	169.66
24076	T		Remove arm/elbow lesion	0022	19.3700	1103.76	354.45	220.75
24077	T		Remove tumor of arm/elbow	0022	19.3700	1103.76	354.45	220.75
24100	T		Biopsy elbow joint lining	0049	20.2046	1151.32	.	230.26
24101	T		Explore/treat elbow joint	0050	24.6002	1401.79	.	280.36
24102	T		Remove elbow joint lining	0050	24.6002	1401.79	.	280.36
24105	T		Removal of elbow bursa	0049	20.2046	1151.32	.	230.26
24110	T		Remove humerus lesion	0049	20.2046	1151.32	.	230.26
24115	T		Remove/graft bone lesion	0050	24.6002	1401.79	.	280.36
24116	T		Remove/graft bone lesion	0050	24.6002	1401.79	.	280.36
24120	T		Remove elbow lesion	0049	20.2046	1151.32	.	230.26
24125	T		Remove/graft bone lesion	0050	24.6002	1401.79	.	280.36
24126	T		Remove/graft bone lesion	0050	24.6002	1401.79	.	280.36
24130	T		Removal of head of radius	0050	24.6002	1401.79	.	280.36
24134	T		Removal of arm bone lesion	0050	24.6002	1401.79	.	280.36
24136	T		Remove radius bone lesion	0050	24.6002	1401.79	.	280.36
24138	T		Remove elbow bone lesion	0050	24.6002	1401.79	.	280.36
24140	T		Partial removal of arm bone	0050	24.6002	1401.79	.	280.36
24145	T		Partial removal of radius	0050	24.6002	1401.79	.	280.36
24147	T		Partial removal of elbow	0050	24.6002	1401.79	.	280.36
24149	T		Radical resection of elbow	0050	24.6002	1401.79	.	280.36
24150	T		Extensive humerus surgery	0052	43.5754	2483.06	.	496.61
24151	T		Extensive humerus surgery	0052	43.5754	2483.06	.	496.61
24152	T		Extensive radius surgery	0052	43.5754	2483.06	.	496.61
24153	T		Extensive radius surgery	0052	43.5754	2483.06	.	496.61
24155	T		Removal of elbow joint	0051	35.8607	2043.45	.	408.69
24160	T		Remove elbow joint implant	0050	24.6002	1401.79	.	280.36
24164	T		Remove radius head implant	0050	24.6002	1401.79	.	280.36
24200	T		Removal of arm foreign body	0019	4.1677	237.49	71.87	47.50
24201	T		Removal of arm foreign body	0021	14.8872	848.32	219.48	169.66
24220	N		Injection for elbow x-ray		.	.	.	.
24300	T		Manipulate elbow w/anesth	0045	14.2091	809.68	268.47	161.94
24301	T		Muscle/tendon transfer	0050	24.6002	1401.79	.	280.36
24305	T		Arm tendon lengthening	0050	24.6002	1401.79	.	280.36
24310	T		Revision of arm tendon	0049	20.2046	1151.32	.	230.26
24320	T		Repair of arm tendon	0051	35.8607	2043.45	.	408.69
24330	T		Revision of arm muscles	0051	35.8607	2043.45	.	408.69
24331	T		Revision of arm muscles	0051	35.8607	2043.45	.	408.69
24332	T		Tenolysis, triceps	0049	20.2046	1151.32	.	230.26

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24340	T		Repair of biceps tendon	0051	35.8607	2043.45		408.69
24341	T		Repair arm tendon/muscle	0051	35.8607	2043.45		408.69
24342	T		Repair of ruptured tendon	0051	35.8607	2043.45		408.69
24343	T		Repr elbow lat ligmnt w/tiss	0050	24.6002	1401.79		280.36
24344	T		Reconstruct elbow lat ligmnt	0051	35.8607	2043.45		408.69
24345	T		Repr elbw med ligmnt w/tissu	0050	24.6002	1401.79		280.36
24346	T		Reconstruct elbow med ligmnt	0051	35.8607	2043.45		408.69
24350	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24351	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24352	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24354	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24356	T		Revision of tennis elbow	0050	24.6002	1401.79		280.36
24360	T		Reconstruct elbow joint	0047	31.0492	1769.28	537.03	353.86
24361	T		Reconstruct elbow joint	0425	97.6127	5562.26	1378.01	1112.45
24362	T		Reconstruct elbow joint	0048	40.3978	2301.99	570.30	460.40
24363	T		Replace elbow joint	0425	97.6127	5562.26	1378.01	1112.45
24365	T		Reconstruct head of radius	0047	31.0492	1769.28	537.03	353.86
24366	T		Reconstruct head of radius	0425	97.6127	5562.26	1378.01	1112.45
24400	T		Revision of humerus	0050	24.6002	1401.79		280.36
24410	T		Revision of humerus	0050	24.6002	1401.79		280.36
24420	T		Revision of humerus	0051	35.8607	2043.45		408.69
24430	T		Repair of humerus	0051	35.8607	2043.45		408.69
24435	T		Repair humerus with graft	0051	35.8607	2043.45		408.69
24470	T		Revision of elbow joint	0051	35.8607	2043.45		408.69
24495	T		Decompression of forearm	0050	24.6002	1401.79		280.36
24498	T		Reinforce humerus	0051	35.8607	2043.45		408.69
24500	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24505	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24515	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24516	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24530	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24535	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24538	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24545	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24546	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24560	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24565	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24566	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24575	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24576	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24577	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24579	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24582	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24586	T		Treat elbow fracture	0046	35.1105	2000.70	535.76	400.14
24587	T		Treat elbow fracture	0046	35.1105	2000.70	535.76	400.14
24600	T		Treat elbow dislocation	0043	1.8527	105.57	.	21.11
24605	T		Treat elbow dislocation	0045	14.2091	809.68	268.47	161.94
24615	T		Treat elbow dislocation	0046	35.1105	2000.70	535.76	400.14
24620	T		Treat elbow fracture	0043	1.8527	105.57	.	21.11
24635	T		Treat elbow fracture	0046	35.1105	2000.70	535.76	400.14
24640	T		Treat elbow dislocation	0043	1.8527	105.57	.	21.11
24650	T		Treat radius fracture	0043	1.8527	105.57	.	21.11
24655	T		Treat radius fracture	0043	1.8527	105.57	.	21.11
24665	T		Treat radius fracture	0046	35.1105	2000.70	535.76	400.14
24666	T		Treat radius fracture	0046	35.1105	2000.70	535.76	400.14
24670	T		Treat ulnar fracture	0043	1.8527	105.57	.	21.11
24675	T		Treat ulnar fracture	0043	1.8527	105.57	.	21.11
24685	T		Treat ulnar fracture	0046	35.1105	2000.70	535.76	400.14
24800	T		Fusion of elbow joint	0051	35.8607	2043.45	.	408.69
24802	T		Fusion/graft of elbow joint	0051	35.8607	2043.45	.	408.69
24900	C		Amputation of upper arm		.	.	.	.
24920	C		Amputation of upper arm		.	.	.	.
24925	T		Amputation follow-up surgery	0049	20.2046	1151.32	.	230.26
24930	C		Amputation follow-up surgery		.	.	.	.
24931	C		Amputate upper arm & implant		.	.	.	.
24935	T		Revision of amputation	0052	43.5754	2483.06	.	496.61
24940	C		Revision of upper arm		.	.	.	.
24999	T		Upper arm/elbow surgery	0043	1.8527	105.57	.	21.11
25000	T		Incision of tendon sheath	0049	20.2046	1151.32	.	230.26
25001	T		Incise flexor carpi radialis	0049	20.2046	1151.32	.	230.26
25020	T		Decompress forearm 1 space	0049	20.2046	1151.32	.	230.26
25023	T		Decompress forearm 1 space	0050	24.6002	1401.79	.	280.36
25024	T		Decompress forearm 2 spaces	0050	24.6002	1401.79	.	280.36
25025	T		Decompress forearm 2 spaces	0050	24.6002	1401.79	.	280.36
25028	T		Drainage of forearm lesion	0049	20.2046	1151.32	.	230.26
25031	T		Drainage of forearm bursa	0049	20.2046	1151.32	.	230.26
25035	T		Treat forearm bone lesion	0049	20.2046	1151.32	.	230.26
25040	T		Explore/treat wrist joint	0050	24.6002	1401.79	.	280.36
25065	T		Biopsy forearm soft tissues	0021	14.8872	848.32	219.48	169.66
25066	T		Biopsy forearm soft tissues	0022	19.3700	1103.76	354.45	220.75
25075	T		Removal forearm lesion subcu	0021	14.8872	848.32	219.48	169.66
25076	T		Removal forearm lesion deep	0022	19.3700	1103.76	354.45	220.75
25077	T		Remove tumor, forearm/wrist	0022	19.3700	1103.76	354.45	220.75
25085	T		Incision of wrist capsule	0049	20.2046	1151.32	.	230.26
25100	T		Biopsy of wrist joint	0049	20.2046	1151.32	.	230.26
25101	T		Explore/treat wrist joint	0050	24.6002	1401.79	.	280.36

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25105	T		Remove wrist joint lining	0050	24.6002	1401.79	.	280.36
25107	T		Remove wrist joint cartilage	0050	24.6002	1401.79	.	280.36
25110	T		Remove wrist tendon lesion	0049	20.2046	1151.32	.	230.26
25111	T		Remove wrist tendon lesion	0053	15.5097	883.79	253.49	176.76
25112	T		Reremove wrist tendon lesion	0053	15.5097	883.79	253.49	176.76
25115	T		Remove wrist/forearm lesion	0049	20.2046	1151.32	.	230.26
25116	T		Remove wrist/forearm lesion	0049	20.2046	1151.32	.	230.26
25118	T		Excise wrist tendon sheath	0050	24.6002	1401.79	.	280.36
25119	T		Partial removal of ulna	0050	24.6002	1401.79	.	280.36
25120	T		Removal of forearm lesion	0050	24.6002	1401.79	.	280.36
25125	T		Remove/graft forearm lesion	0050	24.6002	1401.79	.	280.36
25126	T		Remove/graft forearm lesion	0050	24.6002	1401.79	.	280.36
25130	T		Removal of wrist lesion	0050	24.6002	1401.79	.	280.36
25135	T		Remove & graft wrist lesion	0050	24.6002	1401.79	.	280.36
25136	T		Remove & graft wrist lesion	0050	24.6002	1401.79	.	280.36
25145	T		Remove forearm bone lesion	0050	24.6002	1401.79	.	280.36
25150	T		Partial removal of ulna	0050	24.6002	1401.79	.	280.36
25151	T		Partial removal of radius	0050	24.6002	1401.79	.	280.36
25170	T		Extensive forearm surgery	0052	43.5754	2483.06	.	496.61
25210	T		Removal of wrist bone	0054	24.8731	1417.34	.	283.47
25215	T		Removal of wrist bones	0054	24.8731	1417.34	.	283.47
25230	T		Partial removal of radius	0050	24.6002	1401.79	.	280.36
25240	T		Partial removal of ulna	0050	24.6002	1401.79	.	280.36
25246	N		Injection for wrist x-ray		.	.	.	.
25248	T		Remove forearm foreign body	0049	20.2046	1151.32	.	230.26
25250	T		Removal of wrist prosthesis	0050	24.6002	1401.79	.	280.36
25251	T		Removal of wrist prosthesis	0050	24.6002	1401.79	.	280.36
25259	T		Manipulate wrist w/anesthes	0043	1.8527	105.57	.	21.11
25260	T		Repair forearm tendon/muscle	0050	24.6002	1401.79	.	280.36
25263	T		Repair forearm tendon/muscle	0050	24.6002	1401.79	.	280.36
25265	T		Repair forearm tendon/muscle	0050	24.6002	1401.79	.	280.36
25270	T		Repair forearm tendon/muscle	0050	24.6002	1401.79	.	280.36
25272	T		Repair forearm tendon/muscle	0050	24.6002	1401.79	.	280.36
25274	T		Repair forearm tendon/muscle	0050	24.6002	1401.79	.	280.36
25275	T		Repair forearm tendon sheath	0050	24.6002	1401.79	.	280.36
25280	T		Revise wrist/forearm tendon	0050	24.6002	1401.79	.	280.36
25290	T		Incise wrist/forearm tendon	0050	24.6002	1401.79	.	280.36
25295	T		Release wrist/forearm tendon	0049	20.2046	1151.32	.	230.26
25300	T		Fusion of tendons at wrist	0050	24.6002	1401.79	.	280.36
25301	T		Fusion of tendons at wrist	0050	24.6002	1401.79	.	280.36
25310	T		Transplant forearm tendon	0051	35.8607	2043.45	.	408.69
25312	T		Transplant forearm tendon	0051	35.8607	2043.45	.	408.69
25315	T		Revise palsy hand tendon(s)	0051	35.8607	2043.45	.	408.69

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25316	T		Revise palsy hand tendon(s)	0051	35.8607	2043.45	.	408.69
25320	T		Repair/revise wrist joint	0051	35.8607	2043.45	.	408.69
25332	T		Revise wrist joint	0047	31.0492	1769.28	537.03	353.86
25335	T		Realignment of hand	0051	35.8607	2043.45	.	408.69
25337	T		Reconstruct ulna/radioulnar	0051	35.8607	2043.45	.	408.69
25350	T		Revision of radius	0051	35.8607	2043.45	.	408.69
25355	T		Revision of radius	0051	35.8607	2043.45	.	408.69
25360	T		Revision of ulna	0050	24.6002	1401.79	.	280.36
25365	T		Revise radius & ulna	0050	24.6002	1401.79	.	280.36
25370	T		Revise radius or ulna	0051	35.8607	2043.45	.	408.69
25375	T		Revise radius & ulna	0051	35.8607	2043.45	.	408.69
25390	T		Shorten radius or ulna	0050	24.6002	1401.79	.	280.36
25391	T		Lengthen radius or ulna	0051	35.8607	2043.45	.	408.69
25392	T		Shorten radius & ulna	0050	24.6002	1401.79	.	280.36
25393	T		Lengthen radius & ulna	0051	35.8607	2043.45	.	408.69
25394	T		Repair carpal bone, shorten	0053	15.5097	883.79	253.49	176.76
25400	T		Repair radius or ulna	0050	24.6002	1401.79	.	280.36
25405	T		Repair/graft radius or ulna	0050	24.6002	1401.79	.	280.36
25415	T		Repair radius & ulna	0050	24.6002	1401.79	.	280.36
25420	T		Repair/graft radius & ulna	0051	35.8607	2043.45	.	408.69
25425	T		Repair/graft radius or ulna	0051	35.8607	2043.45	.	408.69
25426	T		Repair/graft radius & ulna	0051	35.8607	2043.45	.	408.69
25430	T		Vasc graft into carpal bone	0054	24.8731	1417.34	.	283.47
25431	T		Repair nonunion carpal bone	0054	24.8731	1417.34	.	283.47
25440	T		Repair/graft wrist bone	0051	35.8607	2043.45	.	408.69
25441	T		Reconstruct wrist joint	0425	97.6127	5562.26	1378.01	1112.45
25442	T		Reconstruct wrist joint	0425	97.6127	5562.26	1378.01	1112.45
25443	T		Reconstruct wrist joint	0048	40.3978	2301.99	570.30	460.40
25444	T		Reconstruct wrist joint	0048	40.3978	2301.99	570.30	460.40
25445	T		Reconstruct wrist joint	0048	40.3978	2301.99	570.30	460.40
25446	T		Wrist replacement	0425	97.6127	5562.26	1378.01	1112.45
25447	T		Repair wrist joint(s)	0047	31.0492	1769.28	537.03	353.86
25449	T		Remove wrist joint implant	0047	31.0492	1769.28	537.03	353.86
25450	T		Revision of wrist joint	0051	35.8607	2043.45	.	408.69
25455	T		Revision of wrist joint	0051	35.8607	2043.45	.	408.69
25490	T		Reinforce radius	0051	35.8607	2043.45	.	408.69
25491	T		Reinforce ulna	0051	35.8607	2043.45	.	408.69
25492	T		Reinforce radius and ulna	0051	35.8607	2043.45	.	408.69
25500	T		Treat fracture of radius	0043	1.8527	105.57	.	21.11
25505	T		Treat fracture of radius	0043	1.8527	105.57	.	21.11
25515	T		Treat fracture of radius	0046	35.1105	2000.70	535.76	400.14
25520	T		Treat fracture of radius	0043	1.8527	105.57	.	21.11
25525	T		Treat fracture of radius	0046	35.1105	2000.70	535.76	400.14

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25526	T		Treat fracture of radius	0046	35.1105	2000.70	535.76	400.14
25530	T		Treat fracture of ulna	0043	1.8527	105.57	.	21.11
25535	T		Treat fracture of ulna	0043	1.8527	105.57	.	21.11
25545	T		Treat fracture of ulna	0046	35.1105	2000.70	535.76	400.14
25560	T		Treat fracture radius & ulna	0043	1.8527	105.57	.	21.11
25565	T		Treat fracture radius & ulna	0043	1.8527	105.57	.	21.11
25574	T		Treat fracture radius & ulna	0046	35.1105	2000.70	535.76	400.14
25575	T		Treat fracture radius/ulna	0046	35.1105	2000.70	535.76	400.14
25600	T		Treat fracture radius/ulna	0043	1.8527	105.57	.	21.11
25605	T		Treat fracture radius/ulna	0043	1.8527	105.57	.	21.11
25611	T		Treat fracture radius/ulna	0046	35.1105	2000.70	535.76	400.14
25620	T		Treat fracture radius/ulna	0046	35.1105	2000.70	535.76	400.14
25622	T		Treat wrist bone fracture	0043	1.8527	105.57	.	21.11
25624	T		Treat wrist bone fracture	0043	1.8527	105.57	.	21.11
25628	T		Treat wrist bone fracture	0046	35.1105	2000.70	535.76	400.14
25630	T		Treat wrist bone fracture	0043	1.8527	105.57	.	21.11
25635	T		Treat wrist bone fracture	0043	1.8527	105.57	.	21.11
25645	T		Treat wrist bone fracture	0046	35.1105	2000.70	535.76	400.14
25650	T		Treat wrist bone fracture	0043	1.8527	105.57	.	21.11
25651	T		Pin ulnar styloid fracture	0046	35.1105	2000.70	535.76	400.14
25652	T		Treat fracture ulnar styloid	0046	35.1105	2000.70	535.76	400.14
25660	T		Treat wrist dislocation	0043	1.8527	105.57	.	21.11
25670	T		Treat wrist dislocation	0046	35.1105	2000.70	535.76	400.14
25671	T		Pin radioulnar dislocation	0046	35.1105	2000.70	535.76	400.14
25675	T		Treat wrist dislocation	0043	1.8527	105.57	.	21.11
25676	T		Treat wrist dislocation	0046	35.1105	2000.70	535.76	400.14
25680	T		Treat wrist fracture	0043	1.8527	105.57	.	21.11
25685	T		Treat wrist fracture	0046	35.1105	2000.70	535.76	400.14
25690	T		Treat wrist dislocation	0043	1.8527	105.57	.	21.11
25695	T		Treat wrist dislocation	0046	35.1105	2000.70	535.76	400.14
25800	T		Fusion of wrist joint	0051	35.8607	2043.45	.	408.69
25805	T		Fusion/graft of wrist joint	0051	35.8607	2043.45	.	408.69
25810	T		Fusion/graft of wrist joint	0051	35.8607	2043.45	.	408.69
25820	T		Fusion of hand bones	0053	15.5097	883.79	253.49	176.76
25825	T		Fuse hand bones with graft	0054	24.8731	1417.34	.	283.47
25830	T		Fusion, radioulnar jnt/ulna	0051	35.8607	2043.45	.	408.69
25900	C		Amputation of forearm		.	.	.	.
25905	C		Amputation of forearm		.	.	.	.
25907	T		Amputation follow-up surgery	0049	20.2046	1151.32	.	230.26
25909	C		Amputation follow-up surgery		.	.	.	.
25915	C		Amputation of forearm		.	.	.	.
25920	C		Amputate hand at wrist		.	.	.	.
25922	T		Amputate hand at wrist	0049	20.2046	1151.32	.	230.26

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25924	C		Amputation follow-up surgery		.	.	.	.
25927	C		Amputation of hand		.	.	.	.
25929	T		Amputation follow-up surgery	0027	16.8355	959.34	329.72	191.87
25931	C		Amputation follow-up surgery		.	.	.	.
25999	T		Forearm or wrist surgery	0043	1.8527	105.57	.	21.11
26010	T		Drainage of finger abscess	0006	1.6854	96.04	23.26	19.21
26011	T		Drainage of finger abscess	0007	12.4496	709.42	.	141.88
26020	T		Drain hand tendon sheath	0053	15.5097	883.79	253.49	176.76
26025	T		Drainage of palm bursa	0053	15.5097	883.79	253.49	176.76
26030	T		Drainage of palm bursa(s)	0053	15.5097	883.79	253.49	176.76
26034	T		Treat hand bone lesion	0053	15.5097	883.79	253.49	176.76
26035	T		Decompress fingers/hand	0053	15.5097	883.79	253.49	176.76
26037	T		Decompress fingers/hand	0053	15.5097	883.79	253.49	176.76
26040	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26045	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26055	T		Incise finger tendon sheath	0053	15.5097	883.79	253.49	176.76
26060	T		Incision of finger tendon	0053	15.5097	883.79	253.49	176.76
26070	T		Explore/treat hand joint	0053	15.5097	883.79	253.49	176.76
26075	T		Explore/treat finger joint	0053	15.5097	883.79	253.49	176.76
26080	T		Explore/treat finger joint	0053	15.5097	883.79	253.49	176.76
26100	T		Biopsy hand joint lining	0053	15.5097	883.79	253.49	176.76
26105	T		Biopsy finger joint lining	0053	15.5097	883.79	253.49	176.76
26110	T		Biopsy finger joint lining	0053	15.5097	883.79	253.49	176.76
26115	T		Removal hand lesion subcut	0022	19.3700	1103.76	354.45	220.75
26116	T		Removal hand lesion, deep	0022	19.3700	1103.76	354.45	220.75
26117	T		Remove tumor, hand/finger	0022	19.3700	1103.76	354.45	220.75
26121	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26123	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26125	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26130	T		Remove wrist joint lining	0053	15.5097	883.79	253.49	176.76
26135	T		Revise finger joint, each	0054	24.8731	1417.34	.	283.47
26140	T		Revise finger joint, each	0053	15.5097	883.79	253.49	176.76
26145	T		Tendon excision, palm/finger	0053	15.5097	883.79	253.49	176.76
26160	T		Remove tendon sheath lesion	0053	15.5097	883.79	253.49	176.76
26170	T		Removal of palm tendon, each	0053	15.5097	883.79	253.49	176.76
26180	T		Removal of finger tendon	0053	15.5097	883.79	253.49	176.76
26185	T		Remove finger bone	0053	15.5097	883.79	253.49	176.76
26200	T		Remove hand bone lesion	0053	15.5097	883.79	253.49	176.76
26205	T		Remove/graft bone lesion	0054	24.8731	1417.34	.	283.47
26210	T		Removal of finger lesion	0053	15.5097	883.79	253.49	176.76
26215	T		Remove/graft finger lesion	0053	15.5097	883.79	253.49	176.76
26230	T		Partial removal of hand bone	0053	15.5097	883.79	253.49	176.76
26235	T		Partial removal, finger bone	0053	15.5097	883.79	253.49	176.76

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26236	T		Partial removal, finger bone	0053	15.5097	883.79	253.49	176.76
26250	T		Extensive hand surgery	0053	15.5097	883.79	253.49	176.76
26255	T		Extensive hand surgery	0054	24.8731	1417.34		283.47
26260	T		Extensive finger surgery	0053	15.5097	883.79	253.49	176.76
26261	T		Extensive finger surgery	0053	15.5097	883.79	253.49	176.76
26262	T		Partial removal of finger	0053	15.5097	883.79	253.49	176.76
26320	T		Removal of implant from hand	0021	14.8872	848.32	219.48	169.66
26340	T		Manipulate finger w/anesth	0043	1.8527	105.57		21.11
26350	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26352	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26356	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26357	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26358	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26370	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26372	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26373	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26390	T		Revise hand/finger tendon	0054	24.8731	1417.34		283.47
26392	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26410	T		Repair hand tendon	0053	15.5097	883.79	253.49	176.76
26412	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26415	T		Excision, hand/finger tendon	0054	24.8731	1417.34		283.47
26416	T		Graft hand or finger tendon	0054	24.8731	1417.34		283.47
26418	T		Repair finger tendon	0053	15.5097	883.79	253.49	176.76
26420	T		Repair/graft finger tendon	0054	24.8731	1417.34		283.47
26426	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26428	T		Repair/graft finger tendon	0054	24.8731	1417.34		283.47
26432	T		Repair finger tendon	0053	15.5097	883.79	253.49	176.76
26433	T		Repair finger tendon	0053	15.5097	883.79	253.49	176.76
26434	T		Repair/graft finger tendon	0054	24.8731	1417.34		283.47
26437	T		Realignment of tendons	0053	15.5097	883.79	253.49	176.76
26440	T		Release palm/finger tendon	0053	15.5097	883.79	253.49	176.76
26442	T		Release palm & finger tendon	0054	24.8731	1417.34		283.47
26445	T		Release hand/finger tendon	0053	15.5097	883.79	253.49	176.76
26449	T		Release forearm/hand tendon	0054	24.8731	1417.34		283.47
26450	T		Incision of palm tendon	0053	15.5097	883.79	253.49	176.76
26455	T		Incision of finger tendon	0053	15.5097	883.79	253.49	176.76
26460	T		Incise hand/finger tendon	0053	15.5097	883.79	253.49	176.76
26471	T		Fusion of finger tendons	0053	15.5097	883.79	253.49	176.76
26474	T		Fusion of finger tendons	0053	15.5097	883.79	253.49	176.76
26476	T		Tendon lengthening	0053	15.5097	883.79	253.49	176.76
26477	T		Tendon shortening	0053	15.5097	883.79	253.49	176.76
26478	T		Lengthening of hand tendon	0053	15.5097	883.79	253.49	176.76
26479	T		Shortening of hand tendon	0053	15.5097	883.79	253.49	176.76

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26480	T		Transplant hand tendon	0054	24.8731	1417.34	.	283.47
26483	T		Transplant/graft hand tendon	0054	24.8731	1417.34	.	283.47
26485	T		Transplant palm tendon	0054	24.8731	1417.34	.	283.47
26489	T		Transplant/graft palm tendon	0054	24.8731	1417.34	.	283.47
26490	T		Revise thumb tendon	0054	24.8731	1417.34	.	283.47
26492	T		Tendon transfer with graft	0054	24.8731	1417.34	.	283.47
26494	T		Hand tendon/muscle transfer	0054	24.8731	1417.34	.	283.47
26496	T		Revise thumb tendon	0054	24.8731	1417.34	.	283.47
26497	T		Finger tendon transfer	0054	24.8731	1417.34	.	283.47
26498	T		Finger tendon transfer	0054	24.8731	1417.34	.	283.47
26499	T		Revision of finger	0054	24.8731	1417.34	.	283.47
26500	T		Hand tendon reconstruction	0053	15.5097	883.79	253.49	176.76
26502	T		Hand tendon reconstruction	0054	24.8731	1417.34	.	283.47
26504	T		Hand tendon reconstruction	0054	24.8731	1417.34	.	283.47
26508	T		Release thumb contracture	0053	15.5097	883.79	253.49	176.76
26510	T		Thumb tendon transfer	0054	24.8731	1417.34	.	283.47
26516	T		Fusion of knuckle joint	0054	24.8731	1417.34	.	283.47
26517	T		Fusion of knuckle joints	0054	24.8731	1417.34	.	283.47
26518	T		Fusion of knuckle joints	0054	24.8731	1417.34	.	283.47
26520	T		Release knuckle contracture	0053	15.5097	883.79	253.49	176.76
26525	T		Release finger contracture	0053	15.5097	883.79	253.49	176.76
26530	T		Revise knuckle joint	0047	31.0492	1769.28	537.03	353.86
26531	T		Revise knuckle with implant	0048	40.3978	2301.99	570.30	460.40
26535	T		Revise finger joint	0047	31.0492	1769.28	537.03	353.86
26536	T		Revise/implant finger joint	0048	40.3978	2301.99	570.30	460.40
26540	T		Repair hand joint	0053	15.5097	883.79	253.49	176.76
26541	T		Repair hand joint with graft	0054	24.8731	1417.34	.	283.47
26542	T		Repair hand joint with graft	0053	15.5097	883.79	253.49	176.76
26545	T		Reconstruct finger joint	0054	24.8731	1417.34	.	283.47
26546	T		Repair nonunion hand	0054	24.8731	1417.34	.	283.47
26548	T		Reconstruct finger joint	0054	24.8731	1417.34	.	283.47
26550	T		Construct thumb replacement	0054	24.8731	1417.34	.	283.47
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	24.8731	1417.34	.	283.47
26556	C		Toe joint transfer		.	.	.	.
26560	T		Repair of web finger	0053	15.5097	883.79	253.49	176.76
26561	T		Repair of web finger	0054	24.8731	1417.34	.	283.47
26562	T		Repair of web finger	0054	24.8731	1417.34	.	283.47
26565	T		Correct metacarpal flaw	0054	24.8731	1417.34	.	283.47
26567	T		Correct finger deformity	0054	24.8731	1417.34	.	283.47
26568	T		Lengthen metacarpal/finger	0054	24.8731	1417.34	.	283.47

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26580	T		Repair hand deformity	0054	24.8731	1417.34		283.47
26587	T		Reconstruct extra finger	0053	15.5097	883.79	253.49	176.76
26590	T		Repair finger deformity	0054	24.8731	1417.34		283.47
26591	T		Repair muscles of hand	0054	24.8731	1417.34		283.47
26593	T		Release muscles of hand	0053	15.5097	883.79	253.49	176.76
26596	T		Excision constricting tissue	0054	24.8731	1417.34		283.47
26600	T		Treat metacarpal fracture	0043	1.8527	105.57		21.11
26605	T		Treat metacarpal fracture	0043	1.8527	105.57		21.11
26607	T		Treat metacarpal fracture	0043	1.8527	105.57		21.11
26608	T		Treat metacarpal fracture	0046	35.1105	2000.70	535.76	400.14
26615	T		Treat metacarpal fracture	0046	35.1105	2000.70	535.76	400.14
26641	T		Treat thumb dislocation	0043	1.8527	105.57		21.11
26645	T		Treat thumb fracture	0043	1.8527	105.57		21.11
26650	T		Treat thumb fracture	0046	35.1105	2000.70	535.76	400.14
26665	T		Treat thumb fracture	0046	35.1105	2000.70	535.76	400.14
26670	T		Treat hand dislocation	0043	1.8527	105.57		21.11
26675	T		Treat hand dislocation	0043	1.8527	105.57		21.11
26676	T		Pin hand dislocation	0046	35.1105	2000.70	535.76	400.14
26685	T		Treat hand dislocation	0046	35.1105	2000.70	535.76	400.14
26686	T		Treat hand dislocation	0046	35.1105	2000.70	535.76	400.14
26700	T		Treat knuckle dislocation	0043	1.8527	105.57		21.11
26705	T		Treat knuckle dislocation	0043	1.8527	105.57		21.11
26706	T		Pin knuckle dislocation	0043	1.8527	105.57		21.11
26715	T		Treat knuckle dislocation	0046	35.1105	2000.70	535.76	400.14
26720	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26725	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26727	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26735	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26740	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26742	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26746	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26750	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26755	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26756	T		Pin finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26765	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26770	T		Treat finger dislocation	0043	1.8527	105.57		21.11
26775	T		Treat finger dislocation	0045	14.2091	809.68	268.47	161.94
26776	T		Pin finger dislocation	0046	35.1105	2000.70	535.76	400.14
26785	T		Treat finger dislocation	0046	35.1105	2000.70	535.76	400.14
26820	T		Thumb fusion with graft	0054	24.8731	1417.34		283.47
26841	T		Fusion of thumb	0054	24.8731	1417.34		283.47
26842	T		Thumb fusion with graft	0054	24.8731	1417.34		283.47
26843	T		Fusion of hand joint	0054	24.8731	1417.34		283.47

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26844	T		Fusion/graft of hand joint	0054	24.8731	1417.34	.	283.47
26850	T		Fusion of knuckle	0054	24.8731	1417.34	.	283.47
26852	T		Fusion of knuckle with graft	0054	24.8731	1417.34	.	283.47
26860	T		Fusion of finger joint	0054	24.8731	1417.34	.	283.47
26861	T		Fusion of finger jnt, add-on	0054	24.8731	1417.34	.	283.47
26862	T		Fusion/graft of finger joint	0054	24.8731	1417.34	.	283.47
26863	T		Fuse/graft added joint	0054	24.8731	1417.34	.	283.47
26910	T		Amputate metacarpal bone	0054	24.8731	1417.34	.	283.47
26951	T		Amputation of finger/thumb	0053	15.5097	883.79	253.49	176.76
26952	T		Amputation of finger/thumb	0053	15.5097	883.79	253.49	176.76
26989	T		Hand/finger surgery	0043	1.8527	105.57	.	21.11
26990	T		Drainage of pelvis lesion	0049	20.2046	1151.32	.	230.26
26991	T		Drainage of pelvis bursa	0049	20.2046	1151.32	.	230.26
26992	C		Drainage of bone lesion		.	.	.	.
27000	T		Incision of hip tendon	0049	20.2046	1151.32	.	230.26
27001	T		Incision of hip tendon	0050	24.6002	1401.79	.	280.36
27003	T		Incision of hip tendon	0050	24.6002	1401.79	.	280.36
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	35.8607	2043.45	.	408.69
27035	T		Denervation of hip joint	0052	43.5754	2483.06	.	496.61
27036	C		Excision of hip joint/muscle		.	.	.	.
27040	T		Biopsy of soft tissues	0020	7.6248	434.48	113.25	86.90
27041	T		Biopsy of soft tissues	0020	7.6248	434.48	113.25	86.90
27047	T		Remove hip/pelvis lesion	0022	19.3700	1103.76	354.45	220.75
27048	T		Remove hip/pelvis lesion	0022	19.3700	1103.76	354.45	220.75
27049	T		Remove tumor, hip/pelvis	0022	19.3700	1103.76	354.45	220.75
27050	T		Biopsy of sacroiliac joint	0049	20.2046	1151.32	.	230.26
27052	T		Biopsy of hip joint	0049	20.2046	1151.32	.	230.26
27054	C		Removal of hip joint lining		.	.	.	.
27060	T		Removal of ischial bursa	0049	20.2046	1151.32	.	230.26
27062	T		Remove femur lesion/bursa	0049	20.2046	1151.32	.	230.26
27065	T		Removal of hip bone lesion	0049	20.2046	1151.32	.	230.26
27066	T		Removal of hip bone lesion	0050	24.6002	1401.79	.	280.36
27067	T		Remove/graft hip bone lesion	0050	24.6002	1401.79	.	280.36
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27079	C		Extensive hip surgery		.	.	.	.
27080	T		Removal of tail bone	0050	24.6002	1401.79	.	280.36
27086	T		Remove hip foreign body	0020	7.6248	434.48	113.25	86.90
27087	T		Remove hip foreign body	0049	20.2046	1151.32	.	230.26
27090	C		Removal of hip prosthesis		.	.	.	.
27091	C		Removal of hip prosthesis		.	.	.	.
27093	N		Injection for hip x-ray		.	.	.	.
27095	N		Injection for hip x-ray		.	.	.	.
27096	B		Inject sacroiliac joint		.	.	.	.
27097	T		Revision of hip tendon	0050	24.6002	1401.79	.	280.36
27098	T		Transfer tendon to pelvis	0050	24.6002	1401.79	.	280.36
27100	T		Transfer of abdominal muscle	0051	35.8607	2043.45	.	408.69
27105	T		Transfer of spinal muscle	0051	35.8607	2043.45	.	408.69
27110	T		Transfer of iliopsoas muscle	0051	35.8607	2043.45	.	408.69
27111	T		Transfer of iliopsoas muscle	0051	35.8607	2043.45	.	408.69
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		.	.	.	.
27193	T		Treat pelvic ring fracture	0043	1.8527	105.57	.	21.11
27194	T		Treat pelvic ring fracture	0045	14.2091	809.68	268.47	161.94
27200	T		Treat tail bone fracture	0043	1.8527	105.57	.	21.11

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27202	T		Treat tail bone fracture	0046	35.1105	2000.70	535.76	400.14
27215	C		Treat pelvic fracture(s)					
27216	T		Treat pelvic ring fracture	0050	24.6002	1401.79		280.36
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	1.8527	105.57		21.11
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	1.8527	105.57		21.11
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	24.6002	1401.79		280.36
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	1.8527	105.57		21.11
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	1.8527	105.57		21.11
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	1.8527	105.57		21.11
27252	T		Treat hip dislocation	0045	14.2091	809.68	268.47	161.94
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	1.8527	105.57		21.11
27257	T		Treat hip dislocation	0045	14.2091	809.68	268.47	161.94
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	1.8527	105.57		21.11
27266	T		Treat hip dislocation	0045	14.2091	809.68	268.47	161.94
27275	T		Manipulation of hip joint	0045	14.2091	809.68	268.47	161.94
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	1.8527	105.57		21.11
27301	T		Drain thigh/knee lesion	0008	19.3572	1103.03		220.61
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	20.2046	1151.32		230.26
27306	T		Incision of thigh tendon	0049	20.2046	1151.32		230.26
27307	T		Incision of thigh tendons	0049	20.2046	1151.32		230.26

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27310	T		Exploration of knee joint	0050	24.6002	1401.79	.	280.36
27315	T		Partial removal, thigh nerve	0220	17.2963	985.60	.	197.12
27320	T		Partial removal, thigh nerve	0220	17.2963	985.60	.	197.12
27323	T		Biopsy, thigh soft tissues	0021	14.8872	848.32	219.48	169.66
27324	T		Biopsy, thigh soft tissues	0022	19.3700	1103.76	354.45	220.75
27327	T		Removal of thigh lesion	0022	19.3700	1103.76	354.45	220.75
27328	T		Removal of thigh lesion	0022	19.3700	1103.76	354.45	220.75
27329	T		Remove tumor, thigh/knee	0022	19.3700	1103.76	354.45	220.75
27330	T		Biopsy, knee joint lining	0050	24.6002	1401.79	.	280.36
27331	T		Explore/treat knee joint	0050	24.6002	1401.79	.	280.36
27332	T		Removal of knee cartilage	0050	24.6002	1401.79	.	280.36
27333	T		Removal of knee cartilage	0050	24.6002	1401.79	.	280.36
27334	T		Remove knee joint lining	0050	24.6002	1401.79	.	280.36
27335	T		Remove knee joint lining	0050	24.6002	1401.79	.	280.36
27340	T		Removal of kneecap bursa	0049	20.2046	1151.32	.	230.26
27345	T		Removal of knee cyst	0049	20.2046	1151.32	.	230.26
27347	T		Remove knee cyst	0049	20.2046	1151.32	.	230.26
27350	T		Removal of kneecap	0050	24.6002	1401.79	.	280.36
27355	T		Remove femur lesion	0050	24.6002	1401.79	.	280.36
27356	T		Remove femur lesion/graft	0050	24.6002	1401.79	.	280.36
27357	T		Remove femur lesion/graft	0050	24.6002	1401.79	.	280.36
27358	T		Remove femur lesion/fixation	0050	24.6002	1401.79	.	280.36
27360	T		Partial removal, leg bone(s)	0050	24.6002	1401.79	.	280.36
27365	C		Extensive leg surgery		.	.	.	.
27370	N		Injection for knee x-ray		.	.	.	.
27372	T		Removal of foreign body	0022	19.3700	1103.76	354.45	220.75
27380	T		Repair of kneecap tendon	0049	20.2046	1151.32	.	230.26
27381	T		Repair/graft kneecap tendon	0049	20.2046	1151.32	.	230.26
27385	T		Repair of thigh muscle	0049	20.2046	1151.32	.	230.26
27386	T		Repair/graft of thigh muscle	0049	20.2046	1151.32	.	230.26
27390	T		Incision of thigh tendon	0049	20.2046	1151.32	.	230.26
27391	T		Incision of thigh tendons	0049	20.2046	1151.32	.	230.26
27392	T		Incision of thigh tendons	0049	20.2046	1151.32	.	230.26
27393	T		Lengthening of thigh tendon	0050	24.6002	1401.79	.	280.36
27394	T		Lengthening of thigh tendons	0050	24.6002	1401.79	.	280.36
27395	T		Lengthening of thigh tendons	0051	35.8607	2043.45	.	408.69
27396	T		Transplant of thigh tendon	0050	24.6002	1401.79	.	280.36
27397	T		Transplants of thigh tendons	0051	35.8607	2043.45	.	408.69
27400	T		Revise thigh muscles/tendons	0051	35.8607	2043.45	.	408.69
27403	T		Repair of knee cartilage	0050	24.6002	1401.79	.	280.36
27405	T		Repair of knee ligament	0051	35.8607	2043.45	.	408.69
27407	T		Repair of knee ligament	0051	35.8607	2043.45	.	408.69
27409	T		Repair of knee ligaments	0051	35.8607	2043.45	.	408.69

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27412	T	NI	Autochondrocyte implant knee	0042	43.5802	2483.33	804.74	496.67
27415	T	NI	Osteochondral knee allograft	0042	43.5802	2483.33	804.74	496.67
27418	T		Repair degenerated kneecap	0051	35.8607	2043.45	.	408.69
27420	T		Revision of unstable kneecap	0051	35.8607	2043.45	.	408.69
27422	T		Revision of unstable kneecap	0051	35.8607	2043.45	.	408.69
27424	T		Revision/removal of kneecap	0051	35.8607	2043.45	.	408.69
27425	T		Lat retinacular release open	0050	24.6002	1401.79	.	280.36
27427	T		Reconstruction, knee	0052	43.5754	2483.06	.	496.61
27428	T		Reconstruction, knee	0052	43.5754	2483.06	.	496.61
27429	T		Reconstruction, knee	0052	43.5754	2483.06	.	496.61
27430	T		Revision of thigh muscles	0051	35.8607	2043.45	.	408.69
27435	T		Incision of knee joint	0051	35.8607	2043.45	.	408.69
27437	T		Revise kneecap	0047	31.0492	1769.28	537.03	353.86
27438	T		Revise kneecap with implant	0048	40.3978	2301.99	570.30	460.40
27440	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27441	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27442	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27443	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27445	C		Revision of knee joint		.	.	.	.
27446	T		Revision of knee joint	0681	91.7896	5230.45	2081.48	1046.09
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	20.2046	1151.32	.	230.26
27497	T		Decompression of thigh/knee	0049	20.2046	1151.32	.	230.26
27498	T		Decompression of thigh/knee	0049	20.2046	1151.32	.	230.26
27499	T		Decompression of thigh/knee	0049	20.2046	1151.32	.	230.26

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27500	T		Treatment of thigh fracture	0043	1.8527	105.57	.	21.11
27501	T		Treatment of thigh fracture	0043	1.8527	105.57	.	21.11
27502	T		Treatment of thigh fracture	0043	1.8527	105.57	.	21.11
27503	T		Treatment of thigh fracture	0043	1.8527	105.57	.	21.11
27506	C		Treatment of thigh fracture		.	.	.	.
27507	C		Treatment of thigh fracture		.	.	.	.
27508	T		Treatment of thigh fracture	0043	1.8527	105.57	.	21.11
27509	T		Treatment of thigh fracture	0046	35.1105	2000.70	535.76	400.14
27510	T		Treatment of thigh fracture	0043	1.8527	105.57	.	21.11
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	1.8527	105.57	.	21.11
27517	T		Treat thigh fx growth plate	0043	1.8527	105.57	.	21.11
27519	C		Treat thigh fx growth plate		.	.	.	.
27520	T		Treat kneecap fracture	0043	1.8527	105.57	.	21.11
27524	T		Treat kneecap fracture	0046	35.1105	2000.70	535.76	400.14
27530	T		Treat knee fracture	0043	1.8527	105.57	.	21.11
27532	T		Treat knee fracture	0043	1.8527	105.57	.	21.11
27535	C		Treat knee fracture		.	.	.	.
27536	C		Treat knee fracture		.	.	.	.
27538	T		Treat knee fracture(s)	0043	1.8527	105.57	.	21.11
27540	C		Treat knee fracture		.	.	.	.
27550	T		Treat knee dislocation	0043	1.8527	105.57	.	21.11
27552	T		Treat knee dislocation	0045	14.2091	809.68	268.47	161.94
27556	C		Treat knee dislocation		.	.	.	.
27557	C		Treat knee dislocation		.	.	.	.
27558	C		Treat knee dislocation		.	.	.	.
27560	T		Treat kneecap dislocation	0043	1.8527	105.57	.	21.11
27562	T		Treat kneecap dislocation	0045	14.2091	809.68	268.47	161.94
27566	T		Treat kneecap dislocation	0046	35.1105	2000.70	535.76	400.14
27570	T		Fixation of knee joint	0045	14.2091	809.68	268.47	161.94
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	20.2046	1151.32	.	230.26
27596	C		Amputation follow-up surgery		.	.	.	.
27598	C		Amputate lower leg at knee		.	.	.	.
27599	T		Leg surgery procedure	0043	1.8527	105.57	.	21.11
27600	T		Decompression of lower leg	0049	20.2046	1151.32	.	230.26
27601	T		Decompression of lower leg	0049	20.2046	1151.32	.	230.26
27602	T		Decompression of lower leg	0049	20.2046	1151.32	.	230.26

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27603	T		Drain lower leg lesion	0007	12.4496	709.42	.	141.88
27604	T		Drain lower leg bursa	0049	20.2046	1151.32	.	230.26
27605	T		Incision of achilles tendon	0055	19.3444	1102.30	355.34	220.46
27606	T		Incision of achilles tendon	0049	20.2046	1151.32	.	230.26
27607	T		Treat lower leg bone lesion	0049	20.2046	1151.32	.	230.26
27610	T		Explore/treat ankle joint	0050	24.6002	1401.79	.	280.36
27612	T		Exploration of ankle joint	0050	24.6002	1401.79	.	280.36
27613	T		Biopsy lower leg soft tissue	0020	7.6248	434.48	113.25	86.90
27614	T		Biopsy lower leg soft tissue	0022	19.3700	1103.76	354.45	220.75
27615	T		Remove tumor, lower leg	0046	35.1105	2000.70	535.76	400.14
27618	T		Remove lower leg lesion	0021	14.8872	848.32	219.48	169.66
27619	T		Remove lower leg lesion	0022	19.3700	1103.76	354.45	220.75
27620	T		Explore/treat ankle joint	0050	24.6002	1401.79	.	280.36
27625	T		Remove ankle joint lining	0050	24.6002	1401.79	.	280.36
27626	T		Remove ankle joint lining	0050	24.6002	1401.79	.	280.36
27630	T		Removal of tendon lesion	0049	20.2046	1151.32	.	230.26
27635	T		Remove lower leg bone lesion	0050	24.6002	1401.79	.	280.36
27637	T		Remove/graft leg bone lesion	0050	24.6002	1401.79	.	280.36
27638	T		Remove/graft leg bone lesion	0050	24.6002	1401.79	.	280.36
27640	T		Partial removal of tibia	0051	35.8607	2043.45	.	408.69
27641	T		Partial removal of fibula	0050	24.6002	1401.79	.	280.36
27645	C		Extensive lower leg surgery		.	.	.	.
27646	C		Extensive lower leg surgery		.	.	.	.
27647	T		Extensive ankle/heel surgery	0051	35.8607	2043.45	.	408.69
27648	N		Injection for ankle x-ray		.	.	.	.
27650	T		Repair achilles tendon	0051	35.8607	2043.45	.	408.69
27652	T		Repair/graft achilles tendon	0051	35.8607	2043.45	.	408.69
27654	T		Repair of achilles tendon	0051	35.8607	2043.45	.	408.69
27656	T		Repair leg fascia defect	0049	20.2046	1151.32	.	230.26
27658	T		Repair of leg tendon, each	0049	20.2046	1151.32	.	230.26
27659	T		Repair of leg tendon, each	0049	20.2046	1151.32	.	230.26
27664	T		Repair of leg tendon, each	0049	20.2046	1151.32	.	230.26
27665	T		Repair of leg tendon, each	0050	24.6002	1401.79	.	280.36
27675	T		Repair lower leg tendons	0049	20.2046	1151.32	.	230.26
27676	T		Repair lower leg tendons	0050	24.6002	1401.79	.	280.36
27680	T		Release of lower leg tendon	0050	24.6002	1401.79	.	280.36
27681	T		Release of lower leg tendons	0050	24.6002	1401.79	.	280.36
27685	T		Revision of lower leg tendon	0050	24.6002	1401.79	.	280.36
27686	T		Revise lower leg tendons	0050	24.6002	1401.79	.	280.36
27687	T		Revision of calf tendon	0050	24.6002	1401.79	.	280.36
27690	T		Revise lower leg tendon	0051	35.8607	2043.45	.	408.69
27691	T		Revise lower leg tendon	0051	35.8607	2043.45	.	408.69
27692	T		Revise additional leg tendon	0051	35.8607	2043.45	.	408.69

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27695	T		Repair of ankle ligament	0050	24.6002	1401.79	.	280.36
27696	T		Repair of ankle ligaments	0050	24.6002	1401.79	.	280.36
27698	T		Repair of ankle ligament	0050	24.6002	1401.79	.	280.36
27700	T		Revision of ankle joint	0047	31.0492	1769.28	537.03	353.86
27702	C		Reconstruct ankle joint		.	.	.	.
27703	C		Reconstruction, ankle joint		.	.	.	.
27704	T		Removal of ankle implant	0049	20.2046	1151.32	.	230.26
27705	T		Incision of tibia	0051	35.8607	2043.45	.	408.69
27707	T		Incision of fibula	0049	20.2046	1151.32	.	230.26
27709	T		Incision of tibia & fibula	0050	24.6002	1401.79	.	280.36
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	24.6002	1401.79	.	280.36
27732	T		Repair of fibula epiphysis	0050	24.6002	1401.79	.	280.36
27734	T		Repair lower leg epiphyses	0050	24.6002	1401.79	.	280.36
27740	T		Repair of leg epiphyses	0050	24.6002	1401.79	.	280.36
27742	T		Repair of leg epiphyses	0051	35.8607	2043.45	.	408.69
27745	T		Reinforce tibia	0051	35.8607	2043.45	.	408.69
27750	T		Treatment of tibia fracture	0043	1.8527	105.57	.	21.11
27752	T		Treatment of tibia fracture	0043	1.8527	105.57	.	21.11
27756	T		Treatment of tibia fracture	0046	35.1105	2000.70	535.76	400.14
27758	T		Treatment of tibia fracture	0046	35.1105	2000.70	535.76	400.14
27759	T		Treatment of tibia fracture	0046	35.1105	2000.70	535.76	400.14
27760	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27762	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27766	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27780	T		Treatment of fibula fracture	0043	1.8527	105.57	.	21.11
27781	T		Treatment of fibula fracture	0043	1.8527	105.57	.	21.11
27784	T		Treatment of fibula fracture	0046	35.1105	2000.70	535.76	400.14
27786	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27788	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27792	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27808	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27810	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27814	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27816	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27818	T		Treatment of ankle fracture	0043	1.8527	105.57	.	21.11
27822	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27823	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27824	T		Treat lower leg fracture	0043	1.8527	105.57	.	21.11
27825	T		Treat lower leg fracture	0043	1.8527	105.57	.	21.11
27826	T		Treat lower leg fracture	0046	35.1105	2000.70	535.76	400.14
27827	T		Treat lower leg fracture	0046	35.1105	2000.70	535.76	400.14
27828	T		Treat lower leg fracture	0046	35.1105	2000.70	535.76	400.14
27829	T		Treat lower leg joint	0046	35.1105	2000.70	535.76	400.14
27830	T		Treat lower leg dislocation	0043	1.8527	105.57	.	21.11
27831	T		Treat lower leg dislocation	0043	1.8527	105.57	.	21.11
27832	T		Treat lower leg dislocation	0046	35.1105	2000.70	535.76	400.14
27840	T		Treat ankle dislocation	0043	1.8527	105.57	.	21.11
27842	T		Treat ankle dislocation	0045	14.2091	809.68	268.47	161.94
27846	T		Treat ankle dislocation	0046	35.1105	2000.70	535.76	400.14
27848	T		Treat ankle dislocation	0046	35.1105	2000.70	535.76	400.14
27860	T		Fixation of ankle joint	0045	14.2091	809.68	268.47	161.94
27870	T		Fusion of ankle joint, open	0051	35.8607	2043.45	.	408.69
27871	T		Fusion of tibiofibular joint	0051	35.8607	2043.45	.	408.69
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	20.2046	1151.32	.	230.26
27886	C		Amputation follow-up surgery		.	.	.	.
27888	C		Amputation of foot at ankle		.	.	.	.
27889	T		Amputation of foot at ankle	0050	24.6002	1401.79	.	280.36
27892	T		Decompression of leg	0049	20.2046	1151.32	.	230.26
27893	T		Decompression of leg	0049	20.2046	1151.32	.	230.26
27894	T		Decompression of leg	0049	20.2046	1151.32	.	230.26
27899	T		Leg/ankle surgery procedure	0043	1.8527	105.57	.	21.11
28001	T		Drainage of bursa of foot	0007	12.4496	709.42	.	144.88
28002	T		Treatment of foot infection	0049	20.2046	1151.32	.	230.26
28003	T		Treatment of foot infection	0049	20.2046	1151.32	.	230.26
28005	T		Treat foot bone lesion	0055	19.3444	1102.30	355.34	220.46
28008	T		Incision of foot fascia	0055	19.3444	1102.30	355.34	220.46
28010	T		Incision of toe tendon	0055	19.3444	1102.30	355.34	220.46
28011	T		Incision of toe tendons	0055	19.3444	1102.30	355.34	220.46
28020	T		Exploration of foot joint	0055	19.3444	1102.30	355.34	220.46
28022	T		Exploration of foot joint	0055	19.3444	1102.30	355.34	220.46
28024	T		Exploration of toe joint	0055	19.3444	1102.30	355.34	220.46
28030	T		Removal of foot nerve	0220	17.2963	985.60	.	197.12
28035	T		Decompression of tibia nerve	0220	17.2963	985.60	.	197.12
28043	T		Excision of foot lesion	0021	14.8872	848.32	219.48	169.66
28045	T		Excision of foot lesion	0055	19.3444	1102.30	355.34	220.46
28046	T		Resection of tumor, foot	0055	19.3444	1102.30	355.34	220.46

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28050	T		Biopsy of foot joint lining	0055	19.3444	1102.30	355.34	220.46
28052	T		Biopsy of foot joint lining	0055	19.3444	1102.30	355.34	220.46
28054	T		Biopsy of toe joint lining	0055	19.3444	1102.30	355.34	220.46
28060	T		Partial removal, foot fascia	0056	26.5813	1514.68	405.81	302.94
28062	T		Removal of foot fascia	0056	26.5813	1514.68	405.81	302.94
28070	T		Removal of foot joint lining	0056	26.5813	1514.68	405.81	302.94
28072	T		Removal of foot joint lining	0056	26.5813	1514.68	405.81	302.94
28080	T		Removal of foot lesion	0055	19.3444	1102.30	355.34	220.46
28086	T		Excise foot tendon sheath	0055	19.3444	1102.30	355.34	220.46
28088	T		Excise foot tendon sheath	0055	19.3444	1102.30	355.34	220.46
28090	T		Removal of foot lesion	0055	19.3444	1102.30	355.34	220.46
28092	T		Removal of toe lesions	0055	19.3444	1102.30	355.34	220.46
28100	T		Removal of ankle/heel lesion	0055	19.3444	1102.30	355.34	220.46
28102	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28103	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28104	T		Removal of foot lesion	0055	19.3444	1102.30	355.34	220.46
28106	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28107	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28108	T		Removal of toe lesions	0055	19.3444	1102.30	355.34	220.46
28110	T		Part removal of metatarsal	0056	26.5813	1514.68	405.81	302.94
28111	T		Part removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28112	T		Part removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28113	T		Part removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28114	T		Removal of metatarsal heads	0055	19.3444	1102.30	355.34	220.46
28116	T		Revision of foot	0055	19.3444	1102.30	355.34	220.46
28118	T		Removal of heel bone	0055	19.3444	1102.30	355.34	220.46
28119	T		Removal of heel spur	0055	19.3444	1102.30	355.34	220.46
28120	T		Part removal of ankle/heel	0055	19.3444	1102.30	355.34	220.46
28122	T		Partial removal of foot bone	0055	19.3444	1102.30	355.34	220.46
28124	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28126	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28130	T		Removal of ankle bone	0055	19.3444	1102.30	355.34	220.46
28140	T		Removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28150	T		Removal of toe	0055	19.3444	1102.30	355.34	220.46
28153	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28160	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28171	T		Extensive foot surgery	0055	19.3444	1102.30	355.34	220.46
28173	T		Extensive foot surgery	0055	19.3444	1102.30	355.34	220.46
28175	T		Extensive foot surgery	0055	19.3444	1102.30	355.34	220.46
28190	T		Removal of foot foreign body	0019	4.1677	237.49	71.87	47.50
28192	T		Removal of foot foreign body	0021	14.8872	848.32	219.48	169.66
28193	T		Removal of foot foreign body	0020	7.6248	434.48	113.25	86.90
28200	T		Repair of foot tendon	0055	19.3444	1102.30	355.34	220.46

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28202	T		Repair/graft of foot tendon	0056	26.5813	1514.68	405.81	302.94
28208	T		Repair of foot tendon	0055	19.3444	1102.30	355.34	220.46
28210	T		Repair/graft of foot tendon	0056	26.5813	1514.68	405.81	302.94
28220	T		Release of foot tendon	0055	19.3444	1102.30	355.34	220.46
28222	T		Release of foot tendons	0055	19.3444	1102.30	355.34	220.46
28225	T		Release of foot tendon	0055	19.3444	1102.30	355.34	220.46
28226	T		Release of foot tendons	0055	19.3444	1102.30	355.34	220.46
28230	T		Incision of foot tendon(s)	0055	19.3444	1102.30	355.34	220.46
28232	T		Incision of toe tendon	0055	19.3444	1102.30	355.34	220.46
28234	T		Incision of foot tendon	0055	19.3444	1102.30	355.34	220.46
28238	T		Revision of foot tendon	0056	26.5813	1514.68	405.81	302.94
28240	T		Release of big toe	0055	19.3444	1102.30	355.34	220.46
28250	T		Revision of foot fascia	0056	26.5813	1514.68	405.81	302.94
28260	T		Release of midfoot joint	0056	26.5813	1514.68	405.81	302.94
28261	T		Revision of foot tendon	0056	26.5813	1514.68	405.81	302.94
28262	T		Revision of foot and ankle	0056	26.5813	1514.68	405.81	302.94
28264	T		Release of midfoot joint	0056	26.5813	1514.68	405.81	302.94
28270	T		Release of foot contracture	0055	19.3444	1102.30	355.34	220.46
28272	T		Release of toe joint, each	0055	19.3444	1102.30	355.34	220.46
28280	T		Fusion of toes	0055	19.3444	1102.30	355.34	220.46
28285	T		Repair of hammertoe	0055	19.3444	1102.30	355.34	220.46
28286	T		Repair of hammertoe	0055	19.3444	1102.30	355.34	220.46
28288	T		Partial removal of foot bone	0056	26.5813	1514.68	405.81	302.94
28289	T		Repair hallux rigidus	0056	26.5813	1514.68	405.81	302.94
28290	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28292	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28293	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28294	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28296	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28297	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28298	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28299	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28300	T		Incision of heel bone	0056	26.5813	1514.68	405.81	302.94
28302	T		Incision of ankle bone	0056	26.5813	1514.68	405.81	302.94
28304	T		Incision of midfoot bones	0056	26.5813	1514.68	405.81	302.94
28305	T		Incise/graft midfoot bones	0056	26.5813	1514.68	405.81	302.94
28306	T		Incision of metatarsal	0056	26.5813	1514.68	405.81	302.94
28307	T		Incision of metatarsal	0056	26.5813	1514.68	405.81	302.94
28308	T		Incision of metatarsal	0056	26.5813	1514.68	405.81	302.94
28309	T		Incision of metatarsals	0056	26.5813	1514.68	405.81	302.94
28310	T		Revision of big toe	0055	19.3444	1102.30	355.34	220.46
28312	T		Revision of toe	0055	19.3444	1102.30	355.34	220.46
28313	T		Repair deformity of toe	0055	19.3444	1102.30	355.34	220.46

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28315	T		Removal of sesamoid bone	0055	19.3444	1102.30	355.34	220.46
28320	T		Repair of foot bones	0056	26.5813	1514.68	405.81	302.94
28322	T		Repair of metatarsals	0056	26.5813	1514.68	405.81	302.94
28340	T		Resect enlarged toe tissue	0055	19.3444	1102.30	355.34	220.46
28341	T		Resect enlarged toe	0055	19.3444	1102.30	355.34	220.46
28344	T		Repair extra toe(s)	0056	26.5813	1514.68	405.81	302.94
28345	T		Repair webbed toe(s)	0056	26.5813	1514.68	405.81	302.94
28360	T		Reconstruct cleft foot	0056	26.5813	1514.68	405.81	302.94
28400	T		Treatment of heel fracture	0043	1.8527	105.57		21.11
28405	T		Treatment of heel fracture	0043	1.8527	105.57		21.11
28406	T		Treatment of heel fracture	0046	35.1105	2000.70	535.76	400.14
28415	T		Treat heel fracture	0046	35.1105	2000.70	535.76	400.14
28420	T		Treat/graft heel fracture	0046	35.1105	2000.70	535.76	400.14
28430	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
28435	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
28436	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
28445	T		Treat ankle fracture	0046	35.1105	2000.70	535.76	400.14
28450	T		Treat midfoot fracture, each	0043	1.8527	105.57		21.11
28455	T		Treat midfoot fracture, each	0043	1.8527	105.57		21.11
28456	T		Treat midfoot fracture	0046	35.1105	2000.70	535.76	400.14
28465	T		Treat midfoot fracture, each	0046	35.1105	2000.70	535.76	400.14
28470	T		Treat metatarsal fracture	0043	1.8527	105.57		21.11
28475	T		Treat metatarsal fracture	0043	1.8527	105.57		21.11
28476	T		Treat metatarsal fracture	0046	35.1105	2000.70	535.76	400.14
28485	T		Treat metatarsal fracture	0046	35.1105	2000.70	535.76	400.14
28490	T		Treat big toe fracture	0043	1.8527	105.57		21.11
28495	T		Treat big toe fracture	0043	1.8527	105.57		21.11
28496	T		Treat big toe fracture	0046	35.1105	2000.70	535.76	400.14
28505	T		Treat big toe fracture	0046	35.1105	2000.70	535.76	400.14
28510	T		Treatment of toe fracture	0043	1.8527	105.57		21.11
28515	T		Treatment of toe fracture	0043	1.8527	105.57		21.11
28525	T		Treat toe fracture	0046	35.1105	2000.70	535.76	400.14
28530	T		Treat sesamoid bone fracture	0043	1.8527	105.57		21.11
28531	T		Treat sesamoid bone fracture	0046	35.1105	2000.70	535.76	400.14
28540	T		Treat foot dislocation	0043	1.8527	105.57		21.11
28545	T		Treat foot dislocation	0045	14.2091	809.68	268.47	161.94
28546	T		Treat foot dislocation	0046	35.1105	2000.70	535.76	400.14
28555	T		Repair foot dislocation	0046	35.1105	2000.70	535.76	400.14
28570	T		Treat foot dislocation	0043	1.8527	105.57		21.11
28575	T		Treat foot dislocation	0043	1.8527	105.57		21.11
28576	T		Treat foot dislocation	0046	35.1105	2000.70	535.76	400.14
28585	T		Repair foot dislocation	0046	35.1105	2000.70	535.76	400.14
28600	T		Treat foot dislocation	0043	1.8527	105.57		21.11

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28605	T		Treat foot dislocation	0043	1.8527	105.57	.	21.11
28606	T		Treat foot dislocation	0046	35.1105	2000.70	535.76	400.14
28615	T		Repair foot dislocation	0046	35.1105	2000.70	535.76	400.14
28630	T		Treat toe dislocation	0043	1.8527	105.57	.	21.11
28635	T		Treat toe dislocation	0045	14.2091	809.68	268.47	161.94
28636	T		Treat toe dislocation	0046	35.1105	2000.70	535.76	400.14
28645	T		Repair toe dislocation	0046	35.1105	2000.70	535.76	400.14
28660	T		Treat toe dislocation	0043	1.8527	105.57	.	21.11
28665	T		Treat toe dislocation	0045	14.2091	809.68	268.47	161.94
28666	T		Treat toe dislocation	0046	35.1105	2000.70	535.76	400.14
28675	T		Repair of toe dislocation	0046	35.1105	2000.70	535.76	400.14
28705	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28715	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28725	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28730	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28735	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28737	T		Revision of foot bones	0056	26.5813	1514.68	405.81	302.94
28740	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28750	T		Fusion of big toe joint	0056	26.5813	1514.68	405.81	302.94
28755	T		Fusion of big toe joint	0055	19.3444	1102.30	355.34	220.46
28760	T		Fusion of big toe joint	0056	26.5813	1514.68	405.81	302.94
28800	C		Amputation of midfoot		.	.	.	.
28805	C		Amputation thru metatarsal		.	.	.	.
28810	T		Amputation toe & metatarsal	0055	19.3444	1102.30	355.34	220.46
28820	T		Amputation of toe	0055	19.3444	1102.30	355.34	220.46
28825	T		Partial amputation of toe	0055	19.3444	1102.30	355.34	220.46
28899	T		Foot/toes surgery procedure	0043	1.8527	105.57	.	21.11
29000	S		Application of body cast	0426	1.9972	113.81	.	22.76
29010	S		Application of body cast	0426	1.9972	113.81	.	22.76
29015	S		Application of body cast	0426	1.9972	113.81	.	22.76
29020	S		Application of body cast	0058	1.1091	63.20	.	12.64
29025	S		Application of body cast	0426	1.9972	113.81	.	22.76
29035	S		Application of body cast	0426	1.9972	113.81	.	22.76
29040	S		Application of body cast	0058	1.1091	63.20	.	12.64
29044	S		Application of body cast	0426	1.9972	113.81	.	22.76
29046	S		Application of body cast	0426	1.9972	113.81	.	22.76
29049	S		Application of figure eight	0058	1.1091	63.20	.	12.64
29055	S		Application of shoulder cast	0426	1.9972	113.81	.	22.76
29058	S		Application of shoulder cast	0058	1.1091	63.20	.	12.64
29065	S		Application of long arm cast	0426	1.9972	113.81	.	22.76
29075	S		Application of forearm cast	0426	1.9972	113.81	.	22.76
29085	S		Apply hand/wrist cast	0426	1.9972	113.81	.	22.76
29086	S		Apply finger cast	0426	1.9972	113.81	.	22.76

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29105	S		Apply long arm splint	0058	1.1091	63.20		12.64
29125	S		Apply forearm splint	0058	1.1091	63.20		12.64
29126	S		Apply forearm splint	0058	1.1091	63.20		12.64
29130	S		Application of finger splint	0058	1.1091	63.20		12.64
29131	S		Application of finger splint	0058	1.1091	63.20		12.64
29200	S		Strapping of chest	0058	1.1091	63.20		12.64
29220	S		Strapping of low back	0058	1.1091	63.20		12.64
29240	S		Strapping of shoulder	0058	1.1091	63.20		12.64
29260	S		Strapping of elbow or wrist	0058	1.1091	63.20		12.64
29280	S		Strapping of hand or finger	0058	1.1091	63.20		12.64
29305	S		Application of hip cast	0426	1.9972	113.81		22.76
29325	S		Application of hip casts	0426	1.9972	113.81		22.76
29345	S		Application of long leg cast	0426	1.9972	113.81		22.76
29355	S		Application of long leg cast	0426	1.9972	113.81		22.76
29358	S		Apply long leg cast brace	0426	1.9972	113.81		22.76
29365	S		Application of long leg cast	0426	1.9972	113.81		22.76
29405	S		Apply short leg cast	0426	1.9972	113.81		22.76
29425	S		Apply short leg cast	0426	1.9972	113.81		22.76
29435	S		Apply short leg cast	0426	1.9972	113.81		22.76
29440	S		Addition of walker to cast	0426	1.9972	113.81		22.76
29445	S		Apply rigid leg cast	0426	1.9972	113.81		22.76
29450	S		Application of leg cast	0058	1.1091	63.20		12.64
29505	S		Application, long leg splint	0058	1.1091	63.20		12.64
29515	S		Application lower leg splint	0058	1.1091	63.20		12.64
29520	S		Strapping of hip	0058	1.1091	63.20		12.64
29530	S		Strapping of knee	0058	1.1091	63.20		12.64
29540	S		Strapping of ankle and/or ft	0058	1.1091	63.20		12.64
29550	S		Strapping of toes	0058	1.1091	63.20		12.64
29580	S		Application of paste boot	0058	1.1091	63.20		12.64
29590	S		Application of foot splint	0058	1.1091	63.20		12.64
29700	S		Removal/revision of cast	0058	1.1091	63.20		12.64
29705	S		Removal/revision of cast	0058	1.1091	63.20		12.64
29710	S		Removal/revision of cast	0426	1.9972	113.81		22.76
29715	S		Removal/revision of cast	0058	1.1091	63.20		12.64
29720	S		Repair of body cast	0058	1.1091	63.20		12.64
29730	S		Windowing of cast	0058	1.1091	63.20		12.64
29740	S		Wedging of cast	0058	1.1091	63.20		12.64
29750	S		Wedging of clubfoot cast	0058	1.1091	63.20		12.64
29799	S		Casting/strapping procedure	0058	1.1091	63.20		12.64
29800	T		Jaw arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29804	T		Jaw arthroscopy/surgery	0041	28.0254	1596.97		319.39
29805	T		Shoulder arthroscopy, dx	0041	28.0254	1596.97		319.39
29806	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29807	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29819	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29820	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29821	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29822	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29823	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29824	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29825	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29826	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29827	T		Arthroscop rotator cuff repr	0042	43.5802	2483.33	804.74	496.67
29830	T		Elbow arthroscopy	0041	28.0254	1596.97	.	319.39
29834	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29835	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29836	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29837	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29838	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29840	T		Wrist arthroscopy	0041	28.0254	1596.97	.	319.39
29843	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29844	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29845	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29846	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29847	T		Wrist arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29848	T		Wrist endoscopy/surgery	0041	28.0254	1596.97	.	319.39
29850	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29851	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29855	T		Tibial arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29856	T		Tibial arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29860	T		Hip arthroscopy, dx	0041	28.0254	1596.97	.	319.39
29861	T		Hip arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29862	T		Hip arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29863	T		Hip arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29866	T	NI	Autgrft implnt, knee w/scope	0042	43.5802	2483.33	804.74	496.67
29867	T	NI	Allgrft implnt, knee w/scope	0042	43.5802	2483.33	804.74	496.67
29868	T	NI	Meniscal trnspl, knee w/scpe	0042	43.5802	2483.33	804.74	496.67
29870	T		Knee arthroscopy, dx	0041	28.0254	1596.97	.	319.39
29871	T		Knee arthroscopy/drainage	0041	28.0254	1596.97	.	319.39
29873	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29874	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29875	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29876	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29877	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29879	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29880	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29881	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29882	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29883	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29884	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29885	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29886	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29887	T		Knee arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29888	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29889	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29891	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29892	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29893	T		Scope, plantar fasciotomy	0055	19.3444	1102.30	355.34	220.46
29894	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29895	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29897	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29898	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97	.	319.39
29899	T		Ankle arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29900	T		Mcp joint arthroscopy, dx	0053	15.5097	883.79	253.49	176.76
29901	T		Mcp joint arthroscopy, surg	0053	15.5097	883.79	253.49	176.76
29902	T		Mcp joint arthroscopy, surg	0053	15.5097	883.79	253.49	176.76
29999	T		Arthroscopy of joint	0041	28.0254	1596.97	.	319.39
30000	T		Drainage of nose lesion	0251	1.9352	110.27	.	22.05
30020	T		Drainage of nose lesion	0251	1.9352	110.27	.	22.05
30100	T		Intranasal biopsy	0252	6.5183	371.43	113.41	74.29
30110	T		Removal of nose polyp(s)	0253	15.9877	911.03	282.29	182.21
30115	T		Removal of nose polyp(s)	0253	15.9877	911.03	282.29	182.21
30117	T		Removal of intranasal lesion	0253	15.9877	911.03	282.29	182.21
30118	T		Removal of intranasal lesion	0254	23.3442	1330.22	321.35	266.04
30120	T		Revision of nose	0253	15.9877	911.03	282.29	182.21
30124	T		Removal of nose lesion	0252	6.5183	371.43	113.41	74.29
30125	T		Removal of nose lesion	0256	36.9298	2104.37	.	420.87
30130	T		Removal of turbinate bones	0253	15.9877	911.03	282.29	182.21
30140	T		Removal of turbinate bones	0254	23.3442	1330.22	321.35	266.04
30150	T		Partial removal of nose	0256	36.9298	2104.37	.	420.87
30160	T		Removal of nose	0256	36.9298	2104.37	.	420.87
30200	T		Injection treatment of nose	0252	6.5183	371.43	113.41	74.29
30210	T		Nasal sinus therapy	0252	6.5183	371.43	113.41	74.29
30220	T		Insert nasal septal button	0252	6.5183	371.43	113.41	74.29
30300	X		Remove nasal foreign body	0340	0.6328	36.06	.	7.21
30310	T		Remove nasal foreign body	0253	15.9877	911.03	282.29	182.21
30320	T		Remove nasal foreign body	0253	15.9877	911.03	282.29	182.21
30400	T		Reconstruction of nose	0256	36.9298	2104.37	.	420.87
30410	T		Reconstruction of nose	0256	36.9298	2104.37	.	420.87

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30420	T		Reconstruction of nose	0256	36.9298	2104.37	.	420.87
30430	T		Revision of nose	0254	23.3442	1330.22	321.35	266.04
30435	T		Revision of nose	0256	36.9298	2104.37	.	420.87
30450	T		Revision of nose	0256	36.9298	2104.37	.	420.87
30460	T		Revision of nose	0256	36.9298	2104.37	.	420.87
30462	T		Revision of nose	0256	36.9298	2104.37	.	420.87
30465	T		Repair nasal stenosis	0256	36.9298	2104.37	.	420.87
30520	T		Repair of nasal septum	0254	23.3442	1330.22	321.35	266.04
30540	T		Repair nasal defect	0256	36.9298	2104.37	.	420.87
30545	T		Repair nasal defect	0256	36.9298	2104.37	.	420.87
30560	T		Release of nasal adhesions	0251	1.9352	110.27	.	22.05
30580	T		Repair upper jaw fistula	0256	36.9298	2104.37	.	420.87
30600	T		Repair mouth/nose fistula	0256	36.9298	2104.37	.	420.87
30620	T		Intranasal reconstruction	0256	36.9298	2104.37	.	420.87
30630	T		Repair nasal septum defect	0254	23.3442	1330.22	321.35	266.04
30801	T		Cauterization, inner nose	0252	6.5183	371.43	113.41	74.29
30802	T		Cauterization, inner nose	0252	6.5183	371.43	113.41	74.29
30901	T		Control of nosebleed	0250	1.3781	78.53	27.49	15.71
30903	T		Control of nosebleed	0250	1.3781	78.53	27.49	15.71
30905	T		Control of nosebleed	0250	1.3781	78.53	27.49	15.71
30906	T		Repeat control of nosebleed	0250	1.3781	78.53	27.49	15.71
30915	T		Ligation, nasal sinus artery	0091	29.6620	1690.23	348.23	338.05
30920	T		Ligation, upper jaw artery	0092	26.9952	1538.27	505.37	307.65
30930	T		Therapy, fracture of nose	0253	15.9877	911.03	282.29	182.21
30999	T		Nasal surgery procedure	0251	1.9352	110.27	.	22.05
31000	T		Irrigation, maxillary sinus	0251	1.9352	110.27	.	22.05
31002	T		Irrigation, sphenoid sinus	0252	6.5183	371.43	113.41	74.29
31020	T		Exploration, maxillary sinus	0254	23.3442	1330.22	321.35	266.04
31030	T		Exploration, maxillary sinus	0256	36.9298	2104.37	.	420.87
31032	T		Explore sinus, remove polyps	0256	36.9298	2104.37	.	420.87
31040	T		Exploration behind upper jaw	0254	23.3442	1330.22	321.35	266.04
31050	T		Exploration, sphenoid sinus	0256	36.9298	2104.37	.	420.87
31051	T		Sphenoid sinus surgery	0256	36.9298	2104.37	.	420.87
31070	T		Exploration of frontal sinus	0254	23.3442	1330.22	321.35	266.04
31075	T		Exploration of frontal sinus	0256	36.9298	2104.37	.	420.87
31080	T		Removal of frontal sinus	0256	36.9298	2104.37	.	420.87
31081	T		Removal of frontal sinus	0256	36.9298	2104.37	.	420.87
31084	T		Removal of frontal sinus	0256	36.9298	2104.37	.	420.87
31085	T		Removal of frontal sinus	0256	36.9298	2104.37	.	420.87
31086	T		Removal of frontal sinus	0256	36.9298	2104.37	.	420.87
31087	T		Removal of frontal sinus	0256	36.9298	2104.37	.	420.87
31090	T		Exploration of sinuses	0256	36.9298	2104.37	.	420.87
31200	T		Removal of ethmoid sinus	0256	36.9298	2104.37	.	420.87

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31201	T		Removal of ethmoid sinus	0256	36.9298	2104.37	.	420.87
31205	T		Removal of ethmoid sinus	0256	36.9298	2104.37	.	420.87
31225	C		Removal of upper jaw		.	.	.	.
31230	C		Removal of upper jaw		.	.	.	.
31231	T		Nasal endoscopy, dx	0072	1.3903	79.22	21.27	15.84
31233	T		Nasal/sinus endoscopy, dx	0072	1.3903	79.22	21.27	15.84
31235	T		Nasal/sinus endoscopy, dx	0074	16.1205	918.59	295.70	183.72
31237	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31238	T		Nasal/sinus endoscopy, surg	0074	16.1205	918.59	295.70	183.72
31239	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31240	T		Nasal/sinus endoscopy, surg	0074	16.1205	918.59	295.70	183.72
31254	T		Revision of ethmoid sinus	0075	20.9362	1193.01	445.92	238.60
31255	T		Removal of ethmoid sinus	0075	20.9362	1193.01	445.92	238.60
31256	T		Exploration maxillary sinus	0075	20.9362	1193.01	445.92	238.60
31267	T		Endoscopy, maxillary sinus	0075	20.9362	1193.01	445.92	238.60
31276	T		Sinus endoscopy, surgical	0075	20.9362	1193.01	445.92	238.60
31287	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31288	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31290	C		Nasal/sinus endoscopy, surg		.	.	.	.
31291	C		Nasal/sinus endoscopy, surg		.	.	.	.
31292	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31293	C		Nasal/sinus endoscopy, surg		.	.	.	.
31294	C		Nasal/sinus endoscopy, surg		.	.	.	.
31299	T		Sinus surgery procedure	0251	1.9352	110.27	.	22.05
31300	T		Removal of larynx lesion	0254	23.3442	1330.22	321.35	266.04
31320	T		Diagnostic incision, larynx	0256	36.9298	2104.37	.	420.87
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	36.9298	2104.37	.	420.87
31420	T		Removal of epiglottis	0256	36.9298	2104.37	.	420.87
31500	S		Insert emergency airway	0094	2.6945	153.54	48.58	30.71
31502	T		Change of windpipe airway	0121	2.2909	130.54	43.80	26.11
31505	T		Diagnostic laryngoscopy	0071	0.7396	42.14	11.31	8.43
31510	T		Laryngoscopy with biopsy	0074	16.1205	918.59	295.70	183.72
31511	T		Remove foreign body, larynx	0072	1.3903	79.22	21.27	15.84

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31512	T		Removal of larynx lesion	0074	16.1205	918.59	295.70	183.72
31513	T		Injection into vocal cord	0072	1.3903	79.22	21.27	15.84
31515	T		Laryngoscopy for aspiration	0074	16.1205	918.59	295.70	183.72
31520	T		Diagnostic laryngoscopy	0072	1.3903	79.22	21.27	15.84
31525	T		Diagnostic laryngoscopy	0074	16.1205	918.59	295.70	183.72
31526	T		Diagnostic laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31527	T		Laryngoscopy for treatment	0075	20.9362	1193.01	445.92	238.60
31528	T		Laryngoscopy and dilation	0074	16.1205	918.59	295.70	183.72
31529	T		Laryngoscopy and dilation	0074	16.1205	918.59	295.70	183.72
31530	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31531	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31535	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31536	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31540	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31541	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31545	T	NI	Remove vc lesion w/scope	0075	20.9362	1193.01	445.92	238.60
31546	T	NI	Remove vc lesion scope/graft	0075	20.9362	1193.01	445.92	238.60
31560	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31561	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31570	T		Laryngoscopy with injection	0074	16.1205	918.59	295.70	183.72
31571	T		Laryngoscopy with injection	0075	20.9362	1193.01	445.92	238.60
31575	T		Diagnostic laryngoscopy	0072	1.3903	79.22	21.27	15.84
31576	T		Laryngoscopy with biopsy	0075	20.9362	1193.01	445.92	238.60
31577	T		Remove foreign body, larynx	0073	4.1373	235.76	73.38	47.15
31578	T		Removal of larynx lesion	0075	20.9362	1193.01	445.92	238.60
31579	T		Diagnostic laryngoscopy	0073	4.1373	235.76	73.38	47.15
31580	T		Revision of larynx	0256	36.9298	2104.37	.	420.87
31582	T		Revision of larynx	0256	36.9298	2104.37	.	420.87
31584	C		Treat larynx fracture		.	.	.	.
31585	T		Treat larynx fracture	0253	15.9877	911.03	282.29	182.21
31586	T		Treat larynx fracture	0256	36.9298	2104.37	.	420.87
31587	C		Revision of larynx		.	.	.	.
31588	T		Revision of larynx	0256	36.9298	2104.37	.	420.87
31590	T		Reinnervate larynx	0256	36.9298	2104.37	.	420.87
31595	T		Larynx nerve surgery	0256	36.9298	2104.37	.	420.87
31599	T		Larynx surgery procedure	0251	1.9352	110.27	.	22.05
31600	T		Incision of windpipe	0254	23.3442	1330.22	321.35	266.04
31601	T		Incision of windpipe	0254	23.3442	1330.22	321.35	266.04
31603	T		Incision of windpipe	0252	6.5183	371.43	113.41	74.29
31605	T		Incision of windpipe	0252	6.5183	371.43	113.41	74.29
31610	T		Incision of windpipe	0254	23.3442	1330.22	321.35	266.04
31611	T		Surgery/speech prosthesis	0254	23.3442	1330.22	321.35	266.04
31612	T		Puncture/clear windpipe	0254	23.3442	1330.22	321.35	266.04

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31613	T		Repair windpipe opening	0254	23.3442	1330.22	321.35	266.04
31614	T		Repair windpipe opening	0256	36.9298	2104.37	.	420.87
31615	T		Visualization of windpipe	0076	9.4372	537.76	189.82	107.55
31620	S	NI	Endobronchial us add-on	0670	30.3817	1731.24	542.37	346.25
31622	T		Dx bronchoscope/wash	0076	9.4372	537.76	189.82	107.55
31623	T		Dx bronchoscope/brush	0076	9.4372	537.76	189.82	107.55
31624	T		Dx bronchoscope/lavage	0076	9.4372	537.76	189.82	107.55
31625	T		Bronchoscopy w/biopsy(s)	0076	9.4372	537.76	189.82	107.55
31628	T		Bronchoscopy/lung bx, each	0076	9.4372	537.76	189.82	107.55
31629	T		Bronchoscopy/needle bx, each	0076	9.4372	537.76	189.82	107.55
31630	T		Bronchoscopy dilate/fx repr	0415	21.9912	1253.12	459.92	250.62
31631	T		Bronchoscopy, dilate w/stent	0415	21.9912	1253.12	459.92	250.62
31632	T		Bronchoscopy/lung bx, add'l	0076	9.4372	537.76	189.82	107.55
31633	T		Bronchoscopy/needle bx add'l	0076	9.4372	537.76	189.82	107.55
31635	T		Bronchoscopy w/fb removal	0076	9.4372	537.76	189.82	107.55
31636	T	NI	Bronchoscopy, bronch stents	0415	21.9912	1253.12	459.92	250.62
31637	T	NI	Bronchoscopy, stent add-on	0076	9.4372	537.76	189.82	107.55
31638	T	NI	Bronchoscopy, revise stent	0415	21.9912	1253.12	459.92	250.62
31640	T		Bronchoscopy w/tumor excise	0415	21.9912	1253.12	459.92	250.62
31641	T		Bronchoscopy, treat blockage	0415	21.9912	1253.12	459.92	250.62
31643	T		Diag bronchoscope/catheter	0076	9.4372	537.76	189.82	107.55
31645	T		Bronchoscopy, clear airways	0076	9.4372	537.76	189.82	107.55
31646	T		Bronchoscopy, reclear airway	0076	9.4372	537.76	189.82	107.55
31656	T		Bronchoscopy, inj for x-ray	0076	9.4372	537.76	189.82	107.55
31700	T		Insertion of airway catheter	0072	1.3903	79.22	21.27	15.84
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	4.1373	235.76	73.38	47.15
31720	T		Clearance of airways	0071	0.7396	42.14	11.31	8.43
31725	C		Clearance of airways		.	.	.	.
31730	T		Intro, windpipe wire/tube	0073	4.1373	235.76	73.38	47.15
31750	T		Repair of windpipe	0256	36.9298	2104.37	.	420.87
31755	T		Repair of windpipe	0256	36.9298	2104.37	.	420.87
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	23.3442	1330.22	321.35	266.04
31786	C		Remove windpipe lesion		.	.	.	.
31800	C		Repair of windpipe injury		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31805	C		Repair of windpipe injury		.	.	.	.
31820	T		Closure of windpipe lesion	0253	15.9877	911.03	282.29	182.21
31825	T		Repair of windpipe defect	0254	23.3442	1330.22	321.35	266.04
31830	T		Revise windpipe scar	0254	23.3442	1330.22	321.35	266.04
31899	T		Airways surgical procedure	0076	9.4372	537.76	189.82	107.55
32000	T		Drainage of chest	0070	3.3166	188.99	.	37.80
32002	T		Treatment of collapsed lung	0070	3.3166	188.99	.	37.80
32005	T		Treat lung lining chemically	0070	3.3166	188.99	.	37.80
32019	T	NI	Insert pleural catheter	0070	3.3166	188.99	.	37.80
32020	T		Insertion of chest tube	0070	3.3166	188.99	.	37.80
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	3.3166	188.99	.	37.80
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	0685	5.8806	335.09	115.47	67.02
32402	C		Open biopsy chest lining		.	.	.	.
32405	T		Biopsy, lung or mediastinum	0685	5.8806	335.09	115.47	67.02
32420	T		Puncture/clear lung	0070	3.3166	188.99	.	37.80
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32501	C		Repair bronchus add-on		.	.	.	.
32520	C		Remove lung & revise chest		.	.	.	.
32522	C		Remove lung & revise chest		.	.	.	.
32525	C		Remove lung & revise chest		.	.	.	.
32540	C		Removal of lung lesion		.	.	.	.
32601	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32602	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32603	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32604	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32605	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32606	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
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		.	.	.	.
32855	C	NI	Prepare donor lung, single		.	.	.	.
32856	C	NI	Prepare donor lung, double		.	.	.	.
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	3.3166	188.99	.	37.80

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32997	C		Total lung lavage		.	.	.	.
32999	T		Chest surgery procedure	0070	3.3166	188.99	.	37.80
33010	T		Drainage of heart sac	0070	3.3166	188.99	.	37.80
33011	T		Repeat drainage of heart sac	0070	3.3166	188.99	.	37.80
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	109.5827	6244.35	1682.28	1248.87
33207	T		Insertion of heart pacemaker	0089	109.5827	6244.35	1682.28	1248.87
33208	T		Insertion of heart pacemaker	0655	135.1464	7701.05	.	1540.21
33210	T		Insertion of heart electrode	0106	55.1440	3142.27	.	628.45
33211	T		Insertion of heart electrode	0106	55.1440	3142.27	.	628.45
33212	T		Insertion of pulse generator	0090	90.5432	5159.42	1612.80	1031.88
33213	T		Insertion of pulse generator	0654	105.3805	6004.90	.	1200.98
33214	T		Upgrade of pacemaker system	0655	135.1464	7701.05	.	1540.21
33215	T		Reposition pacing-defib lead	0105	21.5449	1227.69	370.40	245.54
33216	T		Insert lead pace-defib, one	0106	55.1440	3142.27	.	628.45
33217	T		Insert lead pace-defib, dual	0106	55.1440	3142.27	.	628.45
33218	T		Repair lead pace-defib, one	0106	55.1440	3142.27	.	628.45
33220	T		Repair lead pace-defib, dual	0106	55.1440	3142.27	.	628.45
33222	T		Revise pocket, pacemaker	0027	16.8355	959.34	329.72	191.87
33223	T		Revise pocket, pacing-defib	0027	16.8355	959.34	329.72	191.87
33224	T		Insert pacing lead & connect	0418	74.5141	4246.04	.	849.21
33225	S		L ventric pacing lead add-on	1525	.	3750.00	.	750.00
33226	T		Reposition l ventric lead	0105	21.5449	1227.69	370.40	245.54
33233	T		Removal of pacemaker system	0105	21.5449	1227.69	370.40	245.54
33234	T		Removal of pacemaker system	0105	21.5449	1227.69	370.40	245.54
33235	T		Removal pacemaker electrode	0105	21.5449	1227.69	370.40	245.54
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	21.5449	1227.69	370.40	245.54
33243	C		Remove eltrd/thoracotomy		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33244	T		Remove eltrd, transven	0105	21.5449	1227.69	370.40	245.54
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	63.9488	3643.99	.	728.80
33284	T		Remove pat-active ht record	0109	7.5181	428.40	131.49	85.68
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
33933	C	NI	Prepare donor heart/lung		.	.	.	.
33935	C		Transplantation, heart/lung		.	.	.	.
33940	C		Removal of donor heart		.	.	.	.
33944	C	NI	Prepare 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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	3.3166	188.99	.	37.80
34001	C		Removal of artery clot		.	.	.	.
34051	C		Removal of artery clot		.	.	.	.
34101	T		Removal of artery clot	0088	36.0282	2052.99	655.22	410.60
34111	T		Removal of arm artery clot	0088	36.0282	2052.99	655.22	410.60
34151	C		Removal of artery clot		.	.	.	.
34201	T		Removal of artery clot	0088	36.0282	2052.99	655.22	410.60
34203	T		Removal of leg artery clot	0088	36.0282	2052.99	655.22	410.60
34401	C		Removal of vein clot		.	.	.	.
34421	T		Removal of vein clot	0088	36.0282	2052.99	655.22	410.60
34451	C		Removal of vein clot		.	.	.	.
34471	T		Removal of vein clot	0088	36.0282	2052.99	655.22	410.60
34490	T		Removal of vein clot	0088	36.0282	2052.99	655.22	410.60
34501	T		Repair valve, femoral vein	0088	36.0282	2052.99	655.22	410.60
34502	C		Reconstruct vena cava		.	.	.	.
34510	T		Transposition of vein valve	0088	36.0282	2052.99	655.22	410.60
34520	T		Cross-over vein graft	0088	36.0282	2052.99	655.22	410.60
34530	T		Leg vein fusion	0088	36.0282	2052.99	655.22	410.60
34800	C		Endovas aaa repr w/sm tube		.	.	.	.
34802	C		Endovas aaa repr w/2-p part		.	.	.	.
34803	C	NI	Endovas aaa repr w/3-p part		.	.	.	.
34804	C		Endovas aaa repr w/1-p part		.	.	.	.
34805	C		Endovas aaa repr w/long tube		.	.	.	.
34808	C		Endovas iliac a device addon		.	.	.	.
34812	C		Xpose for endoprosth, femorl		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35002	C		Repair artery rupture, neck		.	.	.	.
35005	C		Repair defect of artery		.	.	.	.
35011	T		Repair defect of artery	0653	28.0840	1600.31	.	320.06
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	D		Repair defect of artery		.	.	.	.
35162	D		Repair artery rupture		.	.	.	.
35180	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35182	C		Repair blood vessel lesion		.	.	.	.
35184	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35188	T		Repair blood vessel lesion	0088	36.0282	2052.99	655.22	410.60
35189	C		Repair blood vessel lesion		.	.	.	.
35190	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35201	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35206	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35207	T		Repair blood vessel lesion	0088	36.0282	2052.99	655.22	410.60
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	24.0351	1369.59	277.34	273.92
35231	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35236	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35241	C		Repair blood vessel lesion		.	.	.	.
35246	C		Repair blood vessel lesion		.	.	.	.
35251	C		Repair blood vessel lesion		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35256	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35261	T		Repair blood vessel lesion	0653	28.0840	1600.31	.	320.06
35266	T		Repair blood vessel lesion	0653	28.0840	1600.31	.	320.06
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	28.0840	1600.31	.	320.06
35301	C		Rechanneling of artery		.	.	.	.
35311	C		Rechanneling of artery		.	.	.	.
35321	T		Rechanneling of artery	0093	24.0351	1369.59	277.34	273.92
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	32.7548	1866.47	.	373.29
35459	T		Repair arterial blockage	0081	32.7548	1866.47	.	373.29
35460	T		Repair venous blockage	0081	32.7548	1866.47	.	373.29
35470	T		Repair arterial blockage	0081	32.7548	1866.47	.	373.29
35471	T		Repair arterial blockage	0081	32.7548	1866.47	.	373.29
35472	T		Repair arterial blockage	0081	32.7548	1866.47	.	373.29
35473	T		Repair arterial blockage	0081	32.7548	1866.47	.	373.29
35474	T		Repair arterial blockage	0081	32.7548	1866.47	.	373.29
35475	T		Repair arterial blockage	0081	32.7548	1866.47	.	373.29
35476	T		Repair venous blockage	0081	32.7548	1866.47	.	373.29
35480	C		Atherectomy, open		.	.	.	.
35481	C		Atherectomy, open		.	.	.	.
35482	C		Atherectomy, open		.	.	.	.
35483	C		Atherectomy, open		.	.	.	.
35484	T		Atherectomy, open	0081	32.7548	1866.47	.	373.29
35485	T		Atherectomy, open	0081	32.7548	1866.47	.	373.29
35490	T		Atherectomy, percutaneous	0081	32.7548	1866.47	.	373.29
35491	T		Atherectomy, percutaneous	0081	32.7548	1866.47	.	373.29

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35492	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35493	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35494	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35495	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35500	N		Harvest vein for bypass					
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					
35572	N		Harvest femoropopliteal vein					
35582	D		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					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	24.0351	1369.59	277.34	273.92
35686	T		Bypass graft/av fist patency	0093	24.0351	1369.59	277.34	273.92
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		.	.	.	.
35761	T		Exploration of artery/vein	0115	25.6621	1462.30	459.35	292.46
35800	C		Explore neck vessels		.	.	.	.
35820	C		Explore chest vessels		.	.	.	.
35840	C		Explore abdominal vessels		.	.	.	.
35860	T		Explore limb vessels	0093	24.0351	1369.59	277.34	273.92
35870	C		Repair vessel graft defect		.	.	.	.
35875	T		Removal of clot in graft	0088	36.0282	2052.99	655.22	410.60
35876	T		Removal of clot in graft	0088	36.0282	2052.99	655.22	410.60

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35879	T		Revise graft w/vein	0088	36.0282	2052.99	655.22	410.60
35881	T		Revise graft w/vein	0088	36.0282	2052.99	655.22	410.60
35901	C		Excision, graft, neck		.	.	.	.
35903	T		Excision, graft, extremity	0115	25.6621	1462.30	459.35	292.46
35905	C		Excision, graft, thorax		.	.	.	.
35907	C		Excision, graft, abdomen		.	.	.	.
36000	N		Place needle in vein		.	.	.	.
36002	S		Pseudoaneurysm injection trt	0267	2.4250	138.18	62.18	27.64
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	125.9746	7178.41	.	1435.68
36261	T		Revision of infusion pump	0124	19.9665	1137.75	.	227.55
36262	T		Removal of infusion pump	0124	19.9665	1137.75	.	227.55
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		Routine venipuncture		.	.	.	.
36416	E		Capillary blood draw		.	.	.	.
36420	T		Vein access cutdown < 1 yr	0035	0.2889	16.46	.	3.29
36425	T		Vein access cutdown > 1 yr	0035	0.2889	16.46	.	3.29
36430	S		Blood transfusion service	0110	3.7809	215.45	.	43.09
36440	S		Bl push transfuse, 2 yr or <	0110	3.7809	215.45	.	43.09

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36450	S		Bl exchange/transfuse, nb	0110	3.7809	215.45	.	43.09
36455	S		Bl exchange/transfuse non-nb	0110	3.7809	215.45	.	43.09
36460	S		Transfusion service, fetal	0110	3.7809	215.45	.	43.09
36468	T		Injection(s), spider veins	0098	1.3424	76.49	.	15.30
36469	T		Injection(s), spider veins	0098	1.3424	76.49	.	15.30
36470	T		Injection therapy of vein	0098	1.3424	76.49	.	15.30
36471	T		Injection therapy of veins	0098	1.3424	76.49	.	15.30
36475	T	NI	Endovenous rf, 1st vein	0092	26.9952	1538.27	505.37	307.65
36476	T	NI	Endovenous rf, vein add-on	0092	26.9952	1538.27	505.37	307.65
36478	T	NI	Endovenous laser, 1st vein	0092	26.9952	1538.27	505.37	307.65
36479	T	NI	Endovenous laser vein addon	0092	26.9952	1538.27	505.37	307.65
36481	N		Insertion of catheter, vein		.	.	.	.
36500	N		Insertion of catheter, vein		.	.	.	.
36510	C		Insertion of catheter, vein		.	.	.	.
36511	S		Apheresis wbc	0111	12.7259	725.16	200.18	145.03
36512	S		Apheresis rbc	0111	12.7259	725.16	200.18	145.03
36513	S		Apheresis platelets	0111	12.7259	725.16	200.18	145.03
36514	S		Apheresis plasma	0111	12.7259	725.16	200.18	145.03
36515	S		Apheresis, adsorp/reinfuse	0111	12.7259	725.16	200.18	145.03
36516	S		Apheresis, selective	0112	37.3315	2127.26	612.47	425.45
36522	S		Photopheresis	0112	37.3315	2127.26	612.47	425.45
36540	N		Collect blood venous device		.	.	.	.
36550	T		Declot vascular device	0677	2.5535	145.51	.	29.10
36555	T		Insert non-tunnel cv cath	0187	3.8526	219.53	.	43.91
36556	T		Insert non-tunnel cv cath	0187	3.8526	219.53	.	43.91
36557	T		Insert tunneled cv cath	0032	10.7448	612.27	.	122.45
36558	T		Insert tunneled cv cath	0032	10.7448	612.27	.	122.45
36560	T		Insert tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36561	T		Insert tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36563	T		Insert tunneled cv cath	0119	125.9746	7178.41	.	1435.68
36565	T		Insert tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36566	T		Insert tunneled cv cath	1564	.	4750.00	.	950.00
36568	T		Insert picc cath	0187	3.8526	219.53	.	43.91
36569	T		Insert picc cath	0187	3.8526	219.53	.	43.91
36570	T		Insert picvad cath	0032	10.7448	612.27	.	122.45
36571	T		Insert picvad cath	0032	10.7448	612.27	.	122.45
36575	T		Repair tunneled cv cath	0187	3.8526	219.53	.	43.91
36576	T		Repair tunneled cv cath	0187	3.8526	219.53	.	43.91
36578	T		Replace tunneled cv cath	0187	3.8526	219.53	.	43.91
36580	T		Replace cvad cath	0187	3.8526	219.53	.	43.91
36581	T		Replace tunneled cv cath	0032	10.7448	612.27	.	122.45
36582	T		Replace tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36583	T		Replace tunneled cv cath	0119	125.9746	7178.41	.	1435.68

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36584	T		Replace picc cath	0187	3.8526	219.53	.	43.91
36585	T		Replace picvad cath	0032	10.7448	612.27	.	122.45
36589	T		Removal tunneled cv cath	0109	7.5181	428.40	131.49	85.68
36590	T		Removal tunneled cv cath	0187	3.8526	219.53	.	43.91
36595	T		Mech remov tunneled cv cath	0187	3.8526	219.53	.	43.91
36596	T		Mech remov tunneled cv cath	0187	3.8526	219.53	.	43.91
36597	T		Reposition venous catheter	0187	3.8526	219.53	.	43.91
36600	N		Withdrawal of arterial blood		.	.	.	.
36620	N		Insertion catheter, artery		.	.	.	.
36625	N		Insertion catheter, artery		.	.	.	.
36640	T		Insertion catheter, artery	0032	10.7448	612.27	.	122.45
36660	C		Insertion catheter, artery		.	.	.	.
36680	T		Insert needle, bone cavity	0120	1.9620	111.80	28.21	22.36
36800	T		Insertion of cannula	0115	25.6621	1462.30	459.35	292.46
36810	T		Insertion of cannula	0115	25.6621	1462.30	459.35	292.46
36815	T		Insertion of cannula	0115	25.6621	1462.30	459.35	292.46
36818	T	NI	Av fuse, uppr arm, cephalic	0088	36.0282	2052.99	655.22	410.60
36819	T		Av fuse, uppr arm, basilic	0088	36.0282	2052.99	655.22	410.60
36820	T		Av fusion/forearm vein	0088	36.0282	2052.99	655.22	410.60
36821	T		Av fusion direct any site	0088	36.0282	2052.99	655.22	410.60
36822	C		Insertion of cannula(s)		.	.	.	.
36823	C		Insertion of cannula(s)		.	.	.	.
36825	T		Artery-vein autograft	0088	36.0282	2052.99	655.22	410.60
36830	T		Artery-vein nonautograft	0088	36.0282	2052.99	655.22	410.60
36831	T		Open thrombect av fistula	0088	36.0282	2052.99	655.22	410.60
36832	T		Av fistula revision, open	0088	36.0282	2052.99	655.22	410.60
36833	T		Av fistula revision	0088	36.0282	2052.99	655.22	410.60
36834	T		Repair A-V aneurysm	0088	36.0282	2052.99	655.22	410.60
36835	T		Artery to vein shunt	0115	25.6621	1462.30	459.35	292.46
36838	T		Dist revas ligation, hemo	0088	36.0282	2052.99	655.22	410.60
36860	T		External cannula declotting	0677	2.5535	145.51	.	29.10
36861	T		Cannula declotting	0115	25.6621	1462.30	459.35	292.46
36870	T		Percut thrombect av fistula	0653	28.0840	1600.31	.	320.06
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		.	.	.	.
37200	T		Transcatheter biopsy	0685	5.8806	335.09	115.47	67.02
37201	T		Transcatheter therapy infuse	0676	4.2729	243.48	.	48.70

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37202	T		Transcatheter therapy infuse	0677	2.5535	145.51	.	29.10
37203	T		Transcatheter retrieval	0103	13.1337	748.40	223.63	149.68
37204	T		Transcatheter occlusion	0115	25.6621	1462.30	459.35	292.46
37205	T		Transcath iv stent, percut	0229	62.1357	3540.68	771.23	708.14
37206	T		Transcath iv stent/perc addl	0229	62.1357	3540.68	771.23	708.14
37207	T		Transcath iv stent, open	0229	62.1357	3540.68	771.23	708.14
37208	T		Transcath iv stent/open addl	0229	62.1357	3540.68	771.23	708.14
37209	T		Exchange arterial catheter	0103	13.1337	748.40	223.63	149.68
37215	C	NI	Transcath stent, cca w/eps		.	.	.	.
37216	C	NI	Transcath stent, cca w/o eps		.	.	.	.
37250	S		Iv us first vessel add-on	0416	4.8182	274.56	99.43	54.91
37251	S		Iv us each add vessel add-on	0416	4.8182	274.56	99.43	54.91
37500	T		Endoscopy ligate perf veins	0092	26.9952	1538.27	505.37	307.65
37501	T		Vascular endoscopy procedure	0092	26.9952	1538.27	505.37	307.65
37565	T		Ligation of neck vein	0093	24.0351	1369.59	277.34	273.92
37600	T		Ligation of neck artery	0093	24.0351	1369.59	277.34	273.92
37605	T		Ligation of neck artery	0091	29.6620	1690.23	348.23	338.05
37606	T		Ligation of neck artery	0091	29.6620	1690.23	348.23	338.05
37607	T		Ligation of a-v fistula	0092	26.9952	1538.27	505.37	307.65
37609	T		Temporal artery procedure	0021	14.8872	848.32	219.48	169.66
37615	T		Ligation of neck artery	0091	29.6620	1690.23	348.23	338.05
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	29.6620	1690.23	348.23	338.05
37650	T		Revision of major vein	0091	29.6620	1690.23	348.23	338.05
37660	C		Revision of major vein		.	.	.	.
37700	T		Revise leg vein	0091	29.6620	1690.23	348.23	338.05
37720	T		Removal of leg vein	0092	26.9952	1538.27	505.37	307.65
37730	T		Removal of leg veins	0092	26.9952	1538.27	505.37	307.65
37735	T		Removal of leg veins/lesion	0092	26.9952	1538.27	505.37	307.65
37760	T		Ligation, leg veins, open	0091	29.6620	1690.23	348.23	338.05
37765	T		Phleb veins - extrem - to 20	0091	29.6620	1690.23	348.23	338.05
37766	T		Phleb veins - extrem 20+	0091	29.6620	1690.23	348.23	338.05
37780	T		Revision of leg vein	0091	29.6620	1690.23	348.23	338.05
37785	T		Ligate/divide/excise vein	0091	29.6620	1690.23	348.23	338.05
37788	C		Revascularization, penis		.	.	.	.
37790	T		Penile venous occlusion	0181	31.6828	1805.38	621.82	361.08
37799	T		Vascular surgery procedure	0035	0.2889	16.46	.	3.29
38100	C		Removal of spleen, total		.	.	.	.
38101	C		Removal of spleen, partial		.	.	.	.
38102	C		Removal of spleen, total		.	.	.	.
38115	C		Repair of ruptured spleen		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38120	T		Laparoscopy, splenectomy	0131	42.7526	2436.17	1001.89	487.23
38129	T		Laparoscope proc, spleen	0130	31.6832	1805.40	659.53	361.08
38200	N		Injection for spleen x-ray		.	.	.	.
38204	E		Bl donor search management		.	.	.	.
38205	S		Harvest allogenic stem cells	0111	12.7259	725.16	200.18	145.03
38206	S		Harvest auto stem cells	0111	12.7259	725.16	200.18	145.03
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	2.4779	141.20	.	28.24
38221	T		Bone marrow biopsy	0003	2.4779	141.20	.	28.24
38230	S		Bone marrow collection	0111	12.7259	725.16	200.18	145.03
38240	S		Bone marrow/stem transplant	0123	10.6755	608.32	.	121.66
38241	S		Bone marrow/stem transplant	0123	10.6755	608.32	.	121.66
38242	S		Lymphocyte infuse transplant	0111	12.7259	725.16	200.18	145.03
38300	T		Drainage, lymph node lesion	0008	19.3572	1103.03	.	220.61
38305	T		Drainage, lymph node lesion	0008	19.3572	1103.03	.	220.61
38308	T		Incision of lymph channels	0113	21.0044	1196.89	.	239.38
38380	C		Thoracic duct procedure		.	.	.	.
38381	C		Thoracic duct procedure		.	.	.	.
38382	C		Thoracic duct procedure		.	.	.	.
38500	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89	.	239.38
38505	T		Needle biopsy, lymph nodes	0005	3.7391	213.07	71.59	42.61
38510	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89	.	239.38
38520	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89	.	239.38
38525	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89	.	239.38
38530	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89	.	239.38
38542	T		Explore deep node(s), neck	0114	39.6713	2260.59	485.91	452.12
38550	T		Removal, neck/armpit lesion	0113	21.0044	1196.89	.	239.38
38555	T		Removal, neck/armpit lesion	0113	21.0044	1196.89	.	239.38
38562	C		Removal, pelvic lymph nodes		.	.	.	.
38564	C		Removal, abdomen lymph nodes		.	.	.	.
38570	T		Laparoscopy, lymph node biop	0131	42.7526	2436.17	1001.89	487.23
38571	T		Laparoscopy, lymphadenectomy	0132	61.3208	3494.24	1239.22	698.85
38572	T		Laparoscopy, lymphadenectomy	0131	42.7526	2436.17	1001.89	487.23
38589	T		Laparoscope proc, lymphatic	0130	31.6832	1805.40	659.53	361.08
38700	T		Removal of lymph nodes, neck	0113	21.0044	1196.89	.	239.38

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38720	T		Removal of lymph nodes, neck	0113	21.0044	1196.89	.	239.38
38724	C		Removal of lymph nodes, neck		.	.	.	.
38740	T		Remove armpit lymph nodes	0114	39.6713	2260.59	485.91	452.12
38745	T		Remove armpit lymph nodes	0114	39.6713	2260.59	485.91	452.12
38746	C		Remove thoracic lymph nodes		.	.	.	.
38747	C		Remove abdominal lymph nodes		.	.	.	.
38760	T		Remove groin lymph nodes	0113	21.0044	1196.89	.	239.38
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	3.7809	215.45	.	43.09
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	29.9158	1704.69	591.64	340.94
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		.	.	.	.
4000F	E	NI	Tobacco use txmnt counseling		.	.	.	.
4001F	E	NI	Tobacco use txmnt, pharmacol		.	.	.	.
4002F	E	NI	Statin therapy, rx		.	.	.	.
4006F	E	NI	Beta-blocker therapy, rx		.	.	.	.
4009F	E	NI	Ace inhibitor therapy, rx		.	.	.	.
4011F	E	NI	Oral antiplatelet tx, rx		.	.	.	.
40490	T		Biopsy of lip	0251	1.9352	110.27	.	22.05
40500	T		Partial excision of lip	0253	15.9877	911.03	282.29	182.21
40510	T		Partial excision of lip	0254	23.3442	1330.22	321.35	266.04
40520	T		Partial excision of lip	0253	15.9877	911.03	282.29	182.21
40525	T		Reconstruct lip with flap	0254	23.3442	1330.22	321.35	266.04

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40527	T		Reconstruct lip with flap	0254	23.3442	1330.22	321.35	266.04
40530	T		Partial removal of lip	0254	23.3442	1330.22	321.35	266.04
40650	T		Repair lip	0252	6.5183	371.43	113.41	74.29
40652	T		Repair lip	0252	6.5183	371.43	113.41	74.29
40654	T		Repair lip	0252	6.5183	371.43	113.41	74.29
40700	T		Repair cleft lip/nasal	0256	36.9298	2104.37	.	420.87
40701	T		Repair cleft lip/nasal	0256	36.9298	2104.37	.	420.87
40702	T		Repair cleft lip/nasal	0256	36.9298	2104.37	.	420.87
40720	T		Repair cleft lip/nasal	0256	36.9298	2104.37	.	420.87
40761	T		Repair cleft lip/nasal	0256	36.9298	2104.37	.	420.87
40799	T		Lip surgery procedure	0251	1.9352	110.27	.	22.05
40800	T		Drainage of mouth lesion	0251	1.9352	110.27	.	22.05
40801	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29
40804	X		Removal, foreign body, mouth	0340	0.6328	36.06	.	7.21
40805	T		Removal, foreign body, mouth	0252	6.5183	371.43	113.41	74.29
40806	T		Incision of lip fold	0251	1.9352	110.27	.	22.05
40808	T		Biopsy of mouth lesion	0251	1.9352	110.27	.	22.05
40810	T		Excision of mouth lesion	0253	15.9877	911.03	282.29	182.21
40812	T		Excise/repair mouth lesion	0253	15.9877	911.03	282.29	182.21
40814	T		Excise/repair mouth lesion	0253	15.9877	911.03	282.29	182.21
40816	T		Excision of mouth lesion	0254	23.3442	1330.22	321.35	266.04
40818	T		Excise oral mucosa for graft	0251	1.9352	110.27	.	22.05
40819	T		Excise lip or cheek fold	0252	6.5183	371.43	113.41	74.29
40820	T		Treatment of mouth lesion	0253	15.9877	911.03	282.29	182.21
40830	T		Repair mouth laceration	0251	1.9352	110.27	.	22.05
40831	T		Repair mouth laceration	0252	6.5183	371.43	113.41	74.29
40840	T		Reconstruction of mouth	0254	23.3442	1330.22	321.35	266.04
40842	T		Reconstruction of mouth	0254	23.3442	1330.22	321.35	266.04
40843	T		Reconstruction of mouth	0254	23.3442	1330.22	321.35	266.04
40844	T		Reconstruction of mouth	0256	36.9298	2104.37	.	420.87
40845	T		Reconstruction of mouth	0256	36.9298	2104.37	.	420.87
40899	T		Mouth surgery procedure	0251	1.9352	110.27	.	22.05
41000	T		Drainage of mouth lesion	0253	15.9877	911.03	282.29	182.21
41005	T		Drainage of mouth lesion	0251	1.9352	110.27	.	22.05
41006	T		Drainage of mouth lesion	0254	23.3442	1330.22	321.35	266.04
41007	T		Drainage of mouth lesion	0253	15.9877	911.03	282.29	182.21
41008	T		Drainage of mouth lesion	0253	15.9877	911.03	282.29	182.21
41009	T		Drainage of mouth lesion	0251	1.9352	110.27	.	22.05
41010	T		Incision of tongue fold	0252	6.5183	371.43	113.41	74.29
41015	T		Drainage of mouth lesion	0251	1.9352	110.27	.	22.05
41016	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29
41017	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29
41018	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41100	T		Biopsy of tongue	0252	6.5183	371.43	113.41	74.29
41105	T		Biopsy of tongue	0253	15.9877	911.03	282.29	182.21
41108	T		Biopsy of floor of mouth	0252	6.5183	371.43	113.41	74.29
41110	T		Excision of tongue lesion	0253	15.9877	911.03	282.29	182.21
41112	T		Excision of tongue lesion	0253	15.9877	911.03	282.29	182.21
41113	T		Excision of tongue lesion	0253	15.9877	911.03	282.29	182.21
41114	T		Excision of tongue lesion	0254	23.3442	1330.22	321.35	266.04
41115	T		Excision of tongue fold	0252	6.5183	371.43	113.41	74.29
41116	T		Excision of mouth lesion	0253	15.9877	911.03	282.29	182.21
41120	T		Partial removal of tongue	0254	23.3442	1330.22	321.35	266.04
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	1.9352	110.27	.	22.05
41251	T		Repair tongue laceration	0251	1.9352	110.27	.	22.05
41252	T		Repair tongue laceration	0252	6.5183	371.43	113.41	74.29
41500	T		Fixation of tongue	0254	23.3442	1330.22	321.35	266.04
41510	T		Tongue to lip surgery	0253	15.9877	911.03	282.29	182.21
41520	T		Reconstruction, tongue fold	0252	6.5183	371.43	113.41	74.29
41599	T		Tongue and mouth surgery	0251	1.9352	110.27	.	22.05
41800	T		Drainage of gum lesion	0251	1.9352	110.27	.	22.05
41805	T		Removal foreign body, gum	0254	23.3442	1330.22	321.35	266.04
41806	T		Removal foreign body,jawbone	0253	15.9877	911.03	282.29	182.21
41820	T		Excision, gum, each quadrant	0252	6.5183	371.43	113.41	74.29
41821	T		Excision of gum flap	0252	6.5183	371.43	113.41	74.29
41822	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41823	T		Excision of gum lesion	0254	23.3442	1330.22	321.35	266.04
41825	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41826	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41827	T		Excision of gum lesion	0254	23.3442	1330.22	321.35	266.04
41828	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41830	T		Removal of gum tissue	0253	15.9877	911.03	282.29	182.21
41850	T		Treatment of gum lesion	0253	15.9877	911.03	282.29	182.21
41870	T		Gum graft	0254	23.3442	1330.22	321.35	266.04
41872	T		Repair gum	0253	15.9877	911.03	282.29	182.21
41874	T		Repair tooth socket	0254	23.3442	1330.22	321.35	266.04
41899	T		Dental surgery procedure	0251	1.9352	110.27	.	22.05
42000	T		Drainage mouth roof lesion	0251	1.9352	110.27	.	22.05
42100	T		Biopsy roof of mouth	0252	6.5183	371.43	113.41	74.29

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42104	T		Excision lesion, mouth roof	0253	15.9877	911.03	282.29	182.21
42106	T		Excision lesion, mouth roof	0253	15.9877	911.03	282.29	182.21
42107	T		Excision lesion, mouth roof	0254	23.3442	1330.22	321.35	266.04
42120	T		Remove palate/lesion	0256	36.9298	2104.37		420.87
42140	T		Excision of uvula	0252	6.5183	371.43	113.41	74.29
42145	T		Repair palate, pharynx/uvula	0254	23.3442	1330.22	321.35	266.04
42160	T		Treatment mouth roof lesion	0253	15.9877	911.03	282.29	182.21
42180	T		Repair palate	0251	1.9352	110.27		22.05
42182	T		Repair palate	0256	36.9298	2104.37		420.87
42200	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42205	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42210	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42215	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42220	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42225	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42226	T		Lengthening of palate	0256	36.9298	2104.37		420.87
42227	T		Lengthening of palate	0256	36.9298	2104.37		420.87
42235	T		Repair palate	0253	15.9877	911.03	282.29	182.21
42260	T		Repair nose to lip fistula	0254	23.3442	1330.22	321.35	266.04
42280	T		Preparation, palate mold	0251	1.9352	110.27		22.05
42281	T		Insertion, palate prosthesis	0253	15.9877	911.03	282.29	182.21
42299	T		Palate/uvula surgery	0251	1.9352	110.27		22.05
42300	T		Drainage of salivary gland	0253	15.9877	911.03	282.29	182.21
42305	T		Drainage of salivary gland	0253	15.9877	911.03	282.29	182.21
42310	T		Drainage of salivary gland	0251	1.9352	110.27		22.05
42320	T		Drainage of salivary gland	0251	1.9352	110.27		22.05
42325	T		Create salivary cyst drain	0251	1.9352	110.27		22.05
42326	T		Create salivary cyst drain	0252	6.5183	371.43	113.41	74.29
42330	T		Removal of salivary stone	0253	15.9877	911.03	282.29	182.21
42335	T		Removal of salivary stone	0253	15.9877	911.03	282.29	182.21
42340	T		Removal of salivary stone	0253	15.9877	911.03	282.29	182.21
42400	T		Biopsy of salivary gland	0005	3.7391	213.07	71.59	42.61
42405	T		Biopsy of salivary gland	0253	15.9877	911.03	282.29	182.21
42408	T		Excision of salivary cyst	0253	15.9877	911.03	282.29	182.21
42409	T		Drainage of salivary cyst	0253	15.9877	911.03	282.29	182.21
42410	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42415	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42420	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42425	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	36.9298	2104.37		420.87
42450	T		Excise sublingual gland	0254	23.3442	1330.22	321.35	266.04
42500	T		Repair salivary duct	0254	23.3442	1330.22	321.35	266.04

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42505	T		Repair salivary duct	0256	36.9298	2104.37	.	420.87
42507	T		Parotid duct diversion	0256	36.9298	2104.37	.	420.87
42508	T		Parotid duct diversion	0256	36.9298	2104.37	.	420.87
42509	T		Parotid duct diversion	0256	36.9298	2104.37	.	420.87
42510	T		Parotid duct diversion	0256	36.9298	2104.37	.	420.87
42550	N		Injection for salivary x-ray		.	.	.	.
42600	T		Closure of salivary fistula	0253	15.9877	911.03	282.29	182.21
42650	T		Dilation of salivary duct	0252	6.5183	371.43	113.41	74.29
42660	T		Dilation of salivary duct	0251	1.9352	110.27	.	22.05
42665	T		Ligation of salivary duct	0254	23.3442	1330.22	321.35	266.04
42699	T		Salivary surgery procedure	0251	1.9352	110.27	.	22.05
42700	T		Drainage of tonsil abscess	0251	1.9352	110.27	.	22.05
42720	T		Drainage of throat abscess	0253	15.9877	911.03	282.29	182.21
42725	T		Drainage of throat abscess	0256	36.9298	2104.37	.	420.87
42800	T		Biopsy of throat	0253	15.9877	911.03	282.29	182.21
42802	T		Biopsy of throat	0253	15.9877	911.03	282.29	182.21
42804	T		Biopsy of upper nose/throat	0253	15.9877	911.03	282.29	182.21
42806	T		Biopsy of upper nose/throat	0254	23.3442	1330.22	321.35	266.04
42808	T		Excise pharynx lesion	0253	15.9877	911.03	282.29	182.21
42809	X		Remove pharynx foreign body	0340	0.6328	36.06	.	7.21
42810	T		Excision of neck cyst	0254	23.3442	1330.22	321.35	266.04
42815	T		Excision of neck cyst	0256	36.9298	2104.37	.	420.87
42820	T		Remove tonsils and adenoids	0258	21.7774	1240.94	437.25	248.19
42821	T		Remove tonsils and adenoids	0258	21.7774	1240.94	437.25	248.19
42825	T		Removal of tonsils	0258	21.7774	1240.94	437.25	248.19
42826	T		Removal of tonsils	0258	21.7774	1240.94	437.25	248.19
42830	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42831	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42835	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42836	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42842	T		Extensive surgery of throat	0254	23.3442	1330.22	321.35	266.04
42844	T		Extensive surgery of throat	0256	36.9298	2104.37	.	420.87
42845	C		Extensive surgery of throat		.	.	.	.
42860	T		Excision of tonsil tags	0258	21.7774	1240.94	437.25	248.19
42870	T		Excision of lingual tonsil	0258	21.7774	1240.94	437.25	248.19
42890	T		Partial removal of pharynx	0256	36.9298	2104.37	.	420.87
42892	T		Revision of pharyngeal walls	0256	36.9298	2104.37	.	420.87
42894	C		Revision of pharyngeal walls		.	.	.	.
42900	T		Repair throat wound	0252	6.5183	371.43	113.41	74.29
42950	T		Reconstruction of throat	0254	23.3442	1330.22	321.35	266.04
42953	C		Repair throat, esophagus		.	.	.	.
42955	T		Surgical opening of throat	0254	23.3442	1330.22	321.35	266.04
42960	T		Control throat bleeding	0250	1.3781	78.53	27.49	15.71

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42961	C		Control throat bleeding		.	.	.	.
42962	T		Control throat bleeding	0256	36.9298	2104.37	.	420.87
42970	T		Control nose/throat bleeding	0250	1.3781	78.53	27.49	15.71
42971	C		Control nose/throat bleeding		.	.	.	.
42972	T		Control nose/throat bleeding	0253	15.9877	911.03	282.29	182.21
42999	T		Throat surgery procedure	0251	1.9352	110.27	.	22.05
43020	T		Incision of esophagus	0252	6.5183	371.43	113.41	74.29
43030	T		Throat muscle surgery	0253	15.9877	911.03	282.29	182.21
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	23.3442	1330.22	321.35	266.04
43135	C		Removal of esophagus pouch		.	.	.	.
43200	T		Esophagus endoscopy	0141	8.0725	460.00	143.38	92.00
43201	T		Esoph scope w/submucous inj	0141	8.0725	460.00	143.38	92.00
43202	T		Esophagus endoscopy, biopsy	0141	8.0725	460.00	143.38	92.00
43204	T		Esoph scope w/sclerosis inj	0141	8.0725	460.00	143.38	92.00
43205	T		Esophagus endoscopy/ligation	0141	8.0725	460.00	143.38	92.00
43215	T		Esophagus endoscopy	0141	8.0725	460.00	143.38	92.00
43216	T		Esophagus endoscopy/lesion	0141	8.0725	460.00	143.38	92.00
43217	T		Esophagus endoscopy	0141	8.0725	460.00	143.38	92.00
43219	T		Esophagus endoscopy	0384	27.0831	1543.28	335.19	308.66
43220	T		Esoph endoscopy, dilation	0141	8.0725	460.00	143.38	92.00
43226	T		Esoph endoscopy, dilation	0141	8.0725	460.00	143.38	92.00
43227	T		Esoph endoscopy, repair	0141	8.0725	460.00	143.38	92.00
43228	T		Esoph endoscopy, ablation	0422	22.1959	1264.79	425.00	252.96
43231	T		Esoph endoscopy w/us exam	0141	8.0725	460.00	143.38	92.00
43232	T		Esoph endoscopy w/us fn bx	0141	8.0725	460.00	143.38	92.00
43234	T		Upper GI endoscopy, exam	0141	8.0725	460.00	143.38	92.00
43235	T		Uppr gi endoscopy, diagnosis	0141	8.0725	460.00	143.38	92.00
43236	T		Uppr gi scope w/submuc inj	0141	8.0725	460.00	143.38	92.00
43237	T		Endoscopic us exam, esoph	0141	8.0725	460.00	143.38	92.00

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43238	T		Uppr gi endoscopy w/us fn bx	0141	8.0725	460.00	143.38	92.00
43239	T		Upper GI endoscopy, biopsy	0141	8.0725	460.00	143.38	92.00
43240	T		Esoph endoscope w/drain cyst	0141	8.0725	460.00	143.38	92.00
43241	T		Upper GI endoscopy with tube	0141	8.0725	460.00	143.38	92.00
43242	T		Uppr gi endoscopy w/us fn bx	0141	8.0725	460.00	143.38	92.00
43243	T		Upper gi endoscopy & inject	0141	8.0725	460.00	143.38	92.00
43244	T		Upper GI endoscopy/ligation	0141	8.0725	460.00	143.38	92.00
43245	T		Uppr gi scope dilate strictr	0141	8.0725	460.00	143.38	92.00
43246	T		Place gastrostomy tube	0141	8.0725	460.00	143.38	92.00
43247	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43248	T		Uppr gi endoscopy/guide wire	0141	8.0725	460.00	143.38	92.00
43249	T		Esoph endoscopy, dilation	0141	8.0725	460.00	143.38	92.00
43250	T		Upper GI endoscopy/tumor	0141	8.0725	460.00	143.38	92.00
43251	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43255	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43256	T		Uppr gi endoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
43257	T	NI	Uppr gi scope w/thrml txmnt	0422	22.1959	1264.79	425.00	252.96
43258	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43259	T		Endoscopic ultrasound exam	0141	8.0725	460.00	143.38	92.00
43260	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43261	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43262	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43263	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43264	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43265	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43267	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43268	T		Endo cholangiopancreatograph	0384	27.0831	1543.28	335.19	308.66
43269	T		Endo cholangiopancreatograph	0384	27.0831	1543.28	335.19	308.66
43271	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43272	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43280	T		Laparoscopy, fundoplasty	0132	61.3208	3494.24	1239.22	698.85
43289	T		Laparoscope proc, esoph	0130	31.6832	1805.40	659.53	361.08
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	6.4907	369.86	107.24	73.97
43453	T		Dilate esophagus	0140	6.4907	369.86	107.24	73.97
43456	T		Dilate esophagus	0140	6.4907	369.86	107.24	73.97
43458	T		Dilate esophagus	0140	6.4907	369.86	107.24	73.97
43460	C		Pressure treatment esophagus		.	.	.	.
43496	C		Free jejunum flap, microvasc		.	.	.	.
43499	T		Esophagus surgery procedure	0141	8.0725	460.00	143.38	92.00
43500	C		Surgical opening of stomach		.	.	.	.
43501	C		Surgical repair of stomach		.	.	.	.
43502	C		Surgical repair of stomach		.	.	.	.
43510	T		Surgical opening of stomach	0141	8.0725	460.00	143.38	92.00
43520	C		Incision of pyloric muscle		.	.	.	.
43600	T		Biopsy of stomach	0141	8.0725	460.00	143.38	92.00
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43644	C	NI	Lap gastric bypass/roux-en-y		.	.	.	.
43645	C	NI	Lap gastr bypass incl smll i		.	.	.	.
43651	T		Laparoscopy, vagus nerve	0132	61.3208	3494.24	1239.22	698.85
43652	T		Laparoscopy, vagus nerve	0132	61.3208	3494.24	1239.22	698.85
43653	T		Laparoscopy, gastrostomy	0131	42.7526	2436.17	1001.89	487.23
43659	T		Laparoscope proc, stom	0130	31.6832	1805.40	659.53	361.08
43750	T		Place gastrostomy tube	0141	8.0725	460.00	143.38	92.00
43752	X		Nasal/orogastric w/stent	0272	1.3880	79.09	35.59	15.82
43760	T		Change gastrostomy tube	0121	2.2909	130.54	43.80	26.11
43761	T		Reposition gastrostomy tube	0121	2.2909	130.54	43.80	26.11
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	0422	22.1959	1264.79	425.00	252.96
43831	T		Place gastrostomy tube	0141	8.0725	460.00	143.38	92.00
43832	C		Place gastrostomy tube		.	.	.	.
43840	C		Repair of stomach lesion		.	.	.	.
43842	C		V-band gastroplasty		.	.	.	.
43843	C		Gastroplasty w/o v-band		.	.	.	.
43845	C	NI	Gastroplasty duodenal switch		.	.	.	.
43846	C		Gastric bypass for obesity		.	.	.	.
43847	C		Gastric bypass incl small i		.	.	.	.
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	8.0725	460.00	143.38	92.00
43880	C		Repair stomach-bowel fistula		.	.	.	.
43999	T		Stomach surgery procedure	0141	8.0725	460.00	143.38	92.00
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	8.0725	460.00	143.38	92.00
44110	C		Excise intestine lesion(s)		.	.	.	.
44111	C		Excision of bowel lesion(s)		.	.	.	.
44120	C		Removal of small intestine		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
44137	C	NI	Remove intestinal allograft		.	.	.	.
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	42.7526	2436.17	1001.89	487.23
44201	T		Laparoscopy, jejunostomy	0131	42.7526	2436.17	1001.89	487.23
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	61.3208	3494.24	1239.22	698.85
44207	T		L colectomy/coloproctostomy	0132	61.3208	3494.24	1239.22	698.85
44208	T		L colectomy/coloproctostomy	0132	61.3208	3494.24	1239.22	698.85
44210	C		Laparo total proctocolectomy		.	.	.	.
44211	C		Laparo total proctocolectomy		.	.	.	.
44212	C		Laparo total proctocolectomy		.	.	.	.
44238	T		Laparoscope proc, intestine	0130	31.6832	1805.40	659.53	361.08
44239	T		Laparoscope proc, rectum	0130	31.6832	1805.40	659.53	361.08
44300	C		Open bowel to skin		.	.	.	.
44310	C		Ileostomy/jejunostomy		.	.	.	.
44312	T		Revision of ileostomy	0027	16.8355	959.34	329.72	191.87

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44314	C		Revision of ileostomy		.	.	.	.
44316	C		Devise bowel pouch		.	.	.	.
44320	C		Colostomy		.	.	.	.
44322	C		Colostomy with biopsies		.	.	.	.
44340	T		Revision of colostomy	0027	16.8355	959.34	329.72	191.87
44345	C		Revision of colostomy		.	.	.	.
44346	C		Revision of colostomy		.	.	.	.
44360	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44361	T		Small bowel endoscopy/biopsy	0142	8.7069	496.15	152.78	99.23
44363	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44364	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44365	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44366	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44369	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44370	T		Small bowel endoscopy/stent	0384	27.0831	1543.28	335.19	308.66
44372	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44373	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44376	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44377	T		Small bowel endoscopy/biopsy	0142	8.7069	496.15	152.78	99.23
44378	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44379	T		S bowel endoscope w/stent	0384	27.0831	1543.28	335.19	308.66
44380	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44382	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44383	T		Ileoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
44385	T		Endoscopy of bowel pouch	0143	8.5992	490.01	186.06	98.00
44386	T		Endoscopy, bowel pouch/biop	0143	8.5992	490.01	186.06	98.00
44388	T		Colonoscopy	0143	8.5992	490.01	186.06	98.00
44389	T		Colonoscopy with biopsy	0143	8.5992	490.01	186.06	98.00
44390	T		Colonoscopy for foreign body	0143	8.5992	490.01	186.06	98.00
44391	T		Colonoscopy for bleeding	0143	8.5992	490.01	186.06	98.00
44392	T		Colonoscopy & polypectomy	0143	8.5992	490.01	186.06	98.00
44393	T		Colonoscopy, lesion removal	0143	8.5992	490.01	186.06	98.00
44394	T		Colonoscopy w/snare	0143	8.5992	490.01	186.06	98.00
44397	T		Colonoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
44500	T		Intro, gastrointestinal tube	0121	2.2909	130.54	43.80	26.11
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
44715	C	NI	Prepare donor intestine		.	.	.	.
44720	C	NI	Prep donor intestine/venous		.	.	.	.
44721	C	NI	Prep donor intestine/artery		.	.	.	.
44799	T		Unlisted procedure intestine	0142	8.7069	496.15	152.78	99.23
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	T		Drain app abscess, percut	0037	9.3421	532.34	234.20	106.47
44950	C		Appendectomy		.	.	.	.
44955	C		Appendectomy add-on		.	.	.	.
44960	C		Appendectomy		.	.	.	.
44970	T		Laparoscopy, appendectomy	0131	42.7526	2436.17	1001.89	487.23
44979	T		Laparoscope proc, app	0130	31.6832	1805.40	659.53	361.08
45000	T		Drainage of pelvic abscess	0148	4.3129	245.76	63.38	49.15
45005	T		Drainage of rectal abscess	0155	13.1091	747.00	188.89	149.40
45020	T		Drainage of rectal abscess	0155	13.1091	747.00	188.89	149.40
45100	T		Biopsy of rectum	0149	17.7572	1011.86	293.06	202.37
45108	T		Removal of anorectal lesion	0150	23.1856	1321.19	437.12	264.24
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	17.7572	1011.86	293.06	202.37
45160	T		Excision of rectal lesion	0150	23.1856	1321.19	437.12	264.24

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45170	T		Excision of rectal lesion	0150	23.1856	1321.19	437.12	264.24
45190	T		Destruction, rectal tumor	0150	23.1856	1321.19	437.12	264.24
45300	T		Proctosigmoidoscopy dx	0146	4.3484	247.78	64.40	49.56
45303	T		Proctosigmoidoscopy dilate	0146	4.3484	247.78	64.40	49.56
45305	T		Proctosigmoidoscopy w/bx	0146	4.3484	247.78	64.40	49.56
45307	T		Proctosigmoidoscopy fb	0146	4.3484	247.78	64.40	49.56
45308	T		Proctosigmoidoscopy removal	0147	8.0251	457.29	.	91.46
45309	T		Proctosigmoidoscopy removal	0147	8.0251	457.29	.	91.46
45315	T		Proctosigmoidoscopy removal	0147	8.0251	457.29	.	91.46
45317	T		Proctosigmoidoscopy bleed	0147	8.0251	457.29	.	91.46
45320	T		Proctosigmoidoscopy ablate	0147	8.0251	457.29	.	91.46
45321	T		Proctosigmoidoscopy volvul	0147	8.0251	457.29	.	91.46
45327	T		Proctosigmoidoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
45330	T		Diagnostic sigmoidoscopy	0146	4.3484	247.78	64.40	49.56
45331	T		Sigmoidoscopy and biopsy	0146	4.3484	247.78	64.40	49.56
45332	T		Sigmoidoscopy w/fb removal	0146	4.3484	247.78	64.40	49.56
45333	T		Sigmoidoscopy & polypectomy	0147	8.0251	457.29	.	91.46
45334	T		Sigmoidoscopy for bleeding	0147	8.0251	457.29	.	91.46
45335	T		Sigmoidoscopy w/submuc inj	0147	8.0251	457.29	.	91.46
45337	T		Sigmoidoscopy & decompress	0147	8.0251	457.29	.	91.46
45338	T		Sigmoidoscopy w/tumr remove	0147	8.0251	457.29	.	91.46
45339	T		Sigmoidoscopy w/ablate tumr	0147	8.0251	457.29	.	91.46
45340	T		Sig w/balloon dilation	0147	8.0251	457.29	.	91.46
45341	T		Sigmoidoscopy w/ultrasound	0147	8.0251	457.29	.	91.46
45342	T		Sigmoidoscopy w/us guide bx	0147	8.0251	457.29	.	91.46
45345	T		Sigmoidoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
45355	T		Surgical colonoscopy	0143	8.5992	490.01	186.06	98.00
45378	T		Diagnostic colonoscopy	0143	8.5992	490.01	186.06	98.00
45379	T		Colonoscopy w/fb removal	0143	8.5992	490.01	186.06	98.00
45380	T		Colonoscopy and biopsy	0143	8.5992	490.01	186.06	98.00
45381	T		Colonoscopy, submucous inj	0143	8.5992	490.01	186.06	98.00
45382	T		Colonoscopy/control bleeding	0143	8.5992	490.01	186.06	98.00
45383	T		Lesion removal colonoscopy	0143	8.5992	490.01	186.06	98.00
45384	T		Lesion remove colonoscopy	0143	8.5992	490.01	186.06	98.00
45385	T		Lesion removal colonoscopy	0143	8.5992	490.01	186.06	98.00
45386	T		Colonoscopy dilate stricture	0143	8.5992	490.01	186.06	98.00
45387	T		Colonoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
45391	T	NI	Colonoscopy w/endoscope us	0143	8.5992	490.01	186.06	98.00
45392	T	NI	Colonoscopy w/endoscopic fnb	0143	8.5992	490.01	186.06	98.00
45500	T		Repair of rectum	0149	17.7572	1011.86	293.06	202.37
45505	T		Repair of rectum	0150	23.1856	1321.19	437.12	264.24
45520	T		Treatment of rectal prolapse	0098	1.3424	76.49	.	15.30
45540	C		Correct rectal prolapse		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45541	T		Correct rectal prolapse	0150	23.1856	1321.19	437.12	264.24
45550	C		Repair rectum/remove sigmoid		.	.	.	.
45560	T		Repair of rectocele	0150	23.1856	1321.19	437.12	264.24
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	4.3129	245.76	63.38	49.15
45905	T		Dilation of anal sphincter	0149	17.7572	1011.86	293.06	202.37
45910	T		Dilation of rectal narrowing	0149	17.7572	1011.86	293.06	202.37
45915	T		Remove rectal obstruction	0148	4.3129	245.76	63.38	49.15
45999	T		Rectum surgery procedure	0148	4.3129	245.76	63.38	49.15
46020	T		Placement of seton	0150	23.1856	1321.19	437.12	264.24
46030	T		Removal of rectal marker	0148	4.3129	245.76	63.38	49.15
46040	T		Incision of rectal abscess	0149	17.7572	1011.86	293.06	202.37
46045	T		Incision of rectal abscess	0150	23.1856	1321.19	437.12	264.24
46050	T		Incision of anal abscess	0148	4.3129	245.76	63.38	49.15
46060	T		Incision of rectal abscess	0150	23.1856	1321.19	437.12	264.24
46070	T		Incision of anal septum	0155	13.1091	747.00	188.89	149.40
46080	T		Incision of anal sphincter	0149	17.7572	1011.86	293.06	202.37
46083	T		Incise external hemorrhoid	0148	4.3129	245.76	63.38	49.15
46200	T		Removal of anal fissure	0150	23.1856	1321.19	437.12	264.24
46210	T		Removal of anal crypt	0149	17.7572	1011.86	293.06	202.37
46211	T		Removal of anal crypts	0150	23.1856	1321.19	437.12	264.24
46220	T		Removal of anal tag	0149	17.7572	1011.86	293.06	202.37
46221	T		Ligation of hemorrhoid(s)	0148	4.3129	245.76	63.38	49.15
46230	T		Removal of anal tags	0149	17.7572	1011.86	293.06	202.37
46250	T		Hemorrhoidectomy	0150	23.1856	1321.19	437.12	264.24
46255	T		Hemorrhoidectomy	0150	23.1856	1321.19	437.12	264.24
46257	T		Remove hemorrhoids & fissure	0150	23.1856	1321.19	437.12	264.24
46258	T		Remove hemorrhoids & fistula	0150	23.1856	1321.19	437.12	264.24
46260	T		Hemorrhoidectomy	0150	23.1856	1321.19	437.12	264.24
46261	T		Remove hemorrhoids & fissure	0150	23.1856	1321.19	437.12	264.24
46262	T		Remove hemorrhoids & fistula	0150	23.1856	1321.19	437.12	264.24
46270	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46275	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46280	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46285	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46288	T		Repair anal fistula	0150	23.1856	1321.19	437.12	264.24
46320	T		Removal of hemorrhoid clot	0148	4.3129	245.76	63.38	49.15
46500	T		Injection into hemorrhoid(s)	0155	13.1091	747.00	188.89	149.40

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46600	X		Diagnostic anoscopy	0340	0.6328	36.06	.	7.21
46604	T		Anoscopy and dilation	0147	8.0251	457.29	.	91.46
46606	T		Anoscopy and biopsy	0147	8.0251	457.29	.	91.46
46608	T		Anoscopy, remove for body	0147	8.0251	457.29	.	91.46
46610	T		Anoscopy, remove lesion	0147	8.0251	457.29	.	91.46
46611	T		Anoscopy	0147	8.0251	457.29	.	91.46
46612	T		Anoscopy, remove lesions	0147	8.0251	457.29	.	91.46
46614	T		Anoscopy, control bleeding	0147	8.0251	457.29	.	91.46
46615	T		Anoscopy	0147	8.0251	457.29	.	91.46
46700	T		Repair of anal stricture	0150	23.1856	1321.19	437.12	264.24
46705	C		Repair of anal stricture		.	.	.	.
46706	T		Repr of anal fistula w/glue	0150	23.1856	1321.19	437.12	264.24
46715	C		Rep perf anoper fistu		.	.	.	.
46716	C		Rep perf anoper/vestib fistu		.	.	.	.
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	23.1856	1321.19	437.12	264.24
46751	C		Repair of anal sphincter		.	.	.	.
46753	T		Reconstruction of anus	0150	23.1856	1321.19	437.12	264.24
46754	T		Removal of suture from anus	0149	17.7572	1011.86	293.06	202.37
46760	T		Repair of anal sphincter	0150	23.1856	1321.19	437.12	264.24
46761	T		Repair of anal sphincter	0150	23.1856	1321.19	437.12	264.24
46762	T		Implant artificial sphincter	0150	23.1856	1321.19	437.12	264.24
46900	T		Destruction, anal lesion(s)	0016	2.8321	161.38	57.31	32.28
46910	T		Destruction, anal lesion(s)	0017	17.3894	990.90	227.84	198.18
46916	T		Cryosurgery, anal lesion(s)	0013	1.1380	64.85	14.20	12.97
46917	T		Laser surgery, anal lesions	0695	20.5193	1169.25	266.59	233.85
46922	T		Excision of anal lesion(s)	0695	20.5193	1169.25	266.59	233.85
46924	T		Destruction, anal lesion(s)	0695	20.5193	1169.25	266.59	233.85
46934	T		Destruction of hemorrhoids	0155	13.1091	747.00	188.89	149.40
46935	T		Destruction of hemorrhoids	0155	13.1091	747.00	188.89	149.40
46936	T		Destruction of hemorrhoids	0149	17.7572	1011.86	293.06	202.37
46937	T		Cryotherapy of rectal lesion	0149	17.7572	1011.86	293.06	202.37
46938	T		Cryotherapy of rectal lesion	0150	23.1856	1321.19	437.12	264.24
46940	T		Treatment of anal fissure	0149	17.7572	1011.86	293.06	202.37
46942	T		Treatment of anal fissure	0148	4.3129	245.76	63.38	49.15
46945	T		Ligation of hemorrhoids	0155	13.1091	747.00	188.89	149.40
46946	T		Ligation of hemorrhoids	0155	13.1091	747.00	188.89	149.40

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46947	T	NI	Hemorrhoidopexy by stapling	0150	23.1856	1321.19	437.12	264.24
46999	T		Anus surgery procedure	0148	4.3129	245.76	63.38	49.15
47000	T		Needle biopsy of liver	0685	5.8806	335.09	115.47	67.02
47001	N		Needle biopsy, liver add-on		.	.	.	.
47010	C		Open drainage, liver lesion		.	.	.	.
47011	T		Percut drain, liver lesion	0037	9.3421	532.34	234.20	106.47
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		.	.	.	.
47135	C		Transplantation of liver		.	.	.	.
47136	C		Transplantation of liver		.	.	.	.
47140	C		Partial removal, donor liver		.	.	.	.
47141	C		Partial removal, donor liver		.	.	.	.
47142	C		Partial removal, donor liver		.	.	.	.
47143	C	NI	Prep donor liver, whole		.	.	.	.
47144	C	NI	Prep donor liver, 3-segment		.	.	.	.
47145	C	NI	Prep donor liver, lobe split		.	.	.	.
47146	C	NI	Prep donor liver/venous		.	.	.	.
47147	C	NI	Prep donor liver/arterial		.	.	.	.
47300	C		Surgery for liver lesion		.	.	.	.
47350	C		Repair liver wound		.	.	.	.
47360	C		Repair liver wound		.	.	.	.
47361	C		Repair liver wound		.	.	.	.
47362	C		Repair liver wound		.	.	.	.
47370	T		Laparo ablate liver tumor rf	0131	42.7526	2436.17	1001.89	487.23
47371	T		Laparo ablate liver cryosurg	0131	42.7526	2436.17	1001.89	487.23
47379	T		Laparoscope procedure, liver	0130	31.6832	1805.40	659.53	361.08
47380	C		Open ablate liver tumor rf		.	.	.	.
47381	C		Open ablate liver tumor cryo		.	.	.	.
47382	T		Percut ablate liver rf	0423	30.7704	1753.39	.	350.68
47399	T		Liver surgery procedure	0002	0.9553	54.44	.	10.89
47400	C		Incision of liver duct		.	.	.	.
47420	C		Incision of bile duct		.	.	.	.
47425	C		Incision of bile duct		.	.	.	.
47460	C		Incise bile duct sphincter		.	.	.	.
47480	C		Incision of gallbladder		.	.	.	.
47490	T		Incision of gallbladder	0152	12.4585	709.92	.	141.98
47500	N		Injection for liver x-rays		.	.	.	.
47505	N		Injection for liver x-rays		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47510	T		Insert catheter, bile duct	0152	12.4585	709.92	.	141.98
47511	T		Insert bile duct drain	0152	12.4585	709.92	.	141.98
47525	T		Change bile duct catheter	0122	8.2869	472.21	96.84	94.44
47530	T		Revise/reinsert bile tube	0122	8.2869	472.21	96.84	94.44
47550	C		Bile duct endoscopy add-on		.	.	.	.
47552	T		Biliary endoscopy thru skin	0152	12.4585	709.92	.	141.98
47553	T		Biliary endoscopy thru skin	0152	12.4585	709.92	.	141.98
47554	T		Biliary endoscopy thru skin	0152	12.4585	709.92	.	141.98
47555	T		Biliary endoscopy thru skin	0152	12.4585	709.92	.	141.98
47556	T		Biliary endoscopy thru skin	0152	12.4585	709.92	.	141.98
47560	T		Laparoscopy w/cholangio	0130	31.6832	1805.40	659.53	361.08
47561	T		Laparo w/cholangio/biopsy	0130	31.6832	1805.40	659.53	361.08
47562	T		Laparoscopic cholecystectomy	0131	42.7526	2436.17	1001.89	487.23
47563	T		Laparo cholecystectomy/graph	0131	42.7526	2436.17	1001.89	487.23
47564	T		Laparo cholecystectomy/explr	0131	42.7526	2436.17	1001.89	487.23
47570	C		Laparo cholecystoenterostomy		.	.	.	.
47579	T		Laparoscope proc, biliary	0130	31.6832	1805.40	659.53	361.08
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	12.4585	709.92	.	141.98
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	12.4585	709.92	.	141.98
48000	C		Drainage of abdomen		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	5.8806	335.09	115.47	67.02
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	9.3421	532.34	234.20	106.47
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		.	.	.	.
48551	C	NI	Prep donor pancreas		.	.	.	.
48552	C	NI	Prep donor pancreas/venous		.	.	.	.
48554	E		Transpl allograft pancreas		.	.	.	.
48556	C		Removal, allograft pancreas		.	.	.	.
48999	T		Pancreas surgery procedure	0004	1.7081	97.33	22.36	19.47
49000	C		Exploration of abdomen		.	.	.	.
49002	C		Reopening of abdomen		.	.	.	.
49010	C		Exploration behind abdomen		.	.	.	.
49020	C		Drain abdominal abscess		.	.	.	.
49021	T		Drain abdominal abscess	0037	9.3421	532.34	234.20	106.47
49040	C		Drain, open, abdom abscess		.	.	.	.
49041	T		Drain, percut, abdom abscess	0037	9.3421	532.34	234.20	106.47
49060	C		Drain, open, retrop abscess		.	.	.	.
49061	T		Drain, percut, retroper absc	0037	9.3421	532.34	234.20	106.47
49062	C		Drain to peritoneal cavity		.	.	.	.
49080	T		Puncture, peritoneal cavity	0070	3.3166	188.99	.	37.80
49081	T		Removal of abdominal fluid	0070	3.3166	188.99	.	37.80

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49085	T		Remove abdomen foreign body	0153	24.2544	1382.09	410.87	276.42
49180	T		Biopsy, abdominal mass	0685	5.8806	335.09	115.47	67.02
49200	T		Removal of abdominal lesion	0130	31.6832	1805.40	659.53	361.08
49201	C		Remove abdom lesion, complex		.	.	.	.
49215	C		Excise sacral spine tumor		.	.	.	.
49220	C		Multiple surgery, abdomen		.	.	.	.
49250	T		Excision of umbilicus	0153	24.2544	1382.09	410.87	276.42
49255	C		Removal of omentum		.	.	.	.
49320	T		Diag laparo separate proc	0130	31.6832	1805.40	659.53	361.08
49321	T		Laparoscopy, biopsy	0130	31.6832	1805.40	659.53	361.08
49322	T		Laparoscopy, aspiration	0130	31.6832	1805.40	659.53	361.08
49323	T		Laparo drain lymphocele	0130	31.6832	1805.40	659.53	361.08
49329	T		Laparo proc, abdm/per/oment	0130	31.6832	1805.40	659.53	361.08
49400	N		Air injection into abdomen		.	.	.	.
49419	T		Insrt abdom cath for chemotx	0115	25.6621	1462.30	459.35	292.46
49420	T		Insert abdom drain, temp	0652	27.7725	1582.56	.	316.51
49421	T		Insert abdom drain, perm	0652	27.7725	1582.56	.	316.51
49422	T		Remove perm cannula/catheter	0105	21.5449	1227.69	370.40	245.54
49423	T		Exchange drainage catheter	0152	12.4585	709.92	.	141.98
49424	N		Assess cyst, contrast inject		.	.	.	.
49425	C		Insert abdomen-venous drain		.	.	.	.
49426	T		Revise abdomen-venous shunt	0153	24.2544	1382.09	410.87	276.42
49427	N		Injection, abdominal shunt		.	.	.	.
49428	C		Ligation of shunt		.	.	.	.
49429	T		Removal of shunt	0105	21.5449	1227.69	370.40	245.54
49491	T		Rpr hern preemie reduc	0154	28.0759	1599.85	464.85	319.97
49492	T		Rpr ing hern premie, blocked	0154	28.0759	1599.85	464.85	319.97
49495	T		Rpr ing hernia baby, reduc	0154	28.0759	1599.85	464.85	319.97
49496	T		Rpr ing hernia baby, blocked	0154	28.0759	1599.85	464.85	319.97
49500	T		Rpr ing hernia, init, reduce	0154	28.0759	1599.85	464.85	319.97
49501	T		Rpr ing hernia, init blocked	0154	28.0759	1599.85	464.85	319.97
49505	T		Prp i/hern init reduc >5 yr	0154	28.0759	1599.85	464.85	319.97
49507	T		Prp i/hern init block >5 yr	0154	28.0759	1599.85	464.85	319.97
49520	T		Rerepair ing hernia, reduce	0154	28.0759	1599.85	464.85	319.97
49521	T		Rerepair ing hernia, blocked	0154	28.0759	1599.85	464.85	319.97
49525	T		Repair ing hernia, sliding	0154	28.0759	1599.85	464.85	319.97
49540	T		Repair lumbar hernia	0154	28.0759	1599.85	464.85	319.97
49550	T		Rpr rem hernia, init, reduce	0154	28.0759	1599.85	464.85	319.97
49553	T		Rpr fem hernia, init blocked	0154	28.0759	1599.85	464.85	319.97
49555	T		Rerepair fem hernia, reduce	0154	28.0759	1599.85	464.85	319.97
49557	T		Rerepair fem hernia, blocked	0154	28.0759	1599.85	464.85	319.97
49560	T		Rpr ventral hern init, reduc	0154	28.0759	1599.85	464.85	319.97
49561	T		Rpr ventral hern init, block	0154	28.0759	1599.85	464.85	319.97

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49565	T		Rerepair ventrl hern, reduce	0154	28.0759	1599.85	464.85	319.97
49566	T		Rerepair ventrl hern, block	0154	28.0759	1599.85	464.85	319.97
49568	T		Hernia repair w/mesh	0154	28.0759	1599.85	464.85	319.97
49570	T		Rpr epigastric hern, reduce	0154	28.0759	1599.85	464.85	319.97
49572	T		Rpr epigastric hern, blocked	0154	28.0759	1599.85	464.85	319.97
49580	T		Rpr umbil hern, reduc < 5 yr	0154	28.0759	1599.85	464.85	319.97
49582	T		Rpr umbil hern, block < 5 yr	0154	28.0759	1599.85	464.85	319.97
49585	T		Rpr umbil hern, reduc > 5 yr	0154	28.0759	1599.85	464.85	319.97
49587	T		Rpr umbil hern, block > 5 yr	0154	28.0759	1599.85	464.85	319.97
49590	T		Repair spigelian hernia	0154	28.0759	1599.85	464.85	319.97
49600	T		Repair umbilical lesion	0154	28.0759	1599.85	464.85	319.97
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	42.7526	2436.17	1001.89	487.23
49651	T		Laparo hernia repair recur	0131	42.7526	2436.17	1001.89	487.23
49659	T		Laparo proc, hernia repair	0130	31.6832	1805.40	659.53	361.08
49900	C		Repair of abdominal wall		.	.	.	.
49904	C		Omental flap, extra-abdom		.	.	.	.
49905	C		Omental flap, intra-abdom		.	.	.	.
49906	C		Free omental flap, microvasc		.	.	.	.
49999	T		Abdomen surgery procedure	0153	24.2544	1382.09	410.87	276.42
50010	C		Exploration of kidney		.	.	.	.
50020	T		Renal abscess, open drain	0162	23.0182	1311.65	.	262.33
50021	T		Renal abscess, percut drain	0037	9.3421	532.34	234.20	106.47
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	36.0744	2055.63	.	411.13
50081	T		Removal of kidney stone	0163	36.0744	2055.63	.	411.13
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	5.8806	335.09	115.47	67.02
50205	C		Biopsy of kidney		.	.	.	.
50220	C		Remove kidney, open		.	.	.	.
50225	C		Removal kidney open, complex		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		Remove cadaver donor kidney		.	.	.	.
50320	C		Remove kidney, living donor		.	.	.	.
50323	C	NI	Prep cadaver renal allograft		.	.	.	.
50325	C	NI	Prep donor renal graft		.	.	.	.
50327	C	NI	Prep renal graft/venous		.	.	.	.
50328	C	NI	Prep renal graft/arterial		.	.	.	.
50329	C	NI	Prep renal graft/ureteral		.	.	.	.
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	5.8806	335.09	115.47	67.02
50391	T	NI	Instll rx agnt into rnal tub	0156	2.4782	141.22	40.52	28.24
50392	T		Insert kidney drain	0161	17.8851	1019.15	249.36	203.83
50393	T		Insert ureteral tube	0161	17.8851	1019.15	249.36	203.83
50394	N		Injection for kidney x-ray		.	.	.	.
50395	T		Create passage to kidney	0161	17.8851	1019.15	249.36	203.83
50396	T		Measure kidney pressure	0164	1.2563	71.59	17.59	14.32
50398	T		Change kidney tube	0122	8.2869	472.21	96.84	94.44
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	31.6832	1805.40	659.53	361.08
50542	T		Laparo ablate renal mass	0131	42.7526	2436.17	1001.89	487.23
50543	T		Laparo partial nephrectomy	0131	42.7526	2436.17	1001.89	487.23
50544	T		Laparoscopy, pyeloplasty	0130	31.6832	1805.40	659.53	361.08
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	31.6832	1805.40	659.53	361.08
50551	T		Kidney endoscopy	0160	6.7674	385.63	105.06	77.13

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50553	T		Kidney endoscopy	0161	17.8851	1019.15	249.36	203.83
50555	T		Kidney endoscopy & biopsy	0160	6.7674	385.63	105.06	77.13
50557	T		Kidney endoscopy & treatment	0162	23.0182	1311.65	.	262.33
50559	D		Renal endoscopy/radiotracer		.	.	.	.
50561	T		Kidney endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50562	T		Renal scope w/tumor resect	0160	6.7674	385.63	105.06	77.13
50570	T		Kidney endoscopy	0160	6.7674	385.63	105.06	77.13
50572	T		Kidney endoscopy	0160	6.7674	385.63	105.06	77.13
50574	T		Kidney endoscopy & biopsy	0160	6.7674	385.63	105.06	77.13
50575	T		Kidney endoscopy	0163	36.0744	2055.63	.	411.13
50576	T		Kidney endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50578	D		Renal endoscopy/radiotracer		.	.	.	.
50580	C		Kidney endoscopy & treatment		.	.	.	.
50590	T		Fragmenting of kidney stone	0169	44.6235	2542.78	1115.69	508.56
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	1.2563	71.59	17.59	14.32
50688	T		Change of ureter tube	0122	8.2869	472.21	96.84	94.44
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	42.7526	2436.17	1001.89	487.23
50947	T		Laparo new ureter/bladder	0131	42.7526	2436.17	1001.89	487.23
50948	T		Laparo new ureter/bladder	0131	42.7526	2436.17	1001.89	487.23
50949	T		Laparoscope proc, ureter	0130	31.6832	1805.40	659.53	361.08
50951	T		Endoscopy of ureter	0160	6.7674	385.63	105.06	77.13
50953	T		Endoscopy of ureter	0160	6.7674	385.63	105.06	77.13
50955	T		Ureter endoscopy & biopsy	0161	17.8851	1019.15	249.36	203.83
50957	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50959	D		Ureter endoscopy & tracer		.	.	.	.
50961	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50970	T		Ureter endoscopy	0160	6.7674	385.63	105.06	77.13
50972	T		Ureter endoscopy & catheter	0160	6.7674	385.63	105.06	77.13
50974	T		Ureter endoscopy & biopsy	0161	17.8851	1019.15	249.36	203.83
50976	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50978	D		Ureter endoscopy & tracer		.	.	.	.
50980	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
51000	T		Drainage of bladder	0164	1.2563	71.59	17.59	14.32
51005	T		Drainage of bladder	0164	1.2563	71.59	17.59	14.32
51010	T		Drainage of bladder	0165	16.0415	914.09	.	182.82
51020	T		Incise & treat bladder	0162	23.0182	1311.65	.	262.33
51030	T		Incise & treat bladder	0162	23.0182	1311.65	.	262.33
51040	T		Incise & drain bladder	0162	23.0182	1311.65	.	262.33
51045	T		Incise bladder/drain ureter	0160	6.7674	385.63	105.06	77.13
51050	T		Removal of bladder stone	0162	23.0182	1311.65	.	262.33
51060	C		Removal of ureter stone		.	.	.	.
51065	T		Remove ureter calculus	0162	23.0182	1311.65	.	262.33
51080	T		Drainage of bladder abscess	0007	12.4496	709.42	.	141.88
51500	T		Removal of bladder cyst	0154	28.0759	1599.85	464.85	319.97
51520	T		Removal of bladder lesion	0162	23.0182	1311.65	.	262.33
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51565	C		Revise bladder & ureter(s)		.	.	.	.
51570	C		Removal of bladder		.	.	.	.
51575	C		Removal of bladder & nodes		.	.	.	.
51580	C		Remove bladder/revise tract		.	.	.	.
51585	C		Removal of bladder & nodes		.	.	.	.
51590	C		Remove bladder/revise tract		.	.	.	.
51595	C		Remove bladder/revise tract		.	.	.	.
51596	C		Remove bladder/create pouch		.	.	.	.
51597	C		Removal of pelvic structures		.	.	.	.
51600	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	1.2563	71.59	17.59	14.32
51701	N		Insert bladder catheter		.	.	.	.
51702	N		Insert temp bladder cath		.	.	.	.
51703	N		Insert bladder cath, complex		.	.	.	.
51705	T		Change of bladder tube	0121	2.2909	130.54	43.80	26.11
51710	T		Change of bladder tube	0122	8.2869	472.21	96.84	94.44
51715	T		Endoscopic injection/implant	0167	28.4301	1620.03	549.80	324.01
51720	T		Treatment of bladder lesion	0156	2.4782	141.22	40.52	28.24
51725	T		Simple cystometrogram	0156	2.4782	141.22	40.52	28.24
51726	T		Complex cystometrogram	0156	2.4782	141.22	40.52	28.24
51736	T		Urine flow measurement	0164	1.2563	71.59	17.59	14.32
51741	T		Electro-uroflowmetry, first	0164	1.2563	71.59	17.59	14.32
51772	T		Urethra pressure profile	0164	1.2563	71.59	17.59	14.32
51784	T		Anal/urinary muscle study	0164	1.2563	71.59	17.59	14.32
51785	T		Anal/urinary muscle study	0164	1.2563	71.59	17.59	14.32
51792	T		Urinary reflex study	0164	1.2563	71.59	17.59	14.32
51795	T		Urine voiding pressure study	0164	1.2563	71.59	17.59	14.32
51797	T		Intraabdominal pressure test	0164	1.2563	71.59	17.59	14.32
51798	X		Us urine capacity measure	0340	0.6328	36.06	.	7.21
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	23.0182	1311.65	.	262.33
51900	C		Repair bladder/vagina lesion		.	.	.	.
51920	C		Close bladder-uterus fistula		.	.	.	.
51925	C		Hysterectomy/bladder repair		.	.	.	.
51940	C		Correction of bladder defect		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51960	C		Revision of bladder & bowel		.	.	.	.
51980	C		Construct bladder opening		.	.	.	.
51990	T		Laparo urethral suspension	0131	42.7526	2436.17	1001.89	487.23
51992	T		Laparo sling operation	0132	61.3208	3494.24	1239.22	698.85
52000	T		Cystoscopy	0160	6.7674	385.63	105.06	77.13
52001	T		Cystoscopy, removal of clots	0160	6.7674	385.63	105.06	77.13
52005	T		Cystoscopy & ureter catheter	0161	17.8851	1019.15	249.36	203.83
52007	T		Cystoscopy and biopsy	0161	17.8851	1019.15	249.36	203.83
52010	T		Cystoscopy & duct catheter	0160	6.7674	385.63	105.06	77.13
52204	T		Cystoscopy	0161	17.8851	1019.15	249.36	203.83
52214	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52224	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52234	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52235	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52240	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52250	T		Cystoscopy and radiotracer	0162	23.0182	1311.65	.	262.33
52260	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52265	T		Cystoscopy and treatment	0160	6.7674	385.63	105.06	77.13
52270	T		Cystoscopy & revise urethra	0161	17.8851	1019.15	249.36	203.83
52275	T		Cystoscopy & revise urethra	0161	17.8851	1019.15	249.36	203.83
52276	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52277	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52281	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52282	T		Cystoscopy, implant stent	0163	36.0744	2055.63	.	411.13
52283	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52285	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52290	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52300	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52301	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52305	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52310	T		Cystoscopy and treatment	0160	6.7674	385.63	105.06	77.13
52315	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52317	T		Remove bladder stone	0162	23.0182	1311.65	.	262.33
52318	T		Remove bladder stone	0162	23.0182	1311.65	.	262.33
52320	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52325	T		Cystoscopy, stone removal	0162	23.0182	1311.65	.	262.33
52327	T		Cystoscopy, inject material	0162	23.0182	1311.65	.	262.33
52330	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52332	T		Cystoscopy and treatment	0162	23.0182	1311.65	.	262.33
52334	T		Create passage to kidney	0162	23.0182	1311.65	.	262.33
52341	T		Cysto w/ureter stricture tx	0162	23.0182	1311.65	.	262.33
52342	T		Cysto w/up stricture tx	0162	23.0182	1311.65	.	262.33
52343	T		Cysto w/renal stricture tx	0162	23.0182	1311.65	.	262.33

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52344	T		Cysto/uretero, stricture tx	0162	23.0182	1311.65		262.33
52345	T		Cysto/uretero w/up stricture	0162	23.0182	1311.65		262.33
52346	T		Cystouretero w/renal strict	0162	23.0182	1311.65		262.33
52347	D		Cystoscopy, resect ducts					
52351	T		Cystouretero & or pyeloscope	0161	17.8851	1019.15	249.36	203.83
52352	T		Cystouretero w/stone remove	0162	23.0182	1311.65		262.33
52353	T		Cystouretero w/lithotripsy	0163	36.0744	2055.63		411.13
52354	T		Cystouretero w/biopsy	0162	23.0182	1311.65		262.33
52355	T		Cystouretero w/excise tumor	0162	23.0182	1311.65		262.33
52400	T		Cystouretero w/congen repr	0162	23.0182	1311.65		262.33
52402	T	NI	Cystourethro cut ejacul duct	0162	23.0182	1311.65		262.33
52450	T		Incision of prostate	0162	23.0182	1311.65		262.33
52500	T		Revision of bladder neck	0162	23.0182	1311.65		262.33
52510	T		Dilation prostatic urethra	0161	17.8851	1019.15	249.36	203.83
52601	T		Prostatectomy (TURP)	0163	36.0744	2055.63		411.13
52606	T		Control postop bleeding	0162	23.0182	1311.65		262.33
52612	T		Prostatectomy, first stage	0163	36.0744	2055.63		411.13
52614	T		Prostatectomy, second stage	0163	36.0744	2055.63		411.13
52620	T		Remove residual prostate	0163	36.0744	2055.63		411.13
52630	T		Remove prostate regrowth	0163	36.0744	2055.63		411.13
52640	T		Relieve bladder contracture	0162	23.0182	1311.65		262.33
52647	T		Laser surgery of prostate	0163	36.0744	2055.63		411.13
52648	T		Laser surgery of prostate	0163	36.0744	2055.63		411.13
52700	T		Drainage of prostate abscess	0162	23.0182	1311.65		262.33
53000	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53010	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53020	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53025	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53040	T		Drainage of urethra abscess	0167	28.4301	1620.03	549.80	324.01
53060	T		Drainage of urethra abscess	0166	17.7694	1012.55	218.73	202.51
53080	T		Drainage of urinary leakage	0166	17.7694	1012.55	218.73	202.51
53085	T		Drainage of urinary leakage	0166	17.7694	1012.55	218.73	202.51
53200	T		Biopsy of urethra	0166	17.7694	1012.55	218.73	202.51
53210	T		Removal of urethra	0168	30.7725	1753.51	405.60	350.70
53215	T		Removal of urethra	0166	17.7694	1012.55	218.73	202.51
53220	T		Treatment of urethra lesion	0168	30.7725	1753.51	405.60	350.70
53230	T		Removal of urethra lesion	0168	30.7725	1753.51	405.60	350.70
53235	T		Removal of urethra lesion	0166	17.7694	1012.55	218.73	202.51
53240	T		Surgery for urethra pouch	0168	30.7725	1753.51	405.60	350.70
53250	T		Removal of urethra gland	0166	17.7694	1012.55	218.73	202.51
53260	T		Treatment of urethra lesion	0166	17.7694	1012.55	218.73	202.51
53265	T		Treatment of urethra lesion	0166	17.7694	1012.55	218.73	202.51
53270	T		Removal of urethra gland	0167	28.4301	1620.03	549.80	324.01

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53275	T		Repair of urethra defect	0166	17.7694	1012.55	218.73	202.51
53400	T		Revise urethra, stage 1	0168	30.7725	1753.51	405.60	350.70
53405	T		Revise urethra, stage 2	0168	30.7725	1753.51	405.60	350.70
53410	T		Reconstruction of urethra	0168	30.7725	1753.51	405.60	350.70
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	30.7725	1753.51	405.60	350.70
53425	T		Reconstruct urethra, stage 2	0168	30.7725	1753.51	405.60	350.70
53430	T		Reconstruction of urethra	0168	30.7725	1753.51	405.60	350.70
53431	T		Reconstruct urethra/bladder	0168	30.7725	1753.51	405.60	350.70
53440	S		Male sling procedure	0385	69.6845	3970.83		794.17
53442	T		Remove/revise male sling	0167	28.4301	1620.03	549.80	324.01
53444	S		Insert tandem cuff	0385	69.6845	3970.83		794.17
53445	S		Insert uro/ves nck sphincter	0386	113.9823	6495.05		1299.01
53446	T		Remove uro sphincter	0168	30.7725	1753.51	405.60	350.70
53447	S		Remove/replace ur sphincter	0386	113.9823	6495.05		1299.01
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	30.7725	1753.51	405.60	350.70
53450	T		Revision of urethra	0168	30.7725	1753.51	405.60	350.70
53460	T		Revision of urethra	0166	17.7694	1012.55	218.73	202.51
53500	T		Urethrlys, transvag w/ scope	0168	30.7725	1753.51	405.60	350.70
53502	T		Repair of urethra injury	0166	17.7694	1012.55	218.73	202.51
53505	T		Repair of urethra injury	0167	28.4301	1620.03	549.80	324.01
53510	T		Repair of urethra injury	0166	17.7694	1012.55	218.73	202.51
53515	T		Repair of urethra injury	0168	30.7725	1753.51	405.60	350.70
53520	T		Repair of urethra defect	0168	30.7725	1753.51	405.60	350.70
53600	T		Dilate urethra stricture	0156	2.4782	141.22	40.52	28.24
53601	T		Dilate urethra stricture	0164	1.2563	71.59	17.59	14.32
53605	T		Dilate urethra stricture	0161	17.8851	1019.15	249.36	203.83
53620	T		Dilate urethra stricture	0165	16.0415	914.09		182.82
53621	T		Dilate urethra stricture	0164	1.2563	71.59	17.59	14.32
53660	T		Dilation of urethra	0164	1.2563	71.59	17.59	14.32
53661	T		Dilation of urethra	0164	1.2563	71.59	17.59	14.32
53665	T		Dilation of urethra	0166	17.7694	1012.55	218.73	202.51
53850	T		Prostatic microwave thermotx	0675	46.1821	2631.59		526.32
53852	T		Prostatic rf thermotx	0675	46.1821	2631.59		526.32
53853	T		Prostatic water thermother	0162	23.0182	1311.65		262.33
53899	T		Urology surgery procedure	0164	1.2563	71.59	17.59	14.32
54000	T		Slitting of prepuce	0166	17.7694	1012.55	218.73	202.51
54001	T		Slitting of prepuce	0166	17.7694	1012.55	218.73	202.51
54015	T		Drain penis lesion	0007	12.4496	709.42		141.88
54050	T		Destruction, penis lesion(s)	0013	1.1380	64.85	14.20	12.97
54055	T		Destruction, penis lesion(s)	0017	17.3894	990.90	227.84	198.18
54056	T		Cryosurgery, penis lesion(s)	0012	0.7477	42.61	11.18	8.52

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54057	T		Laser surg, penis lesion(s)	0017	17.3894	990.90	227.84	198.18
54060	T		Excision of penis lesion(s)	0017	17.3894	990.90	227.84	198.18
54065	T		Destruction, penis lesion(s)	0695	20.5193	1169.25	266.59	233.85
54100	T		Biopsy of penis	0021	14.8872	848.32	219.48	169.66
54105	T		Biopsy of penis	0022	19.3700	1103.76	354.45	220.75
54110	T		Treatment of penis lesion	0181	31.6828	1805.38	621.82	361.08
54111	T		Treat penis lesion, graft	0181	31.6828	1805.38	621.82	361.08
54112	T		Treat penis lesion, graft	0181	31.6828	1805.38	621.82	361.08
54115	T		Treatment of penis lesion	0008	19.3572	1103.03		220.61
54120	T		Partial removal of penis	0181	31.6828	1805.38	621.82	361.08
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54152	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54160	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54161	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54162	T		Lysis penil circumic lesion	0180	19.7320	1124.39	304.87	224.88
54163	T		Repair of circumcision	0180	19.7320	1124.39	304.87	224.88
54164	T		Frenulotomy of penis	0180	19.7320	1124.39	304.87	224.88
54200	T		Treatment of penis lesion	0156	2.4782	141.22	40.52	28.24
54205	T		Treatment of penis lesion	0181	31.6828	1805.38	621.82	361.08
54220	T		Treatment of penis lesion	0156	2.4782	141.22	40.52	28.24
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	16.0415	914.09		182.82
54235	T		Penile injection	0164	1.2563	71.59	17.59	14.32
54240	T		Penis study	0164	1.2563	71.59	17.59	14.32
54250	T		Penis study	0164	1.2563	71.59	17.59	14.32
54300	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54304	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54308	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54312	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54316	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54318	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54322	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54324	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54326	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54328	T		Revise penis/urethra	0181	31.6828	1805.38	621.82	361.08
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	31.6828	1805.38	621.82	361.08
54344	T		Secondary urethral surgery	0181	31.6828	1805.38	621.82	361.08
54348	T		Secondary urethral surgery	0181	31.6828	1805.38	621.82	361.08

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54352	T		Reconstruct urethra/penis	0181	31.6828	1805.38	621.82	361.08
54360	T		Penis plastic surgery	0181	31.6828	1805.38	621.82	361.08
54380	T		Repair penis	0181	31.6828	1805.38	621.82	361.08
54385	T		Repair penis	0181	31.6828	1805.38	621.82	361.08
54390	C		Repair penis and bladder		.	.	.	.
54400	S		Insert semi-rigid prosthesis	0385	69.6845	3970.83	.	794.17
54401	S		Insert self-contd prosthesis	0386	113.9823	6495.05	.	1299.01
54405	S		Insert multi-comp penis pros	0386	113.9823	6495.05	.	1299.01
54406	T		Remove muti-comp penis pros	0181	31.6828	1805.38	621.82	361.08
54408	T		Repair multi-comp penis pros	0181	31.6828	1805.38	621.82	361.08
54410	S		Remove/replace penis prosth	0386	113.9823	6495.05	.	1299.01
54411	C		Remov/replc penis pros, comp		.	.	.	.
54415	T		Remove self-contd penis pros	0181	31.6828	1805.38	621.82	361.08
54416	S		Remv/repl penis contain pros	0386	113.9823	6495.05	.	1299.01
54417	C		Remv/replc penis pros, compl		.	.	.	.
54420	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54430	C		Revision of penis		.	.	.	.
54435	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54440	T		Repair of penis	0181	31.6828	1805.38	621.82	361.08
54450	T		Preputial stretching	0156	2.4782	141.22	40.52	28.24
54500	T		Biopsy of testis	0037	9.3421	532.34	234.20	106.47
54505	T		Biopsy of testis	0183	23.0563	1313.82	.	262.76
54512	T		Excise lesion testis	0183	23.0563	1313.82	.	262.76
54520	T		Removal of testis	0183	23.0563	1313.82	.	262.76
54522	T		Orchiectomy, partial	0183	23.0563	1313.82	.	262.76
54530	T		Removal of testis	0154	28.0759	1599.85	464.85	319.97
54535	C		Extensive testis surgery		.	.	.	.
54550	T		Exploration for testis	0154	28.0759	1599.85	464.85	319.97
54560	C		Exploration for testis		.	.	.	.
54600	T		Reduce testis torsion	0183	23.0563	1313.82	.	262.76
54620	T		Suspension of testis	0183	23.0563	1313.82	.	262.76
54640	T		Suspension of testis	0154	28.0759	1599.85	464.85	319.97
54650	C		Orchiopexy (Fowler-Stephens)		.	.	.	.
54660	T		Revision of testis	0183	23.0563	1313.82	.	262.76
54670	T		Repair testis injury	0183	23.0563	1313.82	.	262.76
54680	T		Relocation of testis(es)	0183	23.0563	1313.82	.	262.76
54690	T		Laparoscopy, orchiectomy	0131	42.7526	2436.17	1001.89	487.23
54692	T		Laparoscopy, orchiopexy	0132	61.3208	3494.24	1239.22	698.85
54699	T		Laparoscope proc, testis	0130	31.6832	1805.40	659.53	361.08
54700	T		Drainage of scrotum	0183	23.0563	1313.82	.	262.76
54800	T		Biopsy of epididymis	0004	1.7081	97.33	22.36	19.47
54820	T		Exploration of epididymis	0183	23.0563	1313.82	.	262.76
54830	T		Remove epididymis lesion	0183	23.0563	1313.82	.	262.76

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54840	T		Remove epididymis lesion	0183	23.0563	1313.82		262.76
54860	T		Removal of epididymis	0183	23.0563	1313.82		262.76
54861	T		Removal of epididymis	0183	23.0563	1313.82		262.76
54900	T		Fusion of spermatic ducts	0183	23.0563	1313.82		262.76
54901	T		Fusion of spermatic ducts	0183	23.0563	1313.82		262.76
55000	T		Drainage of hydrocele	0004	1.7081	97.33	22.36	19.47
55040	T		Removal of hydrocele	0154	28.0759	1599.85	464.85	319.97
55041	T		Removal of hydroceles	0154	28.0759	1599.85	464.85	319.97
55060	T		Repair of hydrocele	0183	23.0563	1313.82		262.76
55100	T		Drainage of scrotum abscess	0007	12.4496	709.42		141.88
55110	T		Explore scrotum	0183	23.0563	1313.82		262.76
55120	T		Removal of scrotum lesion	0183	23.0563	1313.82		262.76
55150	T		Removal of scrotum	0183	23.0563	1313.82		262.76
55175	T		Revision of scrotum	0183	23.0563	1313.82		262.76
55180	T		Revision of scrotum	0183	23.0563	1313.82		262.76
55200	T		Incision of sperm duct	0183	23.0563	1313.82		262.76
55250	T		Removal of sperm duct(s)	0183	23.0563	1313.82		262.76
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	23.0563	1313.82		262.76
55450	T		Ligation of sperm duct	0183	23.0563	1313.82		262.76
55500	T		Removal of hydrocele	0183	23.0563	1313.82		262.76
55520	T		Removal of sperm cord lesion	0183	23.0563	1313.82		262.76
55530	T		Revise spermatic cord veins	0183	23.0563	1313.82		262.76
55535	T		Revise spermatic cord veins	0154	28.0759	1599.85	464.85	319.97
55540	T		Revise hernia & sperm veins	0154	28.0759	1599.85	464.85	319.97
55550	T		Laparo ligate spermatic vein	0131	42.7526	2436.17	1001.89	487.23
55559	T		Laparo proc, spermatic cord	0130	31.6832	1805.40	659.53	361.08
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	23.0563	1313.82		262.76
55700	T		Biopsy of prostate	0184	4.1543	236.72	96.27	47.34
55705	T		Biopsy of prostate	0184	4.1543	236.72	96.27	47.34
55720	T		Drainage of prostate abscess	0162	23.0182	1311.65		262.33
55725	T		Drainage of prostate abscess	0162	23.0182	1311.65		262.33
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					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55845	C		Extensive prostate surgery		.	.	.	.
55859	T		Percut/needle insert, pros	0163	36.0744	2055.63	.	411.13
55860	T		Surgical exposure, prostate	0165	16.0415	914.09	.	182.82
55862	C		Extensive prostate surgery		.	.	.	.
55865	C		Extensive prostate surgery		.	.	.	.
55866	C		Laparo radical prostatectomy		.	.	.	.
55870	T		Electroejaculation	0197	2.2368	127.46	.	25.49
55873	T		Cryoablate prostate	0674	112.1858	6392.68	.	1278.54
55899	T		Genital surgery procedure	0164	1.2563	71.59	17.59	14.32
55970	E		Sex transformation, M to F		.	.	.	.
55980	E		Sex transformation, F to M		.	.	.	.
56405	T		I & D of vulva/perineum	0192	3.8280	218.13	.	43.63
56420	T		Drainage of gland abscess	0189	2.1451	122.23	.	24.45
56440	T		Surgery for vulva lesion	0194	19.1146	1089.21	397.84	217.84
56441	T		Lysis of labial lesion(s)	0193	13.3052	758.17	158.05	151.63
56501	T		Destroy, vulva lesions, sim	0017	17.3894	990.90	227.84	198.18
56515	T		Destroy vulva lesion/s compl	0695	20.5193	1169.25	266.59	233.85
56605	T		Biopsy of vulva/perineum	0019	4.1677	237.49	71.87	47.50
56606	T		Biopsy of vulva/perineum	0019	4.1677	237.49	71.87	47.50
56620	T		Partial removal of vulva	0195	26.4573	1507.62	483.80	301.52
56625	T		Complete removal of vulva	0195	26.4573	1507.62	483.80	301.52
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	19.1146	1089.21	397.84	217.84
56720	T		Incision of hymen	0193	13.3052	758.17	158.05	151.63
56740	T		Remove vagina gland lesion	0194	19.1146	1089.21	397.84	217.84
56800	T		Repair of vagina	0194	19.1146	1089.21	397.84	217.84
56805	T		Repair clitoris	0194	19.1146	1089.21	397.84	217.84
56810	T		Repair of perineum	0194	19.1146	1089.21	397.84	217.84
56820	T		Exam of vulva w/scope	0188	1.1045	62.94	.	12.59
56821	T		Exam/biopsy of vulva w/scope	0189	2.1451	122.23	.	24.45
57000	T		Exploration of vagina	0194	19.1146	1089.21	397.84	217.84
57010	T		Drainage of pelvic abscess	0194	19.1146	1089.21	397.84	217.84
57020	T		Drainage of pelvic fluid	0192	3.8280	218.13	.	43.63
57022	T		I & d vaginal hematoma, pp	0007	12.4496	709.42	.	141.88
57023	T		I & d vag hematoma, non-ob	0007	12.4496	709.42	.	141.88
57061	T		Destroy vag lesions, simple	0194	19.1146	1089.21	397.84	217.84
57065	T		Destroy vag lesions, complex	0194	19.1146	1089.21	397.84	217.84

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57100	T		Biopsy of vagina	0192	3.8280	218.13	.	43.63
57105	T		Biopsy of vagina	0194	19.1146	1089.21	397.84	217.84
57106	T		Remove vagina wall, partial	0194	19.1146	1089.21	397.84	217.84
57107	T		Remove vagina tissue, part	0195	26.4573	1507.62	483.80	301.52
57109	T		Vaginectomy partial w/nodes	0195	26.4573	1507.62	483.80	301.52
57110	C		Remove vagina wall, complete		.	.	.	.
57111	C		Remove vagina tissue, compl		.	.	.	.
57112	C		Vaginectomy w/nodes, compl		.	.	.	.
57120	T		Closure of vagina	0195	26.4573	1507.62	483.80	301.52
57130	T		Remove vagina lesion	0194	19.1146	1089.21	397.84	217.84
57135	T		Remove vagina lesion	0194	19.1146	1089.21	397.84	217.84
57150	T		Treat vagina infection	0191	0.1831	10.43	2.93	2.09
57155	T		Insert uteri tandems/ovoids	0193	13.3052	758.17	158.05	151.63
57160	T		Insert pessary/other device	0188	1.1045	62.94	.	12.59
57170	T		Fitting of diaphragm/cap	0191	0.1831	10.43	2.93	2.09
57180	T		Treat vaginal bleeding	0189	2.1451	122.23	.	24.45
57200	T		Repair of vagina	0194	19.1146	1089.21	397.84	217.84
57210	T		Repair vagina/perineum	0194	19.1146	1089.21	397.84	217.84
57220	T		Revision of urethra	0202	39.6674	2260.37	1017.16	452.07
57230	T		Repair of urethral lesion	0195	26.4573	1507.62	483.80	301.52
57240	T		Repair bladder & vagina	0195	26.4573	1507.62	483.80	301.52
57250	T		Repair rectum & vagina	0195	26.4573	1507.62	483.80	301.52
57260	T		Repair of vagina	0195	26.4573	1507.62	483.80	301.52
57265	T		Extensive repair of vagina	0202	39.6674	2260.37	1017.16	452.07
57267	T	NI	Insert mesh/pelvic flr addon	0154	28.0759	1599.85	464.85	319.97
57268	T		Repair of bowel bulge	0195	26.4573	1507.62	483.80	301.52
57270	C		Repair of bowel pouch		.	.	.	.
57280	C		Suspension of vagina		.	.	.	.
57282	C		Colpopexy, extraperitoneal		.	.	.	.
57283	C	NI	Colpopexy, intraperitoneal		.	.	.	.
57284	T		Repair paravaginal defect	0202	39.6674	2260.37	1017.16	452.07
57287	T		Revise/remove sling repair	0202	39.6674	2260.37	1017.16	452.07
57288	T		Repair bladder defect	0202	39.6674	2260.37	1017.16	452.07
57289	T		Repair bladder & vagina	0195	26.4573	1507.62	483.80	301.52
57291	T		Construction of vagina	0195	26.4573	1507.62	483.80	301.52
57292	C		Construct vagina with graft		.	.	.	.
57300	T		Repair rectum-vagina fistula	0195	26.4573	1507.62	483.80	301.52
57305	C		Repair rectum-vagina fistula		.	.	.	.
57307	C		Fistula repair & colostomy		.	.	.	.
57308	C		Fistula repair, transperine		.	.	.	.
57310	T		Repair urethrovaginal lesion	0202	39.6674	2260.37	1017.16	452.07
57311	C		Repair urethrovaginal lesion		.	.	.	.
57320	T		Repair bladder-vagina lesion	0195	26.4573	1507.62	483.80	301.52

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57330	T		Repair bladder-vagina lesion	0195	26.4573	1507.62	483.80	301.52
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	19.1146	1089.21	397.84	217.84
57410	T		Pelvic examination	0194	19.1146	1089.21	397.84	217.84
57415	T		Remove vaginal foreign body	0194	19.1146	1089.21	397.84	217.84
57420	T		Exam of vagina w/scope	0189	2.1451	122.23		24.45
57421	T		Exam/biopsy of vag w/scope	0189	2.1451	122.23		24.45
57425	T		Laparoscopy, surg, colpopexy	0130	31.6832	1805.40	659.53	361.08
57452	T		Exam of cervix w/scope	0189	2.1451	122.23		24.45
57454	T		Bx/curett of cervix w/scope	0189	2.1451	122.23		24.45
57455	T		Biopsy of cervix w/scope	0189	2.1451	122.23		24.45
57456	T		Endocerv curettage w/scope	0189	2.1451	122.23		24.45
57460	T		Bx of cervix w/scope, leep	0193	13.3052	758.17	158.05	151.63
57461	T		Conz of cervix w/scope, leep	0194	19.1146	1089.21	397.84	217.84
57500	T		Biopsy of cervix	0192	3.8280	218.13		43.63
57505	T		Endocervical curettage	0189	2.1451	122.23		24.45
57510	T		Cauterization of cervix	0193	13.3052	758.17	158.05	151.63
57511	T		Cryocautery of cervix	0189	2.1451	122.23		24.45
57513	T		Laser surgery of cervix	0193	13.3052	758.17	158.05	151.63
57520	T		Conization of cervix	0194	19.1146	1089.21	397.84	217.84
57522	T		Conization of cervix	0195	26.4573	1507.62	483.80	301.52
57530	T		Removal of cervix	0195	26.4573	1507.62	483.80	301.52
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	26.4573	1507.62	483.80	301.52
57555	T		Remove cervix/repair vagina	0195	26.4573	1507.62	483.80	301.52
57556	T		Remove cervix, repair bowel	0202	39.6674	2260.37	1017.16	452.07
57700	T		Revision of cervix	0194	19.1146	1089.21	397.84	217.84
57720	T		Revision of cervix	0194	19.1146	1089.21	397.84	217.84
57800	T		Dilation of cervical canal	0193	13.3052	758.17	158.05	151.63
57820	T		D & c of residual cervix	0196	16.9266	964.53	338.23	192.91
58100	T		Biopsy of uterus lining	0188	1.1045	62.94		12.59
58120	T		Dilation and curettage	0196	16.9266	964.53	338.23	192.91
58140	C		Myomectomy abdom method					
58145	T		Myomectomy vag method	0195	26.4573	1507.62	483.80	301.52
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					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	2.1451	122.23	.	24.45
58321	T		Artificial insemination	0197	2.2368	127.46	.	25.49
58322	T		Artificial insemination	0197	2.2368	127.46	.	25.49
58323	T		Sperm washing	0197	2.2368	127.46	.	25.49
58340	N		Catheter for hysterography		.	.	.	.
58345	T		Reopen fallopian tube	0194	19.1146	1089.21	397.84	217.84
58346	T		Insert heyman uteri capsule	0193	13.3052	758.17	158.05	151.63
58350	T		Reopen fallopian tube	0195	26.4573	1507.62	483.80	301.52
58353	T		Endometr ablate, thermal	0195	26.4573	1507.62	483.80	301.52
58356	T	NI	Endometrial cryoablation	0202	39.6674	2260.37	1017.16	452.07
58400	C		Suspension of uterus		.	.	.	.
58410	C		Suspension of uterus		.	.	.	.
58520	C		Repair of ruptured uterus		.	.	.	.
58540	C		Revision of uterus		.	.	.	.
58545	T		Laparoscopic myomectomy	0130	31.6832	1805.40	659.53	361.08
58546	T		Laparo-myomectomy, complex	0131	42.7526	2436.17	1001.89	487.23
58550	T		Laparo-asst vag hysterectomy	0132	61.3208	3494.24	1239.22	698.85
58552	T		Laparo-vag hyst incl t/o	0131	42.7526	2436.17	1001.89	487.23
58553	T		Laparo-vag hyst, complex	0131	42.7526	2436.17	1001.89	487.23
58554	T		Laparo-vag hyst w/t/o, compl	0131	42.7526	2436.17	1001.89	487.23
58555	T		Hysteroscopy, dx, sep proc	0190	20.5171	1169.13	424.28	233.83
58558	T		Hysteroscopy, biopsy	0190	20.5171	1169.13	424.28	233.83
58559	T		Hysteroscopy, lysis	0190	20.5171	1169.13	424.28	233.83
58560	T		Hysteroscopy, resect septum	0387	30.3356	1728.61	655.55	345.72
58561	T		Hysteroscopy, remove myoma	0387	30.3356	1728.61	655.55	345.72
58562	T		Hysteroscopy, remove fb	0190	20.5171	1169.13	424.28	233.83
58563	T		Hysteroscopy, ablation	0387	30.3356	1728.61	655.55	345.72
58565	T	NI	Hysteroscopy, sterilization	0202	39.6674	2260.37	1017.16	452.07
58578	T		Laparo proc, uterus	0130	31.6832	1805.40	659.53	361.08

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58579	T		Hysteroscope procedure	0190	20.5171	1169.13	424.28	233.83
58600	T		Division of fallopian tube	0195	26.4573	1507.62	483.80	301.52
58605	C		Division of fallopian tube		.	.	.	.
58611	C		Ligate oviduct(s) add-on		.	.	.	.
58615	T		Occlude fallopian tube(s)	0194	19.1146	1089.21	397.84	217.84
58660	T		Laparoscopy, lysis	0131	42.7526	2436.17	1001.89	487.23
58661	T		Laparoscopy, remove adnexa	0131	42.7526	2436.17	1001.89	487.23
58662	T		Laparoscopy, excise lesions	0131	42.7526	2436.17	1001.89	487.23
58670	T		Laparoscopy, tubal cautery	0131	42.7526	2436.17	1001.89	487.23
58671	T		Laparoscopy, tubal block	0131	42.7526	2436.17	1001.89	487.23
58672	T		Laparoscopy, fimbrioplasty	0131	42.7526	2436.17	1001.89	487.23
58673	T		Laparoscopy, salpingostomy	0131	42.7526	2436.17	1001.89	487.23
58679	T		Laparo proc, oviduct-ovary	0130	31.6832	1805.40	659.53	361.08
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	T		Create new tubal opening	0195	26.4573	1507.62	483.80	301.52
58800	T		Drainage of ovarian cyst(s)	0193	13.3052	758.17	158.05	151.63
58805	C		Drainage of ovarian cyst(s)		.	.	.	.
58820	T		Drain ovary abscess, open	0195	26.4573	1507.62	483.80	301.52
58822	C		Drain ovary abscess, percut		.	.	.	.
58823	T		Drain pelvic abscess, percut	0193	13.3052	758.17	158.05	151.63
58825	C		Transposition, ovary(s)		.	.	.	.
58900	T		Biopsy of ovary(s)	0193	13.3052	758.17	158.05	151.63
58920	T		Partial removal of ovary(s)	0195	26.4573	1507.62	483.80	301.52
58925	T		Removal of ovarian cyst(s)	0195	26.4573	1507.62	483.80	301.52
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		.	.	.	.
58956	C	NI	Bso, omentectomy w/tah		.	.	.	.
58960	C		Exploration of abdomen		.	.	.	.
58970	T		Retrieval of oocyte	0194	19.1146	1089.21	397.84	217.84
58974	T		Transfer of embryo	0197	2.2368	127.46	.	25.49
58976	T		Transfer of embryo	0197	2.2368	127.46	.	25.49
58999	T		Genital surgery procedure	0191	0.1831	10.43	2.93	2.09
59000	T		Amniocentesis, diagnostic	0198	1.3503	76.94	32.19	15.39

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59001	T		Amniocentesis, therapeutic	0198	1.3503	76.94	32.19	15.39
59012	T		Fetal cord puncture,prenatal	0198	1.3503	76.94	32.19	15.39
59015	T		Chorion biopsy	0198	1.3503	76.94	32.19	15.39
59020	T		Fetal contract stress test	0198	1.3503	76.94	32.19	15.39
59025	T		Fetal non-stress test	0198	1.3503	76.94	32.19	15.39
59030	T		Fetal scalp blood sample	0198	1.3503	76.94	32.19	15.39
59050	E		Fetal monitor w/report		.	.	.	.
59051	B		Fetal monitor/interpret only		.	.	.	.
59070	T		Transabdom amnioinfus w/us	0198	1.3503	76.94	32.19	15.39
59072	T		Umbilical cord occlud w/us	0198	1.3503	76.94	32.19	15.39
59074	T		Fetal fluid drainage w/us	0198	1.3503	76.94	32.19	15.39
59076	T		Fetal shunt placement, w/us	0198	1.3503	76.94	32.19	15.39
59100	C		Remove uterus lesion		.	.	.	.
59120	C		Treat ectopic pregnancy		.	.	.	.
59121	C		Treat ectopic pregnancy		.	.	.	.
59130	C		Treat ectopic pregnancy		.	.	.	.
59135	C		Treat ectopic pregnancy		.	.	.	.
59136	C		Treat ectopic pregnancy		.	.	.	.
59140	C		Treat ectopic pregnancy		.	.	.	.
59150	T		Treat ectopic pregnancy	0131	42.7526	2436.17	1001.89	487.23
59151	T		Treat ectopic pregnancy	0131	42.7526	2436.17	1001.89	487.23
59160	T		D & c after delivery	0196	16.9266	964.53	338.23	192.91
59200	T		Insert cervical dilator	0189	2.1451	122.23	.	24.45
59300	T		Episiotomy or vaginal repair	0193	13.3052	758.17	158.05	151.63
59320	T		Revision of cervix	0194	19.1146	1089.21	397.84	217.84
59325	C		Revision of cervix		.	.	.	.
59350	C		Repair of uterus		.	.	.	.
59400	B		Obstetrical care		.	.	.	.
59409	T		Obstetrical care	0194	19.1146	1089.21	397.84	217.84
59410	B		Obstetrical care		.	.	.	.
59412	T		Antepartum manipulation	0700	3.6661	208.91	.	41.78
59414	T		Deliver placenta	0194	19.1146	1089.21	397.84	217.84
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	0194	19.1146	1089.21	397.84	217.84
59614	E		Vbac care after delivery		.	.	.	.
59618	E		Attempted vbac delivery		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59620	C		Attempted vbac delivery only		.	.	.	.
59622	E		Attempted vbac after care		.	.	.	.
59812	T		Treatment of miscarriage	0201	18.0011	1025.76	329.65	205.15
59820	T		Care of miscarriage	0201	18.0011	1025.76	329.65	205.15
59821	T		Treatment of miscarriage	0201	18.0011	1025.76	329.65	205.15
59830	C		Treat uterus infection		.	.	.	.
59840	T		Abortion	0200	14.7568	840.89	263.69	168.18
59841	T		Abortion	0200	14.7568	840.89	263.69	168.18
59850	C		Abortion		.	.	.	.
59851	C		Abortion		.	.	.	.
59852	C		Abortion		.	.	.	.
59855	C		Abortion		.	.	.	.
59856	C		Abortion		.	.	.	.
59857	C		Abortion		.	.	.	.
59866	T		Abortion (mpr)	0198	1.3503	76.94	32.19	15.39
59870	T		Evacuate mole of uterus	0201	18.0011	1025.76	329.65	205.15
59871	T		Remove cerclage suture	0194	19.1146	1089.21	397.84	217.84
59897	T		Fetal invas px w/us	0198	1.3503	76.94	32.19	15.39
59898	T		Laparo proc, ob care/deliver	0130	31.6832	1805.40	659.53	361.08
59899	T		Maternity care procedure	0198	1.3503	76.94	32.19	15.39
60000	T		Drain thyroid/tongue cyst	0252	6.5183	371.43	113.41	74.29
60001	T		Aspirate/inject thyriod cyst	0004	1.7081	97.33	22.36	19.47
60100	T		Biopsy of thyroid	0004	1.7081	97.33	22.36	19.47
60200	T		Remove thyroid lesion	0114	39.6713	2260.59	485.91	452.12
60210	T		Partial thyroid excision	0114	39.6713	2260.59	485.91	452.12
60212	T		Partial thyroid excision	0114	39.6713	2260.59	485.91	452.12
60220	T		Partial removal of thyroid	0114	39.6713	2260.59	485.91	452.12
60225	T		Partial removal of thyroid	0114	39.6713	2260.59	485.91	452.12
60240	T		Removal of thyroid	0114	39.6713	2260.59	485.91	452.12
60252	T		Removal of thyroid	0256	36.9298	2104.37	.	420.87
60254	C		Extensive thyroid surgery		.	.	.	.
60260	T		Repeat thyroid surgery	0256	36.9298	2104.37	.	420.87
60270	C		Removal of thyroid		.	.	.	.
60271	C		Removal of thyroid		.	.	.	.
60280	T		Remove thyroid duct lesion	0114	39.6713	2260.59	485.91	452.12
60281	T		Remove thyroid duct lesion	0114	39.6713	2260.59	485.91	452.12
60500	T		Explore parathyroid glands	0256	36.9298	2104.37	.	420.87
60502	C		Re-explore parathyroids		.	.	.	.
60505	C		Explore parathyroid glands		.	.	.	.
60512	T		Autotransplant parathyroid	0022	19.3700	1103.76	354.45	220.75
60520	C		Removal of thymus gland		.	.	.	.
60521	C		Removal of thymus gland		.	.	.	.
60522	C		Removal of thymus gland		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	31.6832	1805.40	659.53	361.08
60699	T		Endocrine surgery procedure	0114	39.6713	2260.59	485.91	452.12
61000	T		Remove cranial cavity fluid	0212	2.9465	167.90	74.67	33.58
61001	T		Remove cranial cavity fluid	0212	2.9465	167.90	74.67	33.58
61020	T		Remove brain cavity fluid	0212	2.9465	167.90	74.67	33.58
61026	T		Injection into brain canal	0212	2.9465	167.90	74.67	33.58
61050	T		Remove brain canal fluid	0212	2.9465	167.90	74.67	33.58
61055	T		Injection into brain canal	0212	2.9465	167.90	74.67	33.58
61070	T		Brain canal shunt procedure	0212	2.9465	167.90	74.67	33.58
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	38.8952	2216.37	453.41	443.27
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	36.9298	2104.37	.	420.87
61332	C		Explore/biopsy eye socket		.	.	.	.
61333	C		Explore orbit/remove lesion		.	.	.	.
61334	C		Explore orbit/remove object		.	.	.	.
61340	C		Subtemporal decompression		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
61623	T		Endovasc tempory vessel occl	1555	.	1650.00	.	330.00
61624	C		Transcath occlusion, cns		.	.	.	.
61626	T		Transcath occlusion, non-cns	0081	32.7548	1866.47	.	373.29

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	17.2963	985.60	.	197.12
61791	T		Treat trigeminal tract	0206	5.4311	309.48	75.55	61.90
61793	E		Focus radiation beam		.	.	.	
61795	S		Brain surgery using computer	0302	5.4315	309.50	117.25	61.90
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		.	.	.	.
61880	T		Revise/remove neuroelectrode	0687	20.0762	1144.00	513.05	228.80
61885	S		Insrt/redo neurostim 1 array	0039	219.9203	12531.72	.	2506.34
61886	T		Implant neurostim arrays	0315	352.3658	20078.86	.	4015.77
61888	T		Revise/remove neuroreceiver	0688	41.7281	2377.79	1070.00	475.56
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	2.2909	130.54	43.80	26.11
62200	C		Establish brain cavity shunt		.	.	.	.
62201	C		Brain cavity shunt w/scope		.	.	.	.
62220	C		Establish brain cavity shunt		.	.	.	.
62223	C		Establish brain cavity shunt		.	.	.	.
62225	T		Replace/irrigate catheter	0122	8.2869	472.21	96.84	94.44
62230	T		Replace/revise brain shunt	0224	38.8952	2216.37	453.41	443.27
62252	S		Csf shunt reprogram	0691	2.5289	144.10	64.84	28.82
62256	C		Remove brain cavity shunt		.	.	.	.
62258	C		Replace brain cavity shunt		.	.	.	.
62263	T		Epidural lysis mult sessions	0203	10.9230	622.43	272.25	124.49
62264	T		Epidural lysis on single day	0203	10.9230	622.43	272.25	124.49
62268	T		Drain spinal cord cyst	0212	2.9465	167.90	74.67	33.58
62269	T		Needle biopsy, spinal cord	0685	5.8806	335.09	115.47	67.02
62270	T		Spinal fluid tap, diagnostic	0204	2.1801	124.23	40.13	24.85
62272	T		Drain cerebro spinal fluid	0204	2.1801	124.23	40.13	24.85
62273	T		Inject epidural patch	0206	5.4311	309.48	75.55	61.90
62280	T		Treat spinal cord lesion	0207	5.8248	331.91	86.92	66.38
62281	T		Treat spinal cord lesion	0207	5.8248	331.91	86.92	66.38
62282	T		Treat spinal canal lesion	0207	5.8248	331.91	86.92	66.38
62284	N		Injection for myelogram		.	.	.	.
62287	T		Percutaneous diskectomy	0221	28.7081	1635.87	463.62	327.17
62290	N		Inject for spine disk x-ray		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62291	N		Inject for spine disk x-ray		.	.	.	.
62292	T		Injection into disk lesion	0212	2.9465	167.90	74.67	33.58
62294	T		Injection into spinal artery	0212	2.9465	167.90	74.67	33.58
62310	T		Inject spine c/t	0207	5.8248	331.91	86.92	66.38
62311	T		Inject spine l/s (cd)	0207	5.8248	331.91	86.92	66.38
62318	T		Inject spine w/cath, c/t	0207	5.8248	331.91	86.92	66.38
62319	T		Inject spine w/cath l/s (cd)	0207	5.8248	331.91	86.92	66.38
62350	T		Implant spinal canal cath	0223	26.2731	1497.12	.	299.42
62351	T		Implant spinal canal cath	0208	42.5700	2425.77	.	485.15
62355	T		Remove spinal canal catheter	0203	10.9230	622.43	272.25	124.49
62360	T		Insert spine infusion device	0226	43.4005	2473.09	.	494.62
62361	T		Implant spine infusion pump	0227	150.3961	8570.02	.	1714.00
62362	T		Implant spine infusion pump	0227	150.3961	8570.02	.	1714.00
62365	T		Remove spine infusion device	0221	28.7081	1635.87	463.62	327.17
62367	S		Analyze spine infusion pump	0691	2.5289	144.10	64.84	28.82
62368	S		Analyze spine infusion pump	0691	2.5289	144.10	64.84	28.82
63001	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63003	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63005	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63011	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63012	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63015	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63016	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63017	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63020	T		Neck spine disk surgery	0208	42.5700	2425.77	.	485.15
63030	T		Low back disk surgery	0208	42.5700	2425.77	.	485.15
63035	T		Spinal disk surgery add-on	0208	42.5700	2425.77	.	485.15
63040	T		Laminotomy, single cervical	0208	42.5700	2425.77	.	485.15
63042	T		Laminotomy, single lumbar	0208	42.5700	2425.77	.	485.15
63043	C		Laminotomy, add'l cervical		.	.	.	.
63044	C		Laminotomy, add'l lumbar		.	.	.	.
63045	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63046	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63047	T		Removal of spinal lamina	0208	42.5700	2425.77	.	485.15
63048	T		Remove spinal lamina add-on	0208	42.5700	2425.77	.	485.15
63050	C	NI	Cervical laminoplasty		.	.	.	.
63051	C	NI	C-laminoplasty w/graft/plate		.	.	.	.
63055	T		Decompress spinal cord	0208	42.5700	2425.77	.	485.15
63056	T		Decompress spinal cord	0208	42.5700	2425.77	.	485.15
63057	T		Decompress spine cord add-on	0208	42.5700	2425.77	.	485.15
63064	T		Decompress spinal cord	0208	42.5700	2425.77	.	485.15
63066	T		Decompress spine cord add-on	0208	42.5700	2425.77	.	485.15
63075	C		Neck spine disk surgery		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
63295	C	NI	Repair of laminectomy defect		.	.	.	.
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	17.2963	985.60	.	197.12
63610	T		Stimulation of spinal cord	0220	17.2963	985.60	.	197.12
63615	T		Remove lesion of spinal cord	0220	17.2963	985.60	.	197.12
63650	S		Implant neuroelectrodes	0040	49.2740	2807.78	.	561.56
63655	S		Implant neuroelectrodes	0225	210.5195	11996.03	.	2399.21
63660	T		Revise/remove neuroelectrode	0687	20.0762	1144.00	513.05	228.80
63685	T		Insrt/redo spine n generator	0222	217.1298	12372.71	.	2474.54
63688	T		Revise/remove neuroreceiver	0688	41.7281	2377.79	1070.00	475.56
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	42.1332	2400.88	537.78	480.18
63744	T		Revision of spinal shunt	0228	42.1332	2400.88	537.78	480.18
63746	T		Removal of spinal shunt	0109	7.5181	428.40	131.49	85.68
64400	T		N block inj, trigeminal	0204	2.1801	124.23	40.13	24.85
64402	T		N block inj, facial	0204	2.1801	124.23	40.13	24.85
64405	T		N block inj, occipital	0204	2.1801	124.23	40.13	24.85
64408	T		N block inj, vagus	0204	2.1801	124.23	40.13	24.85
64410	T		N block inj, phrenic	0206	5.4311	309.48	75.55	61.90

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64412	T		N block inj, spinal accessor	0206	5.4311	309.48	75.55	61.90
64413	T		N block inj, cervical plexus	0204	2.1801	124.23	40.13	24.85
64415	T		N block inj, brachial plexus	0204	2.1801	124.23	40.13	24.85
64416	T		N block cont infuse, b plex	0204	2.1801	124.23	40.13	24.85
64417	T		N block inj, axillary	0204	2.1801	124.23	40.13	24.85
64418	T		N block inj, suprascapular	0204	2.1801	124.23	40.13	24.85
64420	T		N block inj, intercost, sng	0204	2.1801	124.23	40.13	24.85
64421	T		N block inj, intercost, mlt	0206	5.4311	309.48	75.55	61.90
64425	T		N block inj, ilio-ing/hypogi	0204	2.1801	124.23	40.13	24.85
64430	T		N block inj, pudendal	0204	2.1801	124.23	40.13	24.85
64435	T		N block inj, paracervical	0204	2.1801	124.23	40.13	24.85
64445	T		N block inj, sciatic, sng	0204	2.1801	124.23	40.13	24.85
64446	T		N blk inj, sciatic, cont inf	0206	5.4311	309.48	75.55	61.90
64447	T		N block inj fem, single	0204	2.1801	124.23	40.13	24.85
64448	T		N block inj fem, cont inf	0204	2.1801	124.23	40.13	24.85
64449	T		N block inj, lumbar plexus	0204	2.1801	124.23	40.13	24.85
64450	T		N block, other peripheral	0204	2.1801	124.23	40.13	24.85
64470	T		Inj paravertebral c/t	0207	5.8248	331.91	86.92	66.38
64472	T		Inj paravertebral c/t add-on	0206	5.4311	309.48	75.55	61.90
64475	T		Inj paravertebral l/s	0207	5.8248	331.91	86.92	66.38
64476	T		Inj paravertebral l/s add-on	0206	5.4311	309.48	75.55	61.90
64479	T		Inj foramen epidural c/t	0207	5.8248	331.91	86.92	66.38
64480	T		Inj foramen epidural add-on	0207	5.8248	331.91	86.92	66.38
64483	T		Inj foramen epidural l/s	0207	5.8248	331.91	86.92	66.38
64484	T		Inj foramen epidural add-on	0207	5.8248	331.91	86.92	66.38
64505	T		N block, spenopalatine gangl	0204	2.1801	124.23	40.13	24.85
64508	T		N block, carotid sinus s/p	0204	2.1801	124.23	40.13	24.85
64510	T		N block, stellate ganglion	0207	5.8248	331.91	86.92	66.38
64517	T		N block inj, hypogas plxs	0204	2.1801	124.23	40.13	24.85
64520	T		N block, lumbar/thoracic	0207	5.8248	331.91	86.92	66.38
64530	T		N block inj, celiac pelus	0207	5.8248	331.91	86.92	66.38
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64555	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64560	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64561	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64565	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64573	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64575	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64577	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64580	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64581	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64585	T		Revise/remove neuroelectrode	0687	20.0762	1144.00	513.05	228.80

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64590	T		Insrt/redo perph n generator	0222	217.1298	12372.71	.	2474.54
64595	T		Revise/remove neuroreceiver	0688	41.7281	2377.79	1070.00	475.56
64600	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64605	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64610	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64612	T		Destroy nerve, face muscle	0204	2.1801	124.23	40.13	24.85
64613	T		Destroy nerve, spine muscle	0204	2.1801	124.23	40.13	24.85
64614	T		Destroy nerve, extrem musc	0204	2.1801	124.23	40.13	24.85
64620	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64622	T		Destr paravertebrl nerve l/s	0203	10.9230	622.43	272.25	124.49
64623	T		Destr paravertebral n add-on	0207	5.8248	331.91	86.92	66.38
64626	T		Destr paravertebrl nerve c/t	0203	10.9230	622.43	272.25	124.49
64627	T		Destr paravertebral n add-on	0207	5.8248	331.91	86.92	66.38
64630	T		Injection treatment of nerve	0206	5.4311	309.48	75.55	61.90
64640	T		Injection treatment of nerve	0206	5.4311	309.48	75.55	61.90
64680	T		Injection treatment of nerve	0207	5.8248	331.91	86.92	66.38
64681	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64702	T		Revise finger/toe nerve	0220	17.2963	985.60	.	197.12
64704	T		Revise hand/foot nerve	0220	17.2963	985.60	.	197.12
64708	T		Revise arm/leg nerve	0220	17.2963	985.60	.	197.12
64712	T		Revision of sciatic nerve	0220	17.2963	985.60	.	197.12
64713	T		Revision of arm nerve(s)	0220	17.2963	985.60	.	197.12
64714	T		Revise low back nerve(s)	0220	17.2963	985.60	.	197.12
64716	T		Revision of cranial nerve	0220	17.2963	985.60	.	197.12
64718	T		Revise ulnar nerve at elbow	0220	17.2963	985.60	.	197.12
64719	T		Revise ulnar nerve at wrist	0220	17.2963	985.60	.	197.12
64721	T		Carpal tunnel surgery	0220	17.2963	985.60	.	197.12
64722	T		Relieve pressure on nerve(s)	0220	17.2963	985.60	.	197.12
64726	T		Release foot/toe nerve	0220	17.2963	985.60	.	197.12
64727	T		Internal nerve revision	0220	17.2963	985.60	.	197.12
64732	T		Incision of brow nerve	0220	17.2963	985.60	.	197.12
64734	T		Incision of cheek nerve	0220	17.2963	985.60	.	197.12
64736	T		Incision of chin nerve	0220	17.2963	985.60	.	197.12
64738	T		Incision of jaw nerve	0220	17.2963	985.60	.	197.12
64740	T		Incision of tongue nerve	0220	17.2963	985.60	.	197.12
64742	T		Incision of facial nerve	0220	17.2963	985.60	.	197.12
64744	T		Incise nerve, back of head	0220	17.2963	985.60	.	197.12
64746	T		Incise diaphragm nerve	0220	17.2963	985.60	.	197.12
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	17.2963	985.60	.	197.12
64763	C		Incise hip/thigh nerve		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64766	C		Incise hip/thigh nerve		.	.	.	.
64771	T		Sever cranial nerve	0220	17.2963	985.60	.	197.12
64772	T		Incision of spinal nerve	0220	17.2963	985.60	.	197.12
64774	T		Remove skin nerve lesion	0220	17.2963	985.60	.	197.12
64776	T		Remove digit nerve lesion	0220	17.2963	985.60	.	197.12
64778	T		Digit nerve surgery add-on	0220	17.2963	985.60	.	197.12
64782	T		Remove limb nerve lesion	0220	17.2963	985.60	.	197.12
64783	T		Limb nerve surgery add-on	0220	17.2963	985.60	.	197.12
64784	T		Remove nerve lesion	0220	17.2963	985.60	.	197.12
64786	T		Remove sciatic nerve lesion	0221	28.7081	1635.87	463.62	327.17
64787	T		Implant nerve end	0220	17.2963	985.60	.	197.12
64788	T		Remove skin nerve lesion	0220	17.2963	985.60	.	197.12
64790	T		Removal of nerve lesion	0220	17.2963	985.60	.	197.12
64792	T		Removal of nerve lesion	0221	28.7081	1635.87	463.62	327.17
64795	T		Biopsy of nerve	0220	17.2963	985.60	.	197.12
64802	T		Remove sympathetic nerves	0220	17.2963	985.60	.	197.12
64804	C		Remove sympathetic nerves		.	.	.	.
64809	C		Remove sympathetic nerves		.	.	.	.
64818	C		Remove sympathetic nerves		.	.	.	.
64820	T		Remove sympathetic nerves	0220	17.2963	985.60	.	197.12
64821	T		Remove sympathetic nerves	0054	24.8731	1417.34	.	283.47
64822	T		Remove sympathetic nerves	0054	24.8731	1417.34	.	283.47
64823	T		Remove sympathetic nerves	0054	24.8731	1417.34	.	283.47
64831	T		Repair of digit nerve	0221	28.7081	1635.87	463.62	327.17
64832	T		Repair nerve add-on	0221	28.7081	1635.87	463.62	327.17
64834	T		Repair of hand or foot nerve	0221	28.7081	1635.87	463.62	327.17
64835	T		Repair of hand or foot nerve	0221	28.7081	1635.87	463.62	327.17
64836	T		Repair of hand or foot nerve	0221	28.7081	1635.87	463.62	327.17
64837	T		Repair nerve add-on	0221	28.7081	1635.87	463.62	327.17
64840	T		Repair of leg nerve	0221	28.7081	1635.87	463.62	327.17
64856	T		Repair/transpose nerve	0221	28.7081	1635.87	463.62	327.17
64857	T		Repair arm/leg nerve	0221	28.7081	1635.87	463.62	327.17
64858	T		Repair sciatic nerve	0221	28.7081	1635.87	463.62	327.17
64859	T		Nerve surgery	0221	28.7081	1635.87	463.62	327.17
64861	T		Repair of arm nerves	0221	28.7081	1635.87	463.62	327.17
64862	T		Repair of low back nerves	0221	28.7081	1635.87	463.62	327.17
64864	T		Repair of facial nerve	0221	28.7081	1635.87	463.62	327.17
64865	T		Repair of facial nerve	0221	28.7081	1635.87	463.62	327.17
64866	C		Fusion of facial/other nerve		.	.	.	.
64868	C		Fusion of facial/other nerve		.	.	.	.
64870	T		Fusion of facial/other nerve	0221	28.7081	1635.87	463.62	327.17
64872	T		Subsequent repair of nerve	0221	28.7081	1635.87	463.62	327.17
64874	T		Repair & revise nerve add-on	0221	28.7081	1635.87	463.62	327.17

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64876	T		Repair nerve/shorten bone	0221	28.7081	1635.87	463.62	327.17
64885	T		Nerve graft, head or neck	0221	28.7081	1635.87	463.62	327.17
64886	T		Nerve graft, head or neck	0221	28.7081	1635.87	463.62	327.17
64890	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64891	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64892	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64893	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64895	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64896	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64897	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64898	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64901	T		Nerve graft add-on	0221	28.7081	1635.87	463.62	327.17
64902	T		Nerve graft add-on	0221	28.7081	1635.87	463.62	327.17
64905	T		Nerve pedicle transfer	0221	28.7081	1635.87	463.62	327.17
64907	T		Nerve pedicle transfer	0221	28.7081	1635.87	463.62	327.17
64999	T		Nervous system surgery	0204	2.1801	124.23	40.13	24.85
65091	T		Revise eye	0242	30.2444	1723.42	597.36	344.68
65093	T		Revise eye with implant	0241	23.5349	1341.09	384.47	268.22
65101	T		Removal of eye	0242	30.2444	1723.42	597.36	344.68
65103	T		Remove eye/insert implant	0242	30.2444	1723.42	597.36	344.68
65105	T		Remove eye/attach implant	0242	30.2444	1723.42	597.36	344.68
65110	T		Removal of eye	0242	30.2444	1723.42	597.36	344.68
65112	T		Remove eye/revise socket	0242	30.2444	1723.42	597.36	344.68
65114	T		Remove eye/revise socket	0242	30.2444	1723.42	597.36	344.68
65125	T		Revise ocular implant	0240	18.0715	1029.77	315.31	205.95
65130	T		Insert ocular implant	0241	23.5349	1341.09	384.47	268.22
65135	T		Insert ocular implant	0241	23.5349	1341.09	384.47	268.22
65140	T		Attach ocular implant	0242	30.2444	1723.42	597.36	344.68
65150	T		Revise ocular implant	0241	23.5349	1341.09	384.47	268.22
65155	T		Reinsert ocular implant	0242	30.2444	1723.42	597.36	344.68
65175	T		Removal of ocular implant	0240	18.0715	1029.77	315.31	205.95
65205	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65210	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65220	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65222	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65235	T		Remove foreign body from eye	0233	14.6847	836.78	266.33	167.36
65260	T		Remove foreign body from eye	0236	21.3506	1216.62	.	243.32
65265	T		Remove foreign body from eye	0236	21.3506	1216.62	.	243.32
65270	T		Repair of eye wound	0240	18.0715	1029.77	315.31	205.95
65272	T		Repair of eye wound	0234	22.1360	1261.38	511.31	252.28
65273	C		Repair of eye wound		.	.	.	.
65275	T		Repair of eye wound	0234	22.1360	1261.38	511.31	252.28
65280	T		Repair of eye wound	0236	21.3506	1216.62	.	243.32

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65285	T		Repair of eye wound	0236	21.3506	1216.62		243.32
65286	T		Repair of eye wound	0232	6.9120	393.87	103.17	78.77
65290	T		Repair of eye socket wound	0243	22.4844	1281.23	431.39	256.25
65400	T		Removal of eye lesion	0233	14.6847	836.78	266.33	167.36
65410	T		Biopsy of cornea	0233	14.6847	836.78	266.33	167.36
65420	T		Removal of eye lesion	0233	14.6847	836.78	266.33	167.36
65426	T		Removal of eye lesion	0234	22.1360	1261.38	511.31	252.28
65430	S		Corneal smear	0230	0.8019	45.69	14.97	9.14
65435	T		Curette/treat cornea	0239	6.7015	381.87		76.37
65436	T		Curette/treat cornea	0233	14.6847	836.78	266.33	167.36
65450	S		Treatment of corneal lesion	0231	2.0073	114.38	44.61	22.88
65600	T		Revision of cornea	0240	18.0715	1029.77	315.31	205.95
65710	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65730	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65750	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65755	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65760	E		Revision of cornea					
65765	E		Revision of cornea					
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	39.6990	2262.17	803.26	452.43
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	14.6847	836.78	266.33	167.36
65775	T		Correction of astigmatism	0233	14.6847	836.78	266.33	167.36
65780	T		Ocular reconst, transplant	0244	39.6990	2262.17	803.26	452.43
65781	T		Ocular reconst, transplant	0244	39.6990	2262.17	803.26	452.43
65782	T		Ocular reconst, transplant	0244	39.6990	2262.17	803.26	452.43
65800	T		Drainage of eye	0233	14.6847	836.78	266.33	167.36
65805	T		Drainage of eye	0233	14.6847	836.78	266.33	167.36
65810	T		Drainage of eye	0234	22.1360	1261.38	511.31	252.28
65815	T		Drainage of eye	0234	22.1360	1261.38	511.31	252.28
65820	T		Relieve inner eye pressure	0232	6.9120	393.87	103.17	78.77
65850	T		Incision of eye	0234	22.1360	1261.38	511.31	252.28
65855	T		Laser surgery of eye	0247	5.0892	290.00	104.31	58.00
65860	T		Incise inner eye adhesions	0247	5.0892	290.00	104.31	58.00
65865	T		Incise inner eye adhesions	0233	14.6847	836.78	266.33	167.36
65870	T		Incise inner eye adhesions	0234	22.1360	1261.38	511.31	252.28
65875	T		Incise inner eye adhesions	0234	22.1360	1261.38	511.31	252.28
65880	T		Incise inner eye adhesions	0233	14.6847	836.78	266.33	167.36
65900	T		Remove eye lesion	0233	14.6847	836.78	266.33	167.36
65920	T		Remove implant of eye	0234	22.1360	1261.38	511.31	252.28
65930	T		Remove blood clot from eye	0234	22.1360	1261.38	511.31	252.28
66020	T		Injection treatment of eye	0233	14.6847	836.78	266.33	167.36
66030	T		Injection treatment of eye	0232	6.9120	393.87	103.17	78.77

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66130	T		Remove eye lesion	0234	22.1360	1261.38	511.31	252.28
66150	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66155	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66160	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66165	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66170	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66172	T		Incision of eye	0673	29.0816	1657.16	649.56	331.43
66180	T		Implant eye shunt	0673	29.0816	1657.16	649.56	331.43
66185	T		Revise eye shunt	0673	29.0816	1657.16	649.56	331.43
66220	T		Repair eye lesion	0236	21.3506	1216.62		243.32
66225	T		Repair/graft eye lesion	0673	29.0816	1657.16	649.56	331.43
66250	T		Follow-up surgery of eye	0233	14.6847	836.78	266.33	167.36
66500	T		Incision of iris	0232	6.9120	393.87	103.17	78.77
66505	T		Incision of iris	0232	6.9120	393.87	103.17	78.77
66600	T		Remove iris and lesion	0234	22.1360	1261.38	511.31	252.28
66605	T		Removal of iris	0234	22.1360	1261.38	511.31	252.28
66625	T		Removal of iris	0232	6.9120	393.87	103.17	78.77
66630	T		Removal of iris	0234	22.1360	1261.38	511.31	252.28
66635	T		Removal of iris	0234	22.1360	1261.38	511.31	252.28
66680	T		Repair iris & ciliary body	0234	22.1360	1261.38	511.31	252.28
66682	T		Repair iris & ciliary body	0234	22.1360	1261.38	511.31	252.28
66700	T		Destruction, ciliary body	0233	14.6847	836.78	266.33	167.36
66710	T		Ciliary transsleral therapy	0233	14.6847	836.78	266.33	167.36
66711	T	NI	Ciliary endoscopic ablation	0233	14.6847	836.78	266.33	167.36
66720	T		Destruction, ciliary body	0233	14.6847	836.78	266.33	167.36
66740	T		Destruction, ciliary body	0234	22.1360	1261.38	511.31	252.28
66761	T		Revision of iris	0247	5.0892	290.00	104.31	58.00
66762	T		Revision of iris	0247	5.0892	290.00	104.31	58.00
66770	T		Removal of inner eye lesion	0247	5.0892	290.00	104.31	58.00
66820	T		Incision, secondary cataract	0232	6.9120	393.87	103.17	78.77
66821	T		After cataract laser surgery	0247	5.0892	290.00	104.31	58.00
66825	T		Reposition intraocular lens	0234	22.1360	1261.38	511.31	252.28
66830	T		Removal of lens lesion	0232	6.9120	393.87	103.17	78.77
66840	T		Removal of lens material	0245	13.9367	794.15	222.22	158.83
66850	T		Removal of lens material	0249	28.4617	1621.83	524.67	324.37
66852	T		Removal of lens material	0249	28.4617	1621.83	524.67	324.37
66920	T		Extraction of lens	0249	28.4617	1621.83	524.67	324.37
66930	T		Extraction of lens	0249	28.4617	1621.83	524.67	324.37
66940	T		Extraction of lens	0245	13.9367	794.15	222.22	158.83
66982	T		Cataract surgery, complex	0246	23.3312	1329.48	495.96	265.90
66983	T		Cataract surg w/iol, 1 stage	0246	23.3312	1329.48	495.96	265.90
66984	T		Cataract surg w/iol, 1 stage	0246	23.3312	1329.48	495.96	265.90
66985	T		Insert lens prosthesis	0246	23.3312	1329.48	495.96	265.90

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66986	T		Exchange lens prosthesis	0246	23.3312	1329.48	495.96	265.90
66990	N		Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	6.9120	393.87	103.17	78.77
67005	T		Partial removal of eye fluid	0237	34.5277	1967.49	818.54	393.50
67010	T		Partial removal of eye fluid	0237	34.5277	1967.49	818.54	393.50
67015	T		Release of eye fluid	0237	34.5277	1967.49	818.54	393.50
67025	T		Replace eye fluid	0236	21.3506	1216.62		243.32
67027	T		Implant eye drug system	0237	34.5277	1967.49	818.54	393.50
67028	T		Injection eye drug	0235	5.1864	295.54	72.04	59.11
67030	T		Incise inner eye strands	0236	21.3506	1216.62		243.32
67031	T		Laser surgery, eye strands	0247	5.0892	290.00	104.31	58.00
67036	T		Removal of inner eye fluid	0237	34.5277	1967.49	818.54	393.50
67038	T		Strip retinal membrane	0237	34.5277	1967.49	818.54	393.50
67039	T		Laser treatment of retina	0237	34.5277	1967.49	818.54	393.50
67040	T		Laser treatment of retina	0672	39.9292	2275.29	988.43	455.06
67101	T		Repair detached retina	0235	5.1864	295.54	72.04	59.11
67105	T		Repair detached retina	0248	4.9276	280.79	95.08	56.16
67107	T		Repair detached retina	0672	39.9292	2275.29	988.43	455.06
67108	T		Repair detached retina	0672	39.9292	2275.29	988.43	455.06
67110	T		Repair detached retina	0236	21.3506	1216.62		243.32
67112	T		Rerepair detached retina	0672	39.9292	2275.29	988.43	455.06
67115	T		Release encircling material	0236	21.3506	1216.62		243.32
67120	T		Remove eye implant material	0236	21.3506	1216.62		243.32
67121	T		Remove eye implant material	0236	21.3506	1216.62		243.32
67141	T		Treatment of retina	0235	5.1864	295.54	72.04	59.11
67145	T		Treatment of retina	0248	4.9276	280.79	95.08	56.16
67208	T		Treatment of retinal lesion	0235	5.1864	295.54	72.04	59.11
67210	T		Treatment of retinal lesion	0248	4.9276	280.79	95.08	56.16
67218	T		Treatment of retinal lesion	0236	21.3506	1216.62		243.32
67220	T		Treatment of choroid lesion	0235	5.1864	295.54	72.04	59.11
67221	T		Ocular photodynamic ther	0235	5.1864	295.54	72.04	59.11
67225	T		Eye photodynamic ther add-on	0235	5.1864	295.54	72.04	59.11
67227	T		Treatment of retinal lesion	0235	5.1864	295.54	72.04	59.11
67228	T		Treatment of retinal lesion	0248	4.9276	280.79	95.08	56.16
67250	T		Reinforce eye wall	0240	18.0715	1029.77	315.31	205.95
67255	T		Reinforce/graft eye wall	0237	34.5277	1967.49	818.54	393.50
67299	T		Eye surgery procedure	0235	5.1864	295.54	72.04	59.11
67311	T		Revise eye muscle	0243	22.4844	1281.23	431.39	256.25
67312	T		Revise two eye muscles	0243	22.4844	1281.23	431.39	256.25
67314	T		Revise eye muscle	0243	22.4844	1281.23	431.39	256.25
67316	T		Revise two eye muscles	0243	22.4844	1281.23	431.39	256.25
67318	T		Revise eye muscle(s)	0243	22.4844	1281.23	431.39	256.25
67320	T		Revise eye muscle(s) add-on	0243	22.4844	1281.23	431.39	256.25

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67331	T		Eye surgery follow-up add-on	0243	22.4844	1281.23	431.39	256.25
67332	T		Rerevise eye muscles add-on	0243	22.4844	1281.23	431.39	256.25
67334	T		Revise eye muscle w/suture	0243	22.4844	1281.23	431.39	256.25
67335	T		Eye suture during surgery	0243	22.4844	1281.23	431.39	256.25
67340	T		Revise eye muscle add-on	0243	22.4844	1281.23	431.39	256.25
67343	T		Release eye tissue	0243	22.4844	1281.23	431.39	256.25
67345	T		Destroy nerve of eye muscle	0238	2.9594	168.64		33.73
67350	T		Biopsy eye muscle	0699	9.7041	552.97		110.59
67399	T		Eye muscle surgery procedure	0243	22.4844	1281.23	431.39	256.25
67400	T		Explore/biopsy eye socket	0241	23.5349	1341.09	384.47	268.22
67405	T		Explore/drain eye socket	0241	23.5349	1341.09	384.47	268.22
67412	T		Explore/treat eye socket	0241	23.5349	1341.09	384.47	268.22
67413	T		Explore/treat eye socket	0241	23.5349	1341.09	384.47	268.22
67414	T		Explr/decompress eye socket	0242	30.2444	1723.42	597.36	344.68
67415	T		Aspiration, orbital contents	0240	18.0715	1029.77	315.31	205.95
67420	T		Explore/treat eye socket	0242	30.2444	1723.42	597.36	344.68
67430	T		Explore/treat eye socket	0242	30.2444	1723.42	597.36	344.68
67440	T		Explore/drain eye socket	0242	30.2444	1723.42	597.36	344.68
67445	T		Explr/decompress eye socket	0242	30.2444	1723.42	597.36	344.68
67450	T		Explore/biopsy eye socket	0242	30.2444	1723.42	597.36	344.68
67500	S		Inject/treat eye socket	0231	2.0073	114.38	44.61	22.88
67505	T		Inject/treat eye socket	0238	2.9594	168.64		33.73
67515	T		Inject/treat eye socket	0238	2.9594	168.64		33.73
67550	T		Insert eye socket implant	0242	30.2444	1723.42	597.36	344.68
67560	T		Revise eye socket implant	0241	23.5349	1341.09	384.47	268.22
67570	T		Decompress optic nerve	0242	30.2444	1723.42	597.36	344.68
67599	T		Orbit surgery procedure	0238	2.9594	168.64		33.73
67700	T		Drainage of eyelid abscess	0238	2.9594	168.64		33.73
67710	T		Incision of eyelid	0239	6.7015	381.87		76.37
67715	T		Incision of eyelid fold	0240	18.0715	1029.77	315.31	205.95
67800	T		Remove eyelid lesion	0238	2.9594	168.64		33.73
67801	T		Remove eyelid lesions	0239	6.7015	381.87		76.37
67805	T		Remove eyelid lesions	0238	2.9594	168.64		33.73
67808	T		Remove eyelid lesion(s)	0240	18.0715	1029.77	315.31	205.95
67810	T		Biopsy of eyelid	0238	2.9594	168.64		33.73
67820	S		Revise eyelashes	0698	1.4649	83.47	18.72	16.69
67825	T		Revise eyelashes	0238	2.9594	168.64		33.73
67830	T		Revise eyelashes	0239	6.7015	381.87		76.37
67835	T		Revise eyelashes	0240	18.0715	1029.77	315.31	205.95
67840	T		Remove eyelid lesion	0239	6.7015	381.87		76.37
67850	T		Treat eyelid lesion	0239	6.7015	381.87		76.37
67875	T		Closure of eyelid by suture	0239	6.7015	381.87		76.37
67880	T		Revision of eyelid	0233	14.6847	836.78	266.33	167.36

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67882	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67900	T		Repair brow defect	0240	18.0715	1029.77	315.31	205.95
67901	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67902	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67903	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67904	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67906	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67908	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67909	T		Revise eyelid defect	0240	18.0715	1029.77	315.31	205.95
67911	T		Revise eyelid defect	0240	18.0715	1029.77	315.31	205.95
67912	T		Correction eyelid w/implant	0239	6.7015	381.87		76.37
67914	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67915	T		Repair eyelid defect	0239	6.7015	381.87		76.37
67916	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67917	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67921	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67922	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67923	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67924	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67930	T		Repair eyelid wound	0240	18.0715	1029.77	315.31	205.95
67935	T		Repair eyelid wound	0240	18.0715	1029.77	315.31	205.95
67938	S		Remove eyelid foreign body	0698	1.4649	83.47	18.72	16.69
67950	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67961	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67966	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67971	T		Reconstruction of eyelid	0241	23.5349	1341.09	384.47	268.22
67973	T		Reconstruction of eyelid	0241	23.5349	1341.09	384.47	268.22
67974	T		Reconstruction of eyelid	0241	23.5349	1341.09	384.47	268.22
67975	T		Reconstruction of eyelid	0240	18.0715	1029.77	315.31	205.95
67999	T		Revision of eyelid	0238	2.9594	168.64		33.73
68020	T		Incise/drain eyelid lining	0240	18.0715	1029.77	315.31	205.95
68040	S		Treatment of eyelid lesions	0698	1.4649	83.47	18.72	16.69
68100	T		Biopsy of eyelid lining	0232	6.9120	393.87	103.17	78.77
68110	T		Remove eyelid lining lesion	0699	9.7041	552.97		110.59
68115	T		Remove eyelid lining lesion	0240	18.0715	1029.77	315.31	205.95
68130	T		Remove eyelid lining lesion	0233	14.6847	836.78	266.33	167.36
68135	T		Remove eyelid lining lesion	0239	6.7015	381.87		76.37
68200	S		Treat eyelid by injection	0230	0.8019	45.69	14.97	9.14
68320	T		Revise/graft eyelid lining	0240	18.0715	1029.77	315.31	205.95
68325	T		Revise/graft eyelid lining	0242	30.2444	1723.42	597.36	344.68
68326	T		Revise/graft eyelid lining	0241	23.5349	1341.09	384.47	268.22
68328	T		Revise/graft eyelid lining	0241	23.5349	1341.09	384.47	268.22
68330	T		Revise eyelid lining	0234	22.1360	1261.38	511.31	252.28

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68335	T		Revise/graft eyelid lining	0241	23.5349	1341.09	384.47	268.22
68340	T		Separate eyelid adhesions	0240	18.0715	1029.77	315.31	205.95
68360	T		Revise eyelid lining	0234	22.1360	1261.38	511.31	252.28
68362	T		Revise eyelid lining	0234	22.1360	1261.38	511.31	252.28
68371	T		Harvest eye tissue, alograft	0233	14.6847	836.78	266.33	167.36
68399	T		Eyelid lining surgery	0238	2.9594	168.64		33.73
68400	T		Incise/drain tear gland	0238	2.9594	168.64		33.73
68420	T		Incise/drain tear sac	0240	18.0715	1029.77	315.31	205.95
68440	T		Incise tear duct opening	0238	2.9594	168.64		33.73
68500	T		Removal of tear gland	0241	23.5349	1341.09	384.47	268.22
68505	T		Partial removal, tear gland	0241	23.5349	1341.09	384.47	268.22
68510	T		Biopsy of tear gland	0240	18.0715	1029.77	315.31	205.95
68520	T		Removal of tear sac	0241	23.5349	1341.09	384.47	268.22
68525	T		Biopsy of tear sac	0240	18.0715	1029.77	315.31	205.95
68530	T		Clearance of tear duct	0240	18.0715	1029.77	315.31	205.95
68540	T		Remove tear gland lesion	0241	23.5349	1341.09	384.47	268.22
68550	T		Remove tear gland lesion	0242	30.2444	1723.42	597.36	344.68
68700	T		Repair tear ducts	0241	23.5349	1341.09	384.47	268.22
68705	T		Revise tear duct opening	0238	2.9594	168.64		33.73
68720	T		Create tear sac drain	0242	30.2444	1723.42	597.36	344.68
68745	T		Create tear duct drain	0241	23.5349	1341.09	384.47	268.22
68750	T		Create tear duct drain	0242	30.2444	1723.42	597.36	344.68
68760	S		Close tear duct opening	0698	1.4649	83.47	18.72	16.69
68761	S		Close tear duct opening	0231	2.0073	114.38	44.61	22.88
68770	T		Close tear system fistula	0240	18.0715	1029.77	315.31	205.95
68801	S		Dilate tear duct opening	0698	1.4649	83.47	18.72	16.69
68810	T		Probe nasolacrimal duct	0699	9.7041	552.97		110.59
68811	T		Probe nasolacrimal duct	0240	18.0715	1029.77	315.31	205.95
68815	T		Probe nasolacrimal duct	0240	18.0715	1029.77	315.31	205.95
68840	S		Explore/irrigate tear ducts	0231	2.0073	114.38	44.61	22.88
68850	N		Injection for tear sac x-ray					
68899	S		Tear duct system surgery	0230	0.8019	45.69	14.97	9.14
69000	T		Drain external ear lesion	0006	1.6854	96.04	23.26	19.21
69005	T		Drain external ear lesion	0007	12.4496	709.42		141.88
69020	T		Drain outer ear canal lesion	0006	1.6854	96.04	23.26	19.21
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	4.1677	237.49	71.87	47.50
69105	T		Biopsy of external ear canal	0253	15.9877	911.03	282.29	182.21
69110	T		Remove external ear, partial	0021	14.8872	848.32	219.48	169.66
69120	T		Removal of external ear	0254	23.3442	1330.22	321.35	266.04
69140	T		Remove ear canal lesion(s)	0254	23.3442	1330.22	321.35	266.04
69145	T		Remove ear canal lesion(s)	0021	14.8872	848.32	219.48	169.66
69150	T		Extensive ear canal surgery	0252	6.5183	371.43	113.41	74.29

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69155	C		Extensive ear/neck surgery		.	.		.
69200	X		Clear outer ear canal	0340	0.6328	36.06	.	7.21
69205	T		Clear outer ear canal	0022	19.3700	1103.76	354.45	220.75
69210	X		Remove impacted ear wax	0340	0.6328	36.06	.	7.21
69220	T		Clean out mastoid cavity	0012	0.7477	42.61	11.18	8.52
69222	T		Clean out mastoid cavity	0253	15.9877	911.03	282.29	182.21
69300	T		Revise external ear	0254	23.3442	1330.22	321.35	266.04
69310	T		Rebuild outer ear canal	0256	36.9298	2104.37	.	420.87
69320	T		Rebuild outer ear canal	0256	36.9298	2104.37	.	420.87
69399	T		Outer ear surgery procedure	0251	1.9352	110.27	.	22.05
69400	T		Inflate middle ear canal	0251	1.9352	110.27	.	22.05
69401	T		Inflate middle ear canal	0251	1.9352	110.27	.	22.05
69405	T		Catheterize middle ear canal	0252	6.5183	371.43	113.41	74.29
69410	T		Inset middle ear (baffle)	0251	1.9352	110.27	.	22.05
69420	T		Incision of eardrum	0252	6.5183	371.43	113.41	74.29
69421	T		Incision of eardrum	0253	15.9877	911.03	282.29	182.21
69424	T		Remove ventilating tube	0252	6.5183	371.43	113.41	74.29
69433	T		Create eardrum opening	0252	6.5183	371.43	113.41	74.29
69436	T		Create eardrum opening	0253	15.9877	911.03	282.29	182.21
69440	T		Exploration of middle ear	0254	23.3442	1330.22	321.35	266.04
69450	T		Eardrum revision	0256	36.9298	2104.37	.	420.87
69501	T		Mastoidectomy	0256	36.9298	2104.37	.	420.87
69502	T		Mastoidectomy	0254	23.3442	1330.22	321.35	266.04
69505	T		Remove mastoid structures	0256	36.9298	2104.37	.	420.87
69511	T		Extensive mastoid surgery	0256	36.9298	2104.37	.	420.87
69530	T		Extensive mastoid surgery	0256	36.9298	2104.37	.	420.87
69535	C		Remove part of temporal bone		.	.	.	.
69540	T		Remove ear lesion	0253	15.9877	911.03	282.29	182.21
69550	T		Remove ear lesion	0256	36.9298	2104.37	.	420.87
69552	T		Remove ear lesion	0256	36.9298	2104.37	.	420.87
69554	C		Remove ear lesion		.	.	.	.
69601	T		Mastoid surgery revision	0256	36.9298	2104.37	.	420.87
69602	T		Mastoid surgery revision	0256	36.9298	2104.37	.	420.87
69603	T		Mastoid surgery revision	0256	36.9298	2104.37	.	420.87
69604	T		Mastoid surgery revision	0256	36.9298	2104.37	.	420.87
69605	T		Mastoid surgery revision	0256	36.9298	2104.37	.	420.87
69610	T		Repair of eardrum	0254	23.3442	1330.22	321.35	266.04
69620	T		Repair of eardrum	0254	23.3442	1330.22	321.35	266.04
69631	T		Repair eardrum structures	0256	36.9298	2104.37	.	420.87
69632	T		Rebuild eardrum structures	0256	36.9298	2104.37	.	420.87
69633	T		Rebuild eardrum structures	0256	36.9298	2104.37	.	420.87
69635	T		Repair eardrum structures	0256	36.9298	2104.37	.	420.87
69636	T		Rebuild eardrum structures	0256	36.9298	2104.37	.	420.87

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69637	T		Rebuild eardrum structures	0256	36.9298	2104.37	.	420.87
69641	T		Revise middle ear & mastoid	0256	36.9298	2104.37	.	420.87
69642	T		Revise middle ear & mastoid	0256	36.9298	2104.37	.	420.87
69643	T		Revise middle ear & mastoid	0256	36.9298	2104.37	.	420.87
69644	T		Revise middle ear & mastoid	0256	36.9298	2104.37	.	420.87
69645	T		Revise middle ear & mastoid	0256	36.9298	2104.37	.	420.87
69646	T		Revise middle ear & mastoid	0256	36.9298	2104.37	.	420.87
69650	T		Release middle ear bone	0254	23.3442	1330.22	321.35	266.04
69660	T		Revise middle ear bone	0256	36.9298	2104.37	.	420.87
69661	T		Revise middle ear bone	0256	36.9298	2104.37	.	420.87
69662	T		Revise middle ear bone	0256	36.9298	2104.37	.	420.87
69666	T		Repair middle ear structures	0256	36.9298	2104.37	.	420.87
69667	T		Repair middle ear structures	0256	36.9298	2104.37	.	420.87
69670	T		Remove mastoid air cells	0256	36.9298	2104.37	.	420.87
69676	T		Remove middle ear nerve	0256	36.9298	2104.37	.	420.87
69700	T		Close mastoid fistula	0256	36.9298	2104.37	.	420.87
69710	E		Implant/replace hearing aid		.	.	.	.
69711	T		Remove/repair hearing aid	0256	36.9298	2104.37	.	420.87
69714	T		Implant temple bone w/stimul	0256	36.9298	2104.37	.	420.87
69715	T		Temple bne implnt w/stimulat	0256	36.9298	2104.37	.	420.87
69717	T		Temple bone implant revision	0256	36.9298	2104.37	.	420.87
69718	T		Revise temple bone implant	0256	36.9298	2104.37	.	420.87
69720	T		Release facial nerve	0256	36.9298	2104.37	.	420.87
69725	T		Release facial nerve	0256	36.9298	2104.37	.	420.87
69740	T		Repair facial nerve	0256	36.9298	2104.37	.	420.87
69745	T		Repair facial nerve	0256	36.9298	2104.37	.	420.87
69799	T		Middle ear surgery procedure	0251	1.9352	110.27	.	22.05
69801	T		Incise inner ear	0256	36.9298	2104.37	.	420.87
69802	T		Incise inner ear	0256	36.9298	2104.37	.	420.87
69805	T		Explore inner ear	0256	36.9298	2104.37	.	420.87
69806	T		Explore inner ear	0256	36.9298	2104.37	.	420.87
69820	T		Establish inner ear window	0256	36.9298	2104.37	.	420.87
69840	T		Revise inner ear window	0256	36.9298	2104.37	.	420.87
69905	T		Remove inner ear	0256	36.9298	2104.37	.	420.87
69910	T		Remove inner ear & mastoid	0256	36.9298	2104.37	.	420.87
69915	T		Incise inner ear nerve	0256	36.9298	2104.37	.	420.87
69930	T		Implant cochlear device	0259	444.1223	25307.42	9394.83	5061.48
69949	T		Inner ear surgery procedure	0251	1.9352	110.27	.	22.05
69950	C		Incise inner ear nerve		.	.	.	.
69955	T		Release facial nerve	0256	36.9298	2104.37	.	420.87
69960	T		Release inner ear canal	0256	36.9298	2104.37	.	420.87
69970	C		Remove inner ear lesion		.	.	.	.
69979	T		Temporal bone surgery	0251	1.9352	110.27	.	22.05

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.2901	187.48	84.36	37.50
70015	S		Contrast x-ray of brain	0274	3.2901	187.48	84.36	37.50
70030	X		X-ray eye for foreign body	0260	0.7698	43.87	19.74	8.77
70100	X		X-ray exam of jaw	0260	0.7698	43.87	19.74	8.77
70110	X		X-ray exam of jaw	0260	0.7698	43.87	19.74	8.77
70120	X		X-ray exam of mastoids	0260	0.7698	43.87	19.74	8.77
70130	X		X-ray exam of mastoids	0260	0.7698	43.87	19.74	8.77
70134	X		X-ray exam of middle ear	0261	1.3351	76.08		15.22
70140	X		X-ray exam of facial bones	0260	0.7698	43.87	19.74	8.77
70150	X		X-ray exam of facial bones	0260	0.7698	43.87	19.74	8.77
70160	X		X-ray exam of nasal bones	0260	0.7698	43.87	19.74	8.77
70170	X		X-ray exam of tear duct	0264	3.4194	194.85	79.41	38.97
70190	X		X-ray exam of eye sockets	0260	0.7698	43.87	19.74	8.77
70200	X		X-ray exam of eye sockets	0260	0.7698	43.87	19.74	8.77
70210	X		X-ray exam of sinuses	0260	0.7698	43.87	19.74	8.77
70220	X		X-ray exam of sinuses	0260	0.7698	43.87	19.74	8.77
70240	X		X-ray exam, pituitary saddle	0260	0.7698	43.87	19.74	8.77
70250	X		X-ray exam of skull	0260	0.7698	43.87	19.74	8.77
70260	X		X-ray exam of skull	0261	1.3351	76.08		15.22
70300	X		X-ray exam of teeth	0262	1.4556	82.94		16.59
70310	X		X-ray exam of teeth	0262	1.4556	82.94		16.59
70320	X		Full mouth x-ray of teeth	0262	1.4556	82.94		16.59
70328	X		X-ray exam of jaw joint	0260	0.7698	43.87	19.74	8.77
70330	X		X-ray exam of jaw joints	0260	0.7698	43.87	19.74	8.77
70332	S		X-ray exam of jaw joint	0275	3.5084	199.92	69.09	39.98
70336	S		Magnetic image, jaw joint	0335	6.0472	344.59	150.64	68.92
70350	X		X-ray head for orthodontia	0260	0.7698	43.87	19.74	8.77
70355	X		Panoramic x-ray of jaws	0260	0.7698	43.87	19.74	8.77
70360	X		X-ray exam of neck	0260	0.7698	43.87	19.74	8.77
70370	X		Throat x-ray & fluoroscopy	0272	1.3880	79.09	35.59	15.82
70371	X		Speech evaluation, complex	0272	1.3880	79.09	35.59	15.82
70373	X		Contrast x-ray of larynx	0263	1.8514	105.50	38.51	21.10
70380	X		X-ray exam of salivary gland	0260	0.7698	43.87	19.74	8.77
70390	X		X-ray exam of salivary duct	0263	1.8514	105.50	38.51	21.10
70450	S		Ct head/brain w/o dye	0332	3.3910	193.23	86.95	38.65
70460	S		Ct head/brain w/dye	0283	4.7485	270.58	121.76	54.12
70470	S		Ct head/brain w/o & w/dye	0333	5.6225	320.39	144.17	64.08
70480	S		Ct orbit/ear/fossa w/o dye	0332	3.3910	193.23	86.95	38.65
70481	S		Ct orbit/ear/fossa w/dye	0283	4.7485	270.58	121.76	54.12
70482	S		Ct orbit/ear/fossa w/o&w/dye	0333	5.6225	320.39	144.17	64.08
70486	S		Ct maxillofacial w/o dye	0332	3.3910	193.23	86.95	38.65
70487	S		Ct maxillofacial w/dye	0283	4.7485	270.58	121.76	54.12

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70488	S		Ct maxillofacial w/o & w/dye	0333	5.6225	320.39	144.17	64.08
70490	S		Ct soft tissue neck w/o dye	0332	3.3910	193.23	86.95	38.65
70491	S		Ct soft tissue neck w/dye	0283	4.7485	270.58	121.76	54.12
70492	S		Ct sft tsue nck w/o & w/dye	0333	5.6225	320.39	144.17	64.08
70496	S		Ct angiography, head	0662	5.6204	320.27	144.12	64.05
70498	S		Ct angiography, neck	0662	5.6204	320.27	144.12	64.05
70540	S		Mri orbit/face/neck w/o dye	0336	6.3150	359.85	161.93	71.97
70542	S		Mri orbit/face/neck w/dye	0284	6.7851	386.64	173.98	77.33
70543	S		Mri orbt/fac/nck w/o & w/dye	0337	9.1701	522.54	235.14	104.51
70544	S		Mr angiography head w/o dye	0336	6.3150	359.85	161.93	71.97
70545	S		Mr angiography head w/dye	0284	6.7851	386.64	173.98	77.33
70546	S		Mr angiograph head w/o&w/dye	0337	9.1701	522.54	235.14	104.51
70547	S		Mr angiography neck w/o dye	0336	6.3150	359.85	161.93	71.97
70548	S		Mr angiography neck w/dye	0284	6.7851	386.64	173.98	77.33
70549	S		Mr angiograph neck w/o&w/dye	0337	9.1701	522.54	235.14	104.51
70551	S		Mri brain w/o dye	0336	6.3150	359.85	161.93	71.97
70552	S		Mri brain w/dye	0284	6.7851	386.64	173.98	77.33
70553	S		Mri brain w/o & w/dye	0337	9.1701	522.54	235.14	104.51
70557	S		Mri brain w/o dye	0336	6.3150	359.85	161.93	71.97
70558	S		Mri brain w/dye	0284	6.7851	386.64	173.98	77.33
70559	S		Mri brain w/o & w/dye	0337	9.1701	522.54	235.14	104.51
71010	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71015	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71020	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71021	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71022	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71023	X		Chest x-ray and fluoroscopy	0272	1.3880	79.09	35.59	15.82
71030	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71034	X		Chest x-ray and fluoroscopy	0272	1.3880	79.09	35.59	15.82
71035	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71040	X		Contrast x-ray of bronchi	0263	1.8514	105.50	38.51	21.10
71060	X		Contrast x-ray of bronchi	0263	1.8514	105.50	38.51	21.10
71090	X		X-ray & pacemaker insertion	0272	1.3880	79.09	35.59	15.82
71100	X		X-ray exam of ribs	0260	0.7698	43.87	19.74	8.77
71101	X		X-ray exam of ribs/chest	0260	0.7698	43.87	19.74	8.77
71110	X		X-ray exam of ribs	0260	0.7698	43.87	19.74	8.77
71111	X		X-ray exam of ribs/chest	0261	1.3351	76.08		15.22
71120	X		X-ray exam of breastbone	0260	0.7698	43.87	19.74	8.77
71130	X		X-ray exam of breastbone	0260	0.7698	43.87	19.74	8.77
71250	S		Ct thorax w/o dye	0332	3.3910	193.23	86.95	38.65
71260	S		Ct thorax w/dye	0283	4.7485	270.58	121.76	54.12
71270	S		Ct thorax w/o & w/dye	0333	5.6225	320.39	144.17	64.08
71275	S		Ct angiography, chest	0662	5.6204	320.27	144.12	64.05

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
71550	S		Mri chest w/o dye	0336	6.3150	359.85	161.93	71.97
71551	S		Mri chest w/dye	0284	6.7851	386.64	173.98	77.33
71552	S		Mri chest w/o & w/dye	0337	9.1701	522.54	235.14	104.51
71555	B		Mri angio chest w or w/o dye		.	.	.	.
72010	X		X-ray exam of spine	0261	1.3351	76.08	.	15.22
72020	X		X-ray exam of spine	0260	0.7698	43.87	19.74	8.77
72040	X		X-ray exam of neck spine	0260	0.7698	43.87	19.74	8.77
72050	X		X-ray exam of neck spine	0261	1.3351	76.08	.	15.22
72052	X		X-ray exam of neck spine	0261	1.3351	76.08	.	15.22
72069	X		X-ray exam of trunk spine	0260	0.7698	43.87	19.74	8.77
72070	X		X-ray exam of thoracic spine	0260	0.7698	43.87	19.74	8.77
72072	X		X-ray exam of thoracic spine	0260	0.7698	43.87	19.74	8.77
72074	X		X-ray exam of thoracic spine	0260	0.7698	43.87	19.74	8.77
72080	X		X-ray exam of trunk spine	0260	0.7698	43.87	19.74	8.77
72090	X		X-ray exam of trunk spine	0261	1.3351	76.08	.	15.22
72100	X		X-ray exam of lower spine	0260	0.7698	43.87	19.74	8.77
72110	X		X-ray exam of lower spine	0261	1.3351	76.08	.	15.22
72114	X		X-ray exam of lower spine	0261	1.3351	76.08	.	15.22
72120	X		X-ray exam of lower spine	0260	0.7698	43.87	19.74	8.77
72125	S		Ct neck spine w/o dye	0332	3.3910	193.23	86.95	38.65
72126	S		Ct neck spine w/dye	0283	4.7485	270.58	121.76	54.12
72127	S		Ct neck spine w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72128	S		Ct chest spine w/o dye	0332	3.3910	193.23	86.95	38.65
72129	S		Ct chest spine w/dye	0283	4.7485	270.58	121.76	54.12
72130	S		Ct chest spine w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72131	S		Ct lumbar spine w/o dye	0332	3.3910	193.23	86.95	38.65
72132	S		Ct lumbar spine w/dye	0283	4.7485	270.58	121.76	54.12
72133	S		Ct lumbar spine w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72141	S		Mri neck spine w/o dye	0336	6.3150	359.85	161.93	71.97
72142	S		Mri neck spine w/dye	0284	6.7851	386.64	173.98	77.33
72146	S		Mri chest spine w/o dye	0336	6.3150	359.85	161.93	71.97
72147	S		Mri chest spine w/dye	0284	6.7851	386.64	173.98	77.33
72148	S		Mri lumbar spine w/o dye	0336	6.3150	359.85	161.93	71.97
72149	S		Mri lumbar spine w/dye	0284	6.7851	386.64	173.98	77.33
72156	S		Mri neck spine w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72157	S		Mri chest spine w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72158	S		Mri lumbar spine w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72159	E		Mr angio spine w/o&w/dye		.	.	.	.
72170	X		X-ray exam of pelvis	0260	0.7698	43.87	19.74	8.77
72190	X		X-ray exam of pelvis	0260	0.7698	43.87	19.74	8.77
72191	S		Ct angiograph pelv w/o&w/dye	0662	5.6204	320.27	144.12	64.05
72192	S		Ct pelvis w/o dye	0332	3.3910	193.23	86.95	38.65
72193	S		Ct pelvis w/dye	0283	4.7485	270.58	121.76	54.12

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72194	S		Ct pelvis w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72195	S		Mri pelvis w/o dye	0336	6.3150	359.85	161.93	71.97
72196	S		Mri pelvis w/dye	0284	6.7851	386.64	173.98	77.33
72197	S		Mri pelvis w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72198	B		Mr angio pelvis w/o & w/dye		.	.	.	.
72200	X		X-ray exam sacroiliac joints	0260	0.7698	43.87	19.74	8.77
72202	X		X-ray exam sacroiliac joints	0260	0.7698	43.87	19.74	8.77
72220	X		X-ray exam of tailbone	0260	0.7698	43.87	19.74	8.77
72240	S		Contrast x-ray of neck spine	0274	3.2901	187.48	84.36	37.50
72255	S		Contrast x-ray, thorax spine	0274	3.2901	187.48	84.36	37.50
72265	S		Contrast x-ray, lower spine	0274	3.2901	187.48	84.36	37.50
72270	S		Contrast x-ray, spine	0274	3.2901	187.48	84.36	37.50
72275	S		Epidurography	0274	3.2901	187.48	84.36	37.50
72285	S		X-ray c/t spine disk	0388	11.7568	669.94	301.47	133.99
72295	S		X-ray of lower spine disk	0388	11.7568	669.94	301.47	133.99
73000	X		X-ray exam of collar bone	0260	0.7698	43.87	19.74	8.77
73010	X		X-ray exam of shoulder blade	0260	0.7698	43.87	19.74	8.77
73020	X		X-ray exam of shoulder	0260	0.7698	43.87	19.74	8.77
73030	X		X-ray exam of shoulder	0260	0.7698	43.87	19.74	8.77
73040	S		Contrast x-ray of shoulder	0275	3.5084	199.92	69.09	39.98
73050	X		X-ray exam of shoulders	0260	0.7698	43.87	19.74	8.77
73060	X		X-ray exam of humerus	0260	0.7698	43.87	19.74	8.77
73070	X		X-ray exam of elbow	0260	0.7698	43.87	19.74	8.77
73080	X		X-ray exam of elbow	0260	0.7698	43.87	19.74	8.77
73085	S		Contrast x-ray of elbow	0275	3.5084	199.92	69.09	39.98
73090	X		X-ray exam of forearm	0260	0.7698	43.87	19.74	8.77
73092	X		X-ray exam of arm, infant	0260	0.7698	43.87	19.74	8.77
73100	X		X-ray exam of wrist	0260	0.7698	43.87	19.74	8.77
73110	X		X-ray exam of wrist	0260	0.7698	43.87	19.74	8.77
73115	S		Contrast x-ray of wrist	0275	3.5084	199.92	69.09	39.98
73120	X		X-ray exam of hand	0260	0.7698	43.87	19.74	8.77
73130	X		X-ray exam of hand	0260	0.7698	43.87	19.74	8.77
73140	X		X-ray exam of finger(s)	0260	0.7698	43.87	19.74	8.77
73200	S		Ct upper extremity w/o dye	0332	3.3910	193.23	86.95	38.65
73201	S		Ct upper extremity w/dye	0283	4.7485	270.58	121.76	54.12
73202	S		Ct uppr extremity w/o&w/dye	0333	5.6225	320.39	144.17	64.08
73206	S		Ct angio upr extrm w/o&w/dye	0662	5.6204	320.27	144.12	64.05
73218	S		Mri upper extremity w/o dye	0336	6.3150	359.85	161.93	71.97
73219	S		Mri upper extremity w/dye	0284	6.7851	386.64	173.98	77.33
73220	S		Mri uppr extremity w/o&w/dye	0337	9.1701	522.54	235.14	104.51
73221	S		Mri joint upr extrem w/o dye	0336	6.3150	359.85	161.93	71.97
73222	S		Mri joint upr extrem w/dye	0284	6.7851	386.64	173.98	77.33
73223	S		Mri joint upr extr w/o&w/dye	0337	9.1701	522.54	235.14	104.51

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73225	E		Mr angio upr extr w/o&w/dye		.	.	.	.
73500	X		X-ray exam of hip	0260	0.7698	43.87	19.74	8.77
73510	X		X-ray exam of hip	0260	0.7698	43.87	19.74	8.77
73520	X		X-ray exam of hips	0260	0.7698	43.87	19.74	8.77
73525	S		Contrast x-ray of hip	0275	3.5084	199.92	69.09	39.98
73530	X		X-ray exam of hip	0261	1.3351	76.08	.	15.22
73540	X		X-ray exam of pelvis & hips	0260	0.7698	43.87	19.74	8.77
73542	S		X-ray exam, sacroiliac joint	0275	3.5084	199.92	69.09	39.98
73550	X		X-ray exam of thigh	0260	0.7698	43.87	19.74	8.77
73560	X		X-ray exam of knee, 1 or 2	0260	0.7698	43.87	19.74	8.77
73562	X		X-ray exam of knee, 3	0260	0.7698	43.87	19.74	8.77
73564	X		X-ray exam, knee, 4 or more	0260	0.7698	43.87	19.74	8.77
73565	X		X-ray exam of knees	0260	0.7698	43.87	19.74	8.77
73580	S		Contrast x-ray of knee joint	0275	3.5084	199.92	69.09	39.98
73590	X		X-ray exam of lower leg	0260	0.7698	43.87	19.74	8.77
73592	X		X-ray exam of leg, infant	0260	0.7698	43.87	19.74	8.77
73600	X		X-ray exam of ankle	0260	0.7698	43.87	19.74	8.77
73610	X		X-ray exam of ankle	0260	0.7698	43.87	19.74	8.77
73615	S		Contrast x-ray of ankle	0275	3.5084	199.92	69.09	39.98
73620	X		X-ray exam of foot	0260	0.7698	43.87	19.74	8.77
73630	X		X-ray exam of foot	0260	0.7698	43.87	19.74	8.77
73650	X		X-ray exam of heel	0260	0.7698	43.87	19.74	8.77
73660	X		X-ray exam of toe(s)	0260	0.7698	43.87	19.74	8.77
73700	S		Ct lower extremity w/o dye	0332	3.3910	193.23	86.95	38.65
73701	S		Ct lower extremity w/dye	0283	4.7485	270.58	121.76	54.12
73702	S		Ct lwr extremity w/o&w/dye	0333	5.6225	320.39	144.17	64.08
73706	S		Ct angio lwr extr w/o&w/dye	0662	5.6204	320.27	144.12	64.05
73718	S		Mri lower extremity w/o dye	0336	6.3150	359.85	161.93	71.97
73719	S		Mri lower extremity w/dye	0284	6.7851	386.64	173.98	77.33
73720	S		Mri lwr extremity w/o&w/dye	0337	9.1701	522.54	235.14	104.51
73721	S		Mri jnt of lwr extre w/o dye	0336	6.3150	359.85	161.93	71.97
73722	S		Mri joint of lwr extr w/dye	0284	6.7851	386.64	173.98	77.33
73723	S		Mri joint lwr extr w/o&w/dye	0337	9.1701	522.54	235.14	104.51
73725	B		Mr ang lwr ext w or w/o dye		.	.	.	.
74000	X		X-ray exam of abdomen	0260	0.7698	43.87	19.74	8.77
74010	X		X-ray exam of abdomen	0260	0.7698	43.87	19.74	8.77
74020	X		X-ray exam of abdomen	0260	0.7698	43.87	19.74	8.77
74022	X		X-ray exam series, abdomen	0261	1.3351	76.08	.	15.22
74150	S		Ct abdomen w/o dye	0332	3.3910	193.23	86.95	38.65
74160	S		Ct abdomen w/dye	0283	4.7485	270.58	121.76	54.12
74170	S		Ct abdomen w/o & w/dye	0333	5.6225	320.39	144.17	64.08
74175	S		Ct angio abdom w/o & w/dye	0662	5.6204	320.27	144.12	64.05
74181	S		Mri abdomen w/o dye	0336	6.3150	359.85	161.93	71.97

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74182	S		Mri abdomen w/dye	0284	6.7851	386.64	173.98	77.33
74183	S		Mri abdomen w/o & w/dye	0337	9.1701	522.54	235.14	104.51
74185	B		Mri angio, abdom w orw/o dye					
74190	X		X-ray exam of peritoneum	0264	3.4194	194.85	79.41	38.97
74210	S		Contrst x-ray exam of throat	0276	1.5808	90.08	40.53	18.02
74220	S		Contrast x-ray, esophagus	0276	1.5808	90.08	40.53	18.02
74230	S		Cine/vid x-ray, throat/esoph	0276	1.5808	90.08	40.53	18.02
74235	S		Remove esophagus obstruction	0296	2.4185	137.81	61.04	27.56
74240	S		X-ray exam, upper gi tract	0276	1.5808	90.08	40.53	18.02
74241	S		X-ray exam, upper gi tract	0276	1.5808	90.08	40.53	18.02
74245	S		X-ray exam, upper gi tract	0277	2.4364	138.83	60.47	27.77
74246	S		Contrst x-ray uppr gi tract	0276	1.5808	90.08	40.53	18.02
74247	S		Contrst x-ray uppr gi tract	0276	1.5808	90.08	40.53	18.02
74249	S		Contrst x-ray uppr gi tract	0277	2.4364	138.83	60.47	27.77
74250	S		X-ray exam of small bowel	0276	1.5808	90.08	40.53	18.02
74251	S		X-ray exam of small bowel	0277	2.4364	138.83	60.47	27.77
74260	S		X-ray exam of small bowel	0277	2.4364	138.83	60.47	27.77
74270	S		Contrast x-ray exam of colon	0276	1.5808	90.08	40.53	18.02
74280	S		Contrast x-ray exam of colon	0277	2.4364	138.83	60.47	27.77
74283	S		Contrast x-ray exam of colon	0276	1.5808	90.08	40.53	18.02
74290	S		Contrast x-ray, gallbladder	0276	1.5808	90.08	40.53	18.02
74291	S		Contrast x-rays, gallbladder	0276	1.5808	90.08	40.53	18.02
74300	X		X-ray bile ducts/pancreas	0263	1.8514	105.50	38.51	21.10
74301	X		X-rays at surgery add-on	0263	1.8514	105.50	38.51	21.10
74305	X		X-ray bile ducts/pancreas	0263	1.8514	105.50	38.51	21.10
74320	X		Contrast x-ray of bile ducts	0264	3.4194	194.85	79.41	38.97
74327	S		X-ray bile stone removal	0296	2.4185	137.81	61.04	27.56
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	1.3880	79.09	35.59	15.82
74350	X		X-ray guide, stomach tube	0263	1.8514	105.50	38.51	21.10
74355	X		X-ray guide, intestinal tube	0263	1.8514	105.50	38.51	21.10
74360	S		X-ray guide, GI dilation	0296	2.4185	137.81	61.04	27.56
74363	S		X-ray, bile duct dilation	0297	5.2294	297.99	122.13	59.60
74400	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74410	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74415	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74420	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74425	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74430	S		Contrast x-ray, bladder	0278	2.8522	162.53	66.07	32.51
74440	S		X-ray, male genital tract	0278	2.8522	162.53	66.07	32.51
74445	S		X-ray exam of penis	0278	2.8522	162.53	66.07	32.51

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74450	S		X-ray, urethra/bladder	0278	2.8522	162.53	66.07	32.51
74455	S		X-ray, urethra/bladder	0278	2.8522	162.53	66.07	32.51
74470	X		X-ray exam of kidney lesion	0263	1.8514	105.50	38.51	21.10
74475	S		X-ray control, cath insert	0297	5.2294	297.99	122.13	59.60
74480	S		X-ray control, cath insert	0296	2.4185	137.81	61.04	27.56
74485	S		X-ray guide, GU dilation	0296	2.4185	137.81	61.04	27.56
74710	X		X-ray measurement of pelvis	0260	0.7698	43.87	19.74	8.77
74740	X		X-ray, female genital tract	0264	3.4194	194.85	79.41	38.97
74742	X		X-ray, fallopian tube	0264	3.4194	194.85	79.41	38.97
74775	S		X-ray exam of perineum	0278	2.8522	162.53	66.07	32.51
75552	S		Heart mri for morph w/o dye	0336	6.3150	359.85	161.93	71.97
75553	S		Heart mri for morph w/dye	0284	6.7851	386.64	173.98	77.33
75554	S		Cardiac MRI/function	0335	6.0472	344.59	150.64	68.92
75555	S		Cardiac MRI/limited study	0335	6.0472	344.59	150.64	68.92
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	20.1741	1149.58	353.85	229.92
75605	S		Contrast x-ray exam of aorta	0280	20.1741	1149.58	353.85	229.92
75625	S		Contrast x-ray exam of aorta	0280	20.1741	1149.58	353.85	229.92
75630	S		X-ray aorta, leg arteries	0280	20.1741	1149.58	353.85	229.92
75635	S		Ct angio abdominal arteries	0662	5.6204	320.27	144.12	64.05
75650	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75658	S		Artery x-rays, arm	0279	8.8113	502.09	150.03	100.42
75660	S		Artery x-rays, head & neck	0668	6.7346	383.76	114.67	76.75
75662	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75665	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75671	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75676	S		Artery x-rays, neck	0280	20.1741	1149.58	353.85	229.92
75680	S		Artery x-rays, neck	0280	20.1741	1149.58	353.85	229.92
75685	S		Artery x-rays, spine	0280	20.1741	1149.58	353.85	229.92
75705	S		Artery x-rays, spine	0668	6.7346	383.76	114.67	76.75
75710	S		Artery x-rays, arm/leg	0280	20.1741	1149.58	353.85	229.92
75716	S		Artery x-rays, arms/legs	0280	20.1741	1149.58	353.85	229.92
75722	S		Artery x-rays, kidney	0280	20.1741	1149.58	353.85	229.92
75724	S		Artery x-rays, kidneys	0280	20.1741	1149.58	353.85	229.92
75726	S		Artery x-rays, abdomen	0280	20.1741	1149.58	353.85	229.92
75731	S		Artery x-rays, adrenal gland	0280	20.1741	1149.58	353.85	229.92
75733	S		Artery x-rays, adrenals	0668	6.7346	383.76	114.67	76.75
75736	S		Artery x-rays, pelvis	0280	20.1741	1149.58	353.85	229.92
75741	S		Artery x-rays, lung	0279	8.8113	502.09	150.03	100.42
75743	S		Artery x-rays, lungs	0280	20.1741	1149.58	353.85	229.92
75746	S		Artery x-rays, lung	0279	8.8113	502.09	150.03	100.42
75756	S		Artery x-rays, chest	0279	8.8113	502.09	150.03	100.42
75774	S		Artery x-ray, each vessel	0279	8.8113	502.09	150.03	100.42

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75790	S		Visualize A-V shunt	0281	7.2117	410.94	115.16	82.19
75801	X		Lymph vessel x-ray, arm/leg	0264	3.4194	194.85	79.41	38.97
75803	X		Lymph vessel x-ray,arms/legs	0264	3.4194	194.85	79.41	38.97
75805	X		Lymph vessel x-ray, trunk	0264	3.4194	194.85	79.41	38.97
75807	X		Lymph vessel x-ray, trunk	0264	3.4194	194.85	79.41	38.97
75809	X		Nonvascular shunt, x-ray	0263	1.8514	105.50	38.51	21.10
75810	S		Vein x-ray, spleen/liver	0279	8.8113	502.09	150.03	100.42
75820	S		Vein x-ray, arm/leg	0281	7.2117	410.94	115.16	82.19
75822	S		Vein x-ray, arms/legs	0281	7.2117	410.94	115.16	82.19
75825	S		Vein x-ray, trunk	0279	8.8113	502.09	150.03	100.42
75827	S		Vein x-ray, chest	0279	8.8113	502.09	150.03	100.42
75831	S		Vein x-ray, kidney	0287	8.3130	473.70	111.33	94.74
75833	S		Vein x-ray, kidneys	0279	8.8113	502.09	150.03	100.42
75840	S		Vein x-ray, adrenal gland	0287	8.3130	473.70	111.33	94.74
75842	S		Vein x-ray, adrenal glands	0287	8.3130	473.70	111.33	94.74
75860	S		Vein x-ray, neck	0287	8.3130	473.70	111.33	94.74
75870	S		Vein x-ray, skull	0287	8.3130	473.70	111.33	94.74
75872	S		Vein x-ray, skull	0287	8.3130	473.70	111.33	94.74
75880	S		Vein x-ray, eye socket	0287	8.3130	473.70	111.33	94.74
75885	S		Vein x-ray, liver	0280	20.1741	1149.58	353.85	229.92
75887	S		Vein x-ray, liver	0279	8.8113	502.09	150.03	100.42
75889	S		Vein x-ray, liver	0280	20.1741	1149.58	353.85	229.92
75891	S		Vein x-ray, liver	0279	8.8113	502.09	150.03	100.42
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	5.2294	297.99	122.13	59.60
75896	S		X-rays, transcath therapy	0297	5.2294	297.99	122.13	59.60
75898	X		Follow-up angiography	0263	1.8514	105.50	38.51	21.10
75900	C		Arterial catheter exchange					
75901	X		Remove cva device obstruct	0263	1.8514	105.50	38.51	21.10
75902	X		Remove cva lumen obstruct	0263	1.8514	105.50	38.51	21.10
75940	T		X-ray placement, vein filter	0187	3.8526	219.53		43.91
75945	S		Intravascular us	0267	2.4250	138.18	62.18	27.64
75946	S		Intravascular us add-on	0267	2.4250	138.18	62.18	27.64
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C		Iliac aneurysm endovas rpr					
75960	S		Transcath iv stent rs&i	0668	6.7346	383.76	114.67	76.75
75961	S		Retrieval, broken catheter	0668	6.7346	383.76	114.67	76.75
75962	S		Repair arterial blockage	0668	6.7346	383.76	114.67	76.75
75964	S		Repair artery blockage, each	0668	6.7346	383.76	114.67	76.75
75966	S		Repair arterial blockage	0668	6.7346	383.76	114.67	76.75
75968	S		Repair artery blockage, each	0668	6.7346	383.76	114.67	76.75
75970	S		Vascular biopsy	0668	6.7346	383.76	114.67	76.75

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75978	S		Repair venous blockage	0668	6.7346	383.76	114.67	76.75
75980	S		Contrast xray exam bile duct	0297	5.2294	297.99	122.13	59.60
75982	S		Contrast xray exam bile duct	0297	5.2294	297.99	122.13	59.60
75984	X		Xray control catheter change	0263	1.8514	105.50	38.51	21.10
75989	N		Abscess drainage under x-ray		.	.	.	.
75992	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75993	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75994	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75995	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75996	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75998	N		Fluoroguide for vein device		.	.	.	.
76000	X		Fluoroscope examination	0272	1.3880	79.09	35.59	15.82
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	0.7698	43.87	19.74	8.77
76010	X		X-ray, nose to rectum	0260	0.7698	43.87	19.74	8.77
76012	S		Percut vertebroplasty fluor	0274	3.2901	187.48	84.36	37.50
76013	S		Percut vertebroplasty, ct	0274	3.2901	187.48	84.36	37.50
76020	X		X-rays for bone age	0260	0.7698	43.87	19.74	8.77
76040	X		X-rays, bone evaluation	0260	0.7698	43.87	19.74	8.77
76061	X		X-rays, bone survey	0261	1.3351	76.08	.	15.22
76062	X		X-rays, bone survey	0261	1.3351	76.08	.	15.22
76065	X		X-rays, bone evaluation	0261	1.3351	76.08	.	15.22
76066	X		Joint survey, single view	0260	0.7698	43.87	19.74	8.77
76070	S		Ct bone density, axial	0288	1.2735	72.57	.	14.51
76071	S		Ct bone density, peripheral	0282	1.7145	97.70	43.96	19.54
76075	S		Dxa bone density, axial	0288	1.2735	72.57	.	14.51
76076	S		Dxa bone density/peripheral	0665	0.7707	43.92	.	8.78
76077	X	NI	Dxa bone density/v-fracture	0260	0.7698	43.87	19.74	8.77
76078	X		Radiographic absorptiometry	0261	1.3351	76.08	.	15.22
76080	X		X-ray exam of fistula	0263	1.8514	105.50	38.51	21.10
76082	A		Computer mammogram add-on		.	.	.	.
76083	A		Computer mammogram add-on		.	.	.	.
76086	X		X-ray of mammary duct	0263	1.8514	105.50	38.51	21.10
76088	X		X-ray of mammary ducts	0263	1.8514	105.50	38.51	21.10
76090	A		Mammogram, one breast		.	.	.	.
76091	A		Mammogram, both breasts		.	.	.	.
76092	A		Mammogram, screening		.	.	.	.
76093	E		Magnetic image, breast		.	.	.	.
76094	E		Magnetic image, both breasts		.	.	.	.
76095	T		Stereotactic breast biopsy	0187	3.8526	219.53	.	43.91
76096	X		X-ray of needle wire, breast	0289	1.5701	89.47	21.05	17.89

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76098	X		X-ray exam, breast specimen	0260	0.7698	43.87	19.74	8.77
76100	X		X-ray exam of body section	0261	1.3351	76.08		15.22
76101	X		Complex body section x-ray	0263	1.8514	105.50	38.51	21.10
76102	X		Complex body section x-rays	0264	3.4194	194.85	79.41	38.97
76120	X		Cine/video x-rays	0272	1.3880	79.09	35.59	15.82
76125	X		Cine/video x-rays add-on	0260	0.7698	43.87	19.74	8.77
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7698	43.87	19.74	8.77
76350	N		Special x-ray contrast study					
76355	S		Ct scan for localization	0283	4.7485	270.58	121.76	54.12
76360	S		Ct scan for needle biopsy	0283	4.7485	270.58	121.76	54.12
76362	S		Ct guide for tissue ablation	0332	3.3910	193.23	86.95	38.65
76370	S		Ct scan for therapy guide	0282	1.7145	97.70	43.96	19.54
76375	S		3d/holograph reconstr add-on	0282	1.7145	97.70	43.96	19.54
76380	S		CAT scan follow-up study	0282	1.7145	97.70	43.96	19.54
76390	E		Mr spectroscopy					
76393	S		Mr guidance for needle place	0335	6.0472	344.59	150.64	68.92
76394	S		Mri for tissue ablation	0335	6.0472	344.59	150.64	68.92
76400	S		Magnetic image, bone marrow	0335	6.0472	344.59	150.64	68.92
76496	X		Fluoroscopic procedure	0272	1.3880	79.09	35.59	15.82
76497	S		Ct procedure	0282	1.7145	97.70	43.96	19.54
76498	S		Mri procedure	0335	6.0472	344.59	150.64	68.92
76499	X		Radiographic procedure	0260	0.7698	43.87	19.74	8.77
76506	S		Echo exam of head	0266	1.6275	92.74	41.73	18.55
76510	S	NI	Ophth us, b & quant a	0266	1.6275	92.74	41.73	18.55
76511	S		Ophth us, quant a only	0266	1.6275	92.74	41.73	18.55
76512	S		Ophth us, b w/non-quant a	0266	1.6275	92.74	41.73	18.55
76513	S		Echo exam of eye, water bath	0266	1.6275	92.74	41.73	18.55
76514	X		Echo exam of eye, thickness	0340	0.6328	36.06		7.21
76516	S		Echo exam of eye	0266	1.6275	92.74	41.73	18.55
76519	S		Echo exam of eye	0266	1.6275	92.74	41.73	18.55
76529	S		Echo exam of eye	0266	1.6275	92.74	41.73	18.55
76536	S		Us exam of head and neck	0266	1.6275	92.74	41.73	18.55
76604	S		Us exam, chest, b-scan	0266	1.6275	92.74	41.73	18.55
76645	S		Us exam, breast(s)	0265	1.0473	59.68	26.85	11.94
76700	S		Us exam, abdom, complete	0266	1.6275	92.74	41.73	18.55
76705	S		Echo exam of abdomen	0266	1.6275	92.74	41.73	18.55
76770	S		Us exam abdo back wall, comp	0266	1.6275	92.74	41.73	18.55
76775	S		Us exam abdo back wall, lim	0266	1.6275	92.74	41.73	18.55
76778	S		Us exam kidney transplant	0266	1.6275	92.74	41.73	18.55
76800	S		Us exam, spinal canal	0266	1.6275	92.74	41.73	18.55
76801	S		Ob us < 14 wks, single fetus	0266	1.6275	92.74	41.73	18.55
76802	S		Ob us < 14 wks, add'l fetus	0265	1.0473	59.68	26.85	11.94

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76805	S		Ob us >/= 14 wks, sngl fetus	0266	1.6275	92.74	41.73	18.55
76810	S		Ob us >/= 14 wks, addl fetus	0266	1.6275	92.74	41.73	18.55
76811	S		Ob us, detailed, sngl fetus	0267	2.4250	138.18	62.18	27.64
76812	S		Ob us, detailed, addl fetus	0266	1.6275	92.74	41.73	18.55
76815	S		Ob us, limited, fetus(s)	0265	1.0473	59.68	26.85	11.94
76816	S		Ob us, follow-up, per fetus	0265	1.0473	59.68	26.85	11.94
76817	S		Transvaginal us, obstetric	0266	1.6275	92.74	41.73	18.55
76818	S		Fetal biophys profile w/nst	0266	1.6275	92.74	41.73	18.55
76819	S		Fetal biophys profil w/o nst	0266	1.6275	92.74	41.73	18.55
76820	S	NI	Umbilical artery echo	0096	1.7035	97.07	43.68	19.41
76821	S	NI	Middle cerebral artery echo	0096	1.7035	97.07	43.68	19.41
76825	S		Echo exam of fetal heart	0671	1.7087	97.37	43.81	19.47
76826	S		Echo exam of fetal heart	0697	1.5184	86.52	38.93	17.30
76827	S		Echo exam of fetal heart	0671	1.7087	97.37	43.81	19.47
76828	S		Echo exam of fetal heart	0697	1.5184	86.52	38.93	17.30
76830	S		Transvaginal us, non-ob	0266	1.6275	92.74	41.73	18.55
76831	S		Echo exam, uterus	0266	1.6275	92.74	41.73	18.55
76856	S		Us exam, pelvic, complete	0266	1.6275	92.74	41.73	18.55
76857	S		Us exam, pelvic, limited	0265	1.0473	59.68	26.85	11.94
76870	S		Us exam, scrotum	0266	1.6275	92.74	41.73	18.55
76872	S		Us, transrectal	0266	1.6275	92.74	41.73	18.55
76873	S		Echograp trans r, pros study	0266	1.6275	92.74	41.73	18.55
76880	S		Us exam, extremity	0266	1.6275	92.74	41.73	18.55
76885	S		Us exam infant hips, dynamic	0266	1.6275	92.74	41.73	18.55
76886	S		Us exam infant hips, static	0266	1.6275	92.74	41.73	18.55
76930	S		Echo guide, cardiocentesis	0268	1.1835	67.44		13.49
76932	S		Echo guide for heart biopsy	0268	1.1835	67.44		13.49
76936	S		Echo guide for artery repair	0268	1.1835	67.44		13.49
76937	N		Us guide, vascular access					
76940	S		Us guide, tissue ablation	0268	1.1835	67.44		13.49
76941	S		Echo guide for transfusion	0268	1.1835	67.44		13.49
76942	S		Echo guide for biopsy	0268	1.1835	67.44		13.49
76945	S		Echo guide, villus sampling	0268	1.1835	67.44		13.49
76946	S		Echo guide for amniocentesis	0268	1.1835	67.44		13.49
76948	S		Echo guide, ova aspiration	0268	1.1835	67.44		13.49
76950	S		Echo guidance radiotherapy	0268	1.1835	67.44		13.49
76965	S		Echo guidance radiotherapy	0268	1.1835	67.44		13.49
76970	S		Ultrasound exam follow-up	0265	1.0473	59.68	26.85	11.94
76975	S		GI endoscopic ultrasound	0266	1.6275	92.74	41.73	18.55
76977	X		Us bone density measure	0340	0.6328	36.06		7.21
76986	S		Ultrasound guide intraoper	0266	1.6275	92.74	41.73	18.55
76999	S		Echo examination procedure	0265	1.0473	59.68	26.85	11.94
77261	E		Radiation therapy planning					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77262	E		Radiation therapy planning		.	.		.
77263	E		Radiation therapy planning		.	.	.	.
77280	X		Set radiation therapy field	0304	1.7107	97.48	41.52	19.50
77285	X		Set radiation therapy field	0305	3.9322	224.07	91.38	44.81
77290	X		Set radiation therapy field	0305	3.9322	224.07	91.38	44.81
77295	X		Set radiation therapy field	0310	14.2774	813.57	325.27	162.71
77299	E		Radiation therapy planning		.	.	.	.
77300	X		Radiation therapy dose plan	0304	1.7107	97.48	41.52	19.50
77301	X		Radiotherapy dose plan, imrt	0310	14.2774	813.57	325.27	162.71
77305	X		Teletx isodose plan simple	0304	1.7107	97.48	41.52	19.50
77310	X		Teletx isodose plan intermed	0304	1.7107	97.48	41.52	19.50
77315	X		Teletx isodose plan complex	0305	3.9322	224.07	91.38	44.81
77321	X		Special teletx port plan	0305	3.9322	224.07	91.38	44.81
77326	X		Brachytx isodose calc simp	0304	1.7107	97.48	41.52	19.50
77327	X		Brachytx isodose calc interm	0305	3.9322	224.07	91.38	44.81
77328	X		Brachytx isodose plan compl	0305	3.9322	224.07	91.38	44.81
77331	X		Special radiation dosimetry	0304	1.7107	97.48	41.52	19.50
77332	X		Radiation treatment aid(s)	0303	2.8722	163.67	66.95	32.73
77333	X		Radiation treatment aid(s)	0303	2.8722	163.67	66.95	32.73
77334	X		Radiation treatment aid(s)	0303	2.8722	163.67	66.95	32.73
77336	X		Radiation physics consult	0304	1.7107	97.48	41.52	19.50
77370	X		Radiation physics consult	0304	1.7107	97.48	41.52	19.50
77399	X		External radiation dosimetry	0304	1.7107	97.48	41.52	19.50
77401	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77402	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77403	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77404	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77406	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77407	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77408	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77409	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77411	S		Radiation treatment delivery	0300	1.5279	87.06	.	17.41
77412	S		Radiation treatment delivery	0301	2.1782	124.12	.	24.82
77413	S		Radiation treatment delivery	0301	2.1782	124.12	.	24.82
77414	S		Radiation treatment delivery	0301	2.1782	124.12	.	24.82
77416	S		Radiation treatment delivery	0301	2.1782	124.12	.	24.82
77417	X		Radiology port film(s)	0260	0.7698	43.87	19.74	8.77
77418	S		Radiation tx delivery, imrt	0412	5.4261	309.20	.	61.84
77427	E		Radiation tx management, x5		.	.	.	.
77431	E		Radiation therapy management		.	.	.	.
77432	E		Stereotactic radiation trmt		.	.	.	.
77470	S		Special radiation treatment	0299	5.8368	332.60	.	66.52
77499	E		Radiation therapy management		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77520	S		Proton trmt, simple w/o comp	0664	9.8560	561.62		112.32
77522	S		Proton trmt, simple w/comp	0664	9.8560	561.62		112.32
77523	S		Proton trmt, intermediate	1510		850.00		170.00
77525	S		Proton treatment, complex	1510		850.00		170.00
77600	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77605	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77610	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77615	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77620	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77750	S		Infuse radioactive materials	0300	1.5279	87.06		17.41
77761	S		Apply intrcav radiat simple	0312	5.5783	317.87		63.57
77762	S		Apply intrcav radiat interm	0312	5.5783	317.87		63.57
77763	S		Apply intrcav radiat compl	0312	5.5783	317.87		63.57
77776	S		Apply interstit radiat simpl	0312	5.5783	317.87		63.57
77777	S		Apply interstit radiat inter	0312	5.5783	317.87		63.57
77778	S		Apply interstit radiat compl	0651	21.9176	1248.93		249.79
77781	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77782	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77783	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77784	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77789	S		Apply surface radiation	0300	1.5279	87.06		17.41
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	13.8770	790.75		158.15
78000	S		Thyroid, single uptake	0389	1.7805	101.46	44.54	20.29
78001	S		Thyroid, multiple uptakes	0389	1.7805	101.46	44.54	20.29
78003	S		Thyroid suppress/stimul	0389	1.7805	101.46	44.54	20.29
78006	S		Thyroid imaging with uptake	0390	2.8999	165.25	74.36	33.05
78007	S		Thyroid image, mult uptakes	0391	3.3043	188.29	84.73	37.66
78010	S		Thyroid imaging	0390	2.8999	165.25	74.36	33.05
78011	S		Thyroid imaging with flow	0390	2.8999	165.25	74.36	33.05
78015	S		Thyroid met imaging	0406	4.5311	258.20	116.19	51.64
78016	S		Thyroid met imaging/studies	0406	4.5311	258.20	116.19	51.64
78018	S		Thyroid met imaging, body	0406	4.5311	258.20	116.19	51.64
78020	S		Thyroid met uptake	0399	1.5961	90.95	40.92	18.19
78070	S		Parathyroid nuclear imaging	0391	3.3043	188.29	84.73	37.66
78075	S		Adrenal nuclear imaging	0391	3.3043	188.29	84.73	37.66
78099	S		Endocrine nuclear procedure	0390	2.8999	165.25	74.36	33.05
78102	S		Bone marrow imaging, ltd	0400	4.1858	238.52	104.32	47.70
78103	S		Bone marrow imaging, mult	0400	4.1858	238.52	104.32	47.70
78104	S		Bone marrow imaging, body	0400	4.1858	238.52	104.32	47.70
78110	S		Plasma volume, single	0393	4.6873	267.10	120.19	53.42
78111	S		Plasma volume, multiple	0393	4.6873	267.10	120.19	53.42
78120	S		Red cell mass, single	0393	4.6873	267.10	120.19	53.42

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78121	S		Red cell mass, multiple	0393	4.6873	267.10	120.19	53.42
78122	S		Blood volume	0393	4.6873	267.10	120.19	53.42
78130	S		Red cell survival study	0393	4.6873	267.10	120.19	53.42
78135	S		Red cell survival kinetics	0393	4.6873	267.10	120.19	53.42
78140	S		Red cell sequestration	0393	4.6873	267.10	120.19	53.42
78160	S		Plasma iron turnover	0393	4.6873	267.10	120.19	53.42
78162	S		Radioiron absorption exam	0393	4.6873	267.10	120.19	53.42
78170	S		Red cell iron utilization	0393	4.6873	267.10	120.19	53.42
78172	S		Total body iron estimation	0393	4.6873	267.10	120.19	53.42
78185	S		Spleen imaging	0400	4.1858	238.52	104.32	47.70
78190	S		Platelet survival, kinetics	0389	1.7805	101.46	44.54	20.29
78191	S		Platelet survival	0389	1.7805	101.46	44.54	20.29
78195	S		Lymph system imaging	0400	4.1858	238.52	104.32	47.70
78199	S		Blood/lymph nuclear exam	0400	4.1858	238.52	104.32	47.70
78201	S		Liver imaging	0394	4.5876	261.42	117.63	52.28
78202	S		Liver imaging with flow	0394	4.5876	261.42	117.63	52.28
78205	S		Liver imaging (3D)	0394	4.5876	261.42	117.63	52.28
78206	S		Liver image (3d) with flow	0394	4.5876	261.42	117.63	52.28
78215	S		Liver and spleen imaging	0394	4.5876	261.42	117.63	52.28
78216	S		Liver & spleen image/flow	0394	4.5876	261.42	117.63	52.28
78220	S		Liver function study	0394	4.5876	261.42	117.63	52.28
78223	S		Hepatobiliary imaging	0394	4.5876	261.42	117.63	52.28
78230	S		Salivary gland imaging	0395	3.9819	226.90	102.10	45.38
78231	S		Serial salivary imaging	0395	3.9819	226.90	102.10	45.38
78232	S		Salivary gland function exam	0395	3.9819	226.90	102.10	45.38
78258	S		Esophageal motility study	0395	3.9819	226.90	102.10	45.38
78261	S		Gastric mucosa imaging	0395	3.9819	226.90	102.10	45.38
78262	S		Gastroesophageal reflux exam	0395	3.9819	226.90	102.10	45.38
78264	S		Gastric emptying study	0395	3.9819	226.90	102.10	45.38
78267	A		Breath tst attain/anal c-14					
78268	A		Breath test analysis, c-14					
78270	S		Vit B-12 absorption exam	0389	1.7805	101.46	44.54	20.29
78271	S		Vit b-12 absrp exam, int fac	0389	1.7805	101.46	44.54	20.29
78272	S		Vit B-12 absorp, combined	0389	1.7805	101.46	44.54	20.29
78278	S		Acute GI blood loss imaging	0395	3.9819	226.90	102.10	45.38
78282	S		GI protein loss exam	0395	3.9819	226.90	102.10	45.38
78290	S		Meckel's divert exam	0395	3.9819	226.90	102.10	45.38
78291	S		Leveen/shunt patency exam	0395	3.9819	226.90	102.10	45.38
78299	S		GI nuclear procedure	0395	3.9819	226.90	102.10	45.38
78300	S		Bone imaging, limited area	0396	4.2024	239.47	107.76	47.89
78305	S		Bone imaging, multiple areas	0396	4.2024	239.47	107.76	47.89
78306	S		Bone imaging, whole body	0396	4.2024	239.47	107.76	47.89
78315	S		Bone imaging, 3 phase	0396	4.2024	239.47	107.76	47.89

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78320	S		Bone imaging (3D)	0396	4.2024	239.47	107.76	47.89
78350	X		Bone mineral, single photon	0261	1.3351	76.08		15.22
78351	E		Bone mineral, dual photon					
78399	S		Musculoskeletal nuclear exam	0396	4.2024	239.47	107.76	47.89
78414	S		Non-imaging heart function	0398	4.6280	263.72	118.67	52.74
78428	S		Cardiac shunt imaging	0398	4.6280	263.72	118.67	52.74
78445	S		Vascular flow imaging	0397	2.5517	145.40	60.51	29.08
78455	S		Venous thrombosis study	0397	2.5517	145.40	60.51	29.08
78456	S		Acute venous thrombus image	0397	2.5517	145.40	60.51	29.08
78457	S		Venous thrombosis imaging	0397	2.5517	145.40	60.51	29.08
78458	S		Ven thrombosis images, bilat	0397	2.5517	145.40	60.51	29.08
78459	B		Heart muscle imaging (PET)					
78460	S		Heart muscle blood, single	0398	4.6280	263.72	118.67	52.74
78461	S		Heart muscle blood, multiple	0377	7.0532	401.91	180.85	80.38
78464	S		Heart image (3d), single	0398	4.6280	263.72	118.67	52.74
78465	S		Heart image (3d), multiple	0377	7.0532	401.91	180.85	80.38
78466	S		Heart infarct image	0398	4.6280	263.72	118.67	52.74
78468	S		Heart infarct image (ef)	0398	4.6280	263.72	118.67	52.74
78469	S		Heart infarct image (3D)	0398	4.6280	263.72	118.67	52.74
78472	S		Gated heart, planar, single	0398	4.6280	263.72	118.67	52.74
78473	S		Gated heart, multiple	0376	4.9171	280.19	121.42	56.04
78478	S		Heart wall motion add-on	0399	1.5961	90.95	40.92	18.19
78480	S		Heart function add-on	0399	1.5961	90.95	40.92	18.19
78481	S		Heart first pass, single	0398	4.6280	263.72	118.67	52.74
78483	S		Heart first pass, multiple	0376	4.9171	280.19	121.42	56.04
78491	E		Heart image (pet), single					
78492	E		Heart image (pet), multiple					
78494	S		Heart image, spect	0398	4.6280	263.72	118.67	52.74
78496	S		Heart first pass add-on	0399	1.5961	90.95	40.92	18.19
78499	S		Cardiovascular nuclear exam	0398	4.6280	263.72	118.67	52.74
78580	S		Lung perfusion imaging	0401	3.3594	191.43	86.14	38.29
78584	S		Lung V/Q image single breath	0378	5.5820	318.08	143.13	63.62
78585	S		Lung V/Q imaging	0378	5.5820	318.08	143.13	63.62
78586	S		Aerosol lung image, single	0401	3.3594	191.43	86.14	38.29
78587	S		Aerosol lung image, multiple	0401	3.3594	191.43	86.14	38.29
78588	S		Perfusion lung image	0378	5.5820	318.08	143.13	63.62
78591	S		Vent image, 1 breath, 1 proj	0401	3.3594	191.43	86.14	38.29
78593	S		Vent image, 1 proj, gas	0401	3.3594	191.43	86.14	38.29
78594	S		Vent image, mult proj, gas	0401	3.3594	191.43	86.14	38.29
78596	S		Lung differential function	0378	5.5820	318.08	143.13	63.62
78599	S		Respiratory nuclear exam	0401	3.3594	191.43	86.14	38.29
78600	S		Brain imaging, ltd static	0402	5.2120	297.00	133.65	59.40
78601	S		Brain imaging, ltd w/flow	0402	5.2120	297.00	133.65	59.40

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78605	S		Brain imaging, complete	0402	5.2120	297.00	133.65	59.40
78606	S		Brain imaging, compl w/flow	0402	5.2120	297.00	133.65	59.40
78607	S		Brain imaging (3D)	0402	5.2120	297.00	133.65	59.40
78608	E		Brain imaging (PET)		.	.	.	.
78609	E		Brain imaging (PET)		.	.	.	.
78610	S		Brain flow imaging only	0402	5.2120	297.00	133.65	59.40
78615	S		Cerebral vascular flow image	0402	5.2120	297.00	133.65	59.40
78630	S		Cerebrospinal fluid scan	0403	3.6801	209.70	94.36	41.94
78635	S		CSF ventriculography	0403	3.6801	209.70	94.36	41.94
78645	S		CSF shunt evaluation	0403	3.6801	209.70	94.36	41.94
78647	S		Cerebrospinal fluid scan	0403	3.6801	209.70	94.36	41.94
78650	S		CSF leakage imaging	0403	3.6801	209.70	94.36	41.94
78660	S		Nuclear exam of tear flow	0403	3.6801	209.70	94.36	41.94
78699	S		Nervous system nuclear exam	0402	5.2120	297.00	133.65	59.40
78700	S		Kidney imaging, static	0404	3.9496	225.06	101.27	45.01
78701	S		Kidney imaging with flow	0404	3.9496	225.06	101.27	45.01
78704	S		Imaging renogram	0404	3.9496	225.06	101.27	45.01
78707	S		Kidney flow/function image	0404	3.9496	225.06	101.27	45.01
78708	S		Kidney flow/function image	0405	4.4571	253.98	114.29	50.80
78709	S		Kidney flow/function image	0405	4.4571	253.98	114.29	50.80
78710	S		Kidney imaging (3D)	0404	3.9496	225.06	101.27	45.01
78715	S		Renal vascular flow exam	0404	3.9496	225.06	101.27	45.01
78725	S		Kidney function study	0389	1.7805	101.46	44.54	20.29
78730	X		Urinary bladder retention	0340	0.6328	36.06		7.21
78740	S		Ureteral reflux study	0404	3.9496	225.06	101.27	45.01
78760	S		Testicular imaging	0404	3.9496	225.06	101.27	45.01
78761	S		Testicular imaging/flow	0404	3.9496	225.06	101.27	45.01
78799	S		Genitourinary nuclear exam	0404	3.9496	225.06	101.27	45.01
78800	S		Tumor imaging, limited area	0406	4.5311	258.20	116.19	51.64
78801	S		Tumor imaging, mult areas	0406	4.5311	258.20	116.19	51.64
78802	S		Tumor imaging, whole body	0406	4.5311	258.20	116.19	51.64
78803	S		Tumor imaging (3D)	0406	4.5311	258.20	116.19	51.64
78804	S		Tumor imaging, whole body	1508	.	650.00	.	130.00
78805	S		Abscess imaging, ltd area	0406	4.5311	258.20	116.19	51.64
78806	S		Abscess imaging, whole body	0406	4.5311	258.20	116.19	51.64
78807	S		Nuclear localization/abscess	0406	4.5311	258.20	116.19	51.64
78810	D		Tumor imaging (PET)		.	.	.	.
78811	E	NI	Tumor imaging (pet), limited		.	.	.	.
78812	E	NI	Tumor image (pet)/skul-thigh		.	.	.	.
78813	E	NI	Tumor image (pet) full body		.	.	.	.
78814	E	NI	Tumor image pet/ct, limited		.	.	.	.
78815	E	NI	Tumorimage pet/ct skul-thigh		.	.	.	.
78816	E	NI	Tumor image pet/ct full body		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78890	N		Nuclear medicine data proc		.	.	.	.
78891	N		Nuclear med data proc		.	.	.	.
78990	D		Provide diag radionuclide(s)		.	.	.	.
78999	S		Nuclear diagnostic exam	0389	1.7805	101.46	44.54	20.29
79000	D		Init hyperthyroid therapy		.	.	.	.
79001	D		Repeat hyperthyroid therapy		.	.	.	.
79005	S	NI	Nuclear rx, oral admin	0407	4.0836	232.70	97.77	46.54
79020	D		Thyroid ablation		.	.	.	.
79030	D		Thyroid ablation, carcinoma		.	.	.	.
79035	D		Thyroid metastatic therapy		.	.	.	.
79100	D		Hematopoetic nuclear therapy		.	.	.	.
79101	S	NI	Nuclear rx, iv admin	0407	4.0836	232.70	97.77	46.54
79200	S		Nuclear rx, intracav admin	0407	4.0836	232.70	97.77	46.54
79300	S		Nuclr rx, interstit colloid	0407	4.0836	232.70	97.77	46.54
79400	D		Nonhemato nuclear therapy		.	.	.	.
79403	S		Hematopoietic nuclear tx	1507	.	550.00	.	110.00
79420	D		Intravascular nuclear ther		.	.	.	.
79440	S		Nuclear rx, intra-articular	0407	4.0836	232.70	97.77	46.54
79445	S	NI	Nuclear rx, intra-arterial	0407	4.0836	232.70	97.77	46.54
79900	D		Provide ther radiopharm(s)		.	.	.	.
79999	S		Nuclear medicine therapy	0407	4.0836	232.70	97.77	46.54
80048	A		Basic metabolic panel		.	.	.	.
80050	E		General health panel		.	.	.	.
80051	A		Electrolyte panel		.	.	.	.
80053	A		Comprehen metabolic panel		.	.	.	.
80055	E		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80166	A		Assay of doxepin		.	.	.	.
80168	A		Assay of ethosuximide		.	.	.	.
80170	A		Assay of gentamicin		.	.	.	.
80172	A		Assay of gold		.	.	.	.
80173	A		Assay of haloperidol		.	.	.	.
80174	A		Assay of imipramine		.	.	.	.
80176	A		Assay of lidocaine		.	.	.	.
80178	A		Assay of lithium		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80436	A		Metyrapone panel		.	.	.	.
80438	A		TRH stimulation panel		.	.	.	.
80439	A		TRH stimulation panel		.	.	.	.
80440	A		TRH stimulation panel		.	.	.	.
80500	X		Lab pathology consultation	0342	0.2068	11.78	5.30	2.36
80502	X		Lab pathology consultation	0342	0.2068	11.78	5.30	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		.	.	.	.
82045	A	NI	Albumin, ischemia modified		.	.	.	.
82055	A		Assay of ethanol		.	.	.	.
82075	A		Assay of breath ethanol		.	.	.	.
82085	A		Assay of aldolase		.	.	.	.
82088	A		Assay of aldosterone		.	.	.	.
82101	A		Assay of urine alkaloids		.	.	.	.
82103	A		Alpha-1-antitrypsin, total		.	.	.	.
82104	A		Alpha-1-antitrypsin, pheno		.	.	.	.
82105	A		Alpha-fetoprotein, serum		.	.	.	.
82106	A		Alpha-fetoprotein, amniotic		.	.	.	.
82108	A		Assay of aluminum		.	.	.	.
82120	A		Amines, vaginal fluid qual		.	.	.	.
82127	A		Amino acid, single qual		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82374	A		Assay, blood carbon dioxide		.	.	.	.
82375	A		Assay, blood carbon monoxide		.	.	.	.
82376	A		Test for carbon monoxide		.	.	.	.
82378	A		Carcinoembryonic antigen		.	.	.	.
82379	A		Assay of carnitine		.	.	.	.
82380	A		Assay of carotene		.	.	.	.
82382	A		Assay, urine catecholamines		.	.	.	.
82383	A		Assay, blood catecholamines		.	.	.	.
82384	A		Assay, three catecholamines		.	.	.	.
82387	A		Assay of cathepsin-d		.	.	.	.
82390	A		Assay of ceruloplasmin		.	.	.	.
82397	A		Chemiluminescent assay		.	.	.	.
82415	A		Assay of chloramphenicol		.	.	.	.
82435	A		Assay of blood chloride		.	.	.	.
82436	A		Assay of urine chloride		.	.	.	.
82438	A		Assay, other fluid chlorides		.	.	.	.
82441	A		Test for chlorohydrocarbons		.	.	.	.
82465	A		Assay, bld/serum cholesterol		.	.	.	.
82480	A		Assay, serum cholinesterase		.	.	.	.
82482	A		Assay, rbc cholinesterase		.	.	.	.
82485	A		Assay, chondroitin sulfate		.	.	.	.
82486	A		Gas/liquid chromatography		.	.	.	.
82487	A		Paper chromatography		.	.	.	.
82488	A		Paper chromatography		.	.	.	.
82489	A		Thin layer chromatography		.	.	.	.
82491	A		Chromotography, quant, sing		.	.	.	.
82492	A		Chromotography, quant, mult		.	.	.	.
82495	A		Assay of chromium		.	.	.	.
82507	A		Assay of citrate		.	.	.	.
82520	A		Assay of cocaine		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
82656	A	NI	Pancreatic elastase, fecal		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82746	A		Blood folic acid serum		.	.	.	.
82747	A		Assay of folic acid, rbc		.	.	.	.
82757	A		Assay of semen fructose		.	.	.	.
82759	A		Assay of rbc galactokinase		.	.	.	.
82760	A		Assay of galactose		.	.	.	.
82775	A		Assay galactose transferase		.	.	.	.
82776	A		Galactose transferase test		.	.	.	.
82784	A		Assay of gammaglobulin igm		.	.	.	.
82785	A		Assay of gammaglobulin ige		.	.	.	.
82787	A		Igg 1, 2, 3 or 4, each		.	.	.	.
82800	A		Blood pH		.	.	.	.
82803	A		Blood gases: pH, pO2 & pCO2		.	.	.	.
82805	A		Blood gases W/02 saturation		.	.	.	.
82810	A		Blood gases, O2 sat only		.	.	.	.
82820	A		Hemoglobin-oxygen affinity		.	.	.	.
82926	A		Assay of gastric acid		.	.	.	.
82928	A		Assay of gastric acid		.	.	.	.
82938	A		Gastrin test		.	.	.	.
82941	A		Assay of gastrin		.	.	.	.
82943	A		Assay of glucagon		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83009	A	NI	H pylori (c-13), blood		.	.	.	.
83010	A		Assay of haptoglobin, quant		.	.	.	.
83012	A		Assay of haptoglobins		.	.	.	.
83013	A		H pylori (c-13), breath		.	.	.	.
83014	A		H pylori drug admin		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
83630	A	NI	Lactoferrin, fecal (qual)		.	.	.	.
83632	A		Placental lactogen		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
84087	A		Assay phosphohexose enzymes		.	.	.	.
84100	A		Assay of phosphorus		.	.	.	.
84105	A		Assay of urine phosphorus		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		Assay of protein, urine		.	.	.	.
84157	A		Assay of protein, other		.	.	.	.
84160	A		Assay of protein, any source		.	.	.	.
84163	A	NI	Pappa, serum		.	.	.	.
84165	A		Protein e-phoresis, serum		.	.	.	.
84166	A	NI	Protein e-phoresis/urine/csf		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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)		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		Bl smear w/diff wbc count		.	.	.	.
85008	A		Bl smear w/o diff wbc count		.	.	.	.
85009	A		Manual diff wbc count b-coat		.	.	.	.
85013	A		Spun microhematocrit		.	.	.	.
85014	A		Hematocrit		.	.	.	.
85018	A		Hemoglobin		.	.	.	.
85025	A		Complete cbc w/auto diff wbc		.	.	.	.
85027	A		Complete cbc, automated		.	.	.	.
85032	A		Manual cell count, each		.	.	.	.
85041	A		Automated rbc count		.	.	.	.
85044	A		Manual reticulocyte count		.	.	.	.
85045	A		Automated reticulocyte count		.	.	.	.
85046	A		Reticyte/hgb concentrate		.	.	.	.
85048	A		Automated leukocyte count		.	.	.	.
85049	A		Automated platelet count		.	.	.	.
85055	A		Reticulated platelet assay		.	.	.	.
85060	X		Blood smear interpretation	0342	0.2068	11.78	5.30	2.36

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85097	X		Bone marrow interpretation	0343	0.4329	24.67	11.10	4.93
85130	A		Chromogenic substrate assay		.	.	.	.
85170	A		Blood clot retraction		.	.	.	.
85175	A		Blood clot lysis time		.	.	.	.
85210	A		Blood clot factor II test		.	.	.	.
85220	A		Blood clot factor V test		.	.	.	.
85230	A		Blood clot factor VII test		.	.	.	.
85240	A		Blood clot factor VIII test		.	.	.	.
85244	A		Blood clot factor VIII test		.	.	.	.
85245	A		Blood clot factor VIII test		.	.	.	.
85246	A		Blood clot factor VIII test		.	.	.	.
85247	A		Blood clot factor VIII test		.	.	.	.
85250	A		Blood clot factor IX test		.	.	.	.
85260	A		Blood clot factor X test		.	.	.	.
85270	A		Blood clot factor XI test		.	.	.	.
85280	A		Blood clot factor XII test		.	.	.	.
85290	A		Blood clot factor XIII test		.	.	.	.
85291	A		Blood clot factor XIII test		.	.	.	.
85292	A		Blood clot factor assay		.	.	.	.
85293	A		Blood clot factor assay		.	.	.	.
85300	A		Antithrombin III test		.	.	.	.
85301	A		Antithrombin III test		.	.	.	.
85302	A		Blood clot inhibitor antigen		.	.	.	.
85303	A		Blood clot inhibitor test		.	.	.	.
85305	A		Blood clot inhibitor assay		.	.	.	.
85306	A		Blood clot inhibitor test		.	.	.	.
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 degrade, semiquant		.	.	.	.
85379	A		Fibrin degradation, quant		.	.	.	.
85380	A		Fibrin degradation, vte		.	.	.	.
85384	A		Fibrinogen		.	.	.	.
85385	A		Fibrinogen		.	.	.	.
85390	A		Fibrinolysins screen		.	.	.	.
85396	N		Clotting assay, whole blood		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86038	A		Antinuclear antibodies		.	.	.	.
86039	A		Antinuclear antibodies (ANA)		.	.	.	.
86060	A		Antistreptolysin o, titer		.	.	.	.
86063	A		Antistreptolysin o, screen		.	.	.	.
86064	A	NI	B cells, total count		.	.	.	.
86077	X	NI	Physician blood bank service	0343	0.4329	24.67	11.10	4.93
86078	X	NI	Physician blood bank service	0343	0.4329	24.67	11.10	4.93
86079	X	NI	Physician blood bank service	0343	0.4329	24.67	11.10	4.93
86140	A		C-reactive protein		.	.	.	.
86141	A		C-reactive protein, hs		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86329	A		Immunodiffusion		.	.	.	.
86331	A		Immunodiffusion ouchterlony		.	.	.	.
86332	A		Immune complex assay		.	.	.	.
86334	A		Immunofix e-phoresis, serum		.	.	.	.
86335	A	NI	Immunfix e-phorsis/urine/csf		.	.	.	.
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		.	.	.	.
86379	A	NI	Nk cells, total count		.	.	.	.
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	0.1132	6.45	2.62	1.29
86490	X		Coccidioidomycosis skin test	0341	0.1132	6.45	2.62	1.29
86510	X		Histoplasmosis skin test	0341	0.1132	6.45	2.62	1.29
86580	X		TB intradermal test	0341	0.1132	6.45	2.62	1.29
86585	X		TB tine test	0341	0.1132	6.45	2.62	1.29
86586	X		Skin test, unlisted	0341	0.1132	6.45	2.62	1.29
86587	A	NI	Stem cells, total count		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86619	A		Borrelia antibody		.	.	.	.
86622	A		Brucella antibody		.	.	.	.
86625	A		Campylobacter antibody		.	.	.	.
86628	A		Candida antibody		.	.	.	.
86631	A		Chlamydia antibody		.	.	.	.
86632	A		Chlamydia igm antibody		.	.	.	.
86635	A		Coccidioides antibody		.	.	.	.
86638	A		Q fever antibody		.	.	.	.
86641	A		Cryptococcus antibody		.	.	.	.
86644	A		CMV antibody		.	.	.	.
86645	A		CMV antibody, IgM		.	.	.	.
86648	A		Diphtheria antibody		.	.	.	.
86651	A		Encephalitis antibody		.	.	.	.
86652	A		Encephalitis antibody		.	.	.	.
86653	A		Encephalitis antibody		.	.	.	.
86654	A		Encephalitis antibody		.	.	.	.
86658	A		Enterovirus antibody		.	.	.	.
86663	A		Epstein-barr antibody		.	.	.	.
86664	A		Epstein-barr antibody		.	.	.	.
86665	A		Epstein-barr antibody		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86709	A		Hep a antibody, igm		.	.	.	.
86710	A		Influenza virus antibody		.	.	.	.
86713	A		Legionella antibody		.	.	.	.
86717	A		Leishmania antibody		.	.	.	.
86720	A		Leptospira antibody		.	.	.	.
86723	A		Listeria monocytogenes ab		.	.	.	.
86727	A		Lymph choriomeningitis ab		.	.	.	.
86729	A		Lympho venereum antibody		.	.	.	.
86732	A		Mucormycosis antibody		.	.	.	.
86735	A		Mumps antibody		.	.	.	.
86738	A		Mycoplasma antibody		.	.	.	.
86741	A		Neisseria meningitidis		.	.	.	.
86744	A		Nocardia antibody		.	.	.	.
86747	A		Parvovirus antibody		.	.	.	.
86750	A		Malaria antibody		.	.	.	.
86753	A		Protozoa antibody nos		.	.	.	.
86756	A		Respiratory virus antibody		.	.	.	.
86757	A		Rickettsia antibody		.	.	.	.
86759	A		Rotavirus antibody		.	.	.	.
86762	A		Rubella antibody		.	.	.	.
86765	A		Rubeola antibody		.	.	.	.
86768	A		Salmonella antibody		.	.	.	.
86771	A		Shigella antibody		.	.	.	.
86774	A		Tetanus antibody		.	.	.	.
86777	A		Toxoplasma antibody		.	.	.	.
86778	A		Toxoplasma antibody, igm		.	.	.	.
86781	A		Treponema pallidum, confirm		.	.	.	.
86784	A		Trichinella antibody		.	.	.	.
86787	A		Varicella-zoster antibody		.	.	.	.
86790	A		Virus antibody nos		.	.	.	.
86793	A		Yersinia antibody		.	.	.	.
86800	A		Thyroglobulin antibody		.	.	.	.
86803	A		Hepatitis c ab test		.	.	.	.
86804	A		Hep c ab test, confirm		.	.	.	.
86805	A		Lymphocytotoxicity assay		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86822	A		Lymphocyte culture, primed		.	.	.	.
86849	A		Immunology procedure		.	.	.	.
86850	X		RBC antibody screen	0345	0.2413	13.75	3.06	2.75
86860	X		RBC antibody elution	0346	0.3586	20.43	5.15	4.09
86870	X		RBC antibody identification	0346	0.3586	20.43	5.15	4.09
86880	X		Coombs test, direct	0409	0.1272	7.25	2.22	1.45
86885	X		Coombs test, indirect, qual	0409	0.1272	7.25	2.22	1.45
86886	X		Coombs test, indirect, titer	0409	0.1272	7.25	2.22	1.45
86890	X		Autologous blood process	0347	0.9386	53.48	13.20	10.70
86891	X		Autologous blood, op salvage	0345	0.2413	13.75	3.06	2.75
86900	X		Blood typing, ABO	0409	0.1272	7.25	2.22	1.45
86901	X		Blood typing, Rh (D)	0409	0.1272	7.25	2.22	1.45
86903	X		Blood typing, antigen screen	0345	0.2413	13.75	3.06	2.75
86904	X		Blood typing, patient serum	0345	0.2413	13.75	3.06	2.75
86905	X		Blood typing, RBC antigens	0345	0.2413	13.75	3.06	2.75
86906	X		Blood typing, Rh phenotype	0345	0.2413	13.75	3.06	2.75
86910	E		Blood typing, paternity test		.	.	.	.
86911	E		Blood typing, antigen system		.	.	.	.
86920	X		Compatibility test	0346	0.3586	20.43	5.15	4.09
86921	X		Compatibility test	0345	0.2413	13.75	3.06	2.75
86922	X		Compatibility test	0346	0.3586	20.43	5.15	4.09
86927	X		Plasma, fresh frozen	0346	0.3586	20.43	5.15	4.09
86930	X		Frozen blood prep	0347	0.9386	53.48	13.20	10.70
86931	X		Frozen blood thaw	0347	0.9386	53.48	13.20	10.70
86932	X		Frozen blood freeze/thaw	0347	0.9386	53.48	13.20	10.70
86940	A		Hemolysins/agglutinins, auto		.	.	.	.
86941	A		Hemolysins/agglutinins		.	.	.	.
86945	X		Blood product/irradiation	0346	0.3586	20.43	5.15	4.09
86950	X		Leukacyte transfusion	0347	0.9386	53.48	13.20	10.70
86965	X		Pooling blood platelets	0346	0.3586	20.43	5.15	4.09
86970	X		RBC pretreatment	0345	0.2413	13.75	3.06	2.75
86971	X		RBC pretreatment	0345	0.2413	13.75	3.06	2.75
86972	X		RBC pretreatment	0345	0.2413	13.75	3.06	2.75
86975	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86976	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86977	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86978	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86985	X		Split blood or products	0347	0.9386	53.48	13.20	10.70
86999	X		Transfusion procedure	0345	0.2413	13.75	3.06	2.75
87001	A		Small animal inoculation		.	.	.	.
87003	A		Small animal inoculation		.	.	.	.
87015	A		Specimen concentration		.	.	.	.
87040	A		Blood culture for bacteria		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		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		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87340	A		Hepatitis b surface ag, eia		.	.	.	.
87341	A		Hepatitis b surface, ag, eia		.	.	.	.
87350	A		Hepatitis be ag, eia		.	.	.	.
87380	A		Hepatitis delta ag, eia		.	.	.	.
87385	A		Histoplasma capsul ag, eia		.	.	.	.
87390	A		Hiv-1 ag, eia		.	.	.	.
87391	A		Hiv-2 ag, eia		.	.	.	.
87400	A		Influenza a/b, ag, eia		.	.	.	.
87420	A		Resp syncytial ag, eia		.	.	.	.
87425	A		Rotavirus ag, eia		.	.	.	.
87427	A		Shiga-like toxin ag, eia		.	.	.	.
87430	A		Strep a ag, eia		.	.	.	.
87449	A		Ag detect nos, eia, mult		.	.	.	.
87450	A		Ag detect nos, eia, single		.	.	.	.
87451	A		Ag detect polyval, eia, mult		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87801	A		Detect agnt mult, dna, ampli		.	.	.	.
87802	A		Strep b assay w/optic		.	.	.	.
87803	A		Clostridium toxin a w/optic		.	.	.	.
87804	A		Influenza assay w/optic		.	.	.	.
87807	A	NI	Rsv 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	0.4329	24.67	11.10	4.93
88106	X		Cytopathology, fluids	0343	0.4329	24.67	11.10	4.93
88107	X		Cytopathology, fluids	0343	0.4329	24.67	11.10	4.93
88108	X		Cytopath, concentrate tech	0343	0.4329	24.67	11.10	4.93
88112	X		Cytopath, cell enhance tech	0343	0.4329	24.67	11.10	4.93
88125	X		Forensic cytopathology	0342	0.2068	11.78	5.30	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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.2068	11.78	5.30	2.36
88161	X		Cytopath smear, other source	0343	0.4329	24.67	11.10	4.93
88162	X		Cytopath smear, other source	0342	0.2068	11.78	5.30	2.36
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	0.4329	24.67	11.10	4.93
88173	X		Cytopath eval, fna, report	0343	0.4329	24.67	11.10	4.93
88174	A		Cytopath, c/v auto, in fluid		.	.	.	.
88175	A		Cytopath c/v auto fluid redo		.	.	.	.
88180	D		Cell marker study		.	.	.	.
88182	X		Cell marker study	0344	0.6110	34.82	15.66	6.96
88184	X	NI	Flowcytometry/ tc, 1 marker	0342	0.2068	11.78	5.30	2.36
88185	X	NI	Flowcytometry/tc, add-on	0342	0.2068	11.78	5.30	2.36
88187	X	NI	Flowcytometry/read, 2-8	0342	0.2068	11.78	5.30	2.36
88188	X	NI	Flowcytometry/read, 9-15	0342	0.2068	11.78	5.30	2.36
88189	X	NI	Flowcytometry/read, 16 & >	0344	0.6110	34.82	15.66	6.96
88199	A		Cytopathology procedure		.	.	.	.
88230	A		Tissue culture, lymphocyte		.	.	.	.
88233	A		Tissue culture, skin/biopsy		.	.	.	.
88235	A		Tissue culture, placenta		.	.	.	.
88237	A		Tissue culture, bone marrow		.	.	.	.
88239	A		Tissue culture, tumor		.	.	.	.
88240	A		Cell cryopreserve/storage		.	.	.	.
88241	A		Frozen cell preparation		.	.	.	.
88245	A		Chromosome analysis, 20-25		.	.	.	.
88248	A		Chromosome analysis, 50-100		.	.	.	.
88249	A		Chromosome analysis, 100		.	.	.	.
88261	A		Chromosome analysis, 5		.	.	.	.
88262	A		Chromosome analysis, 15-20		.	.	.	.
88263	A		Chromosome analysis, 45		.	.	.	.
88264	A		Chromosome analysis, 20-25		.	.	.	.
88267	A		Chromosome analys, placenta		.	.	.	.
88269	A		Chromosome analys, amniotic		.	.	.	.
88271	A		Cytogenetics, dna probe		.	.	.	.
88272	A		Cytogenetics, 3-5		.	.	.	.
88273	A		Cytogenetics, 10-30		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.2068	11.78	5.30	2.36
88300	X		Surgical path, gross	0342	0.2068	11.78	5.30	2.36
88302	X		Tissue exam by pathologist	0342	0.2068	11.78	5.30	2.36
88304	X		Tissue exam by pathologist	0343	0.4329	24.67	11.10	4.93
88305	X		Tissue exam by pathologist	0343	0.4329	24.67	11.10	4.93
88307	X		Tissue exam by pathologist	0344	0.6110	34.82	15.66	6.96
88309	X		Tissue exam by pathologist	0344	0.6110	34.82	15.66	6.96
88311	X		Decalcify tissue	0342	0.2068	11.78	5.30	2.36
88312	X		Special stains	0342	0.2068	11.78	5.30	2.36
88313	X		Special stains	0342	0.2068	11.78	5.30	2.36
88314	X		Histochemical stain	0342	0.2068	11.78	5.30	2.36
88318	X		Chemical histochemistry	0342	0.2068	11.78	5.30	2.36
88319	X		Enzyme histochemistry	0342	0.2068	11.78	5.30	2.36
88321	X		Microslide consultation	0342	0.2068	11.78	5.30	2.36
88323	X		Microslide consultation	0344	0.6110	34.82	15.66	6.96
88325	X		Comprehensive review of data	0344	0.6110	34.82	15.66	6.96
88329	X		Path consult introp	0342	0.2068	11.78	5.30	2.36
88331	X		Path consult intraop, 1 bloc	0343	0.4329	24.67	11.10	4.93
88332	X		Path consult intraop, add'l	0342	0.2068	11.78	5.30	2.36
88342	X		Immunohistochemistry	0344	0.6110	34.82	15.66	6.96
88346	X		Immunofluorescent study	0344	0.6110	34.82	15.66	6.96
88347	X		Immunofluorescent study	0344	0.6110	34.82	15.66	6.96
88348	X		Electron microscopy	0661	3.5068	199.83	88.87	39.97
88349	X		Scanning electron microscopy	0661	3.5068	199.83	88.87	39.97
88355	X		Analysis, skeletal muscle	0344	0.6110	34.82	15.66	6.96
88356	X		Analysis, nerve	0344	0.6110	34.82	15.66	6.96
88358	X		Analysis, tumor	0344	0.6110	34.82	15.66	6.96
88360	X	NI	Tumor immunohistochem/manual	0344	0.6110	34.82	15.66	6.96
88361	X		Tumor immunohistochem/comput	0344	0.6110	34.82	15.66	6.96
88362	X		Nerve teasing preparations	0344	0.6110	34.82	15.66	6.96
88365	X		Insitu hybridization (fish)	0344	0.6110	34.82	15.66	6.96
88367	X	NI	Insitu hybridization, auto	0344	0.6110	34.82	15.66	6.96
88368	X	NI	Insitu hybridization, manual	0344	0.6110	34.82	15.66	6.96
88371	A		Protein, western blot tissue		.	.	.	.
88372	A		Protein analysis w/probe		.	.	.	.
88380	A		Microdissection		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	1.6719	95.27	42.45	19.05
89105	X		Sample intestinal contents	0360	1.6719	95.27	42.45	19.05
89125	A		Specimen fat stain		.	.	.	.
89130	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89132	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89135	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89136	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89140	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89141	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89160	A		Exam feces for meat fibers		.	.	.	.
89190	A		Nasal smear for eosinophils		.	.	.	.
89220	X		Sputum specimen collection	0343	0.4329	24.67	11.10	4.93
89225	A		Starch granules, feces		.	.	.	.
89230	X		Collect sweat for test	0343	0.4329	24.67	11.10	4.93
89235	A		Water load test		.	.	.	.
89240	A		Pathology lab procedure		.	.	.	.
89250	X		Cultr oocyte/embryo <4 days	0348	0.7675	43.73	.	8.75
89251	X		Cultr oocyte/embryo <4 days	0348	0.7675	43.73	.	8.75
89253	X		Embryo hatching	0348	0.7675	43.73	.	8.75
89254	X		Oocyte identification	0348	0.7675	43.73	.	8.75
89255	X		Prepare embryo for transfer	0348	0.7675	43.73	.	8.75
89257	X		Sperm identification	0348	0.7675	43.73	.	8.75
89258	X		Cryopreservation; embryo(s)	0348	0.7675	43.73	.	8.75
89259	X		Cryopreservation, sperm	0348	0.7675	43.73	.	8.75
89260	X		Sperm isolation, simple	0348	0.7675	43.73	.	8.75
89261	X		Sperm isolation, complex	0348	0.7675	43.73	.	8.75
89264	X		Identify sperm tissue	0348	0.7675	43.73	.	8.75
89268	X		Insemination of oocytes	0348	0.7675	43.73	.	8.75
89272	X		Extended culture of oocytes	0348	0.7675	43.73	.	8.75
89280	X		Assist oocyte fertilization	0348	0.7675	43.73	.	8.75
89281	X		Assist oocyte fertilization	0348	0.7675	43.73	.	8.75
89290	X		Biopsy, oocyte polar body	0348	0.7675	43.73	.	8.75
89291	X		Biopsy, oocyte polar body	0348	0.7675	43.73	.	8.75
89300	A		Semen analysis w/huhner		.	.	.	.
89310	A		Semen analysis w/count		.	.	.	.
89320	A		Semen analysis, complete		.	.	.	.
89321	A		Semen analysis & motility		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89325	A		Sperm antibody test		.	.	.	.
89329	A		Sperm evaluation test		.	.	.	.
89330	A		Evaluation, cervical mucus		.	.	.	.
89335	X		Cryopreserve testicular tiss	0348	0.7675	43.73	.	8.75
89342	X		Storage/year; embryo(s)	0348	0.7675	43.73	.	8.75
89343	X		Storage/year; sperm/semen	0348	0.7675	43.73	.	8.75
89344	X		Storage/year; reprod tissue	0348	0.7675	43.73	.	8.75
89346	X		Storage/year; oocyte(s)	0348	0.7675	43.73	.	8.75
89352	X		Thawing cryopresrved; embryo	0348	0.7675	43.73	.	8.75
89353	X		Thawing cryopresrved; sperm	0348	0.7675	43.73	.	8.75
89354	X		Thaw cryoprsvrd; reprod tiss	0348	0.7675	43.73	.	8.75
89356	X		Thawing cryopresrved; oocyte	0348	0.7675	43.73	.	8.75
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	N		Diphtheria antitoxin		.	.	.	.
90371	E		Hep b ig, im		.	.	.	.
90375	N		Rabies ig, im/sc		.	.	.	.
90376	K		Rabies ig, heat treated	0356	1.5752	89.76	.	17.95
90378	E		Rsv ig, im, 50mg		.	.	.	.
90379	E		Rsv ig, iv		.	.	.	.
90384	E		Rh ig, full-dose, im		.	.	.	.
90385	N		Rh ig, minidose, im		.	.	.	.
90386	E		Rh ig, iv		.	.	.	.
90389	E		Tetanus ig, im		.	.	.	.
90393	K		Vaccina ig, im	0356	1.5752	89.76	.	17.95
90396	K		Varicella-zoster ig, im	0356	1.5752	89.76	.	17.95
90399	E		Immune globulin		.	.	.	.
90465	N	NI	Immune admin 1 inj, < 8 yrs		.	.	.	.
90466	N	NI	Immune admin addl inj, < 8 y		.	.	.	.
90467	N	NI	Immune admin o or n, < 8 yrs		.	.	.	.
90468	N	NI	Immune admin o/n, addl < 8 y		.	.	.	.
90471	N		Immunization admin		.	.	.	.
90472	N		Immunization admin, each add		.	.	.	.
90473	E		Immune admin oral/nasal		.	.	.	.
90474	E		Immune admin oral/nasal addl		.	.	.	.
90476	K		Adenovirus vaccine, type 4	0356	1.5752	89.76	.	17.95
90477	N		Adenovirus vaccine, type 7		.	.	.	.
90581	N		Anthrax vaccine, sc		.	.	.	.
90585	N		Bcg vaccine, percut		.	.	.	.
90586	K		Bcg vaccine, intravesical	0356	1.5752	89.76	.	17.95

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0356	1.5752	89.76	.	17.95
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		Flu vaccine no preserv 6-35m		.	.	.	.
90656	L	NI	Flu vaccine no preserv 3 & >		.	.	.	.
90657	L		Flu vaccine, 3 yrs, im		.	.	.	.
90658	L		Flu vaccine, 3 yrs & >, im		.	.	.	.
90660	E		Flu vaccine, nasal		.	.	.	.
90665	K		Lyme disease vaccine, im	0356	1.5752	89.76	.	17.95
90669	E		Pneumococcal vacc, ped <5		.	.	.	.
90675	K		Rabies vaccine, im	0356	1.5752	89.76	.	17.95
90676	K		Rabies vaccine, id	0356	1.5752	89.76	.	17.95
90680	N		Rotovirus vaccine, oral		.	.	.	.
90690	N		Typhoid vaccine, oral		.	.	.	.
90691	N		Typhoid vaccine, im		.	.	.	.
90692	N		Typhoid vaccine, h-p, sc/id		.	.	.	.
90693	N		Typhoid vaccine, akd, sc		.	.	.	.
90698	N	NI	Dtap-hib-ip vaccine, im		.	.	.	.
90700	N		Dtap vaccine, < 7 yrs, 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	K		Mmrv vaccine, sc	0355	0.3596	20.49	.	4.10
90712	N		Oral poliovirus vaccine		.	.	.	.
90713	N		Poliovirus, ipv, sc		.	.	.	.
90715	N		Tdap vaccine >7 im		.	.	.	.
90716	N		Chicken pox vaccine, sc		.	.	.	.
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	E		Dtap-hep b-ipv vaccine, im		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90725	K		Cholera vaccine, injectable	0356	1.5752	89.76	.	17.95
90727	N		Plague vaccine, im		.	.	.	.
90732	L		Pneumococcal vaccine		.	.	.	.
90733	N		Meningococcal vaccine, sc		.	.	.	.
90734	N	NI	Meningococcal vaccine, im		.	.	.	.
90735	K		Encephalitis vaccine, sc	0356	1.5752	89.76	.	17.95
90740	K		Hepb vacc, ill pat 3 dose im	0355	0.3596	20.49	.	4.10
90743	K		Hep b vacc, adol, 2 dose, im	0355	0.3596	20.49	.	4.10
90744	K		Hepb vacc ped/adol 3 dose im	0355	0.3596	20.49	.	4.10
90746	K		Hep b vaccine, adult, im	0355	0.3596	20.49	.	4.10
90747	K		Hepb vacc, ill pat 4 dose im	0356	1.5752	89.76	.	17.95
90748	E		Hep b/hib vaccine, im		.	.	.	.
90749	N		Vaccine toxoid		.	.	.	.
90780	T		IV infusion therapy, 1 hour	0120	1.9620	111.80	28.21	22.36
90781	N		IV infusion, additional hour		.	.	.	.
90782	X		Injection, sc/im	0353	0.3981	22.68	.	4.54
90783	X		Injection, ia	0359	0.8693	49.54	.	9.91
90784	X		Injection, iv	0359	0.8693	49.54	.	9.91
90788	X		Injection of antibiotic	0359	0.8693	49.54	.	9.91
90799	X		Ther/prophylactic/dx inject	0352	0.1197	6.82	.	1.36
90801	S		Psy dx interview	0323	1.7589	100.23	20.90	20.05
90802	S		Intac psy dx interview	0323	1.7589	100.23	20.90	20.05
90804	S		Psytx, office, 20-30 min	0322	1.2917	73.60	.	14.72
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.2917	73.60	.	14.72
90806	S		Psytx, off, 45-50 min	0323	1.7589	100.23	20.90	20.05
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.7589	100.23	20.90	20.05
90808	S		Psytx, office, 75-80 min	0323	1.7589	100.23	20.90	20.05
90809	S		Psytx, off, 75-80, w/e&m	0323	1.7589	100.23	20.90	20.05
90810	S		Intac psytx, off, 20-30 min	0322	1.2917	73.60	.	14.72
90811	S		Intac psytx, 20-30, w/e&m	0322	1.2917	73.60	.	14.72
90812	S		Intac psytx, off, 45-50 min	0323	1.7589	100.23	20.90	20.05
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.7589	100.23	20.90	20.05
90814	S		Intac psytx, off, 75-80 min	0323	1.7589	100.23	20.90	20.05
90815	S		Intac psytx, 75-80 w/e&m	0323	1.7589	100.23	20.90	20.05
90816	S		Psytx, hosp, 20-30 min	0322	1.2917	73.60	.	14.72
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.2917	73.60	.	14.72
90818	S		Psytx, hosp, 45-50 min	0323	1.7589	100.23	20.90	20.05
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.7589	100.23	20.90	20.05
90821	S		Psytx, hosp, 75-80 min	0323	1.7589	100.23	20.90	20.05
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.7589	100.23	20.90	20.05
90823	S		Intac psytx, hosp, 20-30 min	0322	1.2917	73.60	.	14.72
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.2917	73.60	.	14.72
90826	S		Intac psytx, hosp, 45-50 min	0323	1.7589	100.23	20.90	20.05

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.7589	100.23	20.90	20.05
90828	S		Intac psytx, hosp, 75-80 min	0323	1.7589	100.23	20.90	20.05
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.7589	100.23	20.90	20.05
90845	S		Psychoanalysis	0323	1.7589	100.23	20.90	20.05
90846	S		Family psytx w/o patient	0324	2.8357	161.59	.	32.32
90847	S		Family psytx w/patient	0324	2.8357	161.59	.	32.32
90849	S		Multiple family group psytx	0325	1.4675	83.62	18.27	16.72
90853	S		Group psychotherapy	0325	1.4675	83.62	18.27	16.72
90857	S		Intac group psytx	0325	1.4675	83.62	18.27	16.72
90862	X		Medication management	0374	1.0880	62.00	.	12.40
90865	S		Narcosynthesis	0323	1.7589	100.23	20.90	20.05
90870	S		Electroconvulsive therapy	0320	5.3260	303.49	80.06	60.70
90871	E		Electroconvulsive therapy		.	.	.	.
90875	E		Psychophysiological therapy		.	.	.	.
90876	E		Psychophysiological therapy		.	.	.	.
90880	S		Hypnotherapy	0323	1.7589	100.23	20.90	20.05
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	1.2917	73.60	.	14.72
90901	A		Biofeedback train, any meth		.	.	.	.
90911	S		Biofeedback peri/uro/rectal	0321	1.4150	80.63	21.72	16.13
90918	E		ESRD related services, month		.	.	.	.
90919	E		ESRD related services, month		.	.	.	.
90920	E		ESRD related services, month		.	.	.	.
90921	E		ESRD related services, month		.	.	.	.
90922	E		ESRD related services, day		.	.	.	.
90923	E		Esrd related services, day		.	.	.	.
90924	E		Esrd related services, day		.	.	.	.
90925	E		Esrd related services, day		.	.	.	.
90935	S		Hemodialysis, one evaluation	0170	6.2255	354.75	.	70.95
90937	E		Hemodialysis, repeated eval		.	.	.	.
90939	N		Hemodialysis study, transcut		.	.	.	.
90940	N		Hemodialysis access study		.	.	.	.
90945	S		Dialysis, one evaluation	0170	6.2255	354.75	.	70.95
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	3.6408	207.46	83.23	41.49
91010	X		Esophagus motility study	0361	3.6408	207.46	83.23	41.49

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
91011	X		Esophagus motility study	0361	3.6408	207.46	83.23	41.49
91012	X		Esophagus motility study	0361	3.6408	207.46	83.23	41.49
91020	X		Gastric motility	0361	3.6408	207.46	83.23	41.49
91030	X		Acid perfusion of esophagus	0361	3.6408	207.46	83.23	41.49
91032	D		Esophagus, acid reflux test		.	.	.	.
91033	D		Prolonged acid reflux test		.	.	.	.
91034	X	NI	Gastroesophageal reflux test	0361	3.6408	207.46	83.23	41.49
91035	S	NI	G-esoph reflx tst w/electrod	1506	.	450.00	.	90.00
91037	X	NI	Esoph imped function test	0361	3.6408	207.46	83.23	41.49
91038	X	NI	Esoph imped funct test > 1h	0361	3.6408	207.46	83.23	41.49
91040	X	NI	Esoph balloon distension tst	0360	1.6719	95.27	42.45	19.05
91052	X		Gastric analysis test	0361	3.6408	207.46	83.23	41.49
91055	X		Gastric intubation for smear	0360	1.6719	95.27	42.45	19.05
91060	X		Gastric saline load test	0360	1.6719	95.27	42.45	19.05
91065	X		Breath hydrogen test	0360	1.6719	95.27	42.45	19.05
91100	X		Pass intestine bleeding tube	0360	1.6719	95.27	42.45	19.05
91105	X		Gastric intubation treatment	0360	1.6719	95.27	42.45	19.05
91110	T		Gi tract capsule endoscopy	0142	8.7069	496.15	152.78	99.23
91120	T	NI	Rectal sensation test	0156	2.4782	141.22	40.52	28.24
91122	T		Anal pressure record	0156	2.4782	141.22	40.52	28.24
91123	N		Irrigate fecal impaction		.	.	.	.
91132	X		Electrogastrography	0360	1.6719	95.27	42.45	19.05
91133	X		Electrogastrography w/test	0360	1.6719	95.27	42.45	19.05
91299	X		Gastroenterology procedure	0360	1.6719	95.27	42.45	19.05
92002	V		Eye exam, new patient	0601	0.9847	56.11	.	11.22
92004	V		Eye exam, new patient	0602	1.3977	79.65	.	15.93
92012	V		Eye exam established pat	0600	0.9033	51.47	.	10.29
92014	V		Eye exam & treatment	0602	1.3977	79.65	.	15.93
92015	E		Refraction		.	.	.	.
92018	T		New eye exam & treatment	0699	9.7041	552.97	.	110.59
92019	T		Eye exam & treatment	0699	9.7041	552.97	.	110.59
92020	S		Special eye evaluation	0230	0.8019	45.69	14.97	9.14
92060	S		Special eye evaluation	0230	0.8019	45.69	14.97	9.14
92065	S		Orthoptic/pleoptic training	0230	0.8019	45.69	14.97	9.14
92070	N		Fitting of contact lens		.	.	.	.
92081	S		Visual field examination(s)	0230	0.8019	45.69	14.97	9.14
92082	S		Visual field examination(s)	0230	0.8019	45.69	14.97	9.14
92083	S		Visual field examination(s)	0230	0.8019	45.69	14.97	9.14
92100	N		Serial tonometry exam(s)		.	.	.	.
92120	S		Tonography & eye evaluation	0230	0.8019	45.69	14.97	9.14
92130	S		Water provocation tonography	0230	0.8019	45.69	14.97	9.14
92135	S		Opthalmic dx imaging	0230	0.8019	45.69	14.97	9.14
92136	S		Ophthalmic biometry	0230	0.8019	45.69	14.97	9.14

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92140	S		Glaucoma provocative tests	0698	1.4649	83.47	18.72	16.69
92225	S		Special eye exam, initial	0230	0.8019	45.69	14.97	9.14
92226	S		Special eye exam, subsequent	0230	0.8019	45.69	14.97	9.14
92230	T		Eye exam with photos	0699	9.7041	552.97		110.59
92235	S		Eye exam with photos	0231	2.0073	114.38	44.61	22.88
92240	S		Icg angiography	0231	2.0073	114.38	44.61	22.88
92250	S		Eye exam with photos	0230	0.8019	45.69	14.97	9.14
92260	S		Ophthalmoscopy/dynamometry	0230	0.8019	45.69	14.97	9.14
92265	S		Eye muscle evaluation	0230	0.8019	45.69	14.97	9.14
92270	S		Electro-oculography	0230	0.8019	45.69	14.97	9.14
92275	S		Electroretinography	0231	2.0073	114.38	44.61	22.88
92283	S		Color vision examination	0230	0.8019	45.69	14.97	9.14
92284	S		Dark adaptation eye exam	0698	1.4649	83.47	18.72	16.69
92285	S		Eye photography	0230	0.8019	45.69	14.97	9.14
92286	S		Internal eye photography	0698	1.4649	83.47	18.72	16.69
92287	S		Internal eye photography	0698	1.4649	83.47	18.72	16.69
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	1.0861	61.89		12.38
92312	X		Contact lens fitting	0362	1.0861	61.89		12.38
92313	X		Contact lens fitting	0362	1.0861	61.89		12.38
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	1.0861	61.89		12.38
92316	X		Prescription of contact lens	0362	1.0861	61.89		12.38
92317	X		Prescription of contact lens	0362	1.0861	61.89		12.38
92325	X		Modification of contact lens	0362	1.0861	61.89		12.38
92326	X		Replacement of contact lens	0362	1.0861	61.89		12.38
92330	S		Fitting of artificial eye	0230	0.8019	45.69	14.97	9.14
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	1.0861	61.89		12.38
92353	X		Special spectacles fitting	0362	1.0861	61.89		12.38
92354	X		Special spectacles fitting	0362	1.0861	61.89		12.38
92355	X		Special spectacles fitting	0362	1.0861	61.89		12.38
92358	X		Eye prosthesis service	0362	1.0861	61.89		12.38
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	1.0861	61.89		12.38
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					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92396	E		Supply of contact lenses		.	.	.	.
92499	S		Eye service or procedure	0230	0.8019	45.69	14.97	9.14
92502	T		Ear and throat examination	0251	1.9352	110.27	.	22.05
92504	N		Ear microscopy examination		.	.	.	.
92506	A		Speech/hearing evaluation		.	.	.	.
92507	A		Speech/hearing therapy		.	.	.	.
92508	A		Speech/hearing therapy		.	.	.	.
92510	E		Rehab for ear implant		.	.	.	.
92511	T		Nasopharyngoscopy	0071	0.7396	42.14	11.31	8.43
92512	X		Nasal function studies	0363	0.8653	49.31	17.44	9.86
92516	X		Facial nerve function test	0660	1.7060	97.21	30.66	19.44
92520	X		Laryngeal function studies	0660	1.7060	97.21	30.66	19.44
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	0.8653	49.31	17.44	9.86
92542	X		Positional nystagmus test	0363	0.8653	49.31	17.44	9.86
92543	X		Caloric vestibular test	0660	1.7060	97.21	30.66	19.44
92544	X		Optokinetic nystagmus test	0363	0.8653	49.31	17.44	9.86
92545	X		Oscillating tracking test	0363	0.8653	49.31	17.44	9.86
92546	X		Sinusoidal rotational test	0660	1.7060	97.21	30.66	19.44
92547	X		Supplemental electrical test	0363	0.8653	49.31	17.44	9.86
92548	X		Posturography	0660	1.7060	97.21	30.66	19.44
92551	E		Pure tone hearing test, air		.	.	.	.
92552	X		Pure tone audiometry, air	0364	0.4766	27.16	9.06	5.43
92553	X		Audiometry, air & bone	0364	0.4766	27.16	9.06	5.43
92555	X		Speech threshold audiometry	0364	0.4766	27.16	9.06	5.43
92556	X		Speech audiometry, complete	0364	0.4766	27.16	9.06	5.43
92557	X		Comprehensive hearing test	0365	1.2743	72.61	18.95	14.52
92559	E		Group audiometric testing		.	.	.	.
92560	E		Bekesy audiometry, screen		.	.	.	.
92561	X		Bekesy audiometry, diagnosis	0365	1.2743	72.61	18.95	14.52
92562	X		Loudness balance test	0364	0.4766	27.16	9.06	5.43
92563	X		Tone decay hearing test	0364	0.4766	27.16	9.06	5.43
92564	X		Sisi hearing test	0364	0.4766	27.16	9.06	5.43
92565	X		Stenger test, pure tone	0364	0.4766	27.16	9.06	5.43
92567	X		Tympanometry	0364	0.4766	27.16	9.06	5.43
92568	X		Acoustic reflex testing	0364	0.4766	27.16	9.06	5.43
92569	X		Acoustic reflex decay test	0364	0.4766	27.16	9.06	5.43
92571	X		Filtered speech hearing test	0364	0.4766	27.16	9.06	5.43
92572	X		Staggered spondaic word test	0364	0.4766	27.16	9.06	5.43

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92573	X		Lombard test	0364	0.4766	27.16	9.06	5.43
92575	X		Sensorineural acuity test	0364	0.4766	27.16	9.06	5.43
92576	X		Synthetic sentence test	0364	0.4766	27.16	9.06	5.43
92577	X		Stenger test, speech	0365	1.2743	72.61	18.95	14.52
92579	X		Visual audiometry (vra)	0365	1.2743	72.61	18.95	14.52
92582	X		Conditioning play audiometry	0365	1.2743	72.61	18.95	14.52
92583	X		Select picture audiometry	0364	0.4766	27.16	9.06	5.43
92584	X		Electrocochleography	0660	1.7060	97.21	30.66	19.44
92585	S		Auditor evoke potent, compre	0216	2.6359	150.20		30.04
92586	S		Auditor evoke potent, limit	0218	1.1442	65.20		13.04
92587	X		Evoked auditory test	0363	0.8653	49.31	17.44	9.86
92588	X		Evoked auditory test	0363	0.8653	49.31	17.44	9.86
92589	D		Auditory function test(s)					
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	0364	0.4766	27.16	9.06	5.43
92597	A		Oral speech device eval					
92601	X		Cochlear implt f/up exam < 7	0366	1.8412	104.92	30.04	20.98
92602	X		Reprogram cochlear implt < 7	0366	1.8412	104.92	30.04	20.98
92603	X		Cochlear implt f/up exam 7 >	0366	1.8412	104.92	30.04	20.98
92604	X		Reprogram cochlear implt 7 >	0366	1.8412	104.92	30.04	20.98
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					
92620	X	NI	Auditory function, 60 min	0364	0.4766	27.16	9.06	5.43
92621	N	NI	Auditory function, + 15 min					
92625	X	NI	Tinnitus assessment	0364	0.4766	27.16	9.06	5.43
92700	X		Ent procedure/service	0364	0.4766	27.16	9.06	5.43
92950	S		Heart/lung resuscitation cpr	0094	2.6945	153.54	48.58	30.71

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92953	S		Temporary external pacing	0094	2.6945	153.54	48.58	30.71
92960	S		Cardioversion electric, ext	0679	5.5971	318.94	95.30	63.79
92961	S		Cardioversion, electric, int	0679	5.5971	318.94	95.30	63.79
92970	C		Cardioassist, internal		.	.	.	.
92971	C		Cardioassist, external		.	.	.	.
92973	T		Percut coronary thrombectomy	0676	4.2729	243.48	.	48.70
92974	T		Cath place, cardio brachytx	1559	.	2250.00	.	450.00
92975	C		Dissolve clot, heart vessel		.	.	.	.
92977	T		Dissolve clot, heart vessel	0677	2.5535	145.51	.	29.10
92978	S		Intravasc us, heart add-on	0670	30.3817	1731.24	542.37	346.25
92979	S		Intravasc us, heart add-on	0416	4.8182	274.56	99.43	54.91
92980	T		Insert intracoronary stent	0104	81.1177	4622.33	.	924.47
92981	T		Insert intracoronary stent	0104	81.1177	4622.33	.	924.47
92982	T		Coronary artery dilation	0083	55.3618	3154.68	.	630.94
92984	T		Coronary artery dilation	0083	55.3618	3154.68	.	630.94
92986	T		Revision of aortic valve	0083	55.3618	3154.68	.	630.94
92987	T		Revision of mitral valve	0083	55.3618	3154.68	.	630.94
92990	T		Revision of pulmonary valve	0083	55.3618	3154.68	.	630.94
92992	C		Revision of heart chamber		.	.	.	.
92993	C		Revision of heart chamber		.	.	.	.
92995	T		Coronary atherectomy	0082	103.0652	5872.96	1263.32	1174.59
92996	T		Coronary atherectomy add-on	0082	103.0652	5872.96	1263.32	1174.59
92997	T		Pul art balloon repr, percut	0081	32.7548	1866.47	.	373.29
92998	T		Pul art balloon repr, percut	0081	32.7548	1866.47	.	373.29
93000	B		Electrocardiogram, complete		.	.	.	.
93005	S		Electrocardiogram, tracing	0099	0.3812	21.72	.	4.34
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	2.4975	142.32	41.44	28.46
93018	B		Cardiovascular stress test		.	.	.	.
93024	X		Cardiac drug stress test	0100	2.4975	142.32	41.44	28.46
93025	X		Microvolt t-wave assess	0100	2.4975	142.32	41.44	28.46
93040	B		Rhythm ECG with report		.	.	.	.
93041	S		Rhythm ECG, tracing	0099	0.3812	21.72	.	4.34
93042	B		Rhythm ECG, report		.	.	.	.
93224	B		ECG monitor/report, 24 hrs		.	.	.	.
93225	X		ECG monitor/record, 24 hrs	0097	1.0180	58.01	23.79	11.60
93226	X		ECG monitor/report, 24 hrs	0097	1.0180	58.01	23.79	11.60
93227	B		ECG monitor/review, 24 hrs		.	.	.	.
93230	B		ECG monitor/report, 24 hrs		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93231	X		Ecg monitor/record, 24 hrs	0097	1.0180	58.01	23.79	11.60
93232	X		ECG monitor/report, 24 hrs	0097	1.0180	58.01	23.79	11.60
93233	B		ECG monitor/review, 24 hrs		.	.	.	.
93235	B		ECG monitor/report, 24 hrs		.	.	.	.
93236	X		ECG monitor/report, 24 hrs	0097	1.0180	58.01	23.79	11.60
93237	B		ECG monitor/review, 24 hrs		.	.	.	.
93268	B		ECG record/review		.	.	.	.
93270	X		ECG recording	0097	1.0180	58.01	23.79	11.60
93271	X		Ecg/monitoring and analysis	0097	1.0180	58.01	23.79	11.60
93272	B		Ecg/review, interpret only		.	.	.	.
93278	S		ECG/signal-averaged	0099	0.3812	21.72	.	4.34
93303	S		Echo transthoracic	0269	3.2554	185.50	83.47	37.10
93304	S		Echo transthoracic	0697	1.5184	86.52	38.93	17.30
93307	S		Echo exam of heart	0269	3.2554	185.50	83.47	37.10
93308	S		Echo exam of heart	0697	1.5184	86.52	38.93	17.30
93312	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93313	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93314	N		Echo transesophageal		.	.	.	.
93315	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93316	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93317	N		Echo transesophageal		.	.	.	.
93318	S		Echo transesophageal intraop	0270	6.1046	347.86	146.79	69.57
93320	S		Doppler echo exam, heart	0671	1.7087	97.37	43.81	19.47
93321	S		Doppler echo exam, heart	0697	1.5184	86.52	38.93	17.30
93325	S		Doppler color flow add-on	0697	1.5184	86.52	38.93	17.30
93350	S		Echo transthoracic	0269	3.2554	185.50	83.47	37.10
93501	T		Right heart catheterization	0080	36.2660	2066.55	838.92	413.31
93503	T		Insert/place heart catheter	0103	13.1337	748.40	223.63	149.68
93505	T		Biopsy of heart lining	0103	13.1337	748.40	223.63	149.68
93508	T		Cath placement, angiography	0080	36.2660	2066.55	838.92	413.31
93510	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93511	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93514	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93524	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93526	T		Rt & Lt heart catheters	0080	36.2660	2066.55	838.92	413.31
93527	T		Rt & Lt heart catheters	0080	36.2660	2066.55	838.92	413.31
93528	T		Rt & Lt heart catheters	0080	36.2660	2066.55	838.92	413.31
93529	T		Rt, lt heart catheterization	0080	36.2660	2066.55	838.92	413.31
93530	T		Rt heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93531	T		R & l heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93532	T		R & l heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93533	T		R & l heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93539	N		Injection, cardiac cath		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	S	NI	Heart flow reserve measure	0670	30.3817	1731.24	542.37	346.25
93572	S	NI	Heart flow reserve measure	0416	4.8182	274.56	99.43	54.91
93580	T		Transcath closure of asd	1559	.	2250.00	.	450.00
93581	T		Transcath closure of vsd	1559	.	2250.00	.	450.00
93600	T		Bundle of His recording	0087	37.2315	2121.56	.	424.31
93602	T		Intra-atrial recording	0087	37.2315	2121.56	.	424.31
93603	T		Right ventricular recording	0087	37.2315	2121.56	.	424.31
93609	T		Map tachycardia, add-on	0087	37.2315	2121.56	.	424.31
93610	T		Intra-atrial pacing	0087	37.2315	2121.56	.	424.31
93612	T		Intraventricular pacing	0087	37.2315	2121.56	.	424.31
93613	T		Electrophys map 3d, add-on	0087	37.2315	2121.56	.	424.31
93615	T		Esophageal recording	0087	37.2315	2121.56	.	424.31
93616	T		Esophageal recording	0087	37.2315	2121.56	.	424.31
93618	T		Heart rhythm pacing	0087	37.2315	2121.56	.	424.31
93619	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93620	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93621	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93622	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93623	T		Stimulation, pacing heart	0087	37.2315	2121.56	.	424.31
93624	S		Electrophysiologic study	0084	10.6370	606.13	.	121.23
93631	T		Heart pacing, mapping	0087	37.2315	2121.56	.	424.31
93640	S		Evaluation heart device	0084	10.6370	606.13	.	121.23
93641	S		Electrophysiology evaluation	0084	10.6370	606.13	.	121.23
93642	S		Electrophysiology evaluation	0084	10.6370	606.13	.	121.23
93650	T		Ablate heart dysrhythm focus	0086	45.0490	2567.03	833.33	513.41
93651	T		Ablate heart dysrhythm focus	0086	45.0490	2567.03	833.33	513.41
93652	T		Ablate heart dysrhythm focus	0086	45.0490	2567.03	833.33	513.41
93660	S		Tilt table evaluation	0101	4.3954	250.46	105.27	50.09
93662	S		Intracardiac ecg (ice)	0670	30.3817	1731.24	542.37	346.25
93668	E		Peripheral vascular rehab		.	.	.	.
93701	S		Bioimpedance, thoracic	0099	0.3812	21.72	.	4.34
93720	B		Total body plethysmography		.	.	.	.
93721	X		Plethysmography tracing	0368	0.9465	53.93	24.26	10.79

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93722	B		Plethysmography report		.	.	.	.
93724	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93727	S		Analyze ilr system	0690	0.3963	22.58	10.16	4.52
93731	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93732	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93733	S		Telephone analy, pacemaker	0690	0.3963	22.58	10.16	4.52
93734	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93735	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93736	S		Telephonic analy, pacemaker	0690	0.3963	22.58	10.16	4.52
93740	X		Temperature gradient studies	0368	0.9465	53.93	24.26	10.79
93741	S		Analyze ht pace device sngl	0689	0.5852	33.35	.	6.67
93742	S		Analyze ht pace device sngl	0689	0.5852	33.35	.	6.67
93743	S		Analyze ht pace device dual	0689	0.5852	33.35	.	6.67
93744	S		Analyze ht pace device dual	0689	0.5852	33.35	.	6.67
93745	S	NI	Set-up cardiovert-defibrill	0689	0.5852	33.35	.	6.67
93760	E		Cephalic thermogram		.	.	.	.
93762	E		Peripheral thermogram		.	.	.	.
93770	N		Measure venous pressure		.	.	.	.
93784	E		Ambulatory BP monitoring		.	.	.	.
93786	X		Ambulatory BP recording	0097	1.0180	58.01	23.79	11.60
93788	X		Ambulatory BP analysis	0097	1.0180	58.01	23.79	11.60
93790	B		Review/report BP recording		.	.	.	.
93797	S		Cardiac rehab	0095	0.6044	34.44	15.49	6.89
93798	S		Cardiac rehab/monitor	0095	0.6044	34.44	15.49	6.89
93799	S		Cardiovascular procedure	0096	1.7035	97.07	43.68	19.41
93875	S		Extracranial study	0096	1.7035	97.07	43.68	19.41
93880	S		Extracranial study	0267	2.4250	138.18	62.18	27.64
93882	S		Extracranial study	0267	2.4250	138.18	62.18	27.64
93886	S		Intracranial study	0267	2.4250	138.18	62.18	27.64
93888	S		Intracranial study	0266	1.6275	92.74	41.73	18.55
93890	S	NI	Tcd, vasoreactivity study	0266	1.6275	92.74	41.73	18.55
93892	S	NI	Tcd, emboli detect w/o inj	0266	1.6275	92.74	41.73	18.55
93893	S	NI	Tcd, emboli detect w/inj	0266	1.6275	92.74	41.73	18.55
93922	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93923	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93924	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93925	S		Lower extremity study	0267	2.4250	138.18	62.18	27.64
93926	S		Lower extremity study	0267	2.4250	138.18	62.18	27.64
93930	S		Upper extremity study	0267	2.4250	138.18	62.18	27.64
93931	S		Upper extremity study	0266	1.6275	92.74	41.73	18.55
93965	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93970	S		Extremity study	0267	2.4250	138.18	62.18	27.64
93971	S		Extremity study	0267	2.4250	138.18	62.18	27.64

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93975	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93976	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93978	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93979	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93980	S		Penile vascular study	0267	2.4250	138.18	62.18	27.64
93981	S		Penile vascular study	0267	2.4250	138.18	62.18	27.64
93990	S		Doppler flow testing	0267	2.4250	138.18	62.18	27.64
94010	X		Breathing capacity test	0368	0.9465	53.93	24.26	10.79
94014	X		Patient recorded spirometry	0368	0.9465	53.93	24.26	10.79
94015	X		Patient recorded spirometry	0367	0.5775	32.91	14.80	6.58
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	0.9465	53.93	24.26	10.79
94070	X		Evaluation of wheezing	0369	2.7431	156.31	44.18	31.26
94150	X		Vital capacity test	0367	0.5775	32.91	14.80	6.58
94200	X		Lung function test (MBC/MVV)	0367	0.5775	32.91	14.80	6.58
94240	X		Residual lung capacity	0368	0.9465	53.93	24.26	10.79
94250	X		Expired gas collection	0367	0.5775	32.91	14.80	6.58
94260	X		Thoracic gas volume	0368	0.9465	53.93	24.26	10.79
94350	X		Lung nitrogen washout curve	0368	0.9465	53.93	24.26	10.79
94360	X		Measure airflow resistance	0367	0.5775	32.91	14.80	6.58
94370	X		Breath airway closing volume	0367	0.5775	32.91	14.80	6.58
94375	X		Respiratory flow volume loop	0368	0.9465	53.93	24.26	10.79
94400	X		CO2 breathing response curve	0367	0.5775	32.91	14.80	6.58
94450	X		Hypoxia response curve	0368	0.9465	53.93	24.26	10.79
94452	X	NI	Hast w/report	0368	0.9465	53.93	24.26	10.79
94453	X	NI	Hast w/oxygen titrate	0368	0.9465	53.93	24.26	10.79
94620	X		Pulmonary stress test/simple	0368	0.9465	53.93	24.26	10.79
94621	X		Pulm stress test/complex	0369	2.7431	156.31	44.18	31.26
94640	S		Airway inhalation treatment	0077	0.3228	18.39	7.74	3.68
94642	S		Aerosol inhalation treatment	0078	0.8315	47.38	14.55	9.48
94656	S		Initial ventilator mgmt	0079	2.4268	138.29		27.66
94657	S		Continued ventilator mgmt	0079	2.4268	138.29		27.66
94660	S		Pos airway pressure, CPAP	0068	1.1546	65.79	29.48	13.16
94662	S		Neg press ventilation, cnp	0079	2.4268	138.29		27.66
94664	S		Evaluate pt use of inhaler	0077	0.3228	18.39	7.74	3.68
94667	S		Chest wall manipulation	0077	0.3228	18.39	7.74	3.68
94668	S		Chest wall manipulation	0077	0.3228	18.39	7.74	3.68
94680	X		Exhaled air analysis, o2	0367	0.5775	32.91	14.80	6.58
94681	X		Exhaled air analysis, o2/co2	0368	0.9465	53.93	24.26	10.79
94690	X		Exhaled air analysis	0368	0.9465	53.93	24.26	10.79
94720	X		Monoxide diffusing capacity	0368	0.9465	53.93	24.26	10.79
94725	X		Membrane diffusion capacity	0368	0.9465	53.93	24.26	10.79
94750	X		Pulmonary compliance study	0368	0.9465	53.93	24.26	10.79

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.5775	32.91	14.80	6.58
94772	X		Breath recording, infant	0369	2.7431	156.31	44.18	31.26
94799	X		Pulmonary service/procedure	0367	0.5775	32.91	14.80	6.58
95004	X		Percut allergy skin tests	0370	0.9661	55.05	11.58	11.01
95010	X		Percut allergy titrate test	0370	0.9661	55.05	11.58	11.01
95015	X		Id allergy titrate-drug/bug	0370	0.9661	55.05	11.58	11.01
95024	X		Id allergy test, drug/bug	0370	0.9661	55.05	11.58	11.01
95027	X		Id allergy titrate-airborne	0370	0.9661	55.05	11.58	11.01
95028	X		Id allergy test-delayed type	0370	0.9661	55.05	11.58	11.01
95044	X		Allergy patch tests	0370	0.9661	55.05	11.58	11.01
95052	X		Photo patch test	0370	0.9661	55.05	11.58	11.01
95056	X		Photosensitivity tests	0370	0.9661	55.05	11.58	11.01
95060	X		Eye allergy tests	0370	0.9661	55.05	11.58	11.01
95065	X		Nose allergy test	0370	0.9661	55.05	11.58	11.01
95070	X		Bronchial allergy tests	0369	2.7431	156.31	44.18	31.26
95071	X		Bronchial allergy tests	0369	2.7431	156.31	44.18	31.26
95075	X		Ingestion challenge test	0361	3.6408	207.46	83.23	41.49
95078	X		Provocative testing	0370	0.9661	55.05	11.58	11.01
95115	X		Immunotherapy, one injection	0352	0.1197	6.82	.	1.36
95117	X		Immunotherapy injections	0353	0.3981	22.68	.	4.54
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	0.4310	24.56	.	4.91
95145	X		Antigen therapy services	0371	0.4310	24.56	.	4.91
95146	X		Antigen therapy services	0371	0.4310	24.56	.	4.91
95147	X		Antigen therapy services	0371	0.4310	24.56	.	4.91
95148	X		Antigen therapy services	0371	0.4310	24.56	.	4.91
95149	X		Antigen therapy services	0371	0.4310	24.56	.	4.91
95165	X		Antigen therapy services	0371	0.4310	24.56	.	4.91
95170	X		Antigen therapy services	0371	0.4310	24.56	.	4.91
95180	X		Rapid desensitization	0370	0.9661	55.05	11.58	11.01
95199	X		Allergy immunology services	0370	0.9661	55.05	11.58	11.01
95250	X		Glucose monitoring, cont	0421	1.8691	106.51	.	21.30
95805	S		Multiple sleep latency test	0209	11.6170	661.97	280.58	132.39
95806	S		Sleep study, unattended	0213	2.7461	156.48	64.89	31.30

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95807	S		Sleep study, attended	0209	11.6170	661.97	280.58	132.39
95808	S		Polysomnography, 1-3	0209	11.6170	661.97	280.58	132.39
95810	S		Polysomnography, 4 or more	0209	11.6170	661.97	280.58	132.39
95811	S		Polysomnography w/cpap	0209	11.6170	661.97	280.58	132.39
95812	S		Eeg, 41-60 minutes	0213	2.7461	156.48	64.89	31.30
95813	S		Eeg, over 1 hour	0213	2.7461	156.48	64.89	31.30
95816	S		Eeg, awake and drowsy	0214	2.2788	129.85	58.12	25.97
95819	S		Eeg, awake and asleep	0214	2.2788	129.85	58.12	25.97
95822	S		Eeg, coma or sleep only	0214	2.2788	129.85	58.12	25.97
95824	S		Eeg, cerebral death only	0214	2.2788	129.85	58.12	25.97
95827	S		Eeg, all night recording	0213	2.7461	156.48	64.89	31.30
95829	S		Surgery electrocorticogram	0214	2.2788	129.85	58.12	25.97
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	1.1442	65.20	.	13.04
95858	S		Tensilon test & myogram	0215	0.6600	37.61	15.76	7.52
95860	S		Muscle test, one limb	0218	1.1442	65.20	.	13.04
95861	S		Muscle test, 2 limbs	0218	1.1442	65.20	.	13.04
95863	S		Muscle test, 3 limbs	0218	1.1442	65.20	.	13.04
95864	S		Muscle test, 4 limbs	0218	1.1442	65.20	.	13.04
95867	S		Muscle test cran nerv unilat	0218	1.1442	65.20	.	13.04
95868	S		Muscle test cran nerve bilat	0218	1.1442	65.20	.	13.04
95869	S		Muscle test, thor paraspinal	0215	0.6600	37.61	15.76	7.52
95870	S		Muscle test, nonparaspinal	0215	0.6600	37.61	15.76	7.52
95872	S		Muscle test, one fiber	0218	1.1442	65.20	.	13.04
95875	S		Limb exercise test	0215	0.6600	37.61	15.76	7.52
95900	S		Motor nerve conduction test	0215	0.6600	37.61	15.76	7.52
95903	S		Motor nerve conduction test	0215	0.6600	37.61	15.76	7.52
95904	S		Sense nerve conduction test	0215	0.6600	37.61	15.76	7.52
95920	S		Intraop nerve test add-on	0216	2.6359	150.20	.	30.04
95921	S		Autonomic nerv function test	0218	1.1442	65.20	.	13.04
95922	S		Autonomic nerv function test	0218	1.1442	65.20	.	13.04
95923	S		Autonomic nerv function test	0218	1.1442	65.20	.	13.04
95925	S		Somatosensory testing	0216	2.6359	150.20	.	30.04
95926	S		Somatosensory testing	0216	2.6359	150.20	.	30.04
95927	S		Somatosensory testing	0216	2.6359	150.20	.	30.04
95928	S	NI	C motor evoked, uppr limbs	0218	1.1442	65.20	.	13.04
95929	S	NI	C motor evoked, lwr limbs	0218	1.1442	65.20	.	13.04

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95930	S		Visual evoked potential test	0216	2.6359	150.20	.	30.04
95933	S		Blink reflex test	0215	0.6600	37.61	15.76	7.52
95934	S		H-reflex test	0215	0.6600	37.61	15.76	7.52
95936	S		H-reflex test	0215	0.6600	37.61	15.76	7.52
95937	S		Neuromuscular junction test	0218	1.1442	65.20	.	13.04
95950	S		Ambulatory eeg monitoring	0209	11.6170	661.97	280.58	132.39
95951	S		EEG monitoring/videorecord	0209	11.6170	661.97	280.58	132.39
95953	S		EEG monitoring/computer	0209	11.6170	661.97	280.58	132.39
95954	S		EEG monitoring/giving drugs	0214	2.2788	129.85	58.12	25.97
95955	S		EEG during surgery	0213	2.7461	156.48	64.89	31.30
95956	S		Eeg monitoring, cable/radio	0209	11.6170	661.97	280.58	132.39
95957	S		EEG digital analysis	0214	2.2788	129.85	58.12	25.97
95958	S		EEG monitoring/function test	0213	2.7461	156.48	64.89	31.30
95961	S		Electrode stimulation, brain	0216	2.6359	150.20	.	30.04
95962	S		Electrode stim, brain add-on	0216	2.6359	150.20	.	30.04
95965	S		Meg, spontaneous	1528	.	5250.00	.	1050.00
95966	S		Meg, evoked, single	1516	.	1450.00	.	290.00
95967	S		Meg, evoked, each add'l	1511	.	950.00	.	190.00
95970	S		Analyze neurostim, no prog	0218	1.1442	65.20	.	13.04
95971	S		Analyze neurostim, simple	0692	2.0584	117.29	30.16	23.46
95972	S		Analyze neurostim, complex	0692	2.0584	117.29	30.16	23.46
95973	S		Analyze neurostim, complex	0692	2.0584	117.29	30.16	23.46
95974	S		Cranial neurostim, complex	0692	2.0584	117.29	30.16	23.46
95975	S		Cranial neurostim, complex	0692	2.0584	117.29	30.16	23.46
95978	S	NI	Analyze neurostim brain/1h	0692	2.0584	117.29	30.16	23.46
95979	S	NI	Analyz neurostim brain addon	0692	2.0584	117.29	30.16	23.46
95990	T		Spin/brain pump refil & main	0125	2.1652	123.38	.	24.68
95991	T		Spin/brain pump refil & main	0125	2.1652	123.38	.	24.68
95999	S		Neurological procedure	0215	0.6600	37.61	15.76	7.52
96000	S		Motion analysis, video/3d	0216	2.6359	150.20	.	30.04
96001	S		Motion test w/ft press meas	0216	2.6359	150.20	.	30.04
96002	S		Dynamic surface emg	0218	1.1442	65.20	.	13.04
96003	S		Dynamic fine wire emg	0215	0.6600	37.61	15.76	7.52
96004	E		Phys review of motion tests		.	.	.	.
96100	X		Psychological testing	0373	2.3347	133.04	.	26.61
96105	A		Assessment of aphasia		.	.	.	.
96110	X		Developmental test, lim	0373	2.3347	133.04	.	26.61
96111	X		Developmental test, extend	0373	2.3347	133.04	.	26.61
96115	X		Neurobehavior status exam	0373	2.3347	133.04	.	26.61
96117	X		Neuropsych test battery	0373	2.3347	133.04	.	26.61
96150	S		Assess hlth/behave, init	0322	1.2917	73.60	.	14.72
96151	S		Assess hlth/behave, subseq	0322	1.2917	73.60	.	14.72
96152	S		Intervene hlth/behave, indiv	0322	1.2917	73.60	.	14.72

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96153	S		Intervene hlth/behave, group	0322	1.2917	73.60	.	14.72
96154	S		Interv hlth/behav, fam w/pt	0322	1.2917	73.60	.	14.72
96155	E		Interv hlth/behav fam no pt		.	.	.	.
96400	S		Chemotherapy, sc/im	0116	1.1117	63.35	.	12.67
96405	S		Intralesional chemo admin	0116	1.1117	63.35	.	12.67
96406	S		Intralesional chemo admin	0116	1.1117	63.35	.	12.67
96408	S		Chemotherapy, push technique	0116	1.1117	63.35	.	12.67
96410	S		Chemotherapy,infusion method	0117	2.9533	168.29	42.54	33.66
96412	N		Chemo, infuse method add-on		.	.	.	.
96414	S		Chemo, infuse method add-on	0117	2.9533	168.29	42.54	33.66
96420	S		Chemotherapy, push technique	0116	1.1117	63.35	.	12.67
96422	S		Chemotherapy,infusion method	0117	2.9533	168.29	42.54	33.66
96423	N		Chemo, infuse method add-on		.	.	.	.
96425	S		Chemotherapy,infusion method	0117	2.9533	168.29	42.54	33.66
96440	S		Chemotherapy, intracavitary	0116	1.1117	63.35	.	12.67
96445	S		Chemotherapy, intracavitary	0116	1.1117	63.35	.	12.67
96450	S		Chemotherapy, into CNS	0116	1.1117	63.35	.	12.67
96520	T		Port pump refill & main	0125	2.1652	123.38	.	24.68
96530	T		Syst pump refill & main	0125	2.1652	123.38	.	24.68
96542	S		Chemotherapy injection	0116	1.1117	63.35	.	12.67
96545	N		Provide chemotherapy agent		.	.	.	.
96549	S		Chemotherapy, unspecified	0116	1.1117	63.35	.	12.67
96567	T		Photodynamic tx, skin	0013	1.1380	64.85	14.20	12.97
96570	T		Photodynamic tx, 30 min	0015	1.7248	98.28	20.35	19.66
96571	T		Photodynamic tx, addl 15 min	0015	1.7248	98.28	20.35	19.66
96900	S		Ultraviolet light therapy	0001	0.4007	22.83	7.00	4.57
96902	N		Trichogram		.	.	.	.
96910	S		Photochemotherapy with UV-B	0001	0.4007	22.83	7.00	4.57
96912	S		Photochemotherapy with UV-A	0001	0.4007	22.83	7.00	4.57
96913	S		Photochemotherapy, UV-A or B	0683	2.3761	135.40	30.42	27.08
96920	T		Laser tx, skin < 250 sq cm	0013	1.1380	64.85	14.20	12.97
96921	T		Laser tx, skin 250-500 sq cm	0013	1.1380	64.85	14.20	12.97
96922	T		Laser tx, skin > 500 sq cm	0013	1.1380	64.85	14.20	12.97
96999	T		Dermatological procedure	0010	0.5940	33.85	9.65	6.77
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97016	A		Vasopneumatic device therapy		.	.	.	.
97018	A		Paraffin bath therapy		.	.	.	.
97020	A		Microwave therapy		.	.	.	.
97022	A		Whirlpool therapy		.	.	.	.
97024	A		Diathermy treatment		.	.	.	.
97026	A		Infrared therapy		.	.	.	.
97028	A		Ultraviolet therapy		.	.	.	.
97032	A		Electrical stimulation		.	.	.	.
97033	A		Electric current therapy		.	.	.	.
97034	A		Contrast bath therapy		.	.	.	.
97035	A		Ultrasound therapy		.	.	.	.
97036	A		Hydrotherapy		.	.	.	.
97039	A		Physical therapy treatment		.	.	.	.
97110	A		Therapeutic exercises		.	.	.	.
97112	A		Neuromuscular reeducation		.	.	.	.
97113	A		Aquatic therapy/exercises		.	.	.	.
97116	A		Gait training therapy		.	.	.	.
97124	A		Massage therapy		.	.	.	.
97139	A		Physical medicine procedure		.	.	.	.
97140	A		Manual therapy		.	.	.	.
97150	A		Group therapeutic procedures		.	.	.	.
97504	A		Orthotic training		.	.	.	.
97520	A		Prosthetic training		.	.	.	.
97530	A		Therapeutic activities		.	.	.	.
97532	A		Cognitive skills development		.	.	.	.
97533	A		Sensory integration		.	.	.	.
97535	A		Self care mngment training		.	.	.	.
97537	A		Community/work reintegration		.	.	.	.
97542	A		Wheelchair mngment training		.	.	.	.
97545	A		Work hardening		.	.	.	.
97546	A		Work hardening add-on		.	.	.	.
97597	A	NI	Active wound care/20 cm or <		.	.	.	.
97598	A	NI	Active wound care > 20 cm		.	.	.	.
97601	D		Wound(s) care, selective		.	.	.	.
97602	A		Wound(s) care non-selective		.	.	.	.
97605	A	NI	Neg press wound tx, < 50 cm		.	.	.	.
97606	A	NI	Neg press wound tx, > 50 cm		.	.	.	.
97703	A		Prosthetic checkout		.	.	.	.
97750	A		Physical performance test		.	.	.	.
97755	A		Assistive technology assess		.	.	.	.
97780	D		Acupuncture w/o stimul		.	.	.	.
97781	D		Acupuncture w/stimul		.	.	.	.
97799	A		Physical medicine procedure		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97802	A		Medical nutrition, indiv, in		.	.	.	.
97803	A		Med nutrition, indiv, subseq		.	.	.	.
97804	A		Medical nutrition, group		.	.	.	.
97810	B	NI	Acupunct w/o stimul 15 min		.	.	.	.
97811	B	NI	Acupunct w/o stimul addl 15m		.	.	.	.
97813	B	NI	Acupunct w/stimul 15 min		.	.	.	.
97814	B	NI	Acupunct w/stimul addl 15m		.	.	.	.
98925	S		Osteopathic manipulation	0060	0.4737	26.99	.	5.40
98926	S		Osteopathic manipulation	0060	0.4737	26.99	.	5.40
98927	S		Osteopathic manipulation	0060	0.4737	26.99	.	5.40
98928	S		Osteopathic manipulation	0060	0.4737	26.99	.	5.40
98929	S		Osteopathic manipulation	0060	0.4737	26.99	.	5.40
98940	S		Chiropractic manipulation	0060	0.4737	26.99	.	5.40
98941	S		Chiropractic manipulation	0060	0.4737	26.99	.	5.40
98942	S		Chiropractic manipulation	0060	0.4737	26.99	.	5.40
98943	E		Chiropractic manipulation		.	.	.	.
99000	B		Specimen handling		.	.	.	.
99001	B		Specimen handling		.	.	.	.
99002	B		Device handling		.	.	.	.
99024	B		Postop follow-up visit		.	.	.	.
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	B		Emergency anesthesia		.	.	.	.
99141	N		Sedation, iv/im or inhalant		.	.	.	.
99142	N		Sedation, oral/rectal/nasal		.	.	.	.
99170	T		Anogenital exam, child	0191	0.1831	10.43	2.93	2.09
99172	E		Ocular function screen		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.5656	32.23	10.09	6.45
99199	B		Special service/proc/report		.	.	.	.
99201	V		Office/outpatient visit, new	0600	0.9033	51.47	.	10.29
99202	V		Office/outpatient visit, new	0600	0.9033	51.47	.	10.29
99203	V		Office/outpatient visit, new	0601	0.9847	56.11	.	11.22
99204	V		Office/outpatient visit, new	0602	1.3977	79.65	.	15.93
99205	V		Office/outpatient visit, new	0602	1.3977	79.65	.	15.93
99211	V		Office/outpatient visit, est	0600	0.9033	51.47	.	10.29
99212	V		Office/outpatient visit, est	0600	0.9033	51.47	.	10.29
99213	V		Office/outpatient visit, est	0601	0.9847	56.11	.	11.22
99214	V		Office/outpatient visit, est	0602	1.3977	79.65	.	15.93
99215	V		Office/outpatient visit, est	0602	1.3977	79.65	.	15.93
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	0.9033	51.47	.	10.29
99242	V		Office consultation	0600	0.9033	51.47	.	10.29
99243	V		Office consultation	0601	0.9847	56.11	.	11.22
99244	V		Office consultation	0602	1.3977	79.65	.	15.93
99245	V		Office consultation	0602	1.3977	79.65	.	15.93
99251	C		Initial inpatient consult		.	.	.	.
99252	C		Initial inpatient consult		.	.	.	.
99253	C		Initial inpatient consult		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.9033	51.47	.	10.29
99272	V		Confirmatory consultation	0600	0.9033	51.47	.	10.29
99273	V		Confirmatory consultation	0601	0.9847	56.11	.	11.22
99274	V		Confirmatory consultation	0602	1.3977	79.65	.	15.93
99275	V		Confirmatory consultation	0602	1.3977	79.65	.	15.93
99281	V		Emergency dept visit	0610	1.3544	77.18	19.57	15.44
99282	V		Emergency dept visit	0610	1.3544	77.18	19.57	15.44
99283	V		Emergency dept visit	0611	2.3926	136.34	36.16	27.27
99284	V		Emergency dept visit	0612	4.1139	234.42	54.12	46.88
99285	V		Emergency dept visit	0612	4.1139	234.42	54.12	46.88
99288	B		Direct advanced life support		.	.	.	.
99289	N		Ped crit care transport		.	.	.	.
99290	N		Ped crit care transport addl		.	.	.	.
99291	S		Critical care, first hour	0620	9.0648	516.54	142.30	103.31
99292	N		Critical care, add'l 30 min		.	.	.	.
99293	C		Ped critical care, initial		.	.	.	.
99294	C		Ped critical care, subseq		.	.	.	.
99295	C		Neonate crit care, initial		.	.	.	.
99296	C		Neonate critical care subseq		.	.	.	.
99298	C		Ic for lbw infant < 1500 gm		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.
99375	E		Home health care supervision		.	.	.	.
99377	B		Hospice care supervision		.	.	.	.
99378	E		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99412	E		Preventive counseling, group		.	.	.	.
99420	E		Health risk assessment test		.	.	.	.
99429	E		Unlisted preventive service		.	.	.	.
99431	V		Initial care, normal newborn	0600	0.9033	51.47	.	10.29
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	2.6945	153.54	48.58	30.71
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		.	.	.	.
99600	E		Home visit nos		.	.	.	.
99601	E		Home infusion/visit, 2 hrs		.	.	.	.
99602	E		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		Transport parking fees/tolls		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	B		Amb trans 7pm-7am		.	.	.	.
A0888	E		Noncovered ambulance mileage		.	.	.	.
A0999	A		Unlisted ambulance service		.	.	.	.
A4206	E		1 CC sterile syringe&needle		.	.	.	.
A4207	E		2 CC sterile syringe&needle		.	.	.	.
A4208	E		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		.	.	.	.
A4215	E		Sterile needle		.	.	.	.
A4216	A		Sterile water/saline, 10 ml		.	.	.	.
A4217	A		Sterile water/saline, 500 ml		.	.	.	.
A4220	N		Infusion pump refill kit		.	.	.	.
A4221	Y		Maint drug infus cath per wk		.	.	.	.
A4222	Y		Infusion supplies with pump		.	.	.	.
A4223	E	NI	Infusion supplies w/o pump		.	.	.	.
A4230	Y		Infus insulin pump non needl		.	.	.	.
A4231	Y		Infusion insulin pump needle		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4232	Y		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	Y		Blood glucose/reagent strips		.	.	.	.
A4254	Y		Battery for glucose monitor		.	.	.	.
A4255	Y		Glucose monitor platforms		.	.	.	.
A4256	Y		Calibrator solution/chips		.	.	.	.
A4257	Y		Replace Lensshield Cartridge		.	.	.	.
A4258	Y		Lancet device each		.	.	.	.
A4259	Y		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	Y		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	B		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4320	A		Irrigation tray		.	.	.	.
A4321	A		Cath therapeutic irrig agent		.	.	.	.
A4322	A		Irrigation syringe		.	.	.	.
A4324	D		Male ext cath w/adh coating		.	.	.	.
A4325	D		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		Lube sterile packet		.	.	.	.
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	D		Male external catheter		.	.	.	.
A4348	A		Male ext cath extended wear		.	.	.	.
A4349	Y	NI	Disposable male external cat		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	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		Ost pch clsd w barrier/filtr		.	.	.	.
A4417	A		Ost pch w bar/bltinconv/fltr		.	.	.	.
A4418	A		Ost pch clsd w/o bar w filtr		.	.	.	.
A4419	A		Ost pch for bar w flange/flt		.	.	.	.
A4420	A		Ost pch clsd for bar w lk fl		.	.	.	.
A4421	E		Ostomy supply misc		.	.	.	.
A4422	A		Ost pouch absorbent material		.	.	.	.
A4423	A		Ost pch for bar w lk fl/fltr		.	.	.	.
A4424	A		Ost pch drain w bar & filter		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4425	A		Ost pch drain for barrier fl		.	.	.	.
A4426	A		Ost pch drain 2 piece system		.	.	.	.
A4427	A		Ost pch drain/barr lk flng/f		.	.	.	.
A4428	A		Urine ost pouch w faucet/tap		.	.	.	.
A4429	A		Urine ost pouch w bltinconv		.	.	.	.
A4430	A		Ost urine pch w b/bltin conv		.	.	.	.
A4431	A		Ost pch urine w barrier/tapv		.	.	.	.
A4432	A		Os pch urine w bar/fange/tap		.	.	.	.
A4433	A		Urine ost pch bar w lock fln		.	.	.	.
A4434	A		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		.	.	.	.
A4520	E	NI	Incontinence garment anytype		.	.	.	.
A4521	D		Adult size diaper sm each		.	.	.	.
A4522	D		Adult size diaper med each		.	.	.	.
A4523	D		Adult size diaper lg each		.	.	.	.
A4524	D		Adult size diaper xl each		.	.	.	.
A4525	D		Adult size brief sm each		.	.	.	.
A4526	D		Adult size brief med each		.	.	.	.
A4527	D		Adult size brief lg each		.	.	.	.
A4528	D		Adult size brief xl each		.	.	.	.
A4529	D		Child size diaper sm/med ea		.	.	.	.
A4530	D		Child size diaper lg each		.	.	.	.
A4531	D		Child size brief sm/med each		.	.	.	.
A4532	D		Child size brief lg each		.	.	.	.
A4533	D		Youth size diaper each		.	.	.	.
A4534	E		Youth size brief each		.	.	.	.
A4535	D		Disp incont liner/shield ea		.	.	.	.
A4536	D		Prot underwr wshbl any sz ea		.	.	.	.
A4537	D		Under pad reusable any sz ea		.	.	.	.
A4538	D		Reusable diaper from dpr svc		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4550	B		Surgical trays		.	.	.	.
A4554	E		Disposable underpads		.	.	.	.
A4556	Y		Electrodes, pair		.	.	.	.
A4557	Y		Lead wires, pair		.	.	.	.
A4558	Y		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	Y		TENS suppl 2 lead per month		.	.	.	.
A4605	Y	NI	Trach suction cath close sys		.	.	.	.
A4606	A		Oxygen probe used w oximeter		.	.	.	.
A4608	Y		Transtracheal oxygen cath		.	.	.	.
A4609	D		Trach suction cath clsed sys		.	.	.	.
A4610	D		Trach sctn cath 72h clsedsys		.	.	.	.
A4611	Y		Heavy duty battery		.	.	.	.
A4612	Y		Battery cables		.	.	.	.
A4613	Y		Battery charger		.	.	.	.
A4614	A		Hand-held PEFR meter		.	.	.	.
A4615	Y		Cannula nasal		.	.	.	.
A4616	Y		Tubing (oxygen) per foot		.	.	.	.
A4617	Y		Mouth piece		.	.	.	.
A4618	Y		Breathing circuits		.	.	.	.
A4619	Y		Face tent		.	.	.	.
A4620	Y		Variable concentration mask		.	.	.	.
A4623	A		Tracheostomy inner cannula		.	.	.	.
A4624	Y		Tracheal suction tube		.	.	.	.
A4625	A		Trach care kit for new trach		.	.	.	.
A4626	A		Tracheostomy cleaning brush		.	.	.	.
A4627	E		Spacer bag/reservoir		.	.	.	.
A4628	Y		Oropharyngeal suction cath		.	.	.	.
A4629	A		Tracheostomy care kit		.	.	.	.
A4630	Y		Repl bat t.e.n.s. own by pt		.	.	.	.
A4632	Y		Infus pump rplcemnt battery		.	.	.	.
A4633	Y		Uvl replacement bulb		.	.	.	.
A4634	A		Replacement bulb th lightbox		.	.	.	.
A4635	Y		Underarm crutch pad		.	.	.	.
A4636	Y		Handgrip for cane etc		.	.	.	.
A4637	Y		Repl tip cane/crutch/walker		.	.	.	.
A4638	Y		Repl batt pulse gen sys		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4639	Y		Infrared ht sys replcmnt pad		.	.	.	.
A4640	Y		Alternating pressure pad		.	.	.	.
A4641	N		Diagnostic imaging agent		.	.	.	.
A4642	K		Satumomab pendetide per dose	0704	.	1390.25	.	278.05
A4643	K		High dose contrast MRI	9026	0.4605	26.24	.	5.25
A4644	N		Contrast 100-199 MGs iodine		.	.	.	.
A4645	N		Contrast 200-299 MGs iodine		.	.	.	.
A4646	N		Contrast 300-399 MGs iodine		.	.	.	.
A4647	K		Supp- paramagnetic contr mat	9027	0.6245	35.59	.	7.12
A4649	A		Surgical supplies		.	.	.	.
A4651	A		Calibrated microcap tube		.	.	.	.
A4652	A		Microcapillary tube sealant		.	.	.	.
A4653	A		PD catheter anchor belt		.	.	.	.
A4656	A		Needle any size		.	.	.	.
A4657	A		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	B		Disposable cycler set		.	.	.	.
A4672	B		Drainage ext line, dialysis		.	.	.	.
A4673	B		Ext line w easy lock connect		.	.	.	.
A4674	B		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		.	.	.	.
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	B		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5122	A		Solid skin barrier 8x8		.	.	.	.
A5126	A		Disk/foam pad +or- adhesive		.	.	.	.
A5131	A		Appliance cleaner		.	.	.	.
A5200	A		Percutaneous catheter anchor		.	.	.	.
A5500	Y		Diab shoe for density insert		.	.	.	.
A5501	Y		Diabetic custom molded shoe		.	.	.	.
A5503	Y		Diabetic shoe w/roller/rockr		.	.	.	.
A5504	Y		Diabetic shoe with wedge		.	.	.	.
A5505	Y		Diab shoe w/metatarsal bar		.	.	.	.
A5506	Y		Diabetic shoe w/off set heel		.	.	.	.
A5507	Y		Modification diabetic shoe		.	.	.	.
A5508	Y		Diabetic deluxe shoe		.	.	.	.
A5509	B		Direct heat form shoe insert		.	.	.	.
A5510	E		Compression form shoe insert		.	.	.	.
A5511	B		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6215	A		Foam dressing wound filler		.	.	.	.
A6216	A		Non-sterile gauze<=16 sq in		.	.	.	.
A6217	A		Non-sterile gauze>16<=48 sq		.	.	.	.
A6218	A		Non-sterile gauze > 48 sq in		.	.	.	.
A6219	A		Gauze <= 16 sq in w/border		.	.	.	.
A6220	A		Gauze >16 <=48 sq in w/bordr		.	.	.	.
A6221	A		Gauze > 48 sq in w/border		.	.	.	.
A6222	A		Gauze <=16 in no w/sal w/o b		.	.	.	.
A6223	A		Gauze >16<=48 no w/sal w/o b		.	.	.	.
A6224	A		Gauze > 48 in no w/sal w/o b		.	.	.	.
A6228	A		Gauze <= 16 sq in water/sal		.	.	.	.
A6229	A		Gauze >16<=48 sq in watr/sal		.	.	.	.
A6230	A		Gauze > 48 sq in water/salne		.	.	.	.
A6231	A		Hydrogel dsg<=16 sq in		.	.	.	.
A6232	A		Hydrogel dsg>16<=48 sq in		.	.	.	.
A6233	A		Hydrogel dressing >48 sq in		.	.	.	.
A6234	A		Hydrocolld drg <=16 w/o bdr		.	.	.	.
A6235	A		Hydrocolld drg >16<=48 w/o b		.	.	.	.
A6236	A		Hydrocolld drg > 48 in w/o b		.	.	.	.
A6237	A		Hydrocolld drg <=16 in w/bdr		.	.	.	.
A6238	A		Hydrocolld drg >16<=48 w/bdr		.	.	.	.
A6239	A		Hydrocolld drg > 48 in w/bdr		.	.	.	.
A6240	A		Hydrocolld drg filler paste		.	.	.	.
A6241	A		Hydrocolloid drg filler dry		.	.	.	.
A6242	A		Hydrogel drg <=16 in w/o bdr		.	.	.	.
A6243	A		Hydrogel drg >16<=48 w/o bdr		.	.	.	.
A6244	A		Hydrogel drg >48 in w/o bdr		.	.	.	.
A6245	A		Hydrogel drg <= 16 in w/bdr		.	.	.	.
A6246	A		Hydrogel drg >16<=48 in w/b		.	.	.	.
A6247	A		Hydrogel drg > 48 sq in w/b		.	.	.	.
A6248	A		Hydrogel drsg gel filler		.	.	.	.
A6250	A		Skin seal protect moisturizr		.	.	.	.
A6251	A		Absorpt drg <=16 sq in w/o b		.	.	.	.
A6252	A		Absorpt drg >16 <=48 w/o bdr		.	.	.	.
A6253	A		Absorpt drg > 48 sq in w/o b		.	.	.	.
A6254	A		Absorpt drg <=16 sq in w/bdr		.	.	.	.
A6255	A		Absorpt drg >16<=48 in w/bdr		.	.	.	.
A6256	A		Absorpt drg > 48 sq in w/bdr		.	.	.	.
A6257	A		Transparent film <= 16 sq in		.	.	.	.
A6258	A		Transparent film >16<=48 in		.	.	.	.
A6259	A		Transparent film > 48 sq in		.	.	.	.
A6260	A		Wound cleanser any type/size		.	.	.	.
A6261	A		Wound filler gel/paste /oz		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		Packing strips, non-impreg		.	.	.	.
A6410	A		Sterile eye pad		.	.	.	.
A6411	A		Non-sterile eye pad		.	.	.	.
A6412	E		Occlusive eye patch		.	.	.	.
A6441	A		Pad band w>=3" <5"/yd		.	.	.	.
A6442	A		Conform band n/s w<3"/yd		.	.	.	.
A6443	A		Conform band n/s w>=3"<5"/yd		.	.	.	.
A6444	A		Conform band n/s w>=5"/yd		.	.	.	.
A6445	A		Conform band s w <3"/yd		.	.	.	.
A6446	A		Conform band s w>=3" <5"/yd		.	.	.	.
A6447	A		Conform band s w >=5"/yd		.	.	.	.
A6448	A		Lt compres band <3"/yd		.	.	.	.
A6449	A		Lt compres band >=3" <5"/yd		.	.	.	.
A6450	A		Lt compres band >=5"/yd		.	.	.	.
A6451	A		Mod compres band w>=3"<5"/yd		.	.	.	.
A6452	A		High compres band w>=3"<5"yd		.	.	.	.
A6453	A		Self-adher band w <3"/yd		.	.	.	.
A6454	A		Self-adher band w>=3" <5"/yd		.	.	.	.
A6455	A		Self-adher band >=5"/yd		.	.	.	.
A6456	A		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		Neg pres wound ther drsg set		.	.	.	.
A6551	Y		Neg press wound ther canistr		.	.	.	.
A7000	Y		Disposable canister for pump		.	.	.	.
A7001	Y		Nondisposable pump canister		.	.	.	.
A7002	Y		Tubing used w suction pump		.	.	.	.
A7003	Y		Nebulizer administration set		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7004	Y		Disposable nebulizer sml vol		.	.	.	.
A7005	Y		Nondisposable nebulizer set		.	.	.	.
A7006	Y		Filtered nebulizer admin set		.	.	.	.
A7007	Y		Lg vol nebulizer disposable		.	.	.	.
A7008	Y		Disposable nebulizer prefill		.	.	.	.
A7009	Y		Nebulizer reservoir bottle		.	.	.	.
A7010	Y		Disposable corrugated tubing		.	.	.	.
A7011	Y		Nondispos corrugated tubing		.	.	.	.
A7012	Y		Nebulizer water collec devic		.	.	.	.
A7013	Y		Disposable compressor filter		.	.	.	.
A7014	Y		Compressor nondispos filter		.	.	.	.
A7015	Y		Aerosol mask used w nebulize		.	.	.	.
A7016	Y		Nebulizer dome & mouthpiece		.	.	.	.
A7017	Y		Nebulizer not used w oxygen		.	.	.	.
A7018	Y		Water distilled w/nebulizer		.	.	.	.
A7025	Y		Replace chest compress vest		.	.	.	.
A7026	Y		Replace chst cmprss sys hose		.	.	.	.
A7030	Y		CPAP full face mask		.	.	.	.
A7031	Y		Replacement facemask interfa		.	.	.	.
A7032	Y		Replacement nasal cushion		.	.	.	.
A7033	Y		Replacement nasal pillows		.	.	.	.
A7034	Y		Nasal application device		.	.	.	.
A7035	Y		Pos airway press headgear		.	.	.	.
A7036	Y		Pos airway press chinstrap		.	.	.	.
A7037	Y		Pos airway pressure tubing		.	.	.	.
A7038	Y		Pos airway pressure filter		.	.	.	.
A7039	Y		Filter, non disposable w pap		.	.	.	.
A7040	Y	NI	One way chest drain valve		.	.	.	.
A7041	Y	NI	Water seal drain container		.	.	.	.
A7042	A		Implanted pleural catheter		.	.	.	.
A7043	A		Vacuum drainagebottle/tubing		.	.	.	.
A7044	Y		PAP oral interface		.	.	.	.
A7045	Y	NI	Repl exhalation port for PAP		.	.	.	.
A7046	Y		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7520	A		Trach/laryn tube non-cuffed		.	.	.	.
A7521	A		Trach/laryn tube cuffed		.	.	.	.
A7522	A		Trach/laryn tube stainless		.	.	.	.
A7523	A		Tracheostomy shower protect		.	.	.	.
A7524	A		Tracheostoma stent/stud/bttn		.	.	.	.
A7525	A		Tracheostomy mask		.	.	.	.
A7526	A		Tracheostomy tube collar		.	.	.	.
A7527	Y	NI	Trach/laryn tube plug/stop		.	.	.	.
A9150	B		Misc/exper non-prescript dru		.	.	.	.
A9152	E	NI	Single vitamin nos		.	.	.	.
A9153	E	NI	Multi-vitamin nos		.	.	.	.
A9180	E	NI	Lice treatment, topical		.	.	.	.
A9270	E		Non-covered item or service		.	.	.	.
A9280	E		Alert device, noc		.	.	.	.
A9300	E		Exercise equipment		.	.	.	.
A9500	K		Technetium TC 99m sestamibi	1600	.	106.32	.	21.26
A9502	K		Technetium TC99M tetrofosmin	0705	.	104.58	.	20.92
A9503	N		Technetium TC 99m medronate		.	.	.	.
A9504	K		Technetium tc 99m apcitide	1602	.	415.00	.	83.00
A9505	K		Thallous chloride TL 201/mci	1603	.	18.29	.	3.66
A9507	K		Indium/111 capromab pendetid	1604	.	1915.23	.	383.05
A9508	K		Iobenguane sulfate I-131	1045	.	996.00	.	199.20
A9510	N		Technetium TC99m Disofenin		.	.	.	.
A9511	K		Technetium TC 99m depreotide	1095	0.6631	37.79	.	7.56
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	0.1153	6.57	.	1.31
A9519	N		Technetiumtc-99mmacroag albu		.	.	.	.
A9520	N		Technetiumtc-99m sulfur clld		.	.	.	.
A9521	K		Technetiumtc-99m exametazine	1096	.	778.13	.	155.63
A9522	B		Indium111ibritumomabtiuxetan		.	.	.	.
A9523	B		Yttrium90ibritumomabtiuxetan		.	.	.	.
A9524	N		Iodinated I-131 serumalbumin		.	.	.	.
A9525	E		Low/iso-osmolar contrast mat		.	.	.	.
A9526	K		Ammonia N-13, per dose	0737	1.9280	109.86	.	21.97
A9528	K		Dx I131 so iodide cap millic	1064	0.1153	6.57	.	1.31
A9529	K		Dx I131 so iodide sol millic	1065	0.1707	9.73	.	1.95
A9530	K		Th I131 so iodide sol millic	1065	0.1707	9.73	.	1.95
A9531	N		Dx I131 so iodide microcurie		.	.	.	.
A9532	N		I-125 serum albumin micro		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9533	B		I-131 tositumomab diagnostic		.	.	.	.
A9534	B		I-131 tositumomab therapeut		.	.	.	.
A9600	K		Strontium-89 chloride	0701	7.1278	406.16	.	81.23
A9605	K		Samarium sm153 lexidronamm	0702	15.9228	907.33	.	181.47
A9699	N		Noc therapeutic radiopharm		.	.	.	.
A9700	B		Echocardiography Contrast		.	.	.	.
A9900	A		Supply/accessory/service		.	.	.	.
A9901	A		Delivery/set up/dispensing		.	.	.	.
A9999	Y		DME supply or accessory, nos		.	.	.	.
B4034	A		Enter feed supkit syr by day		.	.	.	.
B4035	A		Enteral feed supp pump per d		.	.	.	.
B4036	A		Enteral feed sup kit grav by		.	.	.	.
B4081	A		Enteral ng tubing w/ stylet		.	.	.	.
B4082	A		Enteral ng tubing w/o stylet		.	.	.	.
B4083	A		Enteral stomach tube levine		.	.	.	.
B4086	A		Gastrostomy/jejunostomy tube		.	.	.	.
B4100	E		Food thickener oral		.	.	.	.
B4102	Y	NI	EF adult fluids and electro		.	.	.	.
B4103	Y	NI	EF ped fluid and electrolyte		.	.	.	.
B4104	B	NI	Additive for enteral formula		.	.	.	.
B4149	Y	NI	EF blenderized foods		.	.	.	.
B4150	A		EF complet w/intact nutrient		.	.	.	.
B4151	D		Enteral formulae cat1natural		.	.	.	.
B4152	A		EF calorie dense>/=1.5Kcal		.	.	.	.
B4153	A		EF hydrolyzed/amino acids		.	.	.	.
B4154	A		EF spec metabolic noninherit		.	.	.	.
B4155	A		EF incomplete/modular		.	.	.	.
B4156	D		Enteral formulae category vi		.	.	.	.
B4157	Y	NI	EF special metabolic inherit		.	.	.	.
B4158	Y	NI	EF ped complete intact nut		.	.	.	.
B4159	Y	NI	EF ped complete soy based		.	.	.	.
B4160	Y	NI	EF ped caloric dense>/=0.7kc		.	.	.	.
B4161	Y	NI	EF ped hydrolyzed/amino acid		.	.	.	.
B4162	Y	NI	EF ped specmetabolic inherit		.	.	.	.
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 &		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
C1079	K		CO 57/58 per 0.5 uCi	1079	.	221.78	.	44.36
C1080	K		I-131 tositumomab, dx	1080	.	2241.00	.	448.20
C1081	K		I-131 tositumomab, tx	1081	.	19422.00	.	3884.40
C1082	K		In-111 ibritumomab tiuxetan	9118	.	2419.78	.	483.96
C1083	K		Yttrium 90 ibritumomab tiuxe	9117	.	20948.25	.	4189.65
C1091	K		IN111 oxyquinoline,per0.5mCi	1091	.	373.50	.	74.70
C1092	K		IN 111 pentetate per 0.5 mCi	1092	.	224.10	.	44.82
C1093	K	NI	TC99M fanolesomab	1093	.	1045.80	.	209.16
C1122	K		Tc 99M ARCITUMOMAB PER VIAL	1122	.	1079.00	.	215.80
C1178	K		BUSULFAN IV, 6 Mg	1178	.	24.35	.	4.87
C1200	N		TC 99M Sodium Glucoheptonat		.	.	.	.
C1201	K		TC 99M SUCCIMER, PER Vial	1201	.	118.52	.	23.70
C1300	S		HYPERBARIC Oxygen	0659	1.5926	90.75	.	18.15
C1305	K		Apligraf	1305	.	1130.88	.	226.18
C1713	N		Anchor/screw bn/bn,tis/bn		.	.	.	.
C1714	N		Cath, trans atherectomy, dir		.	.	.	.
C1715	N		Brachytherapy needle		.	.	.	.
C1716	H		Brachytx source, Gold 198	1716	.	.	.	.
C1717	H		Brachytx source, HDR Ir-192	1717	.	.	.	.
C1718	H		Brachytx source, Iodine 125	1718	.	.	.	.
C1719	H		Brachytx sour,Non-HDR Ir-192	1719	.	.	.	.
C1720	H		Brachytx sour, Palladium 103	1720	.	.	.	.
C1721	N		AICD, dual chamber		.	.	.	.
C1722	N		AICD, single chamber		.	.	.	.
C1724	N		Cath, trans atherec,rotation		.	.	.	.
C1725	N		Cath, translumin non-laser		.	.	.	.
C1726	N		Cath, bal dil, non-vascular		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1727	N		Cath, bal tis dis, non-vas		.	.	.	.
C1728	N		Cath, brachytx seed adm		.	.	.	.
C1729	N		Cath, drainage		.	.	.	.
C1730	N		Cath, EP, 19 or few elect		.	.	.	.
C1731	N		Cath, EP, 20 or more elec		.	.	.	.
C1732	N		Cath, EP, diag/abl, 3D/vect		.	.	.	.
C1733	N		Cath, EP, othr than cool-tip		.	.	.	.
C1750	N		Cath, hemodialysis,long-term		.	.	.	.
C1751	N		Cath, inf, per/cent/midline		.	.	.	.
C1752	N		Cath,hemodialysis,short-term		.	.	.	.
C1753	N		Cath, intravas ultrasound		.	.	.	.
C1754	N		Catheter, intradiscal		.	.	.	.
C1755	N		Catheter, intraspinal		.	.	.	.
C1756	N		Cath, pacing, transesoph		.	.	.	.
C1757	N		Cath, thrombectomy/embolect		.	.	.	.
C1758	N		Catheter, ureteral		.	.	.	.
C1759	N		Cath, intra echocardiography		.	.	.	.
C1760	N		Closure dev, vasc		.	.	.	.
C1762	N		Conn tiss, human(inc fascia)		.	.	.	.
C1763	N		Conn tiss, non-human		.	.	.	.
C1764	N		Event recorder, cardiac		.	.	.	.
C1765	N		Adhesion barrier		.	.	.	.
C1766	N		Intro/sheath,strble,non-peel		.	.	.	.
C1767	N		Generator, neurostim, imp		.	.	.	.
C1768	N		Graft, vascular		.	.	.	.
C1769	N		Guide wire		.	.	.	.
C1770	N		Imaging coil, MR, insertable		.	.	.	.
C1771	N		Rep dev, urinary, w/sling		.	.	.	.
C1772	N		Infusion pump, programmable		.	.	.	.
C1773	N		Ret dev, insertable		.	.	.	.
C1775	K		FDG, per dose (4-40 mCi/ml)	1775	3.8803	221.11	.	44.22
C1776	N		Joint device (implantable)		.	.	.	.
C1777	N		Lead, AICD, endo single coil		.	.	.	.
C1778	N		Lead, neurostimulator		.	.	.	.
C1779	N		Lead, pmkr, transvenous VDD		.	.	.	.
C1780	N		Lens, intraocular (new tech)		.	.	.	.
C1781	N		Mesh (implantable)		.	.	.	.
C1782	N		Morcellator		.	.	.	.
C1783	N		Ocular imp, aqueous drain de		.	.	.	.
C1784	N		Ocular dev, intraop, det ret		.	.	.	.
C1785	N		Pmkr, dual, rate-resp		.	.	.	.
C1786	N		Pmkr, single, rate-resp		.	.	.	.
C1787	N		Patient progr, neurostim		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1788	N		Port, indwelling, imp		.	.	.	.
C1789	N		Prosthesis, breast, imp		.	.	.	.
C1813	N		Prosthesis, penile, inflatab		.	.	.	.
C1814	H		Retinal tamp, silicone oil	1814	.	.	.	.
C1815	N		Pros, urinary sph, imp		.	.	.	.
C1816	N		Receiver/transmitter, neuro		.	.	.	.
C1817	N		Septal defect imp sys		.	.	.	.
C1818	H		Integrated keratoprosthesis	1818	.	.	.	.
C1819	H		Tissue localization-excision	1819	.	.	.	.
C1874	N		Stent, coated/cov w/del sys		.	.	.	.
C1875	N		Stent, coated/cov w/o del sy		.	.	.	.
C1876	N		Stent, non-coa/non-cov w/del		.	.	.	.
C1877	N		Stent, non-coat/cov w/o del		.	.	.	.
C1878	N		Matrl for vocal cord		.	.	.	.
C1879	N		Tissue marker, implantable		.	.	.	.
C1880	N		Vena cava filter		.	.	.	.
C1881	N		Dialysis access system		.	.	.	.
C1882	N		AICD, other than sing/dual		.	.	.	.
C1883	N		Adapt/ext, pacing/neuro lead		.	.	.	.
C1884	N		Embolization Protect syst		.	.	.	.
C1885	N		Cath, translumin angio laser		.	.	.	.
C1887	N		Catheter, guiding		.	.	.	.
C1888	N		Endovas non-cardiac abl cath		.	.	.	.
C1891	N		Infusion pump,non-prog, perm		.	.	.	.
C1892	N		Intro/sheath,fixed,peel-away		.	.	.	.
C1893	N		Intro/sheath, fixed,non-peel		.	.	.	.
C1894	N		Intro/sheath, non-laser		.	.	.	.
C1895	N		Lead, AICD, endo dual coil		.	.	.	.
C1896	N		Lead, AICD, non sing/dual		.	.	.	.
C1897	N		Lead, neurostim test kit		.	.	.	.
C1898	N		Lead, pmkr, other than trans		.	.	.	.
C1899	N		Lead, pmkr/AICD combination		.	.	.	.
C1900	N		Lead, coronary venous		.	.	.	.
C2614	N		Probe, perc lumb disc		.	.	.	.
C2615	N		Sealant, pulmonary, liquid		.	.	.	.
C2616	H		Brachytx source, Yttrium-90	2616	.	.	.	.
C2617	N		Stent, non-cor, tem w/o del		.	.	.	.
C2618	N		Probe, cryoablation		.	.	.	.
C2619	N		Pmkr, dual, non rate-resp		.	.	.	.
C2620	N		Pmkr, single, non rate-resp		.	.	.	.
C2621	N		Pmkr, other than sing/dual		.	.	.	.
C2622	N		Prosthesis, penile, non-inf		.	.	.	.
C2625	N		Stent, non-cor, tem w/del sy		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C2626	N		Infusion pump, non-prog,temp		.	.	.	.
C2627	N		Cath, suprapubic/cystoscopic		.	.	.	.
C2628	N		Catheter, occlusion		.	.	.	.
C2629	N		Intro/sheath, laser		.	.	.	.
C2630	N		Cath, EP, cool-tip		.	.	.	.
C2631	N		Rep dev, urinary, w/o sling		.	.	.	.
C2632	H		Brachytx sol, I-125, per mCi	2632	.	.	.	.
C2633	H		Brachytx source, Cesium-131	2633	.	.	.	.
C2634	H	NI	Brachytx source, HA, I-125	2634	.	.	.	.
C2635	H	NI	Brachytx source, HA, P-103	2635	.	.	.	.
C2636	H	NI	Brachytx linear source, P-10	2636	.	.	.	.
C8900	S		MRA w/cont, abd	0284	6.7851	386.64	173.98	77.33
C8901	S		MRA w/o cont, abd	0336	6.3150	359.85	161.93	71.97
C8902	S		MRA w/o fol w/cont, abd	0337	9.1701	522.54	235.14	104.51
C8903	S		MRI w/cont, breast, uni	0284	6.7851	386.64	173.98	77.33
C8904	S		MRI w/o cont, breast, uni	0336	6.3150	359.85	161.93	71.97
C8905	S		MRI w/o fol w/cont, brst, un	0337	9.1701	522.54	235.14	104.51
C8906	S		MRI w/cont, breast, bi	0284	6.7851	386.64	173.98	77.33
C8907	S		MRI w/o cont, breast, bi	0336	6.3150	359.85	161.93	71.97
C8908	S		MRI w/o fol w/cont, breast,	0337	9.1701	522.54	235.14	104.51
C8909	S		MRA w/cont, chest	0284	6.7851	386.64	173.98	77.33
C8910	S		MRA w/o cont, chest	0336	6.3150	359.85	161.93	71.97
C8911	S		MRA w/o fol w/cont, chest	0337	9.1701	522.54	235.14	104.51
C8912	S		MRA w/cont, lwr ext	0284	6.7851	386.64	173.98	77.33
C8913	S		MRA w/o cont, lwr ext	0336	6.3150	359.85	161.93	71.97
C8914	S		MRA w/o fol w/cont, lwr ext	0337	9.1701	522.54	235.14	104.51
C8918	S		MRA w/cont, pelvis	0284	6.7851	386.64	173.98	77.33
C8919	S		MRA w/o cont, pelvis	0336	6.3150	359.85	161.93	71.97
C8920	S		MRA w/o fol w/cont, pelvis	0337	9.1701	522.54	235.14	104.51
C9000	N		Na chromateCr51, per 0.25mCi		.	.	.	.
C9003	K		Palivizumab, per 50 mg	9003	.	576.51	.	115.30
C9007	N		Baclofen Intrathecal kit-1am		.	.	.	.
C9008	K		Baclofen Refill Kit-500mcg	9008	.	10.21	.	2.04
C9009	K		Baclofen Refill Kit-2000mcg	9009	.	37.64	.	7.53
C9013	K		Co 57 cobaltous chloride	9013	2.4999	142.45	.	28.49
C9102	N		51 Na Chromate, 50mCi		.	.	.	.
C9103	N		Na Iothalamate I-125, 10 uCi		.	.	.	.
C9105	K		Hep B imm glob, per 1 ml	9105	.	118.32	.	23.66
C9109	D		Tirofiban hcl, 6.25 mg		.	.	.	.
C9112	K		Perflutren lipid micro, 2ml	9112	.	129.69	.	25.94
C9113	N		Inj pantoprazole sodium, via		.	.	.	.
C9121	K		Injection, argatroban	9121	.	12.45	.	2.49
C9123	G	NF	Transcyte, per 247 sq cm	9123	.	707.97	.	141.59

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C9124	D		Injection, daptomycin		.	.	.	.
C9125	D		Injection, risperidone		.	.	.	.
C9200	K		Orcel, per 36 cm2	9200	.	991.85	.	198.37
C9201	K		Dermagraft, per 37.5 sq cm	9201	.	529.54	.	105.91
C9202	K		Octafluoropropane	9202	.	129.48	.	25.90
C9203	G		Perflexane lipid micro	9203	.	142.20	.	28.50
C9205	G		Oxaliplatin	9205	.	81.61	.	16.32
C9206	K	NI	Integra, per cm2	9206	.	6.60	.	1.32
C9207	D		Injection, bortezomib		.	.	.	.
C9208	D		Injection, agalsidase beta		.	.	.	.
C9209	D		Injection, laronidase		.	.	.	.
C9210	D		Injection, palonosetron HCl		.	.	.	.
C9211	G		Inj, alefacept, IV	9211	.	560.00	.	112.00
C9212	G		Inj, alefacept, IM	9212	.	398.49	.	79.70
C9213	D		Injection, pemetrexed		.	.	.	.
C9214	D		Injection, bevacizumab		.	.	.	.
C9215	D		Injection, cetuximab		.	.	.	.
C9216	D		Abarelix, inject suspension		.	.	.	.
C9217	D		Injection, omalizumab		.	.	.	.
C9218	G	NI	Injection, azacitidine	9218	.	3.81	.	0.76
C9219	D		Mycophenolic acid, oral		.	.	.	.
C9220	G	NI	Sodium hyaluronate	9220	.	238.36	.	47.67
C9221	G	NI	Graftjacket Reg Matrix	9221	.	1068.75	.	213.75
C9222	G	NI	Graftjacket SftTis	9222	.	743.38	.	148.68
C9399	A	NF	Unclassified drugs or biolog		.	.	.	.
C9400	K	NF	Thallous chloride, brand	9400	.	21.19	.	4.24
C9401	K	NF	Strontium-89 chloride,brand	9401	.	406.16	.	81.23
C9402	K	NF	Th I131 so iodide cap, brand	9402	.	6.57	.	1.31
C9403	K	NF	Dx I131 so iodide cap, brand	9403	.	6.57	.	1.31
C9404	K	NF	Dx I131 so iodide sol, brand	9404	.	9.73	.	1.95
C9405	K	NF	Th I131 so iodide sol, brand	9405	.	9.73	.	1.95
C9410	K	NF	Dexrazoxane HCl inj, brand	9410	.	123.93	.	24.79
C9411	K	NF	Pamidronate disodium, brand	9411	.	160.65	.	32.13
C9413	K	NF	Sodium hyaluronate inj, bran	9413	.	53.94	.	10.79
C9414	K	NF	Etoposide oral, brand	9414	.	25.71	.	5.14
C9415	K	NF	Doxorubic hcl chemo, brand	9415	.	6.94	.	1.39
C9417	K	NF	Bleomycin sulfate inj, brand	9417	.	130.56	.	26.11
C9418	K	NF	Cisplatin inj, brand	9418	.	11.42	.	2.28
C9419	K	NF	Inj cladribine, brand	9419	.	36.72	.	7.34
C9420	K	NF	Cyclophosphamide inj, brand	9420	.	4.10	.	0.82
C9421	K	NF	Cyclophosphamide lyo, brand	9421	.	3.50	.	0.70
C9422	K	NF	Cytarabine hcl inj, brand	9422	.	2.28	.	0.46
C9423	K	NF	Dacarbazine inj, brand	9423	.	8.15	.	1.63

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C9424	K	NF	Daunorubicin, brand	9424	.	53.14	.	10.63
C9425	K	NF	Etoposide inj, brand	9425	.	1.22	.	0.24
C9426	K	NF	Floxuridine inj, brand	9426	.	97.92	.	19.58
C9427	K	NF	Ifosfomide inj, brand	9427	.	90.80	.	18.16
C9428	K	NF	Mesna injection, brand	9428	.	23.79	.	4.76
C9429	K	NF	Idarubicin hcl inj, brand	9429	.	66.58	.	13.32
C9430	K	NF	Leuprolide acetate inj, bran	9430	.	21.41	.	4.28
C9431	K	NF	Paclitaxel inj, brand	9431	.	93.50	.	18.70
C9432	K	NF	Mitomycin inj, brand	9432	.	45.70	.	9.14
C9433	K	NF	Thiotepa inj, brand	9433	.	66.98	.	13.40
C9435	K	NF	Gonadorelin hydroch, brand	9435	.	17.08	.	3.42
C9436	K	NF	Azathioprine parenteral,brnd	9436	.	44.61	.	8.92
C9437	K	NI	Carmus bischl nitro inj	9437	.	79.42	.	15.88
C9438	K	NF	Cyclosporine oral, brand	9438	.	1.78	.	0.36
C9439	K	NI	Diethylstilbestrol injection	9439	.	10.32	.	2.06
C9701	D		Stretta System		.	.	.	.
C9703	D		Bard Endoscopic Suturing Sys		.	.	.	.
C9704	T		Inj inert subs upper GI	1556	.	1750.00	.	350.00
C9712	D		Insert pH capsule, GERD		.	.	.	.
C9713	S	NF	Non-contact laser vap prosta	1525	.	3750.00	.	750.00
C9714	D		Breast inters rad tx, immed		.	.	.	.
C9715	D		Breast inters rad tx, delay		.	.	.	.
C9716	S	NF	Radiofrequency energy to anu	1519	.	1750.00	.	350.00
C9717	D		Stapled hemorrhoidopexy		.	.		.
C9718	T	NI	Kyphoplasty, first vertebra	0051	35.8607	2043.45	.	408.69
C9719	T	NI	Kyphoplasty, each addl	0051	35.8607	2043.45	.	408.69
C9720	T	NI	HE ESW tx, tennis elbow	1547	.	850.00	.	170.00
C9721	T	NI	HE ESW tx, plantar fasciitis	1547	.	850.00	.	170.00
C9722	S	NI	KV imaging w/IR tracking	1502	.	75.00	.	15.00
D0120	E		Periodic oral evaluation		.	.	.	.
D0140	E		Limit oral eval problm focus		.	.	.	.
D0150	S		Comprehensve oral evaluation	0330	14.0629	801.35	.	160.27
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	14.0629	801.35	.	160.27
D0250	S		Extraoral first film	0330	14.0629	801.35	.	160.27
D0260	S		Extraoral ea additional film	0330	14.0629	801.35	.	160.27
D0270	S		Dental bitewing single film	0330	14.0629	801.35	.	160.27
D0272	S		Dental bitewings two films	0330	14.0629	801.35	.	160.27

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0274	S		Dental bitewings four films	0330	14.0629	801.35	.	160.27
D0277	S		Vert bitewings-sev to eight	0330	14.0629	801.35	.	160.27
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 photo images		.	.	.	.
D0415	E		Collection of microorganisms		.	.	.	.
D0416	B	NI	Viral culture					
D0421	B	NI	Gen tst suscept oral disease					
D0425	E		Caries susceptibility test		.	.	.	.
D0431	B	NI	Diag tst detect mucos abnorm					
D0460	S		Pulp vitality test	0330	14.0629	801.35	.	160.27
D0470	E		Diagnostic casts		.	.	.	.
D0472	S		Gross exam, prep & report	0330	14.0629	801.35	.	160.27
D0473	S		Micro exam, prep & report	0330	14.0629	801.35	.	160.27
D0474	S		Micro w exam of surg margins	0330	14.0629	801.35	.	160.27
D0475	B	NI	Decalcification procedure					
D0476	B	NI	Spec stains for microorganis					
D0477	B	NI	Spec stains not for microorg					
D0478	B	NI	Immunohistochemical stains					
D0479	B	NI	Tissue in-situ hybridization					
D0480	S		Cytopath smear prep & report	0330	14.0629	801.35	.	160.27
D0481	B	NI	Electron microscopy diagnost					
D0482	B	NI	Direct immunofluorescence					
D0483	B	NI	Indirect immunofluorescence					
D0484	B	NI	Consult slides prep elsewher					
D0485	B	NI	Consult inc prep of slides					
D0502	S		Other oral pathology procedu	0330	14.0629	801.35	.	160.27
D0999	S		Unspecified diagnostic proce	0330	14.0629	801.35	.	160.27
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D1510	S		Space maintainer fxd unilat	0330	14.0629	801.35	.	160.27
D1515	S		Fixed bilat space maintainer	0330	14.0629	801.35	.	160.27
D1520	S		Remove unilat space maintain	0330	14.0629	801.35	.	160.27
D1525	S		Remove bilat space maintain	0330	14.0629	801.35	.	160.27
D1550	S		Recement space maintainer	0330	14.0629	801.35	.	160.27
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		.	.	.	.
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-based indirect		.	.	.	.
D2712	E	NI	Crown 3/4 resin-based compos					
D2720	E		Crown resin w/ high noble me		.	.	.	.
D2721	E		Crown resin w/ base metal		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
D2794	E	NI	Crown-titanium					
D2799	E		Provisional crown		.	.	.	.
D2910	E		Recement inlay onlay or part		.	.	.	.
D2915	E	NI	Recement cast or prefab post					
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		.	.	.	.
D2934	E	NI	Prefab steel crown primary					
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	D		Temporary- fractured tooth				.	
D2971	E	NI	Add proc construct new crown					
D2975	E	NI	Coping					
D2980	E		Crown repair		.	.	.	.
D2999	S		Dental unspec restorative pr	0330	14.0629	801.35	.	160.27
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	14.0629	801.35	.	160.27
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	14.0629	801.35	.	160.27
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	14.0629	801.35	.	160.27
D4261	E		Osseous surgl-3teethperquad		.	.	.	.
D4263	S		Bone replce graft first site	0330	14.0629	801.35	.	160.27
D4264	S		Bone replce graft each add	0330	14.0629	801.35	.	160.27
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	14.0629	801.35	.	160.27
D4270	S		Pedicle soft tissue graft pr	0330	14.0629	801.35	.	160.27
D4271	S		Free soft tissue graft proc	0330	14.0629	801.35	.	160.27
D4273	S		Subepithelial tissue graft	0330	14.0629	801.35	.	160.27
D4274	E		Distal/proximal wedge proc		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	14.0629	801.35	.	160.27
D4381	S		Localized delivery antimicro	0330	14.0629	801.35	.	160.27
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		.	.	.	.
D5225	E	NI	Maxillary part denture flex					
D5226	E	NI	Mandibular part denture flex					
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5741	E		Denture reln part mand chr		.	.	.	.
D5750	E		Denture reln cmplt max lab		.	.	.	.
D5751	E		Denture reln cmplt mand lab		.	.	.	.
D5760	E		Denture reln part maxil lab		.	.	.	.
D5761	E		Denture reln part mand lab		.	.	.	.
D5810	E		Denture interm cmplt maxill		.	.	.	.
D5811	E		Denture interm cmplt mandbl		.	.	.	.
D5820	E		Denture interm part maxill		.	.	.	.
D5821	E		Denture interm part mandbl		.	.	.	.
D5850	E		Denture tiss conditn maxill		.	.	.	.
D5851	E		Denture tiss condtin mandbl		.	.	.	.
D5860	E		Overdenture complete		.	.	.	.
D5861	E		Overdenture partial		.	.	.	.
D5862	E		Precision attachment		.	.	.	.
D5867	E		Replacement of precision att		.	.	.	.
D5875	E		Prosthesis modification		.	.	.	.
D5899	E		Removable prosthodontic proc		.	.	.	.
D5911	S		Facial moulage sectional	0330	14.0629	801.35	.	160.27
D5912	S		Facial moulage complete	0330	14.0629	801.35	.	160.27
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	14.0629	801.35	.	160.27
D5984	S		Radiation shield	0330	14.0629	801.35	.	160.27
D5985	S		Radiation cone locator	0330	14.0629	801.35	.	160.27
D5986	E		Fluoride applicator		.	.	.	.
D5987	S		Commissure splint	0330	14.0629	801.35	.	160.27
D5988	E		Surgical splint		.	.	.	.
D5999	E		Maxillofacial prosthesis		.	.	.	.
D6010	E		Odontics endosteal implant		.	.	.	.
D6020	D		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6080	E		Implant maintenance		.	.	.	.
D6090	E		Repair implant		.	.	.	.
D6094	E	NI	Abut support crown titanium					
D6095	E		Odontics repr abutment		.	.	.	.
D6100	E		Removal of implant		.	.	.	.
D6190	E	NI	Radio/surgical implant index					
D6194	E	NI	Abut support retainer titani					
D6199	E		Implant procedure		.	.	.	.
D6205	E	NI	Pontic-indirect resin based					
D6210	E		Prosthodont high noble metal		.	.	.	.
D6211	E		Bridge base metal cast		.	.	.	.
D6212	E		Bridge noble metal cast		.	.	.	.
D6214	E	NI	Pontic titanium					
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		.	.	.	.
D6624	E	NI	Inlay titanium					
D6634	E	NI	Onlay titanium					
D6710	E	NI	Crown-indirect resin based					
D6720	E		Retain crown resin w hi nble		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
D6794	E	NI	Crown titanium					
D6920	S		Dental connector bar	0330	14.0629	801.35	.	160.27
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		Extraction coronal remnants	0330	14.0629	801.35	.	160.27
D7140	S		Extraction erupted tooth/exr	0330	14.0629	801.35	.	160.27
D7210	S		Rem imp tooth w mucoper flp	0330	14.0629	801.35	.	160.27
D7220	S		Impact tooth remov soft tiss	0330	14.0629	801.35	.	160.27
D7230	S		Impact tooth remov part bony	0330	14.0629	801.35	.	160.27
D7240	S		Impact tooth remov comp bony	0330	14.0629	801.35	.	160.27
D7241	S		Impact tooth rem bony w/comp	0330	14.0629	801.35	.	160.27
D7250	S		Tooth root removal	0330	14.0629	801.35	.	160.27
D7260	S		Oral antral fistula closure	0330	14.0629	801.35	.	160.27
D7261	S		Primary closure sinus perf	0330	14.0629	801.35	.	160.27
D7270	E		Tooth reimplantation		.	.	.	.
D7272	E		Tooth transplantation		.	.	.	.
D7280	E		Exposure impact tooth orthod		.	.	.	.
D7281	D		Exposure tooth aid eruption		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7282	E		Mobilize erupted/malpos toot					
D7283	B	NI	Place device impacted tooth					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					
D7287	E		Exfoliative cytolog collect					
D7288	B	NI	Brush biopsy					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	14.0629	801.35		160.27
D7310	E		Alveoplasty w/ extraction					
D7311	E	NI	Alveoloplasty w/extract 1-3					
D7320	E		Alveoplasty w/o extraction					
D7321	B	NI	Alveoloplasty not w/extracts					
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		Maxilla or mandible resectio					
D7510	E		I&d absc intraoral soft tiss					
D7511	B	NI	Incision/drain abscess intra					
D7520	E		I&d abscess extraoral					
D7521	B	NI	Incision/drain abscess extra					
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					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	14.0629	801.35	.	160.27
D7941	E		Bone cutting ramus closed		.	.	.	.
D7943	E		Cutting ramus open w/graft		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
D7953	E	NI	Bone replacement graft					
D7955	E		Repair maxillofacial defects		.	.	.	.
D7960	E		Frenulectomy/frenulotomy		.	.	.	.
D7963	E	NI	Frenuloplasty					
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	14.0629	801.35	.	160.27
D9910	E		Dent appl desensitizing med		.	.	.	.
D9911	E		Appl desensitizing resin		.	.	.	.
D9920	E		Behavior management		.	.	.	.
D9930	S		Treatment of complications	0330	14.0629	801.35	.	160.27
D9940	S		Dental occlusal guard	0330	14.0629	801.35	.	160.27
D9941	E		Fabrication athletic guard		.	.	.	.
D9942	E	NI	Repair/reline occlusal guard					
D9950	S		Occlusion analysis	0330	14.0629	801.35	.	160.27
D9951	S		Limited occlusal adjustment	0330	14.0629	801.35	.	160.27
D9952	S		Complete occlusal adjustment	0330	14.0629	801.35	.	160.27
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		.	.	.	.
D9999	E		Adjunctive procedure		.	.	.	.
E0100	Y		Cane adjust/fixed with tip		.	.	.	.
E0105	Y		Cane adjust/fixed quad/3 pro		.	.	.	.
E0110	Y		Crutch forearm pair		.	.	.	.
E0111	Y		Crutch forearm each		.	.	.	.
E0112	Y		Crutch underarm pair wood		.	.	.	.
E0113	Y		Crutch underarm each wood		.	.	.	.
E0114	Y		Crutch underarm pair no wood		.	.	.	.
E0116	Y		Crutch underarm each no wood		.	.	.	.
E0117	Y		Underarm springassist crutch		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0118	E		Crutch substitute		.	.	.	.
E0130	Y		Walker rigid adjust/fixed ht		.	.	.	.
E0135	Y		Walker folding adjust/fixed		.	.	.	.
E0140	Y		Walker w trunk support		.	.	.	.
E0141	Y		Rigid wheeled walker adj/fix		.	.	.	.
E0143	Y		Walker folding wheeled w/o s		.	.	.	.
E0144	Y		Enclosed walker w rear seat		.	.	.	.
E0147	Y		Walker variable wheel resist		.	.	.	.
E0148	Y		Heavyduty walker no wheels		.	.	.	.
E0149	Y		Heavy duty wheeled walker		.	.	.	.
E0153	Y		Forearm crutch platform atta		.	.	.	.
E0154	Y		Walker platform attachment		.	.	.	.
E0155	Y		Walker wheel attachment,pair		.	.	.	.
E0156	Y		Walker seat attachment		.	.	.	.
E0157	Y		Walker crutch attachment		.	.	.	.
E0158	Y		Walker leg extenders set of4		.	.	.	.
E0159	Y		Brake for wheeled walker		.	.	.	.
E0160	Y		Sitz type bath or equipment		.	.	.	.
E0161	Y		Sitz bath/equipment w/faucet		.	.	.	.
E0162	Y		Sitz bath chair		.	.	.	.
E0163	Y		Commode chair stationry fxd		.	.	.	.
E0164	Y		Commode chair mobile fixed a		.	.	.	.
E0165	Y		Commode chair stationry det					
E0166	Y		Commode chair mobile detach		.	.	.	.
E0167	Y		Commode chair pail or pan		.	.	.	.
E0168	Y		Heavyduty/wide commode chair		.	.	.	.
E0169	Y		Seatlift incorp commodechair		.	.	.	.
E0175	Y		Commode chair foot rest		.	.	.	.
E0176	D		Air pressre pad/cushion nonp		.	.	.	.
E0177	D		Water press pad/cushion nonp		.	.	.	.
E0178	D		Gel pressre pad/cushion nonp		.	.	.	.
E0179	D		Dry pressre pad/cushion nonp		.	.	.	.
E0180	Y		Press pad alternating w pump		.	.	.	.
E0181	Y		Press pad alternating w/ pum		.	.	.	.
E0182	Y		Pressure pad alternating pum		.	.	.	.
E0184	Y		Dry pressure mattress		.	.	.	.
E0185	Y		Gel pressure mattress pad		.	.	.	.
E0186	Y		Air pressure mattress		.	.	.	.
E0187	Y		Water pressure mattress		.	.	.	.
E0188	Y		Synthetic sheepskin pad		.	.	.	.
E0189	Y		Lambswool sheepskin pad		.	.	.	.
E0190	E		Positioning cushion		.	.	.	.
E0191	Y		Protector heel or elbow		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0192	D		Pad wheelchr low press/posit		.	.	.	.
E0193	Y		Powered air flotation bed		.	.	.	.
E0194	Y		Air fluidized bed		.	.	.	.
E0196	Y		Gel pressure mattress		.	.	.	.
E0197	Y		Air pressure pad for mattres		.	.	.	.
E0198	Y		Water pressure pad for mattr		.	.	.	.
E0199	Y		Dry pressure pad for mattres		.	.	.	.
E0200	Y		Heat lamp without stand		.	.	.	.
E0202	Y		Phototherapy light w/ photom		.	.	.	.
E0203	A		Therapeutic lightbox tabletp		.	.	.	.
E0205	Y		Heat lamp with stand		.	.	.	.
E0210	Y		Electric heat pad standard		.	.	.	.
E0215	Y		Electric heat pad moist		.	.	.	.
E0217	Y		Water circ heat pad w pump		.	.	.	.
E0218	Y		Water circ cold pad w pump		.	.	.	.
E0220	Y		Hot water bottle		.	.	.	.
E0221	Y		Infrared heating pad system		.	.	.	.
E0225	Y		Hydrocollator unit		.	.	.	.
E0230	Y		Ice cap or collar		.	.	.	.
E0231	E		Wound warming device		.	.	.	.
E0232	E		Warming card for NWT		.	.	.	.
E0235	Y		Paraffin bath unit portable		.	.	.	.
E0236	Y		Pump for water circulating p		.	.	.	.
E0238	Y		Heat pad non-electric moist		.	.	.	.
E0239	Y		Hydrocollator unit portable		.	.	.	.
E0240	E		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		Trans bench w/wo comm open		.	.	.	.
E0248	E		HDtrans bench w/wo comm open		.	.	.	.
E0249	Y		Pad water circulating heat u		.	.	.	.
E0250	Y		Hosp bed fixed ht w/ mattres		.	.	.	.
E0251	Y		Hosp bed fixd ht w/o mattres		.	.	.	.
E0255	Y		Hospital bed var ht w/ mattr		.	.	.	.
E0256	Y		Hospital bed var ht w/o matt		.	.	.	.
E0260	Y		Hosp bed semi-electr w/ matt		.	.	.	.
E0261	Y		Hosp bed semi-electr w/o mat		.	.	.	.
E0265	Y		Hosp bed total electr w/ mat		.	.	.	.
E0266	Y		Hosp bed total elec w/o matt		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0270	E		Hospital bed institutional t		.	.	.	.
E0271	Y		Mattress innerspring		.	.	.	.
E0272	Y		Mattress foam rubber		.	.	.	.
E0273	E		Bed board		.	.	.	.
E0274	E		Over-bed table		.	.	.	.
E0275	Y		Bed pan standard		.	.	.	.
E0276	Y		Bed pan fracture		.	.	.	.
E0277	Y		Powered pres-redu air mattrs		.	.	.	.
E0280	Y		Bed cradle		.	.	.	.
E0290	Y		Hosp bed fx ht w/o rails w/m		.	.	.	.
E0291	Y		Hosp bed fx ht w/o rail w/o		.	.	.	.
E0292	Y		Hosp bed var ht w/o rail w/o		.	.	.	.
E0293	Y		Hosp bed var ht w/o rail w/		.	.	.	.
E0294	Y		Hosp bed semi-elect w/ mattr		.	.	.	.
E0295	Y		Hosp bed semi-elect w/o matt		.	.	.	.
E0296	Y		Hosp bed total elect w/ matt		.	.	.	.
E0297	Y		Hosp bed total elect w/o mat		.	.	.	.
E0300	Y		Enclosed ped crib hosp grade		.	.	.	.
E0301	Y		HD hosp bed, 350-600 lbs		.	.	.	.
E0302	Y		Ex hd hosp bed > 600 lbs		.	.	.	.
E0303	Y		Hosp bed hvy dty xtra wide		.	.	.	.
E0304	Y		Hosp bed xtra hvy dty x wide		.	.	.	.
E0305	Y		Rails bed side half length		.	.	.	.
E0310	Y		Rails bed side full length		.	.	.	.
E0315	E		Bed accessory brd/tbl/supprt		.	.	.	.
E0316	Y		Bed safety enclosure		.	.	.	.
E0325	Y		Urinal male jug-type		.	.	.	.
E0326	Y		Urinal female jug-type		.	.	.	.
E0350	E		Control unit bowel system		.	.	.	.
E0352	E		Disposable pack w/bowel syst		.	.	.	.
E0370	E		Air elevator for heel		.	.	.	.
E0371	Y		Nonpower mattress overlay		.	.	.	.
E0372	Y		Powered air mattress overlay		.	.	.	.
E0373	Y		Nonpowered pressure mattress		.	.	.	.
E0424	Y		Stationary compressed gas 02		.	.	.	.
E0425	E		Gas system stationary compre		.	.	.	.
E0430	E		Oxygen system gas portable		.	.	.	.
E0431	Y		Portable gaseous 02		.	.	.	.
E0434	Y		Portable liquid 02		.	.	.	.
E0435	E		Oxygen system liquid portabl		.	.	.	.
E0439	Y		Stationary liquid 02		.	.	.	.
E0440	E		Oxygen system liquid station		.	.	.	.
E0441	Y		Oxygen contents, gaseous		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0442	Y		Oxygen contents, liquid		.			.
E0443	Y		Portable 02 contents, gas		.	.	.	.
E0444	Y		Portable 02 contents, liquid		.	.	.	.
E0445	A		Oximeter non-invasive		.	.	.	.
E0450	Y		Vol control vent invasiv int		.	.	.	.
E0454	D		Pressure ventilator		.	.	.	.
E0455	Y		Oxygen tent excl croup/ped t		.	.	.	.
E0457	Y		Chest shell		.	.	.	.
E0459	Y		Chest wrap		.	.	.	.
E0460	Y		Neg press vent portabl/statn		.	.	.	.
E0461	Y		Vol control vent noninv int		.	.	.	.
E0462	Y		Rocking bed w/ or w/o side r		.	.	.	.
E0463	Y	NI	Press supp vent invasive int		.	.	.	.
E0464	Y	NI	Press supp vent noninv int		.	.	.	.
E0470	Y		RAD w/o backup non-inv intfc		.	.	.	.
E0471	Y		RAD w/backup non inv intrfc		.	.	.	.
E0472	Y		RAD w backup invasive intrfc		.	.	.	.
E0480	Y		Percussor elect/pneum home m		.	.	.	.
E0481	E		Intrpulmnry percuss vent sys		.	.	.	.
E0482	Y		Cough stimulating device		.	.	.	.
E0483	Y		Chest compression gen system		.	.	.	.
E0484	Y		Non-elec oscillatory pep dvc		.	.	.	.
E0500	Y		Ippb all types		.	.	.	.
E0550	Y		Humidif extens supple w ippb		.	.	.	.
E0555	Y		Humidifier for use w/ regula		.	.	.	.
E0560	Y		Humidifier supplemental w/ i		.	.	.	.
E0561	Y		Humidifier nonheated w PAP		.	.	.	.
E0562	Y		Humidifier heated used w PAP		.	.	.	.
E0565	Y		Compressor air power source		.	.	.	.
E0570	Y		Nebulizer with compression		.	.	.	.
E0571	Y		Aerosol compressor for svneb		.	.	.	.
E0572	Y		Aerosol compressor adjust pr		.	.	.	.
E0574	Y		Ultrasonic generator w svneb		.	.	.	.
E0575	Y		Nebulizer ultrasonic		.	.	.	.
E0580	Y		Nebulizer for use w/ regulat		.	.	.	.
E0585	Y		Nebulizer w/ compressor & he		.	.	.	.
E0590	Y		Dispensing fee dme neb drug		.	.	.	.
E0600	Y		Suction pump portab hom modl		.	.	.	.
E0601	Y		Cont airway pressure device		.	.	.	.
E0602	Y		Manual breast pump		.	.	.	.
E0603	A		Electric breast pump		.	.	.	.
E0604	A		Hosp grade elec breast pump		.	.	.	.
E0605	Y		Vaporizer room type		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0606	Y		Drainage board postural		.	.	.	.
E0607	Y		Blood glucose monitor home		.	.	.	.
E0610	Y		Pacemaker monitr audible/vis		.	.	.	.
E0615	Y		Pacemaker monitr digital/vis		.	.	.	.
E0616	N		Cardiac event recorder		.	.	.	.
E0617	Y		Automatic ext defibrillator		.	.	.	.
E0618	A		Apnea monitor		.	.	.	.
E0619	A		Apnea monitor w recorder		.	.	.	.
E0620	Y		Cap bld skin piercing laser		.	.	.	.
E0621	Y		Patient lift sling or seat		.	.	.	.
E0625	E		Patient lift bathroom or toi		.	.	.	.
E0627	Y		Seat lift incorp lift-chair		.	.	.	.
E0628	Y		Seat lift for pt furn-electr		.	.	.	.
E0629	Y		Seat lift for pt furn-non-el		.	.	.	.
E0630	Y		Patient lift hydraulic		.	.	.	.
E0635	Y		Patient lift electric		.	.	.	.
E0636	Y		PT support & positioning sys		.	.	.	.
E0637	Y		Sit-stand w seatlift		.	.	.	.
E0638	Y		Standing frame sys		.	.	.	.
E0639	E	NI	Moveable patient lift system		.	.	.	.
E0640	E	NI	Fixed patient lift system		.	.	.	.
E0650	Y		Pneuma compresor non-segment		.	.	.	.
E0651	Y		Pneum compressor segmental		.	.	.	.
E0652	Y		Pneum compres w/cal pressure		.	.	.	.
E0655	Y		Pneumatic appliance half arm		.	.	.	.
E0660	Y		Pneumatic appliance full leg		.	.	.	.
E0665	Y		Pneumatic appliance full arm		.	.	.	.
E0666	Y		Pneumatic appliance half leg		.	.	.	.
E0667	Y		Seg pneumatic appl full leg		.	.	.	.
E0668	Y		Seg pneumatic appl full arm		.	.	.	.
E0669	Y		Seg pneumatic appli half leg		.	.	.	.
E0671	Y		Pressure pneum appl full leg		.	.	.	.
E0672	Y		Pressure pneum appl full arm		.	.	.	.
E0673	Y		Pressure pneum appl half leg		.	.	.	.
E0675	Y		Pneumatic compression device		.	.	.	.
E0691	Y		Uvl pnl 2 sq ft or less		.	.	.	.
E0692	Y		Uvl sys panel 4 ft		.	.	.	.
E0693	Y		Uvl sys panel 6 ft		.	.	.	.
E0694	Y		Uvl md cabinet sys 6 ft		.	.	.	.
E0700	E		Safety equipment		.	.	.	.
E0701	Y		Helmet w face guard prefab		.	.	.	.
E0710	E		Restraints any type		.	.	.	.
E0720	Y		Tens two lead		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0730	Y		Tens four lead		.	.	.	.
E0731	Y		Conductive garment for tens/		.	.	.	.
E0740	Y		Incontinence treatment systm		.	.	.	.
E0744	Y		Neuromuscular stim for scoli		.	.	.	.
E0745	Y		Neuromuscular stim for shock		.	.	.	.
E0746	E		Electromyograph biofeedback		.	.	.	.
E0747	Y		Elec osteogen stim not spine		.	.	.	.
E0748	Y		Elec osteogen stim spinal		.	.	.	.
E0749	N		Elec osteogen stim implanted		.	.	.	.
E0752	B		Neurostimulator electrode		.	.	.	.
E0754	A		Pulsegenerator pt programmer		.	.	.	.
E0755	E		Electronic salivary reflex s		.	.	.	.
E0756	B		Implantable pulse generator		.	.	.	.
E0757	N		Implantable RF receiver		.	.	.	.
E0758	A		External RF transmitter		.	.	.	.
E0759	A		Replace rdfrquncy transmittr		.	.	.	.
E0760	Y		Osteogen ultrasound stimltor		.	.	.	.
E0761	E		Nontherm electromgntc device		.	.	.	.
E0765	Y		Nerve stimulator for tx n&v		.	.	.	.
E0769	B	NI	Electric wound treatment dev		.	.	.	.
E0776	Y		Iv pole		.	.	.	.
E0779	Y		Amb infusion pump mechanical		.	.	.	.
E0780	Y		Mech amb infusion pump <8hrs		.	.	.	.
E0781	Y		External ambulatory infus pu		.	.	.	.
E0782	N		Non-programble infusion pump		.	.	.	.
E0783	N		Programmable infusion pump		.	.	.	.
E0784	Y		Ext amb infusn pump insulin		.	.	.	.
E0785	N		Replacement impl pump cathet		.	.	.	.
E0786	N		Implantable pump replacement		.	.	.	.
E0791	Y		Parenteral infusion pump sta		.	.	.	.
E0830	N		Ambulatory traction device		.	.	.	.
E0840	Y		Tract frame attach headboard		.	.	.	.
E0849	Y	NI	Cervical pneum trac equip		.	.	.	.
E0850	Y		Traction stand free standing		.	.	.	.
E0855	Y		Cervical traction equipment		.	.	.	.
E0860	Y		Tract equip cervical tract		.	.	.	.
E0870	Y		Tract frame attach footboard		.	.	.	.
E0880	Y		Trac stand free stand extrem		.	.	.	.
E0890	Y		Traction frame attach pelvic		.	.	.	.
E0900	Y		Trac stand free stand pelvic		.	.	.	.
E0910	Y		Trapeze bar attached to bed		.	.	.	.
E0920	Y		Fracture frame attached to b		.	.	.	.
E0930	Y		Fracture frame free standing		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0935	Y		Exercise device passive moti		.	.	.	.
E0940	Y		Trapeze bar free standing		.	.	.	.
E0941	Y		Gravity assisted traction de		.	.	.	.
E0942	Y		Cervical head harness/halter		.	.	.	.
E0944	Y		Pelvic belt/harness/boot		.	.	.	.
E0945	Y		Belt/harness extremity		.	.	.	.
E0946	Y		Fracture frame dual w cross		.	.	.	.
E0947	Y		Fracture frame attachmnts pe		.	.	.	.
E0948	Y		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		Cushioned headrest		.	.	.	.
E0956	Y		W/c lateral trunk/hip suppor		.	.	.	.
E0957	Y		W/c medial thigh support		.	.	.	.
E0958	A		Whlchr att- conv 1 arm drive		.	.	.	.
E0959	B		Amputee adapter		.	.	.	.
E0960	Y		W/c shoulder harness/straps		.	.	.	.
E0961	B		Wheelchair brake extension		.	.	.	.
E0962	D		Wheelchair 1 inch cushion		.	.	.	.
E0963	D		Wheelchair 2 inch cushion		.	.	.	.
E0964	D		Wheelchair 3 inch cushion		.	.	.	.
E0965	D		Wheelchair 4 inch cushion		.	.	.	.
E0966	B		Wheelchair head rest extensi		.	.	.	.
E0967	Y		Wheelchair hand rims		.	.	.	.
E0968	Y		Wheelchair commode seat		.	.	.	.
E0969	Y		Wheelchair narrowing device		.	.	.	.
E0970	B		Wheelchair no. 2 footplates		.	.	.	.
E0971	B		Wheelchair anti-tipping devi		.	.	.	.
E0972	A		Transfer board or device		.	.	.	.
E0973	B		W/Ch access det adj armrest		.	.	.	.
E0974	B		W/Ch access anti-rollback		.	.	.	.
E0977	Y		Wheelchair wedge cushion		.	.	.	.
E0978	B		W/C acc,saf belt pelv strap		.	.	.	.
E0980	Y		Wheelchair safety vest		.	.	.	.
E0981	Y		Seat upholstery, replacement		.	.	.	.
E0982	Y		Back upholstery, replacement		.	.	.	.
E0983	Y		Add pwr joystick		.	.	.	.
E0984	Y		Add pwr tiller		.	.	.	.
E0985	Y		W/c seat lift mechanism		.	.	.	.
E0986	Y		Man w/c push-rim pow assist		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0990	B		Whellchair elevating leg res		.	.	.	.
E0992	B		Wheelchair solid seat insert		.	.	.	.
E0994	Y		Wheelchair arm rest		.	.	.	.
E0995	B		Wheelchair calf rest		.	.	.	.
E0996	B		Wheelchair tire solid		.	.	.	.
E0997	Y		Wheelchair caster w/ a fork		.	.	.	.
E0998	Y		Wheelchair caster w/o a fork		.	.	.	.
E0999	Y		Wheelchr pneumatic tire w/wh		.	.	.	.
E1000	B		Wheelchair tire pneumatic ca		.	.	.	.
E1001	Y		Wheelchair wheel		.	.	.	.
E1002	Y		Pwr seat tilt		.	.	.	.
E1003	Y		Pwr seat recline		.	.	.	.
E1004	Y		Pwr seat recline mech		.	.	.	.
E1005	Y		Pwr seat recline pwr		.	.	.	.
E1006	Y		Pwr seat combo w/o shear		.	.	.	.
E1007	Y		Pwr seat combo w/shear		.	.	.	.
E1008	Y		Pwr seat combo pwr shear		.	.	.	.
E1009	Y		Add mech leg elevation		.	.	.	.
E1010	Y		Add pwr leg elevation		.	.	.	.
E1011	Y		Ped wc modify width adjustm		.	.	.	.
E1012	D		Int seat sys planar ped w/c		.	.	.	.
E1013	D		Int seat sys contour ped w/c		.	.	.	.
E1014	Y		Reclining back add ped w/c		.	.	.	.
E1015	Y		Shock absorber for man w/c		.	.	.	.
E1016	Y		Shock absorber for power w/c		.	.	.	.
E1017	Y		HD shck absrbr for hd man wc		.	.	.	.
E1018	Y		HD shck absrber for hd powwc		.	.	.	.
E1019	Y		HD feature power seat		.	.	.	.
E1020	Y		Residual limb support system		.	.	.	.
E1021	Y		Ex hd feature power seat		.	.	.	.
E1025	Y		Pedwc lat/thor sup nocontour		.	.	.	.
E1026	Y		Pedwc contoured lat/thor sup		.	.	.	.
E1027	Y		Ped wc lat/ant support		.	.	.	.
E1028	Y		W/c manual swingaway		.	.	.	.
E1029	Y		W/c vent tray fixed		.	.	.	.
E1030	Y		W/c vent tray gimbaled		.	.	.	.
E1031	Y		Rollabout chair with casters		.	.	.	.
E1035	Y		Patient transfer system		.	.	.	.
E1037	Y		Transport chair, ped size		.	.	.	.
E1038	Y		Transport chair pt wt <250lb		.	.	.	.
E1039	Y	NI	Transport chair pt wt>=250lb		.	.	.	.
E1050	A		Whelchr fxd full length arms		.	.	.	.
E1060	A		Wheelchair detachable arms		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
E1092	A		Wheelchair wide w/ leg rests		.	.	.	.
E1093	A		Wheelchair wide w/ foot rest		.	.	.	.
E1100	A		Whchr s-recl fxd arm leg res		.	.	.	.
E1110	A		Wheelchair semi-recl detach		.	.	.	.
E1130	A		Whlchr stand fxd arm ft rest		.	.	.	.
E1140	A		Wheelchair standard detach a		.	.	.	.
E1150	Y		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	Y		Whlchr moto ful arm leg rest		.	.	.	.
E1211	Y		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	Y		Manual semi-reclining back		.	.	.	.
E1226	B		Manual fully reclining back		.	.	.	.
E1227	Y		Wheelchair spec sz spec ht a		.	.	.	.
E1228	Y		Wheelchair spec sz spec ht b		.	.	.	.
E1229	Y	NI	Pediatric wheelchair NOS		.	.	.	.
E1230	Y		Power operated vehicle		.	.	.	.
E1231	Y		Rigid ped w/c tilt-in-space		.	.	.	.
E1232	Y		Folding ped wc tilt-in-space		.	.	.	.
E1233	Y		Rig ped wc tltnspc w/o seat		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1234	Y		Fld ped wc tltnspc w/o seat		.	.	.	.
E1235	Y		Rigid ped wc adjustable		.	.	.	.
E1236	Y		Folding ped wc adjustable		.	.	.	.
E1237	Y		Rgd ped wc adjstabl w/o seat		.	.	.	.
E1238	Y		Fld ped wc adjstabl w/o seat		.	.	.	.
E1239	Y	NI	Ped power wheelchair NOS		.	.	.	.
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	Y		Wheelchair special seat heig		.	.	.	.
E1297	Y		Wheelchair special seat dept		.	.	.	.
E1298	Y		Wheelchair spec seat depth/w		.	.	.	.
E1300	E		Whirlpool portable		.	.	.	.
E1310	Y		Whirlpool non-portable		.	.	.	.
E1340	Y		Repair for DME, per 15 min		.	.	.	.
E1353	Y		Oxygen supplies regulator		.	.	.	.
E1355	Y		Oxygen supplies stand/rack		.	.	.	.
E1372	Y		Oxy suppl heater for nebuliz		.	.	.	.
E1390	Y		Oxygen concentrator		.	.	.	.
E1391	Y		Oxygen concentrator, dual		.	.	.	.
E1399	N		Durable medical equipment mi		.	.	.	.
E1405	Y		O2/water vapor enrich w/heat		.	.	.	.
E1406	Y		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	B		Peritoneal dialysis clamp		.	.	.	.
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	Y		Jaw motion rehab system		.	.	.	.
E1701	Y		Repl cushions for jaw motion		.	.	.	.
E1702	Y		Repl measr scales jaw motion		.	.	.	.
E1800	Y		Adjust elbow ext/flex device		.	.	.	.
E1801	Y		SPS elbow device		.	.	.	.
E1802	Y		Adjst forearm pro/sup device		.	.	.	.
E1805	Y		Adjust wrist ext/flex device		.	.	.	.
E1806	Y		SPS wrist device		.	.	.	.
E1810	Y		Adjust knee ext/flex device		.	.	.	.
E1811	Y		SPS knee device		.	.	.	.
E1815	Y		Adjust ankle ext/flex device		.	.	.	.
E1816	Y		SPS ankle device		.	.	.	.
E1818	Y		SPS forearm device		.	.	.	.
E1820	Y		Soft interface material		.	.	.	.
E1821	Y		Replacement interface SPSD		.	.	.	.
E1825	Y		Adjust finger ext/flex devc		.	.	.	.
E1830	Y		Adjust toe ext/flex device		.	.	.	.
E1840	Y		Adj shoulder ext/flex device		.	.	.	.
E1841	Y	NI	Static str shldr dev rom adj		.	.	.	.
E1902	A		AAC non-electronic board		.	.	.	.
E2000	Y		Gastric suction pump hme mdl		.	.	.	.
E2100	Y		Bld glucose monitor w voice		.	.	.	.
E2101	Y		Bld glucose monitor w lance		.	.	.	.
E2120	Y		Pulse gen sys tx endolymp fl		.	.	.	.
E2201	Y		Man w/ch acc seat w>=20"<24"		.	.	.	.
E2202	Y		Seat width 24-27 in		.	.	.	.
E2203	Y		Frame depth less than 22 in		.	.	.	.
E2204	Y		Frame depth 22 to 25 in		.	.	.	.
E2205	Y	NI	Manual wc accessory, handrim		.	.	.	.
E2206	Y	NI	Complete wheel lock assembly		.	.	.	.
E2291	Y	NI	Planar back for ped size wc		.	.	.	.
E2292	Y	NI	Planar seat for ped size wc		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2293	Y	NI	Contour back for ped size wc		.	.	.	.
E2294	Y	NI	Contour seat for ped size wc		.	.	.	.
E2300	Y		Pwr seat elevation sys		.	.	.	.
E2301	Y		Pwr standing		.	.	.	.
E2310	Y		Electro connect btw control		.	.	.	.
E2311	Y		Electro connect btw 2 sys		.	.	.	.
E2320	Y		Hand chin control		.	.	.	.
E2321	Y		Hand interface joystick		.	.	.	.
E2322	Y		Mult mech switches		.	.	.	.
E2323	Y		Special joystick handle		.	.	.	.
E2324	Y		Chin cup interface		.	.	.	.
E2325	Y		Sip and puff interface		.	.	.	.
E2326	Y		Breath tube kit		.	.	.	.
E2327	Y		Head control interface mech		.	.	.	.
E2328	Y		Head/extremity control inter		.	.	.	.
E2329	Y		Head control nonproportional		.	.	.	.
E2330	Y		Head control proximity switc		.	.	.	.
E2331	Y		Attendant control		.	.	.	.
E2340	Y		W/c wdth 20-23 in seat frame		.	.	.	.
E2341	Y		W/c wdth 24-27 in seat frame		.	.	.	.
E2342	Y		W/c dpth 20-21 in seat frame		.	.	.	.
E2343	Y		W/c dpth 22-25 in seat frame		.	.	.	.
E2351	Y		Electronic SGD interface		.	.	.	.
E2360	Y		22nf nonsealed leadacid		.	.	.	.
E2361	Y		22nf sealed leadacid battery		.	.	.	.
E2362	Y		Gr24 nonsealed leadacid		.	.	.	.
E2363	Y		Gr24 sealed leadacid battery		.	.	.	.
E2364	Y		U1nonsealed leadacid battery		.	.	.	.
E2365	Y		U1 sealed leadacid battery		.	.	.	.
E2366	Y		Battery charger, single mode		.	.	.	.
E2367	Y		Battery charger, dual mode		.	.	.	.
E2368	Y	NI	Power wc motor replacement		.	.	.	.
E2369	Y	NI	Pwr wc gear box replacement		.	.	.	.
E2370	Y	NI	Pwr wc motor/gear box combo		.	.	.	.
E2399	Y		Noc interface		.	.	.	.
E2402	Y		Neg press wound therapy pump		.	.	.	.
E2500	Y		SGD digitized pre-rec <=8min		.	.	.	.
E2502	Y		SGD prerec msg >8min <=20min		.	.	.	.
E2504	Y		SGD prerec msg>20min <=40min		.	.	.	.
E2506	Y		SGD prerec msg > 40 min		.	.	.	.
E2508	Y		SGD spelling phys contact		.	.	.	.
E2510	Y		SGD w multi methods msg/accs		.	.	.	.
E2511	Y		SGD sftwre prgrm for PC/PDA		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2512	Y		SGD accessory, mounting sys		.	.	.	.
E2599	Y		SGD accessory noc		.	.	.	.
E2601	Y	NI	Gen w/c cushion wdth < 22 in		.	.	.	.
E2602	Y	NI	Gen w/c cushion wdth >=22 in		.	.	.	.
E2603	Y	NI	Skin protect wc cus wd <22in		.	.	.	.
E2604	Y	NI	Skin protect wc cus wd>=22in		.	.	.	.
E2605	Y	NI	Position wc cush wdth <22 in		.	.	.	.
E2606	Y	NI	Position wc cush wdth>=22 in		.	.	.	.
E2607	Y	NI	Skin pro/pos wc cus wd <22in		.	.	.	.
E2608	Y	NI	Skin pro/pos wc cus wd>=22in		.	.	.	.
E2609	Y	NI	Custom fabricate w/c cushion		.	.	.	.
E2610	B	NI	Powered w/c cushion		.	.	.	.
E2611	Y	NI	Gen use back cush wdth <22in		.	.	.	.
E2612	Y	NI	Gen use back cush wdth>=22in		.	.	.	.
E2613	Y	NI	Position back cush wd <22in		.	.	.	.
E2614	Y	NI	Position back cush wd>=22in		.	.	.	.
E2615	Y	NI	Pos back post/lat wdth <22in		.	.	.	.
E2616	Y	NI	Pos back post/lat wdth>=22in		.	.	.	.
E2617	Y	NI	Custom fab w/c back cushion		.	.	.	.
E2618	Y	NI	Wc acc solid seat supp base		.	.	.	.
E2619	Y	NI	Replace cover w/c seat cush		.	.	.	.
E2620	Y	NI	WC planar back cush wd <22in		.	.	.	.
E2621	Y	NI	WC planar back cush wd>=22in		.	.	.	.
E8000	E	NI	Posterior gait trainer		.	.	.	.
E8001	E	NI	Upright gait trainer		.	.	.	.
E8002	E	NI	Anterior gait trainer		.	.	.	.
G0001	A		Drawing blood for specimen		.	.	.	.
G0008	L		Admin influenza virus vac		.	.	.	.
G0009	L		Admin pneumococcal vaccine		.	.	.	.
G0010	K		Admin hepatitis b vaccine	0355	0.3596	20.49	.	4.10
G0027	A		Semen analysis		.	.	.	.
G0030	S		PET imaging prev PET single	0285	12.9121	735.77	318.72	147.85
G0031	S		PET imaging prev PET multple	0285	12.9121	735.77	318.72	147.85
G0032	S		PET follow SPECT 78464 singl	0285	12.9121	735.77	318.72	147.85
G0033	S		PET follow SPECT 78464 mult	0285	12.9121	735.77	318.72	147.85
G0034	S		PET follow SPECT 76865 singl	0285	12.9121	735.77	318.72	147.85
G0035	S		PET follow SPECT 78465 mult	0285	12.9121	735.77	318.72	147.85
G0036	S		PET follow cornry angio sing	0285	12.9121	735.77	318.72	147.85
G0037	S		PET follow cornry angio mult	0285	12.9121	735.77	318.72	147.85
G0038	S		PET follow myocard perf sing	0285	12.9121	735.77	318.72	147.85
G0039	S		PET follow myocard perf mult	0285	12.9121	735.77	318.72	147.85
G0040	S		PET follow stress echo singl	0285	12.9121	735.77	318.72	147.85
G0041	S		PET follow stress echo mult	0285	12.9121	735.77	318.72	147.85

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0042	S		PET follow ventriculogm sing	0285	12.9121	735.77	318.72	147.85
G0043	S		PET follow ventriculogm mult	0285	12.9121	735.77	318.72	147.85
G0044	S		PET following rest ECG singl	0285	12.9121	735.77	318.72	147.85
G0045	S		PET following rest ECG mult	0285	12.9121	735.77	318.72	147.85
G0046	S		PET follow stress ECG singl	0285	12.9121	735.77	318.72	147.85
G0047	S		PET follow stress ECG mult	0285	12.9121	735.77	318.72	147.85
G0101	V		CA screen;pelvic/breast exam	0600	0.9033	51.47		10.29
G0102	N		Prostate ca screening; dre					
G0103	A		Psa, total screening					
G0104	S		CA screen;flexi sigmoidscope	0159	2.8464	162.20		40.55
G0105	T		Colorectal scrn; hi risk ind	0158	7.7409	441.10		110.28
G0106	S		Colon CA screen;barium enema	0157	2.5110	143.08		28.62
G0107	A		CA screen; fecal blood test					
G0108	A		Diab manage trn per indiv					
G0109	A		Diab manage trn ind/group					
G0110	A		Nett pulm-rehab educ; ind					
G0111	A		Nett pulm-rehab educ; group					
G0112	A		Nett;nutrition guid, initial					
G0113	A		Nett;nutrition guid,subseqnt					
G0114	A		Nett; psychosocial consult					
G0115	A		Nett; psychological testing					
G0116	A		Nett; psychosocial counsel					
G0117	S		Glaucoma scrn hgh risk direc	0230	0.8019	45.69	14.97	9.14
G0118	S		Glaucoma scrn hgh risk direc	0230	0.8019	45.69	14.97	9.14
G0120	S		Colon ca scrn; barium enema	0157	2.5110	143.08		28.62
G0121	T		Colon ca scrn not hi rsk ind	0158	7.7409	441.10		110.28
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 image pulmonary nodule	1513		1150.00		230.00
G0127	T		Trim nail(s)	0009	0.6817	38.85	8.34	7.77
G0128	B		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	4.9370	281.33		56.27
G0130	X		Single energy x-ray study	0260	0.7698	43.87	19.74	8.77
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					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	1.7931	102.18	.	20.44
G0168	N		Wound closure by adhesive		.	.	.	.
G0173	S		Linear acc stereo radsur com	1528	.	5250.00	.	1050.00
G0175	V		OPPS Service,sched team conf	0602	1.3977	79.65	.	15.93
G0176	P		OPPS/PHP;activity therapy	0033	4.9370	281.33	.	56.27
G0177	P		OPPS/PHP; train & educ serv	0033	4.9370	281.33	.	56.27
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	5.1864	295.54	72.04	59.11
G0202	A		Screeningmammographydigital		.	.	.	.
G0204	A		Diagnosticmammographydigital		.	.	.	.
G0206	A		Diagnosticmammographydigital		.	.	.	.
G0210	S		PET img wholebody dxlung	1513	.	1150.00	.	230.00
G0211	S		PET img wholbody init lung	1513	.	1150.00	.	230.00
G0212	S		PET img wholebod restag lung	1513	.	1150.00	.	230.00
G0213	S		PET img wholbody dx	1513	.	1150.00	.	230.00
G0214	S		PET img wholebod init	1513	.	1150.00	.	230.00
G0215	S		PETimg wholebod restag	1513	.	1150.00	.	230.00
G0216	S		PET img wholebod dx melanoma	1513	.	1150.00	.	230.00
G0217	S		PET img wholebod init melan	1513	.	1150.00	.	230.00
G0218	S		PET img wholebod restag mela	1513	.	1150.00	.	230.00
G0219	E		PET img wholbod melano nonco		.	.	.	.
G0220	S		PET img wholebod dx lymphoma	1513	.	1150.00	.	230.00
G0221	S		PET imag wholbod init lympho	1513	.	1150.00	.	230.00
G0222	S		PET imag wholbod resta lymph	1513	.	1150.00	.	230.00
G0223	S		PET imag wholbod reg dx head	1513	.	1150.00	.	230.00
G0224	S		PET imag wholbod reg ini hea	1513	.	1150.00	.	230.00
G0225	S		PET whol restag headneckonly	1513	.	1150.00	.	230.00
G0226	S		PET img wholbody dx esophagl	1513	.	1150.00	.	230.00
G0227	S		PET img wholbod ini esophage	1513	.	1150.00	.	230.00
G0228	S		PET img wholbod restg esopha	1513	.	1150.00	.	230.00
G0229	S		PET img metaboloc brain pres	1513	.	1150.00	.	230.00
G0230	S		PET myocard viability post	1513	.	1150.00	.	230.00
G0231	S		PET WhBD colorec; gamma cam	1513	.	1150.00	.	230.00
G0232	S		PET whbd lymphoma; gamma cam	1513	.	1150.00	.	230.00
G0233	S		PET whbd melanoma; gamma cam	1513	.	1150.00	.	230.00
G0234	S		PET WhBD pulm nod; gamma cam	1513	.	1150.00	.	230.00
G0237	S		Therapeutic procd strg endur	0411	0.4194	23.90	.	4.78

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0238	S		Oth resp proc, indiv	0411	0.4194	23.90		4.78
G0239	S		Oth resp proc, group	0411	0.4194	23.90		4.78
G0242	S		Multisource photon ster plan	1516		1450.00		290.00
G0243	S		Multisour photon stero treat	1528		5250.00		1050.00
G0244	S		Observ care by facility topt	0339	7.1646	408.26		81.65
G0245	V		Initial foot exam pt lops	0600	0.9033	51.47		10.29
G0246	V		Followup eval of foot pt lop	0600	0.9033	51.47		10.29
G0247	T		Routine footcare pt w lops	0009	0.6817	38.85	8.34	7.77
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		1150.00		230.00
G0252	E		PET imaging initial dx					
G0253	S		PET image brst dection recur	1516		1450.00		290.00
G0254	S		PET image brst eval to tx	1516		1450.00		290.00
G0255	E		Current percep threshold tst					
G0257	S		Unsched dialysis ESRD pt hos	0170	6.2255	354.75		70.95
G0258	B		IV infusion during obs stay					
G0259	N		Inject for sacroiliac joint					
G0260	T		Inj for sacroiliac jt anesth	0206	5.4311	309.48	75.55	61.90
G0263	N		Adm with CHF, CP, asthma					
G0264	V		Assmt otr CHF, CP, asthma	0600	0.9033	51.47		10.29
G0265	A		Cryopresevation Freeze+stora					
G0266	A		Thawing + expansion froz cel					
G0267	S		Bone marrow or psc harvest	0110	3.7809	215.45		43.09
G0268	X		Removal of impacted wax md	0340	0.6328	36.06		7.21
G0269	N		Occlusive device in vein art					
G0270	A		MNT subs tx for change dx					
G0271	A		Group MNT 2 or more 30 mins					
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	E		Elect stim wound care not pd					
G0283	A		Elec stim other than wound					
G0288	S		Recon, CTA for surg plan	0417	4.6807	266.72		53.34
G0289	N		Arthro, loose body + chondro					
G0290	T		Drug-eluting stents, single	0656	105.1296	5990.60		1198.12
G0291	T		Drug-eluting stents,each add	0656	105.1296	5990.60		1198.12
G0292	D		Adm exp drugs,clinical trial					
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

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0295	E		Electromagnetic therapy onc		.	.		.
G0296	S		PET imge restag thyrod cance	1513	.	1150.00	.	230.00
G0297	T		Insert single chamber/cd	0107	315.2469	17963.71	3612.57	3592.74
G0298	T		Insert dual chamber/cd	0107	315.2469	17963.71	3612.57	3592.74
G0299	T		Inser/repos single icd+leads	0108	423.3141	24121.71	.	4824.34
G0300	T		Insert reposit lead dual+gen	0108	423.3141	24121.71	.	4824.34
G0302	S		Pre-op service LVRS complete	1509	.	750.00	.	150.00
G0303	S		Pre-op service LVRS 10-15dos	1507	.	550.00	.	110.00
G0304	S		Pre-op service LVRS 1-9 dos	1504	.	250.00	.	50.00
G0305	S		Post op service LVRS min 6	1504	.	250.00	.	50.00
G0306	A		CBC/diffwbc w/o platelet		.	.	.	.
G0307	A		CBC without platelet		.	.	.	.
G0308	A		ESRD related svc 4+mo < 2yrs		.	.	.	.
G0309	A		ESRD related svc 2-3mo <2yrs		.	.	.	.
G0310	A		ESRD related svc 1 vst <2yrs		.	.	.	.
G0311	A		ESRD related svs 4+mo 2-11yr		.	.	.	.
G0312	A		ESRD relate svs 2-3 mo 2-11y		.	.	.	.
G0313	A		ESRD related svs 1 mon 2-11y		.	.	.	.
G0314	A		ESRD related svs 4+ mo 12-19		.	.	.	.
G0315	A		ESRD related svs 2-3mo/12-19		.	.	.	.
G0316	A		ESRD related svs 1vis/12-19y		.	.	.	.
G0317	A		ESRD related svs 4+mo 20+yrs		.	.	.	.
G0318	A		ESRD related svs 2-3 mo 20+y		.	.	.	.
G0319	A		ESRD related svs 1visit 20+y		.	.	.	.
G0320	A		ESD related svs home undr 2		.	.	.	.
G0321	A		ESRDrelatedsvs home mo 2-11y		.	.	.	.
G0322	A		ESRD related svs hom mo12-19		.	.	.	.
G0323	A		ESRD related svs home mo 20+		.	.	.	.
G0324	A		ESRD relate svs home/dy <2yr		.	.	.	.
G0325	A		ESRD relate home/day/ 2-11yr		.	.	.	.
G0326	A		ESRD relate home/dy 12-19yr		.	.	.	.
G0327	A		ESRD relate home/dy 20+yrs		.	.	.	.
G0328	A		Fecal blood scrn immunoassay		.	.	.	.
G0329	A	NF	Electromagntic tx for ulcers		.	.	.	.
G0330	S	NI	PET image initial dx cervcal	1516	.	1450.00	.	290.00
G0331	S	NI	PET image restage ovarian ca	1516	.	1450.00	.	290.00
G0336	S	NI	PET imaging brain alzheimers	1516	.	1450.00	.	290.00
G0337	A	NI	Hospice evaluation preelecti					
G0338	S		Linear accelerator stero pln	1513	.	1150.00	.	230.00
G0339	S		Robot lin-radsurg com, first	1528	.	5250.00	.	1050.00
G0340	S		Robt lin-radsurg fractx 2-5	1525	.	3750.00	.	750.00
G0341	C	NI	Percutaneous islet celltrans		.	.	.	.
G0342	C	NI	Laparoscopy islet cell trans		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0343	C	NI	Laparotomy islet cell transp					
G0344	V	NI	Initial preventive exam	0601	0.9847	56.11		11.22
G0345	B	NI	IV infuse hydration, initial					
G0346	B	NI	Each additional infuse hour					
G0347	B	NI	IV infusion therapy/diagnost					
G0348	B	NI	Each additional hr up to 8hr					
G0349	B	NI	Additional sequential infuse					
G0350	B	NI	Concurrent infusion					
G0351	B	NI	Therapeutic/diagnostic injec					
G0353	B	NI	IV push,single orinitial dru					
G0354	B	NI	Each addition sequential IV					
G0355	B	NI	Chemo adminisrate subcut/IM					
G0356	B	NI	Hormonal anti-neoplastic					
G0357	B	NI	IV push single/initial subst					
G0358	B	NI	IV push each additional drug					
G0359	B	NI	Chemotherapy IV one hr initi					
G0360	B	NI	Each additional hr 1-8 hrs					
G0361	B	NI	Prolong chemo infuse>8hrs pu					
G0362	B	NI	Each add sequential infusion					
G0363	B	NI	Irrigate implanted venous de					
G0364	X	NI	Bone marrow aspirate &biopsy	0342	0.2068	11.78	5.30	2.36
G0365	S	NI	Vessel mapping hemo access	0267	2.4250	138.18	62.18	27.64
G0366	B	NI	EKG for initial prevent exam					
G0367	S	NI	EKG tracing for initial prev	0099	0.3812	21.72		4.34
G0368	A	NI	EKG interpret & report preve					
G3001	S		Admin + supply, tositumomab	1522		2250.00		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					
G9013	E	NI	ESRD demo bundle level I					
G9014	E	NI	ESRD demo bundle-level II					
G9016	E		Demo-smoking cessation coun					
G9017	A	NI	Amantadine HCL, oral					
G9018	A	NI	Zanamivir, inh pwdr					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9019	A	NI	Oseltamivir phosp		.	.	.	.
G9020	A	NI	Rimantadine HCL		.	.	.	.
J0120	K		Tetracyclin injection	9028	1.7547	99.99	.	20.00
J0128	G	NI	Abarelix injection	9216	.	67.62	.	13.52
J0130	K		Abciximab injection	1605	.	448.22	.	89.64
J0135	K	NI	Adalimumab injection	1083	.	620.64	.	124.13
J0150	K		Injection adenosine 6 MG	0379	0.2163	12.33	.	2.47
J0152	K		Adenosine injection	0917	0.1528	8.71	.	1.74
J0170	N		Adrenalin epinephrin inject		.	.	.	.
J0180	G	NI	Agalsidase beta injection	9208	.	121.14	.	24.23
J0190	N		Inj biperiden lactate/5 mg		.	.	.	.
J0200	N		Alatrofloxacin mesylate		.	.	.	.
J0205	K		Alglucerase injection	0900	.	37.53	.	7.51
J0207	K		Amifostine	7000	.	395.75	.	79.15
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	K		Amiodarone HCl	9029	0.1931	11.00	.	2.20
J0285	K		Amphotericin B	9030	0.3622	20.64	.	4.13
J0287	K		Amphotericin b lipid complex	9024	.	19.09	.	3.82
J0288	K		Ampho b cholesteryl sulfate	0735	.	15.20	.	3.04
J0289	K		Amphotericin b liposome inj	0736	.	31.27	.	6.25
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	.	2353.53	.	470.71
J0360	N		Hydralazine hcl injection		.	.	.	.
J0380	N		Inj metaraminol bitartrate		.	.	.	.
J0390	N		Chloroquine injection		.	.	.	.
J0395	K		Arbutamine HCl injection	9031	1.1947	68.08	.	13.62
J0456	N		Azithromycin		.	.	.	.
J0460	N		Atropine sulfate injection		.	.	.	.
J0470	N		Dimecaprol injection		.	.	.	.
J0475	K		Baclofen 10 MG injection	9032	0.1874	10.68	.	2.14
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	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	K		Bivalirudin	9111	.	1.52	.	0.30
J0585	K		Botulinum toxin a per unit	0902	.	4.32	.	0.86
J0587	K		Botulinum toxin type B	9018	.	7.68	.	1.54
J0592	N		Buprenorphine hydrochloride		.	.	.	.
J0595	K		Butorphanol tartrate 1 mg	0703	.	5.00	.	1.00
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	.	28.78	.	5.76
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	K		Cidofovir injection	9033	7.1527	407.58	.	81.52
J0743	K		Cilastatin sodium injection	0846	0.1994	11.37	.	2.27
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	.	622.13	.	124.43

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0878	G	NI	Daptomycin injection	9124	.	0.28	.	0.06
J0880	E		Darbepoetin alfa injection		.	.	.	.
J0895	N		Deferoxamine mesylate inj		.	.	.	.
J0900	K		Testosterone enanthate inj	0848	0.6713	38.27	.	7.65
J0945	K		Brompheniramine maleate inj	9034	1.0356	59.01	.	11.80
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	K		Medroxyprogesterone inj	9035	0.3082	17.56	.	3.51
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	.	113.28	.	22.66
J1200	N		Diphenhydramine hcl injectio		.	.	.	.
J1205	N		Chlorothiazide sodium inj		.	.	.	.
J1212	K		Dimethyl sulfoxide 50% 50 ML	9036	0.9360	53.34	.	10.67
J1230	K		Methadone injection	9037	0.2337	13.32	.	2.66
J1240	N		Dimenhydrinate injection		.	.	.	.
J1245	K		Dipyridamole injection	0380	0.2053	11.70	.	2.34
J1250	N		Inj dobutamine HCL/250 mg		.	.	.	.
J1260	K		Dolasetron mesylate	0750	.	14.38	.	2.88
J1270	N		Injection, doxercalciferol		.	.	.	.
J1320	N		Amitriptyline injection		.	.	.	.
J1325	K		Epoprostenol injection	7003	.	15.78	.	3.16
J1327	K		Eptifibatide injection	1607	.	11.21	.	2.24
J1330	N		Ergonovine maleate injection		.	.	.	.
J1335	N		Ertapenem injection		.	.	.	.
J1364	N		Erythro lactobionate /500 MG		.	.	.	.
J1380	N		Estradiol valerate 10 MG inj		.	.	.	.
J1390	N		Estradiol valerate 20 MG inj		.	.	.	.
J1410	K		Inj estrogen conjugate 25 MG	9038	0.7986	45.51	.	9.10

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1435	N		Injection estrone per 1 MG		.	.	.	.
J1436	N		Etidronate disodium inj		.	.	.	.
J1438	K		Etanercept injection	1608	.	135.56	.	27.11
J1440	K		Filgrastim 300 mcg injection	0728	.	162.41	.	32.48
J1441	K		Filgrastim 480 mcg injection	7049	.	274.40	.	54.88
J1450	N		Fluconazole		.	.	.	.
J1452	K		Intraocular Fomivirsen na	9040	16.4925	939.79	.	187.96
J1455	K		Foscarnet sodium injection	0866	0.2069	11.80	.	2.36
J1457	K	NI	Gallium nitrate injection	1085	.	0.23	.	0.05
J1460	K		Gamma globulin 1 CC inj	9041	0.5550	31.63	.	6.33
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		IV immune globulin	0905	.	80.68	.	16.14
J1564	K		Immune globulin 10 mg	9021	.	0.75	.	0.15
J1565	K		RSV-ivig	0906	.	16.55	.	3.31
J1570	N		Ganciclovir sodium injection		.	.	.	.
J1580	N		Garamycin gentamicin inj		.	.	.	.
J1590	N		Gatifloxacin injection		.	.	.	.
J1595	N		Injection glatiramer acetate		.	.	.	.
J1600	N		Gold sodium thiomaleate inj		.	.	.	.
J1610	K		Glucagon hydrochloride/1 MG	9042	0.8100	46.16	.	9.23
J1620	K		Gonadorelin hydroch/ 100 mcg	7005	0.2998	17.08	.	3.42
J1626	K		Granisetron HCl injection	0764	.	16.20	.	3.24
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1730	N		Diazoxide injection		.	.	.	.
J1742	K		Ibutilide fumarate injection	9044	2.1724	123.79	.	24.76
J1745	K		Infliximab injection	7043	.	57.40	.	11.48
J1750	K		Iron dextran	9045	0.2593	14.78	.	2.96
J1756	K		Iron sucrose injection	9046	0.0093	0.53	.	0.11
J1785	K		Injection imiglucerase /unit	0916	.	3.75	.	0.75
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	E		Interferon beta-1a		.	.	.	.
J1830	K		Interferon beta-1b / .25 MG	0910	.	58.73	.	11.75
J1835	K		Itraconazole injection	9047	0.7389	42.10	.	8.42
J1840	N		Kanamycin sulfate 500 MG inj		.	.	.	.
J1850	N		Kanamycin sulfate 75 MG inj		.	.	.	.
J1885	N		Ketorolac tromethamine inj		.	.	.	.
J1890	N		Cephalothin sodium injection		.	.	.	.
J1931	G	NI	Laronidase injection	9209	.	22.74	.	4.55
J1940	N		Furosemide injection		.	.	.	.
J1950	K		Leuprolide acetate /3.75 MG	0800	.	451.98	.	90.40
J1955	B		Inj levocarnitine per 1 gm		.	.	.	.
J1956	N		Levofloxacin injection		.	.	.	.
J1960	N		Levorphanol tartrate inj		.	.	.	.
J1980	N		Hyoscyamine sulfate inj		.	.	.	.
J1990	N		Chlordiazepoxide injection		.	.	.	.
J2001	N		Lidocaine injection		.	.	.	.
J2010	N		Lincomycin injection		.	.	.	.
J2020	K		Linezolid injection	9001	.	32.15	.	6.43
J2060	N		Lorazepam injection		.	.	.	.
J2150	N		Mannitol injection		.	.	.	.
J2175	N		Meperidine hydrochl /100 MG		.	.	.	.
J2180	N		Meperidine/promethazine inj		.	.	.	.
J2185	K		Meropenem	0729	.	36.26	.	7.25
J2210	N		Methylergonovin maleate inj		.	.	.	.
J2250	N		Inj midazolam hydrochloride		.	.	.	.
J2260	K		Inj milrinone lactate / 5 MG	7007	0.1442	8.22	.	1.64
J2270	N		Morphine sulfate injection		.	.	.	.
J2271	N		Morphine so4 injection 100mg		.	.	.	.
J2275	N		Morphine sulfate injection		.	.	.	.
J2280	K		Inj, moxifloxacin 100 mg	1046	.	8.75	.	1.75
J2300	N		Inj nalbuphine hydrochloride		.	.	.	.
J2310	N		Inj naloxone hydrochloride		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2320	N		Nandrolone decanoate 50 MG		.	.	.	.
J2321	N		Nandrolone decanoate 100 MG		.	.	.	.
J2322	N		Nandrolone decanoate 200 MG		.	.	.	.
J2324	K		Nesiritide	9114	.	132.47	.	26.49
J2353	K		Octreotide injection, depot	1207	.	69.44	.	13.89
J2354	K		Octreotide inj, non-depot	7031	.	3.72	.	0.74
J2355	K		Oprelvekin injection	7011	.	248.16	.	49.63
J2357	G	NI	Omalizumab injection	9300	.	15.24	.	3.05
J2360	N		Orphenadrine injection		.	.	.	.
J2370	N		Phenylephrine hcl injection		.	.	.	.
J2400	N		Chloroprocaine hcl injection		.	.	.	.
J2405	K		Ondansetron hcl injection	0768	.	5.54	.	1.11
J2410	N		Oxymorphone hcl injection		.	.	.	.
J2430	K		Pamidronate disodium /30 MG	0730	.	128.74	.	25.75
J2440	N		Papaverin hcl injection		.	.	.	.
J2460	N		Oxytetracycline injection		.	.	.	.
J2469	G	NI	Palonosetron HCl	9210	.	18.25	.	3.65
J2501	N		Paricalcitol		.	.	.	.
J2505	K		Injection, pegfilgrastim 6mg	9119	.	2448.50	.	489.70
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	K		Inj desmopressin acetate	9048	0.0794	4.52	.	0.90
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	K		Inj protirelin per 250 mcg	9049	0.7161	40.81	.	8.16
J2730	N		Pralidoxime chloride inj		.	.	.	.
J2760	K		Phentolaine mesylate inj	0845	0.3651	20.82	.	4.16
J2765	N		Metoclopramide hcl injection		.	.	.	.
J2770	N		Quinupristin/dalfopristin		.	.	.	.
J2780	N		Ranitidine hydrochloride inj		.	.	.	.
J2783	G		Rasburicase	0738	.	106.04	.	21.21

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2788	K		Rho d immune globulin 50 mcg	9023	.	30.38	.	6.08
J2790	N		Rho d immune globulin inj		.	.	.	.
J2792	K		Rho(D) immune globulin h, sd	1609	.	17.95	.	3.59
J2794	G	NI	Risperidone, long acting	9125	.	4.58	.	0.92
J2795	N		Ropivacaine HCl injection		.	.	.	.
J2800	N		Methocarbamol injection		.	.	.	.
J2810	N		Inj theophylline per 40 MG		.	.	.	.
J2820	K		Sargramostim injection	0731	.	25.39	.	5.08
J2910	N		Aurothioglucose injeciton		.	.	.	.
J2912	N		Sodium chloride injection		.	.	.	.
J2916	K		Na ferric gluconate complex	9050	0.1058	6.03	.	1.21
J2920	N		Methylprednisolone injection		.	.	.	.
J2930	N		Methylprednisolone injection		.	.	.	.
J2940	N		Somatrem injection		.	.	.	.
J2941	K		Somatropin injection	7034	.	280.87	.	56.17
J2950	N		Promazine hcl injection		.	.	.	.
J2993	K		Reteplase injection	9005	.	1192.09	.	238.42
J2995	K		Inj streptokinase /250000 IU	0911	0.7618	43.41	.	8.68
J2997	K		Alteplase recombinant	7048	0.3165	18.04	.	3.61
J3000	N		Streptomycin injection		.	.	.	.
J3010	N		Fentanyl citrate injeciton		.	.	.	.
J3030	N		Sumatriptan succinate / 6 MG		.	.	.	.
J3070	N		Pentazocine injection		.	.	.	.
J3100	K		Tenecteplase injection	9002	.	2350.98	.	470.20
J3105	N		Terbutaline sulfate inj		.	.	.	.
J3110	B	NI	Teriparatide injection		.	.	.	.
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	.	617.50	.	123.50
J3245	D		Tirofiban hydrochloride		.	.	.	.
J3246	K	NI	Tirofiban HCl	7041	.	8.24	.	1.65
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	.	142.50	.	28.50
J3310	N		Perphenazine injeciton		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3315	K		Triptorelin pamoate	9122	.	362.78	.	72.56
J3320	N		Spectinomycn di-hcl inj		.	.	.	.
J3350	K		Urea injection	9051	1.2239	69.74	.	13.95
J3360	N		Diazepam injection		.	.	.	.
J3364	N		Urokinase 5000 IU injection		.	.	.	.
J3365	K		Urokinase 250,000 IU inj	7036	2.1873	124.64	.	24.93
J3370	N		Vancomycin hcl injection		.	.	.	.
J3395	D		Verteporfin injection		.	.	.	.
J3396	K	NI	Verteporfin injection	1203	.	8.49	.	1.70
J3400	N		Triflupromazine hcl inj		.	.	.	.
J3410	N		Hydroxyzine hcl injection		.	.	.	.
J3411	K		Thiamine hcl 100 mg	1049	.	0.95	.	0.19
J3415	K		Pyridoxine hcl 100 mg	1050	.	2.64	.	0.53
J3420	N		Vitamin b12 injection		.	.	.	.
J3430	N		Vitamin k phytonadione inj		.	.	.	.
J3465	K		Injection, voriconazole	1052	.	4.54	.	0.91
J3470	N		Hyaluronidase injection		.	.	.	.
J3475	N		Inj magnesium sulfate		.	.	.	.
J3480	N		Inj potassium chloride		.	.	.	.
J3485	N		Zidovudine		.	.	.	.
J3486	G		Ziprasidone mesylate	9204	.	18.22	.	3.64
J3487	K		Zoledronic acid	9115	.	197.87	.	39.57
J3490	N		Drugs unclassified injection		.	.	.	.
J3520	E		Edetate disodium per 150 mg		.	.	.	.
J3530	K		Nasal vaccine inhalation	9053	1.6217	92.41	.	18.48
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	.	0.76	.	0.15
J7191	K		Factor VIII (porcine)	0926	.	1.78	.	0.36
J7192	K		Factor viii recombinant	0927	.	1.10	.	0.22
J7193	K		Factor IX non-recombinant	0931	.	0.98	.	0.20

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7194	K		Factor ix complex	0928		0.32		0.06
J7195	K		Factor IX recombinant	0932		0.98		0.20
J7197	N		Antithrombin iii injection					
J7198	K		Anti-inhibitor	0929		1.29		0.26
J7199	B		Hemophilia clot factor noc					
J7300	E		Intraut copper contraceptive					
J7302	E		Levonorgestrel iu contracept					
J7303	E		Contraceptive vaginal ring					
J7304	E	NI	Contraceptive hormone patch					
J7308	K		Aminolevulinic acid hcl top	7308		88.76		17.75
J7310	N		Ganciclovir long act implant					
J7317	K		Sodium hyaluronate injection	7316	0.9466	53.94		10.79
J7320	K		Hylan G-F 20 injection	1611		203.70		40.74
J7330	B		Cultured chondrocytes implnt					
J7340	E		Metabolic active D/E tissue					
J7342	K		Metabolically active tissue	9054	0.1255	7.15		1.43
J7343	B	NI	Nonmetabolic act d/e tissue					
J7344	N	NI	Nonmetabolic active tissue					
J7350	K		Injectable human tissue	9055	0.1412	8.05		1.61
J7500	N		Azathioprine oral 50mg					
J7501	K		Azathioprine parenteral	0887		30.18		6.04
J7502	K		Cyclosporine oral 100 mg	0888	0.0312	1.78		0.36
J7504	K		Lymphocyte immune globulin	0890		243.50		48.70
J7505	K		Monoclonal antibodies	7038		747.31		149.46
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891		3.05		0.61
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104		312.41		62.48
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		2.46		0.49
J7518	G	NI	Mycophenolic acid	9219		2.43		0.49
J7520	K		Sirolimus, oral	9020		6.23		1.25
J7525	N		Tacrolimus injection					
J7599	N		Immunosuppressive drug noc					
J7608	Y		Acetylcysteine inh sol u d					
J7611	Y	NI	Albuterol concentrated form					
J7612	Y	NI	Levalbuterol concentrated					
J7613	Y	NI	Albuterol unit dose					
J7614	Y	NI	Levalbuterol unit dose					
J7616	Y	NI	Albuterol compound solution					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7617	Y	NI	Levalbuterol compounded sol		.	.	.	.
J7618	D		Albuterol inh sol con		.	.	.	.
J7619	D		Albuterol inh sol u d		.	.	.	.
J7621	D		(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		.	.	.	.
J7674	K	NI	Methacholine chloride, neb	0867	.	0.47	.	0.09
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		.	.	.	.
J8501	E	NI	Oral aprepitant		.	.	.	.
J8510	K		Oral busulfan	7015	.	2.08	.	0.42
J8520	K		Capecitabine, oral, 150 mg	7042	.	2.96	.	0.59
J8521	E		Capecitabine, oral, 500 mg		.	.	.	.
J8530	N		Cyclophosphamide oral 25 MG		.	.	.	.
J8560	K		Etoposide oral 50 MG	0802	.	21.91	.	4.38
J8565	E	NI	Gefitinib oral		.	.	.	.
J8600	N		Melphalan oral 2 MG		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolomide	1086		6.42		1.28
J8999	B		Oral prescription drug chemo					
J9000	K		Doxorubic hcl 10 MG vl chemo	0847		4.69		0.94
J9001	K		Doxorubicin hcl liposome inj	7046		343.78		68.76
J9010	K		Alemtuzumab injection	9110		541.45		108.29
J9015	K		Aldesleukin/single use vial	0807		680.35		136.07
J9017	K		Arsenic trioxide	9012		34.10		6.82
J9020	K		Asparaginase injection	0814		54.71		10.94
J9031	K		Bcg live intravesical vac	0809		139.90		27.98
J9035	G	NI	Bevacizumab injection	9214		57.13		11.43
J9040	K		Bleomycin sulfate injection	0857		88.32		17.66
J9041	G	NI	Bortezomib injection	9207		27.53		5.51
J9045	K		Carboplatin injection	0811		129.96		25.99
J9050	K		Carmus bischl nitro inj	0812		65.94		13.19
J9055	G	NI	Cetuximab injection	9215		49.87		9.97
J9060	K		Cisplatin 10 MG injection	0813		7.73		1.55
J9062	B		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858		24.84		4.97
J9070	K		Cyclophosphamide 100 MG inj	0815		2.77		0.55
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		2.36		0.47
J9094	B		Cyclophosphamide lyophilized					
J9095	B		Cyclophosphamide lyophilized					
J9096	B		Cyclophosphamide lyophilized					
J9097	B		Cyclophosphamide lyophilized					
J9098	N		Cytarabine liposome					
J9100	K		Cytarabine hcl 100 MG inj	0817		1.55		0.31
J9110	B		Cytarabine hcl 500 MG inj					
J9120	N		Dactinomycin actinomycin d					
J9130	K		Dacarbazine 100 mg inj	0819		6.14		1.23
J9140	B		Dacarbazine 200 MG inj					
J9150	K		Daunorubicin	0820		35.94		7.19
J9151	K		Daunorubicin citrate liposom	0821		56.44		11.29
J9160	K		Denileukin diftitox, 300 mcg	1084		1232.88		246.58
J9165	K		Diethylstilbestrol injection	0822		6.98		1.40
J9170	K		Docetaxel	0823		312.69		62.54
J9178	K		Inj, epirubicin hcl, 2 mg	1167		24.14		4.83
J9181	K		Etoposide 10 MG inj	0824		0.83		0.17
J9182	B		Etoposide 100 MG inj					

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9185	K		Fludarabine phosphate inj	0842	.	311.09	.	62.22
J9190	N		Fluorouracil injection		.	.	.	.
J9200	K		Floxuridine injection	0827	.	66.24	.	13.25
J9201	K		Gemcitabine HCl	0828	.	105.73	.	21.15
J9202	K		Goserelin acetate implant	0810	.	390.09	.	78.02
J9206	K		Irinotecan injection	0830	.	127.33	.	25.47
J9208	K		Ifosfomide injection	0831	.	72.81	.	14.56
J9209	K		Mesna injection	0732	.	17.66	.	3.53
J9211	K		Idarubicin hcl injection	0832	1.1684	66.58	.	13.32
J9212	N		Interferon alfacon-1		.	.	.	.
J9213	K		Interferon alfa-2a inj	0834	.	30.48	.	6.10
J9214	K		Interferon alfa-2b inj	0836	.	13.00	.	2.60
J9215	K		Interferon alfa-n3 inj	0865	.	8.17	.	1.63
J9216	K		Interferon gamma 1-b inj	0838	.	209.22	.	41.84
J9217	K		Leuprolide acetate suspnsion	9217	.	543.72	.	108.74
J9218	K		Leuprolide acetate injeciton	0861	.	14.48	.	2.90
J9219	K		Leuprolide acetate implant	7051	.	4717.72	.	943.54
J9230	N		Mechlorethamine hcl inj		.	.	.	.
J9245	K		Inj melphalan hydrochl 50 MG	0840	.	367.03	.	73.41
J9250	N		Methotrexate sodium inj		.	.	.	.
J9260	B		Methotrexate sodium inj		.	.	.	.
J9263	B		Oxaliplatin		.	.	.	.
J9265	K		Paclitaxel injection	0863	.	79.04	.	15.81
J9266	K		Pegaspargase/singl dose vial	0843	.	1247.08	.	249.42
J9268	K		Pentostatin injection	0844	.	1683.24	.	336.65
J9270	K		Plicamycin (mithramycin) inj	0860	.	93.80	.	18.76
J9280	K		Mitomycin 5 MG inj	0862	.	30.91	.	6.18
J9290	B		Mitomycin 20 MG inj		.	.	.	.
J9291	B		Mitomycin 40 MG inj		.	.	.	.
J9293	K		Mitoxantrone hydrochl / 5 MG	0864	.	313.96	.	62.79
J9300	K		Gemtuzumab ozogamicin	9004	.	2183.81	.	436.76
J9305	G	NI	Pemetrexed injection	9213	.	40.54	.	8.11
J9310	K		Rituximab cancer treatment	0849	.	437.83	.	87.57
J9320	N		Streptozocin injection		.	.	.	.
J9340	K		Thiotepa injection	0851	.	45.31	.	9.06
J9350	K		Topotecan	0852	.	697.76	.	139.55
J9355	K		Trastuzumab	1613	.	50.79	.	10.16
J9357	N		Valrubicin, 200 mg		.	.	.	.
J9360	N		Vinblastine sulfate inj		.	.	.	.
J9370	N		Vincristine sulfate 1 MG inj		.	.	.	.
J9375	B		Vincristine sulfate 2 MG inj		.	.	.	.
J9380	B		Vincristine sulfate 5 MG inj		.	.	.	.
J9390	K		Vinorelbine tartrate/10 mg	0855	.	95.23	.	19.05

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9395	K		Injection, Fulvestrant	9120	.	79.65	.	15.93
J9600	K		Porfimer sodium	0856	.	2274.78	.	454.96
J9999	N		Chemotherapy drug		.	.	.	.
K0001	Y		Standard wheelchair		.	.	.	.
K0002	Y		Stnd hemi (low seat) whlchr		.	.	.	.
K0003	Y		Lightweight wheelchair		.	.	.	.
K0004	Y		High strength ltwt whlchr		.	.	.	.
K0005	Y		Ultralightweight wheelchair		.	.	.	.
K0006	Y		Heavy duty wheelchair		.	.	.	.
K0007	Y		Extra heavy duty wheelchair		.	.	.	.
K0009	Y		Other manual wheelchair/base		.	.	.	.
K0010	Y		Stnd wt frame power whlchr		.	.	.	.
K0011	Y		Stnd wt pwr whlchr w control		.	.	.	.
K0012	Y		Ltwt portbl power whlchr		.	.	.	.
K0014	Y		Other power whlchr base		.	.	.	.
K0015	Y		Detach non-adjus hght armrst		.	.	.	.
K0017	Y		Detach adjust armrest base		.	.	.	.
K0018	Y		Detach adjust armrst upper		.	.	.	.
K0019	Y		Arm pad each		.	.	.	.
K0020	Y		Fixed adjust armrest pair		.	.	.	.
K0023	D		Planr back insrt foam w/strp		.	.	.	.
K0024	D		Plnr back insrt foam w/hrdwr		.	.	.	.
K0037	Y		High mount flip-up footrest		.	.	.	.
K0038	Y		Leg strap each		.	.	.	.
K0039	Y		Leg strap h style each		.	.	.	.
K0040	Y		Adjustable angle footplate		.	.	.	.
K0041	Y		Large size footplate each		.	.	.	.
K0042	Y		Standard size footplate each		.	.	.	.
K0043	Y		Ftrst lower extension tube		.	.	.	.
K0044	Y		Ftrst upper hanger bracket		.	.	.	.
K0045	Y		Footrest complete assembly		.	.	.	.
K0046	Y		Elevat legrst low extension		.	.	.	.
K0047	Y		Elevat legrst up hangr brack		.	.	.	.
K0050	Y		Ratchet assembly		.	.	.	.
K0051	Y		Cam relese assem ftrst/lgrst		.	.	.	.
K0052	Y		Swingaway detach footrest		.	.	.	.
K0053	Y		Elevate footrest articulate		.	.	.	.
K0056	Y		Seat ht <17 or >=21 ltwt wc		.	.	.	.
K0059	D		Plastic coated handrim each		.	.	.	.
K0060	D		Steel handrim each		.	.	.	.
K0061	D		Aluminum handrim each		.	.	.	.
K0064	Y		Zero pressure tube flat free		.	.	.	.
K0065	Y		Spoke protectors		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0066	Y		Solid tire any size each		.	.	.	.
K0067	Y		Pneumatic tire any size each		.	.	.	.
K0068	Y		Pneumatic tire tube each		.	.	.	.
K0069	Y		Rear whl complete solid tire		.	.	.	.
K0070	Y		Rear whl compl pneum tire		.	.	.	.
K0071	Y		Front castr compl pneum tire		.	.	.	.
K0072	Y		Frnt cstr cmpl sem-pneum tir		.	.	.	.
K0073	Y		Caster pin lock each		.	.	.	.
K0074	Y		Pneumatic caster tire each		.	.	.	.
K0075	Y		Semi-pneumatic caster tire		.	.	.	.
K0076	Y		Solid caster tire each		.	.	.	.
K0077	Y		Front caster assem complete		.	.	.	.
K0078	Y		Pneumatic caster tire tube		.	.	.	.
K0081	D		Wheel lock assembly complete		.	.	.	.
K0090	Y		Rear tire power wheelchair		.	.	.	.
K0091	Y		Rear tire tube power whlchr		.	.	.	.
K0092	Y		Rear assem cmplt powr whlchr		.	.	.	.
K0093	Y		Rear zero pressure tire tube		.	.	.	.
K0094	Y		Wheel tire for power base		.	.	.	.
K0095	Y		Wheel tire tube each base		.	.	.	.
K0096	Y		Wheel assem powr base complt		.	.	.	.
K0097	Y		Wheel zero presure tire tube		.	.	.	.
K0098	Y		Drive belt power wheelchair		.	.	.	.
K0099	Y		Pwr wheelchair front caster		.	.	.	.
K0102	Y		Crutch and cane holder		.	.	.	.
K0104	Y		Cylinder tank carrier		.	.	.	.
K0105	Y		Iv hanger		.	.	.	.
K0106	Y		Arm trough each		.	.	.	.
K0108	Y		W/c component-accessory NOS		.	.	.	.
K0114	D		Whlchr back suprt inr frame		.	.	.	.
K0115	D		Back module orthotic system		.	.	.	.
K0116	D		Back & seat modul orthot sys		.	.	.	.
K0195	Y		Elevating whlchair leg rests		.	.	.	.
K0415	B		RX antiemetic drg, oral NOS		.	.	.	.
K0416	B		Rx antiemetic drg,rectal NOS		.	.	.	.
K0452	Y		Wheelchair bearings		.	.	.	.
K0455	Y		Pump uninterrupted infusion		.	.	.	.
K0462	Y		Temporary replacement eqpmnt		.	.	.	.
K0552	Y		Supply/ext inf pump syr type		.	.	.	.
K0600	Y		Functional neuromuscularstim		.	.	.	.
K0601	Y		Repl batt silver oxide 1.5 v		.	.	.	.
K0602	Y		Repl batt silver oxide 3 v		.	.	.	.
K0603	Y		Repl batt alkaline 1.5 v		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0604	Y		Repl batt lithium 3.6 v		.	.	.	.
K0605	Y		Repl batt lithium 4.5 v		.	.	.	.
K0606	Y		AED garment w elec analysis		.	.	.	.
K0607	Y		Repl batt for AED		.	.	.	.
K0608	Y		Repl garment for AED		.	.	.	.
K0609	Y		Repl electrode for AED		.	.	.	.
K0618	A		TLSO 2 piece rigid shell		.	.	.	.
K0619	A		TLSO 3 piece rigid shell		.	.	.	.
K0620	A		Tubular elastic dressing		.	.	.	.
K0627	D		Cervical pneum trac equip		.	.	.	.
K0628	Y	NF	Multi den insert direct form		.	.	.	.
K0629	Y	NF	Multi den insert custom mold		.	.	.	.
K0630	Y	NF	SIO flex pelvisacral prefab		.	.	.	.
K0631	Y	NF	SIO flex pelvisacral custom		.	.	.	.
K0632	Y	NF	SIO panel prefab		.	.	.	.
K0633	Y	NF	SIO panel custom		.	.	.	.
K0634	Y	NF	LO flexibl L1-below L5 pre		.	.	.	.
K0635	Y	NF	LO sag stays/panels pre-fab		.	.	.	.
K0636	Y	NF	LO sagitt rigid panel prefab		.	.	.	.
K0637	Y	NF	LO flex w/o rigid stays pre		.	.	.	.
K0638	Y	NF	LSO flex w/rigid stays cust		.	.	.	.
K0639	Y	NF	LSO post rigid panel pre		.	.	.	.
K0640	Y	NF	LSO sag-coro rigid frame pre		.	.	.	.
K0641	Y	NF	LSO sag-cor rigid frame cust		.	.	.	.
K0642	Y	NF	LSO flexion control prefab		.	.	.	.
K0643	Y	NF	LSO flexion control custom		.	.	.	.
K0644	Y	NF	LSO sagit rigid panel prefab		.	.	.	.
K0645	Y	NF	LSO sagittal rigid panel cus		.	.	.	.
K0646	Y	NF	LSO sag-coronal panel prefab		.	.	.	.
K0647	Y	NF	LSO sag-coronal panel custom		.	.	.	.
K0648	Y	NF	LSO s/c shell/panel prefab		.	.	.	.
K0649	Y	NF	LSO s/c shell/panel custom		.	.	.	.
K0650	D		Gen w/c cushion width < 22"		.	.	.	.
K0651	D		Gen w/c cushion width > 22"		.	.	.	.
K0652	D		Skin pro w/c cus wd < 22"		.	.	.	.
K0653	D		Skin protect w/c cus wd>=22"		.	.	.	.
K0654	D		Position w/c cush width <22"		.	.	.	.
K0655	D		Position w/c cush width >22"		.	.	.	.
K0656	D		Skin pro/pos w/c cus wd <22"		.	.	.	.
K0657	D		Skin pro/pos w/c cus wd>=22"		.	.	.	.
K0658	D		Custom fabricate w/c cushion		.	.	.	.
K0659	D		Powered w/c cushion		.	.	.	.
K0660	D		Gen use back cush width <22"		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0661	D		Gen use back cush width >22"		.	.	.	.
K0662	D		Position back cush wdth <22"		.	.	.	.
K0663	D		Position back cush wdth >22"		.	.	.	.
K0664	D		Pos back post/lat width <22"		.	.	.	.
K0665	D		Pos back post/lat width >22"		.	.	.	.
K0666	D		Custom fab w/c back cushion		.	.	.	.
K0667	D		Mt hardwre man/light pwr w/c		.	.	.	.
K0668	D		Replace cover w/c seat cush		.	.	.	.
K0669	Y	NF	Seat/back cus no sadmerc ver		.	.	.	.
L0100	A		Cranial orthosis/helmet mold		.	.	.	.
L0110	A		Cranial orthosis/helmet nonm		.	.	.	.
L0112	A		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		.	.	.	.
L0430	A	NI	Dewall posture protector					
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		.	.	.	.
L0476	D		TLSO flexion compres jac pre		.	.	.	.
L0478	D		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0486	A		TLSO rigidlined cust fab two		.	.	.	.
L0488	A		TLSO rigid lined pre one pie		.	.	.	.
L0490	A		TLSO rigid plastic pre one		.	.	.	.
L0500	D		Lso flex surgical support		.	.	.	.
L0510	D		Lso flexible custom fabricat		.	.	.	.
L0515	D		Lso flex elas w/ rig post pa		.	.	.	.
L0520	D		Lso a-p-l control with apron		.	.	.	.
L0530	D		Lso ant-pos control w apron		.	.	.	.
L0540	D		Lso lumbar flexion a-p-l		.	.	.	.
L0550	D		Lso a-p-l control molded		.	.	.	.
L0560	D		Lso a-p-l w interface		.	.	.	.
L0561	D		Prefab lso		.	.	.	.
L0565	D		Lso a-p-l control custom		.	.	.	.
L0600	D		Sacroiliac flex surg support		.	.	.	.
L0610	D		Sacroiliac flexible custm fa		.	.	.	.
L0620	D		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		Halo repl liner/interface		.	.	.	.
L0960	E		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1820	A		Ko elas w/ condyle pads & jo		.	.	.	.
L1825	A		Ko elastic knee cap		.	.	.	.
L1830	A		Ko immobilizer canvas longit		.	.	.	.
L1831	A		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					
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		AFO supramalleolar custom		.	.	.	.
L1910	A		Afo sing bar clasp attach sh		.	.	.	.
L1920	A		Afo sing upright w/ adjust s		.	.	.	.
L1930	A		Afo plastic		.	.	.	.
L1932	Y	NI	Afo rig ant tib prefab TCF/=		.	.	.	.
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		AFO spiral prefabricated		.	.	.	.
L1960	A		Afo pos solid ank plastic mo		.	.	.	.
L1970	A		Afo plastic molded w/ankle j		.	.	.	.
L1971	A		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		.	.	.	.
L2005	Y	NI	KAFO sng/dbl mechanical act		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.
L2126	A		Kafo fem fx cast thermoplas		.	.	.	.
L2128	A		Kafo fem fx cast molded to p		.	.	.	.
L2132	A		Kafo femoral fx cast soft		.	.	.	.
L2134	A		Kafo fem fx cast semi-rigid		.	.	.	.
L2136	A		Kafo femoral fx cast rigid		.	.	.	.
L2180	A		Plas shoe insert w ank joint		.	.	.	.
L2182	A		Drop lock knee		.	.	.	.
L2184	A		Limited motion knee joint		.	.	.	.
L2186	A		Adj motion knee jnt lerman t		.	.	.	.
L2188	A		Quadrilateral brim		.	.	.	.
L2190	A		Waist belt		.	.	.	.
L2192	A		Pelvic band & belt thigh fla		.	.	.	.
L2200	A		Limited ankle motion ea jnt		.	.	.	.
L2210	A		Dorsiflexion assist each joi		.	.	.	.
L2220	A		Dorsi & plantar flex ass/res		.	.	.	.
L2230	A		Split flat caliper stirr & p		.	.	.	.
L2232	Y	NI	Rocker bottom, contact AFO		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	D		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	B		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		.	.	.	.
L3480	B		Shoe heel pad & depress for		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	E		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		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		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3964	Y		Seo mobile arm sup att to wc		.	.	.	.
L3965	Y		Arm supp att to wc rancho ty		.	.	.	.
L3966	Y		Mobile arm supports reclinin		.	.	.	.
L3968	Y		Friction dampening arm supp		.	.	.	.
L3969	Y		Monosuspension arm/hand supp		.	.	.	.
L3970	Y		Elevat proximal arm support		.	.	.	.
L3972	Y		Offset/lat rocker arm w/ ela		.	.	.	.
L3974	Y		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		.	.	.	.
L4002	Y	NI	Replace strap, any orthosis		.	.	.	.
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		Ankle control orthosi prefab		.	.	.	.
L4360	A		Pneumati walking boot prefab		.	.	.	.
L4370	A		Pneumatic full leg splint		.	.	.	.
L4380	A		Pneumatic knee splint		.	.	.	.
L4386	A		Non-pneum walk boot prefab		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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 cushion socket		.	.	.	.
L5647	A		Below knee suction socket		.	.	.	.
L5648	A		Above knee cushion socket		.	.	.	.
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		Socket insert w lock mech		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5674	D		Bk suspension sleeve		.	.	.	.
L5675	D		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		Socket insert w/o lock mech		.	.	.	.
L5680	A		Bk thigh lacer non-molded		.	.	.	.
L5681	A		Intl custm cong/latyp insert		.	.	.	.
L5682	A		Bk thigh lacer glut/ischia m		.	.	.	.
L5683	A		Initial custom socket insert		.	.	.	.
L5684	A		Bk fork strap		.	.	.	.
L5685	Y	NI	Below knee sus/seal sleeve		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	D		Knee-shin sys microprocessor		.	.	.	.
L5847	D		Microprocessor cntrl feature		.	.	.	.
L5848	A		Knee-shin sys hydraul stance		.	.	.	.
L5850	A		Endo ak/hip knee extens assi		.	.	.	.
L5855	A		Mech hip extension assist		.	.	.	.
L5856	Y	NI	Elec knee-shin swing/stance		.	.	.	.
L5857	Y	NI	Elec knee-shin swing only		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5984	A		Endoskeletal axial rotation		.	.	.	.
L5985	A		Lwr ext dynamic prosth pylon		.	.	.	.
L5986	A		Multi-axial rotation unit		.	.	.	.
L5987	A		Shank ft w vert load pylon		.	.	.	.
L5988	A		Vertical shock reducing pylo		.	.	.	.
L5989	D		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
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		.	.	.	.
L6694	Y	NI	Elbow socket ins use w/lock		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6695	Y	NI	Elbow socket ins use w/o lck		.	.	.	.
L6696	Y	NI	Cus elbo skt in for con/atyp		.	.	.	.
L6697	Y	NI	Cus elbo skt in not con/atyp		.	.	.	.
L6698	Y	NI	Below/above elbow lock mech		.	.	.	.
L6700	A		Terminal device model #3		.	.	.	.
L6705	A		Terminal device model #5		.	.	.	.
L6710	A		Terminal device model #5x		.	.	.	.
L6715	A		Terminal device model #5xa		.	.	.	.
L6720	A		Terminal device model #6		.	.	.	.
L6725	A		Terminal device model #7		.	.	.	.
L6730	A		Terminal device model #7lo		.	.	.	.
L6735	A		Terminal device model #8		.	.	.	.
L6740	A		Terminal device model #8x		.	.	.	.
L6745	A		Terminal device model #88x		.	.	.	.
L6750	A		Terminal device model #10p		.	.	.	.
L6755	A		Terminal device model #10x		.	.	.	.
L6765	A		Terminal device model #12p		.	.	.	.
L6770	A		Terminal device model #99x		.	.	.	.
L6775	A		Terminal device model#555		.	.	.	.
L6780	A		Terminal device model #ss555		.	.	.	.
L6790	A		Hooks-accu hook or equal		.	.	.	.
L6795	A		Hooks-2 load or equal		.	.	.	.
L6800	A		Hooks-aprl vc or equal		.	.	.	.
L6805	A		Modifier wrist flexion unit		.	.	.	.
L6806	A		Trs grip vc or equal		.	.	.	.
L6807	A		Term device grip1/2 or equal		.	.	.	.
L6808	A		Term device infant or child		.	.	.	.
L6809	A		Trs super sport passive		.	.	.	.
L6810	A		Pincher tool otto bock or eq		.	.	.	.
L6825	A		Hands dorrance vo		.	.	.	.
L6830	A		Hand aprl vc		.	.	.	.
L6835	A		Hand sierra vo		.	.	.	.
L6840	A		Hand becker imperial		.	.	.	.
L6845	A		Hand becker lock grip		.	.	.	.
L6850	A		Term dvc-hand becker plylite		.	.	.	.
L6855	A		Hand robin-aids vo		.	.	.	.
L6860	A		Hand robin-aids vo soft		.	.	.	.
L6865	A		Hand passive hand		.	.	.	.
L6867	A		Hand detroit infant hand		.	.	.	.
L6868	A		Passive inf hand steeper/hos		.	.	.	.
L6870	A		Hand child mitt		.	.	.	.
L6872	A		Hand nyu child hand		.	.	.	.
L6873	A		Hand mech inf steeper or equ		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6875	A		Hand bock vc		.	.	.	.
L6880	A		Hand bock vo		.	.	.	.
L6881	A		Autograsp feature ul term dv		.	.	.	.
L6882	A		Microprocessor control uplmb		.	.	.	.
L6890	A		Prefab glove for term device		.	.	.	.
L6895	A		Custom glove for term device		.	.	.	.
L6900	A		Hand restorat thumb/1 finger		.	.	.	.
L6905	A		Hand restoration multiple fi		.	.	.	.
L6910	A		Hand restoration no fingers		.	.	.	.
L6915	A		Hand restoration replacmnt g		.	.	.	.
L6920	A		Wrist disarticul switch ctrl		.	.	.	.
L6925	A		Wrist disart myoelectronic c		.	.	.	.
L6930	A		Below elbow switch control		.	.	.	.
L6935	A		Below elbow myoelectronic ct		.	.	.	.
L6940	A		Elbow disarticulation switch		.	.	.	.
L6945	A		Elbow disart myoelectronic c		.	.	.	.
L6950	A		Above elbow switch control		.	.	.	.
L6955	A		Above elbow myoelectronic ct		.	.	.	.
L6960	A		Shldr disartic switch contro		.	.	.	.
L6965	A		Shldr disartic myoelectronic		.	.	.	.
L6970	A		Interscapular-thor switch ct		.	.	.	.
L6975	A		Interscap-thor myoelectronic		.	.	.	.
L7010	A		Hand otto back steeper/eq sw		.	.	.	.
L7015	A		Hand sys teknik village swit		.	.	.	.
L7020	A		Electronic greifer switch ct		.	.	.	.
L7025	A		Electron hand myoelectronic		.	.	.	.
L7030	A		Hand sys teknik vill myoelec		.	.	.	.
L7035	A		Electron greifer myoelectro		.	.	.	.
L7040	A		Prehensile actuator hosmer s		.	.	.	.
L7045	A		Electron hook child michigan		.	.	.	.
L7170	A		Electronic elbow hosmer swit		.	.	.	.
L7180	A		Electronic elbow sequential		.	.	.	.
L7181	Y	NI	Electronic elbo simultaneous		.	.	.	.
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8230	E		Gc stocking garter belt		.	.	.	.
L8239	E		G compression stocking NOS		.	.	.	.
L8300	A		Truss single w/ standard pad		.	.	.	.
L8310	A		Truss double w/ standard pad		.	.	.	.
L8320	A		Truss addition to std pad wa		.	.	.	.
L8330	A		Truss add to std pad scrotal		.	.	.	.
L8400	A		Sheath below knee		.	.	.	.
L8410	A		Sheath above knee		.	.	.	.
L8415	A		Sheath upper limb		.	.	.	.
L8417	A		Pros sheath/sock w gel cushn		.	.	.	.
L8420	A		Prosthetic sock multi ply BK		.	.	.	.
L8430	A		Prosthetic sock multi ply AK		.	.	.	.
L8435	A		Pros sock multi ply upper lm		.	.	.	.
L8440	A		Shrinker below knee		.	.	.	.
L8460	A		Shrinker above knee		.	.	.	.
L8465	A		Shrinker upper limb		.	.	.	.
L8470	A		Pros sock single ply BK		.	.	.	.
L8480	A		Pros sock single ply AK		.	.	.	.
L8485	A		Pros sock single ply upper l		.	.	.	.
L8490	D		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		Indwelling trach insert		.	.	.	.
L8512	A		Gel cap for trach voice pros		.	.	.	.
L8513	A		Trach pros cleaning device		.	.	.	.
L8514	A		Repl trach puncture dilator		.	.	.	.
L8515	Y	NI	Gel cap app device for trach		.	.	.	.
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		.	.	.	.
L8615	Y	NI	Coch implant headset replace		.	.	.	.
L8616	Y	NI	Coch implant microphone repl		.	.	.	.
L8617	Y	NI	Coch implant trans coil repl		.	.	.	.
L8618	Y	NI	Coch implant tran cable repl		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8619	A		Replace cochlear processor		.	.	.	.
L8620	Y	NI	Repl lithium ion battery		.	.	.	.
L8621	Y	NI	Repl zinc air battery		.	.	.	.
L8622	Y	NI	Repl alkaline battery		.	.	.	.
L8630	N		Metacarpophalangeal implant		.	.	.	.
L8631	A		MCP joint repl 2 pc or more		.	.	.	.
L8641	N		Metatarsal joint implant		.	.	.	.
L8642	N		Hallux implant		.	.	.	.
L8658	N		Interphalangeal joint spacer		.	.	.	.
L8659	A		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	1.0880	62.00	.	12.40
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	1.9805	112.85	.	22.57
P9011	K		Blood split unit	0967	1.4533	82.81	.	16.56
P9012	K		Cryoprecipitate each unit	0952	0.8467	48.25	.	9.65
P9016	K		RBC leukocytes reduced	0954	2.9079	165.70	.	33.14
P9017	K		Plasma 1 donor frz w/in 8 hr	9508	1.1117	63.35	.	12.67
P9019	K		Platelets, each unit	0957	0.8453	48.17	.	9.63
P9020	K		Plaelet rich plasma unit	0958	2.6561	151.35	.	30.27
P9021	K		Red blood cells unit	0959	1.9881	113.29	.	22.66
P9022	K		Washed red blood cells unit	0960	3.4014	193.82	.	38.76
P9023	K		Frozen plasma, pooled, sd	0949	1.3689	78.00	.	15.60
P9031	K		Platelets leukocytes reduced	1013	1.5161	86.39	.	17.28
P9032	K		Platelets, irradiated	9500	1.5559	88.66	.	17.73
P9033	K		Platelets leukoreduced irrad	0968	2.7068	154.24	.	30.85
P9034	K		Platelets, pheresis	9507	7.6823	437.76	.	87.55
P9035	K		Platelet pheres leukoreduced	9501	8.3026	473.11	.	94.62
P9036	K		Platelet pheresis irradiated	9502	5.8578	333.80	.	66.76

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9037	K		Plate pheres leukoredu irrad	1019	10.3081	587.39	.	117.48
P9038	K		RBC irradiated	9505	2.0849	118.80	.	23.76
P9039	K		RBC deglycerolized	9504	5.2108	296.93	.	59.39
P9040	K		RBC leukoreduced irradiated	0969	3.6080	205.59	.	41.12
P9041	K		Albumin (human),5%, 50ml	0961	0.3303	18.82	.	3.76
P9043	K		Plasma protein fract,5%,50ml	0956	1.1719	66.78	.	13.36
P9044	K		Cryoprecipitatereducedplasma	1009	1.0793	61.50	.	12.30
P9045	K		Albumin (human), 5%, 250 ml	0963	1.0624	60.54	.	12.11
P9046	K		Albumin (human), 25%, 20 ml	0964	0.2284	13.01	.	2.60
P9047	K		Albumin (human), 25%, 50ml	0965	0.9181	52.32	.	10.46
P9048	K		Plasmaprotein fract,5%,250ml	0966	5.6751	323.38	.	64.68
P9050	K		Granulocytes, pheresis unit	9506	17.8797	1018.84	.	203.77
P9051	K		Blood, l/r, cmv-neg	1010	2.9433	167.72	.	33.54
P9052	K		Platelets, hla-m, l/r, unit	1011	9.9709	568.17	.	113.63
P9053	K		Plt, pher, l/r cmv-neg, irr	1020	9.7863	557.65	.	111.53
P9054	K		Blood, l/r, froz/degly/wash	1016	4.7085	268.30	.	53.66
P9055	K		Plt, aph/pher, l/r, cmv-neg	1017	8.3586	476.30	.	95.26
P9056	K		Blood, l/r, irradiated	1018	3.2064	182.71	.	36.54
P9057	K		RBC, frz/deg/wsh, l/r, irrad	1021	5.5861	318.31	.	63.66
P9058	K		RBC, l/r, cmv-neg, irrad	1022	4.7977	273.39	.	54.68
P9059	K		Plasma, frz between 8-24hour	0955	1.3026	74.23	.	14.85
P9060	K		Fr frz plasma donor retested	9503	1.3397	76.34	.	15.27
P9603	A		One-way allow prorated miles		.	.	.	.
P9604	A		One-way allow prorated trip		.	.	.	.
P9612	N		Catheterize for urine spec		.	.	.	.
P9615	N		Urine specimen collect mult		.	.	.	.
Q0035	X		Cardiokymography	0100	2.4975	142.32	41.44	28.46
Q0081	B		Infusion ther other than che		.	.	.	.
Q0083	B		Chemo by other than infusion		.	.	.	.
Q0084	B		Chemotherapy by infusion		.	.	.	.
Q0085	B		Chemo by both infusion and o		.	.	.	.
Q0091	T		Obtaining screen pap smear	0191	0.1831	10.43	2.93	2.09
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	.	11.09	.	2.22
Q0137	K		Darbepoetin alfa, non-esrd	0734	.	3.66	.	0.73
Q0144	E		Azithromycin dihydrate, oral		.	.	.	.
Q0163	N		Diphenhydramine HCl 50mg		.	.	.	.
Q0164	N		Prochlorperazine maleate 5mg		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0165	B		Prochlorperazine maleate10mg					
Q0166	K		Granisetron HCl 1 mg oral	0765		39.04		7.81
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	K		Ondansetron HCl 8mg oral	0769		26.12		5.22
Q0180	K		Dolasetron mesylate oral	0763		63.28		12.66
Q0181	E		Unspecified oral anti-emetic					
Q0182	D		Nonmetabolic act d/e tissue					
Q0183	D		Nonmetabolic active tissue					
Q0187	K		Factor viia recombinant	1409		1410.34		282.07
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	K		Elliotts b solution per ml	7022		1.50		0.30
Q2003	K		Aprotinin, 10,000 kiu	7019		12.51		2.50
Q2004	N		Bladder calculi irrig sol					
Q2005	K		Corticorelin ovine triflutat	7024		353.70		70.74
Q2006	K		Digoxin immune fab (ovine)	7025		332.00		66.40
Q2007	K		Ethanolamine oleate 100 mg	7026		63.29		12.66
Q2008	K		Fomepizole, 15 mg	7027		10.04		2.01
Q2009	K		Fosphenytoin, 50 mg	7028		5.31		1.06
Q2011	K		Hemin, per 1 mg	7030		6.47		1.29
Q2012	N		Pegademase bovine, 25 iu					
Q2013	K		Pentastarch 10% solution	7040		131.99		26.40
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035		224.94		44.99
Q2018	K		Urofollitropin, 75 iu	7037		56.59		11.32
Q2019	K		Basiliximab	1615		1461.34		292.27
Q2020	E		Histrelin acetate					
Q2021	K		Lepirudin	9057		130.30		26.06

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q2022	K		VonWillebrandFactrCmplxperIU	1618	.	0.83	.	0.17
Q3000	K		Rubidium RB-82	9025	.	153.39	.	30.68
Q3001	N		Brachytherapy Radioelements		.	.	.	.
Q3002	K		Gallium ga 67	1619	.	27.10	.	5.42
Q3003	K		Technetium tc99m bicisate	1620	.	370.60	.	74.12
Q3004	N		Xenon xe 133		.	.	.	.
Q3005	K		Technetium tc99m mertiatide	1622	.	31.13	.	6.23
Q3006	N		Technetium tc99m glucepatate		.	.	.	.
Q3007	K		Sodium phosphate p32	1624	.	94.98	.	19.00
Q3008	K		Indium 111-in pentetreotide	1625	.	1079.00	.	215.80
Q3009	N		Technetium tc99m oxidronate		.	.	.	.
Q3010	N		Technetium tc99mlabeledrbcs		.	.	.	.
Q3011	K		Chromic phosphate p32	1628	2.5841	147.25	.	29.45
Q3012	K		Cyanocobalamin cobalt co57	1089	.	85.49	.	17.10
Q3014	A		Telehealth facility fee		.	.	.	.
Q3019	A		ALS emer trans no ALS serv		.	.	.	.
Q3020	A		ALS nonemer trans no ALS ser		.	.	.	.
Q3025	K		IM inj interferon beta 1-a	9022	.	74.44	.	14.89
Q3026	E		Subc inj interferon beta-1a		.	.	.	.
Q3031	N		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
Q4054	A		Darbepoetin alfa, esrd use		.	.	.	.
Q4055	A		Epoetin alfa, esrd use		.	.	.	.
Q4075	K		Acyclovir, 5 mg	1062	.	0.03	.	0.01
Q4076	K		Dopamine hcl, 40 mg	1070	.	0.81	.	0.16
Q4077	K		Treprostinil, 1 mg	1082	.	54.02	.	10.80
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
V2118	A		Lens aniseikonic single		.	.	.	.
V2121	A		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		.	.	.	.
V2218	A		Lens aniseikonic bifocal		.	.	.	.
V2219	A		Lens bifocal seg width over		.	.	.	.
V2220	A		Lens bifocal add over 3.25d		.	.	.	.
V2221	A		Lenticular lens, bifocal		.	.	.	.
V2299	A		Lens bifocal speciality		.	.	.	.
V2300	A		Lens sphere trifocal 4.00d		.	.	.	.
V2301	A		Lens sphere trifocal 4.12-7.		.	.	.	.
V2302	A		Lens sphere trifocal 7.12-20		.	.	.	.
V2303	A		Lens sphcy trifocal 4.0/.12-		.	.	.	.
V2304	A		Lens sphcy trifocal 4.0/2.25		.	.	.	.
V2305	A		Lens sphcy trifocal 4.0/4.25		.	.	.	.
V2306	A		Lens sphcyl trifocal 4.00/>6		.	.	.	.
V2307	A		Lens sphcy trifocal 4.25-7/.		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
V2318	A		Lens aniseikonic trifocal		.	.	.	.
V2319	A		Lens trifocal seg width > 28		.	.	.	.
V2320	A		Lens trifocal add over 3.25d		.	.	.	.
V2321	A		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2632	N		Post chmbr intraocular lens		.	.	.	.
V2700	A		Balance lens		.	.	.	.
V2702	E	NI	Deluxe lens feature		.	.	.	.
V2710	A		Glass/plastic slab off prism		.	.	.	.
V2715	A		Prism lens/es		.	.	.	.
V2718	A		Fresnell prism press-on lens		.	.	.	.
V2730	A		Special base curve		.	.	.	.
V2744	A		Tint photochromatic lens/es		.	.	.	.
V2745	A		Tint, any color/solid/grad		.	.	.	.
V2750	A		Anti-reflective coating		.	.	.	.
V2755	A		UV lens/es		.	.	.	.
V2756	E		Eye glass case		.	.	.	.
V2760	A		Scratch resistant coating		.	.	.	.
V2761	B		Mirror coating		.	.	.	.
V2762	A		Polarization, any lens		.	.	.	.
V2770	A		Occluder lens/es		.	.	.	.
V2780	A		Oversize lens/es		.	.	.	.
V2781	B		Progressive lens per lens		.	.	.	.
V2782	A		Lens, 1.54-1.65 p/1.60-1.79g		.	.	.	.
V2783	A		Lens, >= 1.66 p/>=1.80 g		.	.	.	.
V2784	A		Lens polycarb or equal		.	.	.	.
V2785	F		Corneal tissue processing		.	.	.	.
V2786	A		Occupational multifocal lens		.	.	.	.
V2790	N		Amniotic membrane		.	.	.	.
V2797	A		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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		.	.	.	.
V5364	E		Dysphagia screening		.	.	.	.

CPT codes and descriptions only are copyrighted American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Copyright American Dental Association. All rights reserved.

Addendum D1.--Payment Status Indicators for the Hospital Outpatient Prospective Payment System

Indicator	Item/code/service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, 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 • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by Intermediaries under a fee schedule or 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	Discontinued Codes	Not paid under OPPS.
E	Items, Codes, and Services: • That are not covered by Medicare based on Statutory Exclusion. • That are not covered by Medicare for	Not paid under OPPS.

Indicator	Item/code/service	OPPS Payment Status
	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.	
F	Corneal Tissue Acquisition; Certain CRNA Services	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through Drugs, Biologicals, and Radiopharmaceutical Agents	Paid under OPPS; Separate APC payment includes Pass-Through amount.
H	(1) Pass-through Device Categories; (2) Brachytherapy Sources	Paid under OPPS; (1) Separate cost-based Pass-Through payment; (2) Separate cost-based Non-Pass-Through payment.
K	Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals Agents	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; 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 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 Services	Paid under OPPS; Separate APC payment.

Addendum D2.--Comment Indicators

Comment Indicator	Descriptor
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, 7/12/2004 interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

Addendum E.--CPT Codes That Are Paid Only As Inpatient Procedures

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
0052T	C	Replace component heart syst
0053T	C	Replace component heart syst
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00546	C	Anesth, lung,chest wall surg
00560	C	Anesth, open heart surgery
00561	C	Anesth, heart surg < age 1
00562	C	Anesth, open heart surgery
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
0075T	C	Perq stent/chest vert art
0076T	C	S&i stent/chest vert art
0077T	C	Cereb therm perfusion probe
0078T	C	Endovasc aort repr w/device
0079T	C	Endovasc visc extnsn repr
00792	C	Anesth, hemorr/excise liver
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant
0080T	C	Endovasc aort repr rad s&i
00802	C	Anesth, fat layer removal
0081T	C	Endovasc visc extnsn s&i
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
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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
11004	C	Debride genitalia & perineum
11005	C	Debride abdom wall
11006	C	Debride genit/per/abdom wall
11008	C	Remove mesh from abd wall
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	Escharotomy; add'l incision
19200	C	Removal of breast

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw 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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck 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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee 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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant with bypass
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32855	C	Prepare donor lung, single
32856	C	Prepare donor lung, double
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
33933	C	Prepare donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33944	C	Prepare 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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
34803	C	Endovas aaa repr w/3-p part
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, 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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35600	C	Harvest artery for cabg

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft
35646	C	Artery bypass graft
35647	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
37215	C	Transcath stent, cca w/eps
37216	C	Transcath stent, cca w/o eps
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
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
43644	C	Lap gastric bypass/roux-en-y
43645	C	Lap gastr bypass incl smll i
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
43845	C	Gastroplasty duodenal switch

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
44137	C	Remove intestinal allograft
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon/ileostomy
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
44715	C	Prepare donor intestine
44720	C	Prep donor intestine/venous
44721	C	Prep donor intestine/artery
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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal reservior
45540	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
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
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47140	C	Partial removal, donor liver
47141	C	Partial removal, donor liver
47142	C	Partial removal, donor liver
47143	C	Prep donor liver, whole
47144	C	Prep donor liver, 3-segment

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
47145	C	Prep donor liver, lobe split
47146	C	Prep donor liver/venous
47147	C	Prep donor liver/arterial
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47380	C	Open ablate liver tumor rf
47381	C	Open ablate liver tumor cryo
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, 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
48551	C	Prep donor pancreas
48552	C	Prep donor pancreas/venous
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
49040	C	Drain, open, abdom abscess
49060	C	Drain, open, retrop abscess
49062	C	Drain to peritoneal cavity
49201	C	Remove abdom lesion, complex
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50323	C	Prep cadaver renal allograft
50325	C	Prep donor renal graft
50327	C	Prep renal graft/venous
50328	C	Prep renal graft/arterial
50329	C	Prep renal graft/ureteral

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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 w/ ureter
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
57283	C	Colpopexy, intraperitoneal
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy
57308	C	Fistula repair, transperine
57311	C	Repair urethrovaginal lesion
57335	C	Repair vagina

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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
58956	C	Bso, omentectomy w/tah
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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	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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61697	C	Brain aneurysm repr, complx
61698	C	Brain aneurysm repr, complx
61700	C	Brain aneurysm repr, simple
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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, add'l cervical
63044	C	Laminotomy, add'l lumbar
63050	C	Cervical laminoplasty
63051	C	C-laminoplasty w/graft/plate
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	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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
63295	C	Repair of laminectomy defect
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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
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

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
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, Ibw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital
G0341	C	Percutaneous islet cell trans
G0342	C	Laparoscopy Islet cell Trans
G0343	C	Laparotomy Islet cell tranp

[FR Doc. 04–24759 Filed 11–2–04; 4:45 am]
BILLING CODE 4120–01–P